Experiences of oral health care among immigrants from Iran and Iraq living in Sweden

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Abstract
The aims of this study were to capture a group of immigrants' perceptions of dental care in their native countries and in Sweden; and to describe their views of the way good oral health can be achieved. Twelve informants from Iran and Iraq living in Sweden were interviewed and a phenomenographic approach was used to collect and analyse the data. Three comprehensive categories and four subcategories were identified: “Different traditions”, “Dental pain and fear” and “Trust in and distrust of dental care”. Various traditions of dental self-care and the informants’ ambivalent attitudes towards regular dental check-ups were revealed. Experiences of dental pain and fear of dental treatment appeared to affect dental care behaviour later in life. The informants expressed ambivalent attitudes towards the dentists in their new home country, relating to limitations in communication and language barriers. The importance of using interpreters at the dental clinic was emphasized. The study shows the need for improved communication between dental professionals and the immigrant patient. Communication can be enhanced by an empathetic understanding of the patient’s various experiences of dental care and dental pain.

Key words: Communication, phenomenography, immigrant, oral health, pain, dental check-ups

Introduction
Over the past few decades, many European countries have experienced an increase in immigration. In 2003, more than a million Swedish people (12%) had been born abroad and a large percentage of immigrants originated from non-European countries (SCB, 2003).

In Sweden, inequality in health issues is a matter of great concern to health authorities and providers. Many of the people born abroad are regarded as a vulnerable, high-priority group (SOU, 2000), since it has been recognised that they are at greater risk of developing long-term illness than indigenous Swedes (Hjern, Haglund, Persson & Rosén, 2001). The government and health authorities regard this as a public health problem (SOU, 2000). Socio-economic conditions for many immigrants have been shown to be worse than those conditions for native Swedes. Segregated living, unemployment and experience of discrimination are facts of life for many of these people; factors that are assumed to be determinants of ill-health (Wiking, Johansson & Sundquist, 2004; Sundquist & Johansson, 2002).

From the 1970s, there has been a vast improvement in the oral health of the Swedish population. Today, less than 20% of Swedes aged 64 or more are edentulous, compared with 50% 30 years ago. Of three-year-old children, 94% are caries free and, by the age of 19, Swedish adolescents have an average of 3.5 decayed or filled teeth (DFT) (SOS, 2004). However, several Swedish studies indicate that the oral health of people coming from non-European countries is worse than that of the indigenous Swedish population, and that their visits to dental health clinics are more sporadic and more frequently involve emergency treatment (Unell, Söderfeldt, Halling & Birkhed, 1999; Hjern & Grindefjord, 2000; Collin Bagewitz, Söderfeldt, Palmqvist & Nilner, 2000). Poorer oral health on arrival in Sweden and less knowledge of the prevention of
oral diseases have been suggested as contributory factors to poorer oral health (Hjern & Grindefjord, 2000; Collin Bagewitz et al., 2000).

Some Scandinavian studies (Ekman & Persson, 1990; Selikowitz, 1994; Zimmerman, 1993) have shown that groups of immigrants often lack knowledge of self-care and the aetiological factors associated with oral diseases. Other studies show that the children and adolescents in different immigrant groups have more caries and gingivitis than their Swedish peers, and that they go less regularly for dental check-ups (Wendt, Hallonsten & Koch, 1999; Dahllöf, Björkman, Lindvall, Axel & Modéer, 1991).

In Sweden, as in other western countries, oral health care has been organised from the perspective of preventing dental diseases and promoting oral health. As a rule, dental visits are initiated by the dentists in a recall system (Hugoson et al., 2005). Participation is, of course, voluntary. In order to encourage immigrants to take part in this oral health care system, it is important to understand their experiences and perceptions of dental care in their native countries and their new country. As far as we know, no such study covering this theme has been published.

The aims of the present study were to capture a group of immigrants’ perceptions of dental care in their native countries and in Sweden, and to describe their views of the way good oral health can be achieved.

Method

The phenomenon under study was the informants’ various experiences and perceptions of dental care in their native country and in Sweden. In order to obtain as many qualitatively different perceptions of the phenomenon as possible, a qualitative approach was found to be suitable. In collecting and analysing data, the phenomenographic approach was used. Phenomenography describes how various aspects of reality mean different things to different people. Phenomenographers often use interviews, which are open and semi-structured, recorded on tape and transcribed verbatim (Marton, 1986; Lepp & Ringsberg, 2002).

Informants

A heterogeneous group of 12 persons, seven women and five men, born in Iran or Iraq, living in a medium-sized town in Sweden, were purposefully and strategically selected in order to represent as many aspects of experience of dental care as possible; i.e. those chosen had different educational backgrounds, genders, native environments, family backgrounds and reasons for migration. The median age of the informants was 40 years (range: 29–55 years) and the median length of stay in Sweden was 10 years (range: 3–22 years). All the participants were adults on arrival in Sweden. For further details, see Table 1. Letters were sent to representatives of local immigrant organisations, who helped us to mediate contact with members. All those contacted accepted to participate. Informed consent was obtained by sending information letters to all informants before the interviews. Those were signed in connection with the interviews. For the convenience of the informants, most interviews were conducted in their homes except one that was performed at the interviewer’s office. The study was approved by the ethics committee at Karlstad University.

Data collection

The data were collected in open semi-structured interviews. They were informal and conversational in style, lasting approximately 60 min. Guiding questions of a comprehensive character were used, for example:

a. “Describe your experience of dental care in childhood.”

b. “Tell me about the first time you had toothache.”

c. “Please tell me about your dental visits in Sweden.”

d. “What do you think is the best way to achieve good oral health.”

These topics were covered in all interviews, but the informants were also free to introduce any issues of concern. The first author (GK) carried out all the interviews and the language spoken was Swedish. The informants communicated fluently in Swedish,
except for two people, where an interpreter was used.

**Analysis**

The interviews were tape-recorded and transcribed verbatim. The data were thereafter analysed according to the principles of phenomenography (Lepp & Ringsberg, 2002). This process has four phases, as follows:

1. Read to become familiar with the data and obtain an overall impression;
2. Note qualitative meaning, similarities and differences in the statements;
3. Determine categories of description and
4. Examine the underlying structure of the system of categorization (Marton, 1981; Wenestam, 2000; Lepp & Ringsberg, 2002).

The analysis resulted in three comprehensive categories with four sub-categories, thus forming an outcome space, which describes the subjects’ qualitatively different ways of experiencing dental care. The summaries of the informants’ perceptions are illustrated with quotations from the interviews.

The interviews were also analysed for gender differences and differences between countries. As in the case of qualitative research in general, the credibility of the analysis of the results depends on how well the authors succeed in describing the theoretical framework and the research procedures. It also depends on how the categories correspond to the content of the interviews and are not simply a construction of the researchers (Lincoln & Guba, 1985; Kvale 1997). In this study, the first author (GK), a dentist experienced in treating patients from other countries, had the main responsibility for collecting and analysing data. The second author (KCR), a researcher of public health and experienced in working within the field of international public health, was continuously involved in the discussion of the evolving findings. Inter-rater reliability (Lepp & Ringsberg, 2002) was tested by presenting the categories and subcategories separately to a co-examiner who assigned the sentences and quotations to the appropriate category. Agreement was almost unanimous between the persons who analysed the data and the co-examiner. The quotes listed in this article are intended to facilitate the reader’s evaluation of the credibility of the analysis. The letter written after each quotation represents each informant; A–G represent females and H–L males; the number 1 represents coming from Iran, 2 coming from Iraq.

**Results**

The analysis of the data resulted in an outcome space consisting of three comprehensive categories with four sub-categories: “Different traditions”, “Dental pain and fear” and “Trust in and distrust of dental care”. The categories comprised experiences in the native country as well as in Sweden. All informants had experiences within all categories. An underlying structure was the informants’ ambivalence in attitudes and feelings. The ambivalence was expressed as, on the one hand, knowledge about the positive effects of the regular check-ups initiated by the dental clinic and on the other hand, difficulties in changing patterns of behaviour. Figure 1 shows how the informants’ experiences and influencing factors are linked.

**Different traditions**

The first category includes two subcategories. The first, “Dental self-care”, describes the informants’ experiences of dental self-care in the home, while the second, “Dental care systems”, describes their ambivalent attitudes towards routine dental check-ups.

**Dental self-care**

All the informants stressed that teeth are important and emphasised that it is important to keep them clean. “You need your teeth all your life. Yes, I think one has to take care of one’s teeth” (A1). Some of the older informants said that, as children, they had cleaned their teeth with a finger and salt, while the younger ones said that they always had used a

![Ambivalence Diagram](image-url)
toothbrush. Those coming from urban areas had access to a toothbrush from early childhood as opposed to those coming from rural areas that did not, regardless of the country from which they came. In the analysis of the interviews, it was found that the informants perceived that hygiene habits were also related to educational level. “People who go to school, they brush their teeth like I do” (A1). Today, all the informants used a toothbrush. None remembered ever receiving hygiene instructions from a dentist in their native country. They were just told to brush their teeth, but not told how to brush them.

Dental care systems

None of the informants had visited the dentist for a regular check-up aiming at oral health promotion in their native country. They all had their first experience of dental care because of dental pain. “When I had bad toothache, my mother took me to the dentist” (J2). Some of those brought up in larger cities and in good economic circumstances occasionally had dental examinations initiated by their parents when they thought the child had cavities. Ambivalent feelings were expressed about the regular check-up system as used in Sweden. On the one hand, the informants realized the advantage of detecting caries and having treatment to prevent toothache. On the other hand, they wanted to decide for themselves. “No, I don’t want them to send me an appointment . . . you’re supposed to think for yourself” (C1). A few of the informants, all with a university education, had adopted the regular dental check-up system. “. . . now we go once a year. Sometimes, when it’s only a hygiene control, we see the dental hygienist” (I1). One woman put it like this:

A good job, good knowledge of Swedish and being open to a new culture affects whether you re-think (D1). The informants were, however, very positive about regular examinations for their children. It has been emergencies, otherwise I don’t go to the dentist . . . the children, on the other hand, have to go. Even if they don’t have problems, they have to go for examinations when they get their appointments (B1).

Some said that Swedish dental care is too expensive. They expected to pay for dental treatment but not for advice and information. “He only looked for five minutes and then he only talked and . . . SEK 500!” (A1). On the other hand, those who did go regularly for dental check-ups had a different opinion:

. . . there is so much else in life that people pay for and don’t need . . . It’s a matter of priority what you think is important. Losing a tooth . . . cannot be compensated for by money (L1).

Only the few who went for regular dental check-ups had been given information about preventive measures. Most of the informants stated that brushing your teeth is sufficient to maintain or attain good oral health, but that there is no need for regular check-ups. I already do what I can . . . I don’t visit the dentist just to check my teeth (B1).

Dental pain and fear

All the informants had experience of toothache, often at an early age, and with differing intensity. They described different methods that were used in their native countries to reduce the pain. One experience was described in the following way:

They had a twig, which they put in the fire until it glowed, and they put it red hot on my aching tooth. I was held by two to three people until they had finished (K2).

The informants had the experience from their native countries that, when aching teeth had to be extracted, this was often done by somebody without professional training.

It was awful, yes, and I was terrified. My mates went out and found a dentist there and he took out a pair of forceps and my mates covered my eyes and, yes, he took my tooth out (H1).

On those occasions, no anaesthetics were used. “No, no anaesthetics, it was at the weekend, so, unfortunately, I couldn’t go to a real dentist” (C2). A woman who had grown up in a refugee camp said: “I didn’t have a doctor if I had stomach pain, so how could I . . . I paid little attention to my toothache” (F2). Moreover, those who had access to professional dental care had painful experiences. However, pain was experienced in Swedish dental care as well. “It hurt very much in spite of the injection. He tried to take away the infection in my tooth, but it hurt too much” (A1).

All the informants thus described experiences of emergency treatment and dental fear and they stated that this influenced their dental care behaviour later in life. They described how they avoided contact with the dentist for fear of painful dental treatment. “When I eat, I always think that I must call the dentist, but I don’t” (H1). One of those who did not go for regular examinations said that fear was the
main reason. “The older I get, the more scared I am” (B1). One woman said that she tried to endure treatment in spite of her fears. “I thought I would try to trust them” (G1).

Trust in and distrust of dental care

This third category is made up of two subcategories. The first, “The dentist as an authority”, deals with the informants’ ambivalent attitudes towards the dentists in their new homeland. The second subcategory, “Language barriers”, concentrates on the importance of using an interpreter.

The dentist as an authority

The informants said that, in their native country, there were no discussions between the dentist and the patient about how the treatment should be performed. Always the dentist knew best. The informants described how they had to obey parents and other adults without complaining when visiting the dentist as children in their native countries.

The children had to adapt to parents or other adults. It was impolite to say that it hurt. If you said you were afraid, the dentist would say that you should be ashamed of yourself (G1).

Contrary to this, the informants had observed that in Sweden the dentist asks for the patient’s opinion. Some informants found this strange; they thought that the dentist should decide on the appropriate treatment without consultation with the patient. Others emphasized the importance of communication, “…to listen and hear about your problem. That’s the most important” (L1).

However, it was also stated that sometimes expectations were not met by Swedish dental care. Some people were disappointed when they were not given antibiotics and painkillers at the dental clinic, as they normally were in their native country. One informant explained: “A good dentist prescribes many medicines and repairs many teeth rapidly and effectively” (D1). Sometimes it happened that the dentist in Sweden could not find the source of the pain. “He said everything was OK, but when I came home it hurt badly… and they said that it would go away, but it didn’t” (H1).

Although the informants described negative experiences of dental care in their native country, such as painful treatment, they also stated that dentists in their native counties were very skilled, as the treatment given was of high quality, while some fillings performed by Swedish dentists had fallen out. “… the teeth I had made in Iran last much better, I must say” (B1).

Language limitations

The informants said that communication at the dental clinic in Sweden was hampered by language limitations before they understood Swedish and some informants described misunderstandings about their treatment.

They explained that they often did not have access to interpreters at the dental clinic on every visit before they understood Swedish.

Many people who visit the dentist don’t have an interpreter. They don’t understand what caries is. Nobody understands you. I myself was asked to look at the X-rays and I didn’t understand a thing. And I didn’t dare to ask how to brush my teeth (F2).

Most informants had experienced poor communication with dentists in Sweden. This happened especially on emergency visits, when a filling had fallen out or a tooth was aching. “What I hate about the dentist is that they don’t talk to you. Just open your mouth and fill the cavities and then nothing more” (F2).

Gender and cultural differences

There were no apparent differences between female and male informants or the county from which they originated in their various experiences of dental care in their native country and in Sweden. Nor were there any clear differences in attitude towards the Swedish oral health care system.

Discussion

This study shows that the twelve informants from Iran and Iraq described various experiences and perceptions of oral health and dental treatment, in their native country and in their new country, which might influence their present attitudes towards the oral health care system. They expressed ambivalent feelings; on the one hand, participating in the system is beneficial—on the other hand, they want to decide when dental treatment is needed. Different traditions, lack of trust and language problems appear to prevent an understanding of and participation in an oral health care system based on prevention and oral health promotion.

As an immigrant, you bring your culture and traditions with you when you move to a new country, and this is an important factor for dental profes-
sionals to consider. Most of the informants explained that they are still deeply rooted in the traditions and habits of their native country and that they have ambivalent feelings towards the oral health care system in Sweden. According to the informants, brushing their teeth and visiting the dentist when needed, as they had been used to do in their native country, was enough to maintain good oral health and they added that it was the patient’s place to decide when dental care should be sought.

The informants said that they were not accustomed to the dentists in their native countries consulting with their patients and they expressed ambivalent feelings towards Swedish dentists’ way of discussing dental treatment with the patient. The informants added that, by doing this, the dentist showed hesitation instead of being the expert and, therefore, gave the impression of not being reliable. By stating this, they showed that they had not understood the ideas behind prevention and oral health promotion. The creation of a dialogue is essential in the “Self-Empowerment Model” of health promotion (Tones, Tilford & Keely Robinson, 1994).

In Iran and Iraq, the native countries of the informants, tradition plays an important part in society (Khader, 1996). It is also well known that traditions and habits are difficult to influence (Lindbladh & Lyttkens, 2000). The findings in this study are supported by some Scandinavian studies indicating that many immigrants from non-European countries are less apt to visit health care centres or to make use of preventive facilities (Nørredam et al., 2004; Sundquist & Johansson, 1998; Sachs, 1993). The informants in our study stated that they had experienced language problems when visiting the dentist. Interpreters were not always available and communication between patient and dentist may have been poor. The patients may have been informed about the aetiology of dental diseases, but, due to language problems, they have not understood the meaning of the information they have been given. We believe that a genuine dialogue and understanding can only be created if language barriers are excluded by using an interpreter.

According to most of the informants in this study, dental charges are too high in Sweden. Newsome and Wright (1999) describe how patient satisfaction is related to the acceptance of costs. The implication is that those patients who feel that the charges are too high are also dissatisfied with oral care. In this study, the informants who had understood the benefits of an oral health care system based on prevention and oral health promotion did not regard the dental charges as too high.

Preventing dental diseases and promoting oral health has been the focus of the Swedish dental profession for decades. In the oral health care setting, prevention is regarded as any measure that is taken to avoid disease, while promotion aims at “enabling people to increase control over and to improve their health” (WHO, 1986, p. 1). Empowerment plays an important role in this process. By involving the patient in decisions relating to her/his oral health care, according to the “Self-Empowerment Model”; a dialogue is created so that the needs and wishes of the patient can be established and informed decision-making is facilitated. It has been suggested that, by doing this, changes in habits are more likely to occur. The “Self-Empowerment Model” is derived from models of health education described in various WHO documents about health promotion (Tones et al., 1994). The WHO definition of health promotion has been adopted and is widely used in oral health promotion. Annual check-ups have been a matter of routine for most people in the western countries for decades. In Sweden, these check-ups are initiated by dentists or dental hygienists. There is general agreement that avoiding regular examinations leads to poorer oral health and that this results in higher costs both for the individual and for society, as symptoms often occur late in the disease process (Hjern et al., 2001). It is important to emphasize that every individual must decide on the usefulness of regular dental check-ups. The autonomy of the individual is crucial. If the individual chooses not to participate in an oral health care system of this kind, the decision should be based on sufficient information and understanding of the new system. This study shows that information about the oral health care system has not always been given to or understood by the informants.

Another important factor that affects oral health behaviour is previous experience of pain, which was clearly described by the informants in this study. Henning-Abrahamsson (2003) has shown that fear, anxiety and lack of tradition are the main reasons for avoiding regular dental visits. Therefore, when dental professionals treat people from other countries in emergencies, as well as on regular visits, it is important that they ask about the patients’ earlier experiences of dental care and pain.

The concept of “immigrant” is in itself problematic. In this study, we have used the word “immigrant” in its original sense; someone who has moved from one country to another. O’Dell (2002) states that “immigrants” are easily defined as different from the indigenous population, identified as members of a group rather than unique individuals. Social problems are projected as ethnic and/or
cultural. Immigrants belong to a highly heterogeneous group of people. As with the informants in this study, social, educational, political and religious backgrounds differ, as well as the degree of willingness to adopt new habits. Marshall (1950) described selective measures in health care aimed at groups in welfare systems as stigmatising and counterproductive in terms of integration. We believe that selective measures aimed at immigrants as a group are not needed if every individual is met with interest and empathy.

Methodological considerations

As the purpose of this study was to capture the informants’ various experiences and perceptions of dental care, a qualitative approach, phenomenography, was used. Interviews were chosen in order also to capture unforeseen areas. In addition to the topics in the interview guide, topics introduced by the informants were the cost of dental care and differences in dental care systems. There is an asymmetric power between the researcher and subjects. Since the language spoken was Swedish in all but two of the interviews the asymmetry was possibly enhanced. The interviews were conducted in Swedish. As the informants did not use their native language, there could be a risk that they were not able to express themselves freely in the foreign language. However, the interviewer did not believe that the language was a restricting factor, as ten of the informants communicated well in Swedish. Interestingly, the two interviews conducted with an interpreter were less substantial. The interview situation is an interaction between people and a frequent bias in a qualitative interview is the interviewer influencing the respondent. Awareness of the problem might reduce bias (Kvale, 1997). None of the informants knew the interviewer or was dependent on her.

The credibility of the findings has been checked in different ways, as described in the method section. As in all qualitative studies, care should be taken with generalizations, as the informants were purposefully selected and only twelve informants were interviewed. However, a qualitative study can be valuable by contributing to a deeper understanding of a phenomenon.

Conclusions and implications

We believe it is important for dental professionals to be aware of factors that might prevent individuals from other cultures adopting the concept and behaviour of participating in oral health examinations on a regular basis. People coming from a culture very different from that in the new country might still be deeply rooted in their native habits and traditions. Different cultures have different ways of involving the patient in treatment decisions. There might also be a history of painful treatment.

However, the dental professionals could improve the opportunity for the immigrants to understand and take part in the oral health system by listening to the patients’ individual experiences from their native country, with an interpreter if needed. In addition, creating a dialogue and explaining why working in this way could be seen as a means to promote oral health.

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