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Chamila T. Attanapola

Migration and Health

A literature review of the health of immigrant populations in Norway

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Chamila T. Attanapola

Globalization Research Programme

Faculty of Humanities

Norwegian University of Science and Technology (NTNU)

PREFACE

The purpose of this document is to provide an overview of research on the health of immigrants in Norway and to identify future research areas. As the theme of health is a broad field of research, it was challenging to identify which health aspects to include in this literature review. I have therefore focused mainly on the psychosomatic health aspects and excluded periodontal health, sexuality and health, and accidents. Further, 'health' is a complex concept in itself. What encompasses in this concept varies according to the discipline in which the research is conducted. Disciplines such as medicine, social anthropology, psychology, sociology, and social work have generated a vast amount of literature on issues related to the health of immigrants. Hence, I have included gender-based violence, disability, and care for the elderly, as these factors are associated with health and well-being of individuals, in addition to the five most-often researched health issues presented in existing literature (mental health problems, lifestyle and diet-related health problems, infectious diseases, reproductive health problems, and access to and use of health care services). However, I exclude literature on immigrants' identity and well-being such as, integration, racism, poverty, quality of life, employment, and housing, even though these factors have indirect impacts on the health of individuals. In the section on methodology, I have described my selection criteria for this literature review, search process, and the justification for my choices.

This document is a result of a desk study conducted during the period August 2012 – October 2013. I am solely responsible for the choice of methods and theories, as well as the analysis and results. The views on this document are strictly based on my own disciplinary knowledge.

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1. BACKGROUND

Introduction to migration and health

The relationship between migration and health is a complex issue. Health and disease have been a cause of, a means to, and a result of migration (Gatrell & Elliot 2009). For example, McNeil (1976, cited in McGuire 2012) describes how the transition to sedentary agriculture increased population pressure and migration, and consequently led to the spread of diseases to previously isolated people and eventually diseases became endemic. Another example of disease caused by migration (and vice versa) is the plague known as the Black Death, which occurred in Europe in the medieval period. As the spread of the disease often started at sea ports, many people fled inland to avoid contagion. However, those who fled often carried the virus with them and passed it to people elsewhere (Show et al. 2002). During the colonization era, Europeans were exposed to new diseases such as malaria and tuberculosis when they moved to tropical environments in Asia and Africa, where these diseases were endemic. A more contemporary example of the effect of migration on the spread of disease is the spread of HIV as a result of men becoming infected when they migrated for work and subsequently infecting women when they returned (Lurie 2006). Furthermore, tuberculosis remains a major health problem among immigrants who have moved from Africa and Asia to Europe (Rechel et al. 2011). However, whether as a movement of people from one village/town to other within the same country (internal migration) or as a movement of people across the borders (international migration), migration has had significant impact on the health of the people who have moved (i.e. migrants), those they have left behind, and people in the host population (Gatrell & Elliot 2009, Show et al. 2002).

In the present era of globalization, over 200 million people, equivalent to 3% of the world population, live away from their country of birth and the number is increasing (International Organization for Migration 2010). Several factors at global and local level have contributed to triggering the migration of people since the late 20th century. One of the key factors identified is the increased amount of global trade and trade agreements. In response to economic and political demands, governments have loosened their regulations and opened up their countries for the movement of goods, capital, and people by joining agreements such as the EU, EEA, and NAFTA. A further factor is the significant reduction in the costs of travelling and the time involved. In addition, economic instability in different parts of the world and enormous growth in other parts of the world have created large flows of labour migrants from low-income countries to high-income countries. Most importantly, the increased incidences of political unrest and conflict within countries have contributed to the growing numbers of internal migrants in form of internally displaced people as well as international migration in form of refugees and asylum seekers. As the numbers of migrants have increased worldwide, research has provided evidence for alarming issues relating to the health, human rights, and cultural backgrounds of migrants. Hence, international organizations have become increasingly concerned about the issues of migrants. For example, in 2008, a report to the World Health Assembly on the health of migrants set out four principles that should guide policies for meeting the health needs of migrants through a public health approach. These principles aim to ensure fair access to health services, protect migrants' fundamental right to health, put in place life-saving measures when migration results from conflict or disasters, and guard against adverse health consequences associated with the stresses that often accompany migration. An associated resolution called for World Health Organization to promote the health of migrants on the international health agenda in collaboration with other relevant international organizations (International Organization for Migration 2010).

Aim of the study

In Norway, an understanding immigrants' health problems and their choices and actions related to health, which are based on their socio-economic, cultural, and gender backgrounds, is becoming of crucial interest to policy planners and to service providers (e.g. health care personnel, social workers, and teachers), in order to provide satisfactory services for the country's immigrant population. This is important because the well-being of the immigrant population affects the living conditions of the nation as a whole (Berg & Ask 2011, Forland 2009). Further, the diversity in immigrant population in Norway demands a more nuanced understanding of the demography, culture, disease, and health behaviours of population groups, especially in the case of non-Western immigrants.

A substantial number of studies of immigrant health status in Norway have been undertaken, mainly within the disciplines of psychology, medicine, anthropology, sociology, and social work.[1] Further, several authors have provided comprehensive literature reviews of migration and health (Abebe 2010, Forland 2009, Kumar 2008, Spilker et al. 2009, Syed & Vangen 2003, Sørensen & Vorland 2006).

This document, a desk study of a literature review of health of immigrants in Norway, attempts to contribute to the existing body of knowledge of migration and health.

When compiling this literature review, the research was guided by the following aims:

- to provide an overview of existing literature by categorizing publications into the important health issues and focus groups of the research
- to analyse the theoretical approaches of the studies
- to identify the research gaps and emerging challenges, and in particular identify the missing link in contemporary research regarding migration and health in Norway
- to serve as an information resource for further research on migration and health.

Three approaches to analysing the literature

In this section I present various approaches to analysing the literature on immigrants' health in Norway. Based on my academic background within the social sciences, including health geography, feminist and gender studies, and development and migration studies, I identify three interrelated approaches that are useful for analysing literature.

The first approach to analyse research on immigrants' health is to look at the *research traditions* that the studies are based on. Since the early 1950s, research, especially within social sciences, has developed several scientific traditions to establish the 'truth'. In general, a scientific research can be placed within one or two research traditions, which in turn can be identified as macro-frameworks for research. The **positivist tradition** relies on quantitative data and searches for accurate measurements, statistical regularities, and associations. The end goal of this research tradition is to establish a law and make generalizations. With regard to research on health and disease, the tradition aims to identify who suffers what kinds of diseases and answer the question of 'how many', by measuring the incidences of disease and their distribution within a population group. 'Accessibility' to health care services is also measured. By contrast, the h**umanistic tradition** primarily aims to answer the question of 'why' and relies on qualitative data. Studies within this tradition focus

[1] In Norway, the Norwegian Center for Minority Health Research (NAKMI) (http://www.nakmi.no/), an interdisciplinary resource centre, aims to increase the knowledge of health and welfare of the immigrant population by conducting research and developing and distributing information to the immigrant population. In addition, the Norwegian Institute of Public Health (http://www.fhi.no/) carries out research on migration and health, which are in the interests of the general public as well as policymakers. Also, section for Diversity and Inclusion at NTNU Social Research Ltd (http://samforsk.no/Sider/Fagenheter/Mangfold-og-inkludering.aspx) conducts research particularly on the experiences and perspectives of immigrants' health and access to health care services in Norway.

on the nature of the motivations behind individual health-related behaviour and are concerned with understanding individual's decision-making related to their behaviours. Research is most often carried out at the level of the individual. The **structural-Marxist tradition** describes how a society's hidden structures, such as its political and economic structures, determine who gets what and where. Health research within this tradition focuses on the (unequal) distribution of health care services and suggests solutions for reducing and/or eradicating social injustice. Recent **post-structuralist traditions**, such as structuration theory, feminism, and the cultural turn explore the relationship between the social, economic, political, cultural, and legal institutions in a society, and individuals' status and condition in a given context. One the one hand, institutional contexts determine and regulate the actions of an individual. On the other hand, they provide choices and opportunities for individuals. Thus, in an ideal social world, individuals are able to make choices and take actions that they regard as preferable. Health research within this tradition explores how the health status of an individual is shaped by that individual's interaction with institutions in society (Johnston et al. 2003).

The second approach to analysing the literature is to explore how the research defines *the concept of 'health'* and address the health and/or medical problems. Within the disciplines of medicine, epidemiology, sociology, anthropology, and health geography, several theoretical approaches have been developed to explain the health status of an individual in a particular place and time (Gatrell & Elliot 2009, Meade & Earickson 2000). The **conventional biomedical approach** defines health as the absence of disease. Using germ theory, this approach assumes that diseases are caused by external factors. The approach views diseases as existing independently, and prior to their discovery and description by physicians. Curing diseases, by eliminating the external factor or cause of the disease, is the main target of the conventional biomedical approach. It is assumed that people have similar bodies (biologically) and that they are treated in the same way. Health and well-being are seen as products of medical interventions. The **behavioural approach/risk factor approach** identifies human behaviour as the main cause of diseases and ill health, and assumes that people become ill when they are exposed to risk factors – for example, it is assumed that smoking increases the risk of lung cancer. In this model, the patient or victim is blamed for his or her bad health. The main focus of this approach to health is the prevention of diseases rather than how to cure them. The **diseases ecology model/Multiple risk factor approach** identifies three factors that determining health status: biology (age, sex, and genetics), environment (natural, social, and built), and behaviour (beliefs, social organization, and technology) (Meade & Earickson 2000). This approach recognizes the definition of health as '*a state of complete physical, mental and social well-being and not merely the absence of diseases of infirmity*' (Website: World Health Organization). Hence, to understand the health status of an individual we must explore all of the factors that determine health. **Post-structuralist approaches** have a more holistic view of health and explore the relationship between institutions in a society and individuals' health status. For example, the **political ecology of disease** approach suggests that illness and disease among populations in a local place may be explained as a result of political decisions over the environments in which people live. History provides evidence for how the health of the people in particular places have been impacted by agricultural policies, deforestation or reforestation policies, development projects such as, dam building, and industrialization. The **social policy approach** suggests that society is responsible for the health problems of its populations. Hence, institutional intervention is needed to eliminate the social problems that cause health problems. The **gender approach** to health explores how socio-culturally determined work roles and the identities of men and women influence their actions and behaviours that subsequently lead to them having better or worsened health status (Gatrell & Elliot 2009).

The third approach to analysing the literature is to look at how studies have adapted the *theories on migration and health*. International studies of migration and health primarily adopt three theoretical approaches to understand the health of migrants and immigrants. The three theories are selectivity of migration, acculturation, and the negative effect of migration on health (Im & Yang 2006). The **selectivity of migration** theory assumes that migration is a type of natural selection and explains who

migrates when, where, and why. Within this theory, the concept of a 'healthy migrant effect' explains why always healthy people, particularly young men, choose to migrate first. Studies regard migrants as a healthy and resilient group of people, willing and able to respond to the different possible health hazards of migration, and face the challenges of adapting to their new society. Selective migration not only affects the health of the migrants but also the health of the population in the sending and receiving countries. For example, over time, the population in the sending country becomes smaller, older, and less healthy due to lack of younger, healthier generations. The population in the receiving country (or place) becomes larger, younger, and healthier due to the newcomers. However, some studies show that selective migration has the reverse effect: unhealthy and elderly people who choose to migrate in search of better living environments and better medical facilities (Gatrell & Elliot 2009, Im & Yang 2006). The **negative effect of migration theory** assumes that migration, especially in cases where migrants move to countries where the sociocultural conditions are different from those in their own country, is associated with new health problems, such as stress and depression. The negative conditions in the home country (disease-endemic environments and poor nutrition status), stressful migration process (forced migration, subjection to human trafficking, and risky journeys), and conditions in the host society (poorer living conditions, unemployment, discrimination by the host society, role change, and identity crises) result in a new set of health risks to the immigrants. Men and women may experience migration differently, and therefore the health effects may vary according to gender (Gatrell & Elliot 2009, Im & Yang 2006).). However, effects of migration on health are not always negative. People may experience positive health outcomes as result of migration to a place with better health care facilities or avoid exposer to violence and trauma in daily life. Further, **theories on acculturation** are used to explain the health outcomes of immigrant populations. Acculturation is regarded as a desired process with regard to the health outcomes of immigrants. According to Im & Yang (2006), acculturation has often been equated with de-ethicizing and the incorporation of immigrant minorities into the mainstream population; thus, acculturation is seen as a process. Berry (2008) identifies four acculturation scales or attitudes depending on individual's level of adaptation into their host society. Assimilation is the total disregard of one's own culture and adaptation the culture of the host society. At the other extreme, segregation occurs when individuals want to keep their own culture and either refuse to make contact or avoid contact with the host culture. Most immigrants choose to adopt a position of integration between the two extremes, by choosing the best from both cultures or societies. Usually, immigrants maintain their own culture while adapting to some of the cultural practices of the host society. However, in some cases, immigrants feel marginalized when they experience that they do not belong to either culture because they experience loss of their own cultural identity while the host society denies acceptance of them as equal citizens. Studies show that long-term cultural isolation, either from the host culture or the migrant's own cultural heritage, can result in feelings of alienation and depression (Berry 2008). More recently, the **theory of intersectionality** is become popular due its usefulness when researchers explore inequalities among groups in a society and its suitability for explaining inequalities in health status among groups, especially among immigrants (Viruell-Fuentes et al. 2012).

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2. METHODOLOGY

Defining the concepts

When does a migrant become an immigrant?

A *migrant* is a person who travels from one place to another, either within or by crossing national boarders, in search of opportunities for employment, education, residence, and/or protection on either a temporary or permanent basis.

An *immigrant* is a person who has crossed an international boarder and moved away from their home country, sending country, or country of origin to a host, receiver, or destination country. Based on both the reason to migrate, whether forced or voluntary, and their legal status in the host country, immigrants are categorized into one or more groups: irregular, illegal, or undocumented immigrants; asylum seekers; refugees; work migrants; and family members (International Organization for Migration 2010). Those who are included in or count as part of an immigrant population of a country will vary according to the receiving country and will change over the time. For example, in Norway, since 2008, *immigrant populations* (*innvandrere*) comprise two groups: (1) immigrants born abroad to two foreign-born parents and that have moved to Norway; and (2) Norwegian-born to immigrants, in other words those born in Norway with two immigrant parents (website: Statistics Norway: Population).[2]

What are the main health issues of immigrants in Norway?

As a point of departure for the literature review, I use Abebe's (2010) categorization of the health of immigrants. Abebe (2010) has identified five main *health issues*: lifestyle and diet-related health problems, mental health problems, infectious diseases, reproductive health, and access to and use of health care services. In addition, I identify disability, harmful cultural practices and gender-based violence, and care for elderly immigrants as three issues that have a crucial impact immigrants' health.

Immigrant population in Norway

On 1 January 2013 there were 710,465 immigrant persons living in Norway, of which 593,321 were immigrants and 117,144 were Norwegian-born persons with immigrant parents. Together, the two groups represented 14.1% of Norway's population. Of all immigrants, 302,504 persons had a Western background (from the EU/EEA, USA, Canada, Australia, and New Zealand), 231,872 had an Asian background (including Turkey), 88,764 were of African background, and 21,486 had either a South American or Central American background (website: Statistics Norway: Immigrants and Norwegian-born to immigrant parents, 1 January 2013). Figure 1 shows the development of immigrant populations by their country background since 1970.

[2] These concepts replace the former categories of first-generation immigrants and second-generation immigrants, which were used until 2008. Further, irregular migrants are those who are not registered in the Norwegian population register (Det sentrale folkeregister, commonly known as Folkeregister) and are not included in the categories of immigrant populations. Statistics on immigrants are registered according to the original nationality of the immigrants and not according to their current nationality.

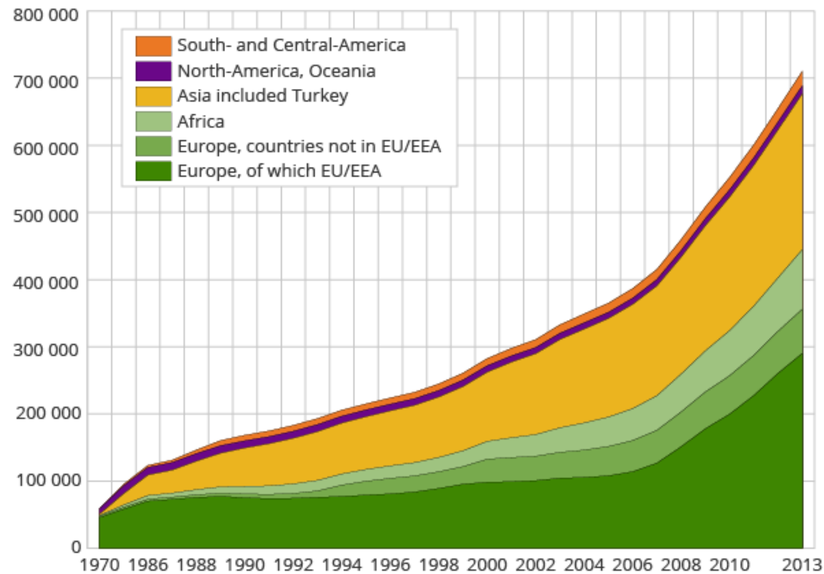

Figure 1: Growth in numbers of Immigrants and Norwegian-born to immigrant parents, by country background, 1970–2013 (Source: Statistics Norway)

Historically, Norway has had solid traditions regarding emigration, while immigration has been a relatively recent phenomenon, which gained momentum in the late 1960s when Norway became a rich country due oil discoveries in the North Sea. Since then, three waves of immigration flows to Norway have occurred. The first wave of immigration started when migrant workers from Pakistan, Turkey, and Morocco arrived in the late 1960s to take on types of work that was no longer attractive to native Norwegians. However, in 1975, the Norwegian Government introduced new immigration policies that put a stop to work-related immigration. Since then, humanitarian-based migration has dominated the Norwegian immigration statistics. During the period 1980–2000, refugees and asylum seekers, as well as family members of labour migrants (who entered Norway under the family reunion scheme) accounted for the second wave of immigration in Norway. Those immigrants were mainly from Vietnam, Chile, Iran, Sri Lanka, Iraq, Somalia, and the war-torn Eastern European countries of former Yugoslavia. The pattern of immigration into Norway changed after the beginning of the 21st century. Following the expansion of the European Union (EU) during the period 2004 – 2007, the number of labour migrants from the new EU member countries increased when Norway became part of European Economic Area (EEA) agreement in 1994. This third wave of immigration has mainly consisted of labour migrants from Poland and the Balkan countries (Berge et al. 2010).

Immigrants in Norway are not a homogenous group. They comprise a wide range of social, cultural, ethnic, and religious backgrounds as well as migration backgrounds. Before 2008, immigrants in Norway were broadly categorized into two groups: Western immigrants and non-Western immigrants. Non-Western immigrants were those from Asia, Africa, Central and Latin America, Oceania (except Australia and New Zealand), and some Eastern European countries with different sociocultural ideologies from those of the Norwegian population and the Western immigrants. However, in 2008 Statistics Norway replaced this categorization to a land-based categorization, which was less discriminatory and stigmatizing. Today, this categorization of immigrants makes it easy to identify the groups include in each category. However, even after 2008, the literature especially on health of immigrants, used the category of non-Western immigrants to refer to groups from Asia, Africa, Latin America, Oceania (except Australia and New Zealand), and Europe (except the EU and EEA).

Before the first wave of immigrants, immigrant population in Norway primarily comprised Western immigrants. In 1970, the percentage of immigrants with non-Western backgrounds was only 0.1% of

the total population. By 2012, the number had increased to 6.4%. Further, non-Western immigrants have different migration backgrounds. The main reasons given for immigration to Norway are work, refuge or asylum, family reunion, and education (website: Statistics Norway: Immigrants by reason for immigration). Further, the immigration backgrounds vary among people from the same country with respect to the gender and age as well as ethnicity. For example, among Pakistani immigrants, men migrated as work immigrants while women came under the category of family reunion.

Searching the literature

For the desk study, literature was searched using several databases, including PubMed & Medline, Bibsys Ask, and MIGHEALTHNET and NAKMI, as well as the Internet search engines Google and Bing, between July 2012 and September 2013.

I limited the search for publications to three sources of literature: (1) peer-reviewed journal articles, (2) books, and (3) reports published by institutions. PhD theses and master's dissertations were not included in the literature review because some of them have also been published as journal articles or as books, whereas others are merely descriptive and/or do not add to the existing knowledge of immigrants' health. Further, discussions and presentations on the Internet, in newspapers, and in other popular media were not included in the analysis because they are not exclusively based on systematic and scientific arguments/studies.

Further, I searched for literature written only in Norwegian or English. I used the following search words in addition to the seven categories of health issues identified.

For the English literature search: *disease*, *ethnic groups*, *ethnic minorities*, *health*, *immigrants*, i*mmigration*, *migration*, *Norway*

For the Norwegian literature search: *asylsøkere*, *etniskegrupper*, *etniskeminoriteter*, *flyktninger*, *helse*, *immigranter*, *innvandrere*, *innvandrerkvinner*, *Norge*, *sykdommer*

Justifying the choices

Combinations of the search words generated a vast number of literature lists. I systematically excluded literature that was exclusively on well-being (poverty, socio-economic status including education, employment, income and housing), identity (sense of place, acculturation, integration, segregation, and assimilation), religion, parenting and family relations, diaspora, human trafficking, criminality and behaviour, and racism and discrimination. Even though these factors may have an indirect impact on health of individuals, I decided to exclude the literature from the analysis because the publications do not exclusively deal with health status. Health aspects such as periodontal health, sexuality and health, and accidents were also excluded. Further, since I decided to include literature published in both Norwegian and English, some of the articles duplicate the published results. For example, most of the articles within the discipline of medicine were first published as short versions in Norwegian in *Tidsskrift for Den norske legeforening*, and subsequently published in longer versions in English in international journals.

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Statistics Norway - Population

Statistics Norway – Immigrants by reason for immigration

Statistics Norway- Immigrants and Norwegian-born to immigrant parents, 1 January 2013

3. CATEGORIZING THE LITERATURE

In this section, I categorize literature on immigrants' health in Norway into different groups. Much of the literature on immigrants' health problems is based on data from an immigrant health study conducted in 2002 in Oslo.[3] Published literature identifies five main health problems relating to immigrant populations in Norway: mental health problems, lifestyle and diet-related health problems, infectious diseases, reproductive health problems, and access to and use of health care services (Abebe 2010, Kumar 2008, Spiker et al. 2009). When performing the literature analysis, I found three other issues identified as equally important for immigrants' health: disability, harmful cultural practices and gender-based violence, and care for elderly immigrants. All three health issues challenge the everyday life of immigrants because they live in a sociocultural environment that is completely different from their own.

In the following, I aim to present the essence of the findings related to the literature for each of the above-mentioned groups. The literature is listed under each category.

Mental health

With regard to the published literature listed below, mental health problems are clearly the most scrutinized health issue of immigrants in Norway. Most of studies focus on the mental health issues of adult immigrants and adolescents with non-Western backgrounds, and the mental health status of refugees and asylum seekers (see Berg & Valenta 2008 for detailed overview of literature on refugees).

The study by Dalgård (2008) compares the mental health status of Western immigrants. Generally, the studies conclude that the immigrant groups, especially those from low-income countries with war and conflict backgrounds, suffer from more mental health problems than ethnic Norwegians and immigrants from high-income countries (Dalgård et al. 2006, Thapa et al. 2007). According to the Norwegian Directorate of Health, mental health problems are lowest among Norwegian-born immigrants (10%), followed by Western immigrants (14%) (Forland 2009). The prevalence rate is high among immigrants from non-Western countries (24%) and highest among the refugee population (31%).

Migration background and mental health: Several studies have focused on the mental health status of immigrants with refugee backgrounds. According to van der Veer (1994), traumatic experiences at three different levels affect the mental health status of refugees: increased political oppression and persecution in the home country; severe traumatic experiences such as imprisonment, torture, and the disappearance and/or murder of friends and family members; and the process of exile and flight. Several other studies have recognized factors relating to pre-migration situations, such as traumatic experiences of war and conflict, and flight that affects the mental health status of immigrants with a refugee background (Hauff & Vaglum 1993, Lei 2004, Lei et al. 2001, Meyer 1994, Teodorescu et al. 2012a & b, Vaglum 1994). Sveaass & Hauff (1997) and Varvin (2003) point out that refugees experience the asylum-seeking process as a greater burden and more painful than they expected. The long waiting period until their applications are processed and the feelings of uncertainty of their future in the new country worsen their already severely affected mental health status due to experiences of trauma. Further, other post-migration factors, primarily the lack of acculturation in terms of poor employment level, language deficiency, and interaction with the host society, as well

[3] The Oslo Immigrant Health Study, Innvandrer-HUBRO, was conducted by the Norwegian Institute of Public Health and the University of Oslo. The study collected data on immigrant groups from five countries: Pakistan, Turkey, Iran, Sri Lanka, and Vietnam (website: Innvandrer-HUBRO)

as experiences of racism and discrimination result in a higher level of mental health problems among adult refugees (Abebe et al. 2012, Ahlberg 1997, Hauff & Vaglum 1995). In addition, studies show that post-traumatic stress syndrome is common among refugees and asylum seekers in Norway (Meyer 1995, Meyer 1997, Sveaass & Lavik 2005, van der Veer 1994).

Studies conducted among the immigrants from low-, middle-, and high-income countries conclude that the level of psychological stress is significantly higher in immigrants from low-income countries compared to other immigrants. The reasons are identified as feelings of powerlessness, negative life events, less social support, less income, and less paid work (Dalgård et al. 2006, Thapa & Hauff 2005). Further, studies show that post-migration experiences, such as economic deprivation and social marginalization, and discrimination in the host society, account for the high prevalence of mental health problems among adult immigrants from low- and middle-income countries, regardless of their migration background (Dalgård et al. 2006, Syed et al. 2006, Thapa & Hauff 2005, Thapa et al. 2007).

Gender: Gender plays a significant role in immigrants' mental health. Studies show that women are more vulnerable to mental health problems than their male counterparts (Dalgård & Thapa 2007, Dalgård et al. 2007, Hauff & Vaglum 1995, Thapa & Hauff 2005). Studies of non-refugee immigrants and Norwegians (Dalgård & Thapa 2007, Thapa & Hauff 2005) identify lack of acculturation and/or social integration as the main reason for increased mental health problems among women. Particularly, when there is a huge disparity between immigrant women's own culture and the host society regarding gender expectations, they feel powerless and marginalized. Lack of employment, language barriers, and lack of social network in the host society have a greater negative affect on women's mental health status compared to men (Abebe et al. 2012).

Young immigrants: Studies of unaccompanied minor asylum seekers identify that children suffer symptoms of post-traumatic stress syndrome and recommend a number of strategies, such as a clear relationship between the Child Welfare Act and the Immigration Act, professionals with competence in both child welfare and refugee matters, and a shorter application process, to reduce their psychological problems (Engebritsen 2002, Lauritsen et al. 2002). Compared with the Norwegian adolescent population, the risk of mental health problems is higher among adolescents with an immigrant background. Studies show a higher prevalence of mental health problems, such as depressive symptoms, emotional symptoms, distress, conduct problems and peer problems, especially among girls (Abebe et al. 2012). Young immigrants' mental health is affected by acculturation pressure, discrimination, and identity crisis, as well as trauma experienced by their parents (Lien et al. 2007, Oppedal et al. 2005, Sam 2000). However, some studies identify similar or better mental health status among young immigrants than their Norwegian peers. For example, Vaage et al. (2009) show that a strong family structure and value system prevents Vietnamese adolescents from having mental problems and as a result the prevalence of such problems is lower than among Norwegian adolescents.

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<u>Mental health of adult immigrants</u>

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See also: European Society for Trauma and Dissociation (ESTD) http://www.estd.org/countries/norway/

Diet and lifestyle-related health problems

Studies identify that the three life-style related health problems, namely obesity, cardiovascular disease, and diabetes, are highly prevalent among immigrants from non-Western countries. In addition, vitamin D deficiency is identified as a major health problem. Alcohol and various types of substance abuse are included in this category too.

Obesity, cardiovascular disease, and diabetes

Kumar et al. (2006) report that Turkish women are found to have the highest rate of obesity (48%) and Vietnamese men have the lowest rate (3%). Generally, obesity is higher among women in all five immigrant groups (i.e. from Pakistan, Turkey, Iran, Sri Lanka, and Vietnam) than among their male counterparts. Women from Turkey, Pakistan, and Sri Lanka have the highest level of obesity and incidences of being overweight compared to Norwegian women, whereas the lowest prevalence of these health issues is among Vietnamese women. Råberg et al.'s (2009) study of South Asian (Pakistani and Sri Lankan) immigrant women in Oslo identifies dietary-related and socio-economic factors associated with weight, weight dissatisfaction, and slimming. South Asian women with a high level of education have similar degrees of body (dis)satisfaction and make similar attempts to slim as Western women. However, the relationship between BMI and slimming attempts is not as strong among Asian women as among Norwegian women. Obesity has also become a health problem of young immigrant populations. Wathne et al.'s (2013) study of children with a Pakistani background who were undergoing treatment for paediatric obesity concludes that in order to treat this group it is necessary to understand their health as a cultural concept.

Due to high levels of obesity, cardiovascular risk factors as well as diabetes have been found to be highest among immigrants from Pakistan, Sri Lanka, and Turkey, especially among women, compared to the Norwegian population (Glenday et al. 2006, Hellset et al. 2011, Kumar et al. 2009, Råberg-Kjøllesdal et al. 2011a). Following a study of Pakistani women living in Oslo, Hjelseth et al. (2011) identified that 98% women were above normal weight and 40% were obese. Further, 29% of the women were at extreme risk of developing type 2 diabetes. Women's lack of physical activity is identified as the main reason for their obesity. From a study of cardiovascular risk among five immigrant groups and ethnic Norwegians, Glenday et al. (2006) and Kumar et al. (2009) identified lack of physical activity, and obesity as the reasons for a high risk of cardiovascular disease (CVD). They explain the high level of obesity and high risk of CVD and diabetes as the consequences of migration, change in environment, and particularly behaviour. For example, the consumption of a high-calorie diet with sugar and fat and low intake of fibre, fruits, and vegetables in combination with less physical activity results in overweight among immigrant women.

Several community-based activities have been implemented to change the unhealthy behaviours of immigrants, particularly in the case of Pakistani women (Helland-Kigen et al. 2013, Hjellset et al. 2011, Hussain et al. 2010, Råberg Kjøllesdal 2010, Råberg Kjøllesdal et al. 2011a) and Pakistani men (Andersen et al. 2012a & Andersen et al. 2012b, Andersen et al. 2013) in Oslo. Few studies have discussed how these culturally adapted lifestyle interventions have significantly increased the levels of physical activity and changed the former unhealthy dietary habits among Pakistani women (Mellin-Olsen & Wandel 2005, Råberg Kjøllesdal et al. 2011b).

The literature review reveals that lifestyle-related health problems are a crucial health issue of the Pakistani population living in Oslo. Given that they have been the largest immigrant population in Oslo for many years (recently replaced by Polish work migrants), and having a different culture than the host population, they have been in the focus of health research conducted since the early 2000s years. With regard to other groups of immigrants, Tennekoon et al. (2010 & 2013) have conducted a comparative study of CVD among Sri Lankans living in Oslo and in Kandy, Sri Lanka.

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Vitamin D deficiency

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Alcohol and substance abuse

Although alcohol and various forms of substance abuse are not a significant health problem among immigrant groups, particularly among adolescents (Amundsen 2012, Amundsen et al. 2005, Bergensen & Larsen 2008, Bergensen 2009), a recent research report has identified that use of traditional substances, such as khat, is becoming a health issue among immigrant men, especially those from North Africa (particulalry Somalia and Ethiopia) (Ali & Kaur 2013).

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Reproductive health problems

According to the existing literature, reproductive health problems are more prevalent among immigrant women from Asia and Africa than Norwegian women. Evidence has been found of higher risks of obstetric-related complications, perinatal mortality, and high rates of termination of pregnancies for women from Asia and Africa. Female genital mutilation (Vangen et al. 2002), consanguineous marriage (Vangen et al. 2000), low or inconsistence use of contraception, low levels of education, and low social status have been identified as the risk factors for reproductive health problems (Vangen et al. 2008, Vangen et al. 2003, Stoltenberg & Magnus 1995).

Although some studies suggest that non-Western women are over-represented among those who request induced abortion (Eskil et al. 2002, Vangen et al. 2008), Eskil et al. (2007) show that the rate of induced abortion among women with a Pakistani background is lower than among Norwegian women.

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Infectious diseases

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Disability

Apart from the above-mentioned four types of health concerns among immigrants, few studies have focused on immigrants with disabilities (Söderström et al. 2011, Sørheim 2000). Many immigrants have a limited knowledge of the Norwegian language. Furthermore, they lack knowledge of the Norwegian welfare system. Together, these challenges are particularly significant for immigrant families' disabled children. In focusing on the twofold vulnerable situations of disabled immigrants and immigrant families with disabled children, Berg (Ed. 2012) provides an in-depth analysis of immigrants' experiences and perspectives on their disabled position and the relationship to the health care provided to them. Berg addresses the following key questions:

- How does it feel to be a newly arrived immigrant in Norway and at the same time to be told that one's child has a serious chronic illness or disability?
- How do immigrants experience cultural differences and language issues when it comes to understanding perceptions on and beliefs about illness and disability?

Although the double burden of disability conditions of immigrants has not been a focal discussion point in the media (i.e. among politicians, general public, policymakers, and immigrants), non-Western immigrants – the group that receiving the largest share of disability pension – are often discussed as an attractive topic among some politicians and general public. However, Claussen et al. (2009) show that immigrants are over-represented in disability pension statistics because they engage in employment sectors that have high health risks, such as industrial work, construction work, and health care services.

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Harmful cultural practices and gender-based violence

Harmful cultural practices and gender-based violence (GBV) are interlinked and usually result in worsened health status (physically and mentally) in exposed individuals. Although many cultural practices and related GBV, such as forced marriage, child marriage, and honour-based violence, are regarded as social problems by health personnel, researchers, and society in general, we must not ignore the health consequences of such practices.

Since the late 1990s, female genital mutilation (FGM) has been regarded as a cultural practice with severe consequences for women's health, both for their reproductive health and their mental health. Existence of the practice was relatively unknown to the global community until recently, when the

migration flows from North African countries (where the practice is common) to Western countries increased (Essen & Wilken-Jensen 2003, Gele et al. 2003, Johansen 2002).

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Access to health care services

Research on health care services provided for immigrant populations in Norway can be categorized into four groups:

- provision of health care services for immigrants
- pattern of use of health care services by immigrants
- immigrants' experiences of health services provided to them
- experiences of health care personnel.

Further, research within these categories can also be subcategorized according to the health problem or issue, such as mental health, infectious diseases, and maternity care services.

Provision of health care for immigrants

Studies of the provision of health care service for immigrants focus on three health issues: psychiatric care, screening for tuberculosis and following-up of patients, and maternity health care. Using focus group discussions with maternity health care personnel (nurses and midwives), Lyberg et al. (2012) studied how the Norwegian model of maternity health care works in a multi-ethnic society. They conclude that the Norwegian model does not adequately address the cultural and health challenges of an educationally, relationally, and culturally diverse population.

In respective studies of tuberculosis treatment processes, Farah et al. (2006) and Harstad & Jacobsen (2012) identify a significant delay to the start of treatment among those who have tested positive and poor follow-up strategies for those are treated. These challenges should be addressed in order to avoid transmissions of the disease.

Mental health problems among immigrants are one of the most frequently discussed health issues in the literature. However, few studies have focused on the quality of the care for immigrants with mental health problems. Hauff & Vaglum's (1997) early study of Vietnamese refugees shows that refugees need psychological care even after several years in Norway. The authors recommended outreach programmes in order to satisfy the needs of future refugee groups with different national backgrounds. When discussing mental health service available for immigrants, Hauff (2008) argues that Norway still needs to improve the service to meet the demand, by increasing the knowledge of health care personnel to address the health issues of patients with different sociocultural backgrounds. Author also suggests that more research should be conducted on the mental health issues of immigrants living indifferent parts of the country and with different migration backgrounds, in order to understand the diversity among immigrant groups. In their evaluation of mental health care provided at asylum centres, Berg et al. (2009) identify the need to address different problems

among different groups, namely immigrant families, men, women, single people, children with families, and minors without families.

Although the above-mentioned studies primarily look at non-Western immigrants' health care needs, a few recent studies have focused on the health care needs of seasonal migrants (Guerin et al. 2005), work migrants (Czapka 2009), and paperless and/or irregular migrants (Aale 2009, Aschehoug 2010, Hjelde 2010, Sjuja 2007).

Pattern of use of health care

The pattern of immigrants' use of health care differs from the native population, and immigrants often face different challenges when accessing health care. Immigrants who lack proficiency in the Norwegian language are hindered with regard to receiving important communications from health care personnel and thus fail to obtain satisfactory treatment and information. Immigrants also lack access to health care services due to their poor knowledge of the available facilities and poor economic conditions, which further reduces their health status (Forland 2009).

Literature on the use of health care by immigrants mainly focuses on two type of health care: (1) access to psychiatric health care, and (2) access to emergency primary health care (EPHC) or a regular general practitioner (RGP).

Studies show that whereas more men with a non-Western immigrant background have been admitted for emergency psychiatric health care than Norwegian men, significantly fewer women with an immigrant background have been admitted compared to Norwegian women (Ayazi & Bøgwald 2008, Berg 2009, Berg & Johnsen 2004). Iversen & Morken (2003) show that the risk of admission to a psychiatric hospital is highest among asylum seekers. Further, studies have shown that non-Western immigrant women have been admitted to hospital due to severe mental disorders, such as schizophrenia, although the hospital admission rates for women with other mental disorders are very low compared to their male counterparts. This reveals that immigrant women use mental health care when their situation worsens, whereas for minor disorders they tend to suppress their mental status due to lack of knowledge and/or social support, or they receive help from their social networks (Hauff & Vaglum 1997). Iversen et al. (2011) show that involuntary admission to psychiatric hospital for schizophrenia is higher among non-Western immigrants than Norwegians. This is due to socio-economic problems, lack of knowledge of available assistance, and/or inability to communicate with service providers, which ultimately leads to increases in immigrants' aggressive or violent behaviour.

Since 2001, the Norwegian health service has been primarily provided through the regular general practitioner (RGP) scheme (*fastlegeordningen*), whereby all individuals who are legal residents have the right to have their own doctor. However, research shows that immigrants use emergency services more often, and underuse their RGP (Goth et al. 2011). A study of immigrants from Germany, Poland, Iraq, and Somalia by Sandvik et al. (2012) shows that immigrants as a whole had a lower contact rate at emergency primary health care centres than Norwegians. However, whereas the contact rate for Polish and German immigrants (work immigrants) was lower than for Norwegians, the rate for Iraqi and Somali immigrants (refugees) was higher than for Norwegians. Further, there was a significant variation among immigrants groups regarding their reasons for contacting EPHC. According to Goth et al. (2011) factors such as, non-Western immigrants' lack of information on available health care, longer waiting time for an appointment at RGP, and differences in understanding between RGPs and immigrant groups regarding their respective roles and expectation, and disease and health, reduce the use of RGP by immigrants.

Immigrants' experiences of health care

The literature identifies immigrants' experiences of health care related to maternal health care, disability care, general practitioner (RGP) care, and treatment for tuberculosis.

Due to lack of opportunities for negotiation regarding treatment options and due to forceful and authoritative decisions, some immigrant patients that have undergone treatment for tuberculosis felt discriminated and humiliated, while those who engaged in educational or occupational activities viewed their treatment programme as a high social cost. Some health care personnel considered that patients should be treated equally, while others aimed to provide diversified treatment options according to their patients' needs (Sagbakken et al. 2011).

Høye & Severinsson (2010) reveal that multicultural family members' experiences of their encounters with nurses were understood as 'struggling to preserve the families' cultural belonging within the health care system'. They conclude that '*family members with a non-Western ethnic background experienced several challenges within the complex ICU [intensive care unit] environment. Multicultural family members had distinct strategies to deal with the hospitalization of a critically ill loved one. Interaction difficulties and cultural traditions were not influenced by the environment alone, however the challenges seemed to deal with universal human interaction independent of the context*' (Høye & Severinsson 2010). Further, the authors recommend that nurses should be sensitive to immigrant families' cultural customs in order to treat their patients with respect.

A study of mental health among asylum seekers conducted by Berg et al. (2009) identifies a number of factors as decisive for their health, such as the waiting time for a decision on application for asylum, opportunities for work and other activities, attention to health issues, and availability of assistance and personnel. In a study of how patients and professionals conceptualized 'depression', Erdal et al. (2011) identified that immigrants and refugees, particularly those of non-Western origin, endorsed different types of depression treatments compared to native Norwegians and mental health professionals, and health personnel judged who deserved treatment and who was overreacting based on the patient's culture and social circumstances. Erdal et al.'s study also reveals cultural differences in preferences toward depression interventions, with immigrants and refugees endorsing more self-help types of intervention (spirituality, exercise, and rest) compared to native Norwegian laypersons.

A survey on immigrants' satisfaction with their RGP (Lein et al. 2008) has revealed that most participants were either moderately or very satisfied with their last visit to a general practitioner. Dissatisfaction among the immigrants was associated with patient's young age and a feeling of not having good health, especially in the case of those who had come from Turkey, Iran, Pakistan, or Vietnam. Lein et al. (2008) conclude that although the degree of satisfaction with the primary health care was relatively high among the participants in their survey, non-Western immigrants were less satisfied with their last visit to a general practitioner than ethnic Norwegians. The rather low response rate from the non-Western immigrants opens for the possibility that the degree of satisfaction may not be representative of all immigrants.

Garnweidner et al.'s (2013) study of experiences with nutrition-related information during routine antenatal care among women of different ethnical backgrounds has revealed that participants experienced that they were provided with little nutrition-related information during antenatal care. The information was perceived as presented in very general terms and focused on food safety. Weight management and the long-term prevention of diet-related chronic diseases were hardly discussed. Participants with immigrant backgrounds appeared to be confused about information given by their midwife, which was incongruent with their original food culture. The participants had actively sought nutrition-related information and had had to navigate between various sources of information. Garnweidner et al. conclude that '*the midwife is considered a trustworthy source of nutrition-related information. Therefore, antenatal care may have considerable potential to promote a healthy diet to pregnant women. Findings suggest that nutrition communication in antenatal care*

should be more tailored towards women's dietary habits and cultural background, nutritional knowledge as well as level of nutrition literacy.'

Berg (Ed. 2012) has presented an in-depth analysis of the relationship between immigrant families with disabled members and their service providers. In Bergs edited book, contributing authors, including such as Sajjad (2012), Söderström (2012), and Kittelsa (2012), explore how immigrant families were vulnerable due to their immigrant status and due to having a disabled child in a sociocultural setting that differed from their own. Lack of knowledge of available services, language barriers, and cultural beliefs and interpretations resulted in poor access to health care, and in cases where services were provided, poor communication led to lack of proper care.

Experiences of health care personnel

According to Goth et al. (2010), general practitioners experience that migrants often seem helpless in dealing with the public health services due to having language difficulties and differences in expectations, as well as systematic failures in the co-ordination of care services. A study conducted on doctors' experiences of their patients with a refugee background identify that both the doctors and the patients were mainly occupied with a language barrier (Varvin & Aasland 2009). As a consequence, the doctors experienced that their patients intentionally withheld information about their pre-migration background even though such information could have been relevant for the identification of the cause of their illness. As a result, the doctors usually did not know whether they were dealing with patients with a traumatic background.

Following an exploration of intensive care unit (ICU) nurses' perceptions of their encounters with family members of patients with a multicultural background, Høye & Severinsson (2008) found that understanding the cultural diversity between and among immigrant groups is important for ICU nurses in order for them to work effectively in a very stressful environment. Johansen (2006) examined Norwegian health workers' care of infibulated Somali women during childbirth, and why the efforts of highly qualified Norwegian health workers did not always produce optimal results despite the fact that most of them were dedicated to their work and tried to be culturally sensitive towards the Somali women. Johansen concludes that health workers' emotional challenges in dealing with female genital cutting (FGC) tend to lead to silence and a misinterpretation of culture, which in turn has a negative effect on the care procedures.

The language barrier between immigrant groups and Norwegian health care personnel is an ongoing discussion with regard to addressing the health issues of immigrants in Norway (Kale et al. 2010, Kale & Syed 2010, Kale et al. 2011, Kale et al. 2013). Further, in order to provide satisfactory health care for immigrants, researchers have urged for an increase cross-cultural understanding between immigrants and health care personnel, and the provision of information on immigrants' backgrounds, socio-economic status, and particularly their migration status to the health personnel (Goth et al. 2010, Høye & Severinsson 2010 & 2008). Table 1 summarises the literature on access to health care services according to the four themes discussed above.

Table 1: Summary of the literature on access to health care services by type of health care service

Health care service	Provision	Pattern of use	Immigrants' experiences	Health care personnel's experiences
RGP	Neass 1992		Lein et al. 2008	Goth et al. 2010, Varvin & Aasland 2009, Kale et al. 2010, Varvin & Aasland 2009
EPHC/ Intensive care		Sandvik et al. 2012 a & b, Goth & Berg 2011, Sørensen 1989	Høye & Severinsson 2010	Kale & Syed 2010, Kale et al. 2011, Kale et al. 2013, Schumaker 1978, Høye & Severinsson 2008
Mental health	Berg et al. 2009, Berg & Johnsen 2004, Hauff 2008	Hauff & Vaglum 1997, Nome & Holsten 2011, Ayazi & Bøgwald 2008, Berg 2009, Iversen & Morken 2003, Iversen et al. 2011	Hjelde & Fangen 2006, Erdal et al. 2011	Erdal et al. 2011
Infectious diseases	Farah et al. 2006, Harstad & Jacobsen 2012		Sagbaken et al. 2010	Sagbaken et al. 2010
Maternity care	Austveg 1987, Haselkamp 1982, Lyberg et al. 2012		Garnweidner et al. 2013	Johansen 2006
Disability care			Sajjad 2012, Söderström 2012, Kittelsa 2012, Berg 2012, Sørheim 2000, Söderström et al. 2011	Berg 2012, Söderström et al. 2011
Health care for work and irregular immigrants	Aale 2009, Aschehoug 2010, Czapka 2009, Hjelde 2010, Guerin et al. 2005, Struja 2007			Stålseth 2012

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Care for elderly immigrants

Elderly care is not included in other literature reviews of immigrants' health issues (Abebe 2010, Kumar 2008, Spilker et al. 2009). In a book edited by Kumar & Viken (2010), the issues of elderly immigrants and care services are discussed as one of the emerging health concerns of immigrants, as the number of elderly immigrants is increasing and health care providers and policymakers are focused on the need to provide special care for aging immigrants (Thyli et al. 2010).

Concern about the health challenges relating to elderly immigrants was first addressed in recently as the first decade of the 21st century, by Magnussen & Johannesson (2005) and Ingebretsen (2005). The aforementioned authors mapped the need for care for elderly immigrants in five large cities in Norway. In addition, several reports from Norwegian Social Research (NOVA, Norsk institutt for forskning om oppvekst, velferd og aldring) have explored the needs of elderly immigrants and the availability of care services for them (Ingebretsen & Nergård 2007, Ingebretsen 2010a, Ingebretsen 2010b, Ingebretsen 2011). Further, Thyli et al. (2007) has studied the challenges related to elderly migrant patients in community health nursing.

The above-mentioned NOVA reports focus on issues such as the diversity among elderly immigrant populations in Norway (e.g. different cultures; work migrants who have been living in Norway for some time and who have good language skills; immigrants who came to Norway at a relatively older age or have arrived recently; and those living with extended families compared to those living alone), as well as the need for special health care and/or elderly care, home care versus institutional care, the challenges faced by health care personnel when encountering elderly immigrants, and the availability and quality of care for elderly immigrants. With regard to the needs of elderly immigrants, Ingebretsen (2010a) states:

> *The perspectives of the elderly users vary with respect to their needs and wishes for adaptation of services. The expectations of the elderly and their family carers toward the formal care systems are often expressed as ordinary wishes for caregiver stability, reliable appointments and staff-cooperation, together with culturally adapted care related to*

customs and cultural norms for cuisine, gender and intimacy. Respectful attitudes by staff and opportunity to speak their native tongue are on the list of wants. Some of the care receivers are unable to express their needs verbally in any language. The combined knowledge and sensitivity of family caregivers and staff are crucial to take the users' needs into consideration. Some of the respondents would have preferred multicultural care units, but most prefer adapted services in general units.

The health of elderly immigrants is not scrutinized to the same extent as the need for care for elderly immigrants. A study conducted by Gele & Harsløf (2012) focuses on the civic engagement of elderly African men and women with respect to their health status. They identify that poor health status in combination with a lack of communication skills results in a lack of engagement in organizational activities. Considering the fact that civic engagement has a positive effect on individual's health, immigrants' poor levels of participation in civic activities leads to poor health among elderly immigrants.

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Other studies of immigrants' health problems

Studies based on the Oslo Immigrant Health Survey have identified sclerosis as health issue among immigrants (Berg-Hansen et al. 2013, Smestad 2008). In addition, a few studies focus on concepts related to health, such as 'pain' (Ahmadi 2008, Dahl et al. 2006, Johansen 2002), 'well-being' (Grønseth 2001, Grønseth 2010), and quality of life (Hjellset et al. 2010). Apart from the literature reviews (Abebe 2010, Kumar et al. 2008, Spiker et al. 2009), a few other studies have focused on general health status of immigrants in Norway (Brunvand & Brunvatne 2011, Syed et all 2006).

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4. ANALYSING THE LITERATURE

Research focus groups

In this section I explore whether and how the literature addresses the diversity of the immigrant populations by looking at their country and migration backgrounds, gender, age, and present socio-economic backgrounds, which affect their health status.

To date, research on migration and health in Norway has focused primarily on the health problems associated with non-Western immigrants. A few studies compare the health of immigrants from Western countries (from high-income countries) and non-Western countries (from low- and middle-income countries) (Dalgård et al. 2006, Syed et al. 2006, Thapa & Hauff 2005, Thapa et al. 2007).

Research on mental health and lifestyle-related health problems has focused on gender differences, but gender is used primarily as a variable (men and women) rather than as an analytical concept. With regard to age groups, only studies of mental health problems have exclusively studied adults and young people with migration backgrounds. However, elderly immigrants are not in focus in studies of health problems. Recently, more researchers have started to examine the health issues of elderly migrant people, such as dementia, and the health care and other forms of care needs of elderly immigrants. This may be due to the fact that immigrant populations in Norway are still comparatively young and therefore problems associated with these groups have yet to materialize and be experienced by the Norwegian health care system.

It is evident from the literature analysis that the health of non-Western immigrants varies according to several factors:

- gender (men, women)
- age (young immigrants, children, adult immigrants)
- migration background (voluntary- work, education, family reunion, forced- refugees and asylum seekers)
- country background (high-, middle-, or low-income countries)
- socio-economic status in the host country.

The following Table 2 summarizes the health issues addressed in the literature and the main focus groups of the research.

Table 2: Health issues addressed in the literature and the main focus groups of the research

Health problem/issue		**Research focus group**
Mental health		Men: with refugee background, poor socio-economic background in host country
		Women: from Pakistan, family reunion background
		Young immigrants: migration backgrounds not specified
Infectious diseases	Tuberculosis	Refugee and asylum seekers from Africa Those who frequently travel to their home countries
	STIs, HIV/AIDS, hepatitis	Immigrants from countries with high incidences of infectious diseases, mainly Africa
	Malaria	
Lifestyle related	Diabetes	Men and women from Vietnam, Turkey, Sri Lanka, Pakistan, and Iran Exclusively women from Pakistan
	CVD	
	Obesity	
	Vitamin D deficiency	Women: from Pakistan

	Alcohol & drug abuse	Men: Kath use among men from Somalia Young immigrants/second generation
Reproductive health		Women from Asia and Africa FGM & reproductive health among women from Somalia
Gender-based violence		Not seen as a health problem, but as a social problem related to forced marriage among families from Pakistan, Iraq, Iran, and Turkey. FGM is not studied as gender-based violence.
Disability	At birth	The double burden of being immigrant and disabled, with examples from families with Pakistani background
	Work-related	Immigrant population in general
Other health issues	Sclerosis	
	Quality of life	Tamil population
Health care	Provision of health care Use of health care Immigrants' experiences Experiences of health care personnel	Non-Western immigrants and their use of RGP, incentive care, and for health problems such as mental health
Strategies adopted	Screening	Mainly on TB
	Treatment	TB, CVD, and diabetes
	Prevention	CVD and diabetes
	Promotional	Pakistani women with lifestyle-related health problems

Research approaches

Most of the studies based on the Oslo Immigrant Health Study (Innvandrer-HUBRO) are within the positivistic framework, with quantifiable data and searches for patterns and generalizations. Further, these studies have a biomedical approach to the health of immigrants. Studies primarily focus on two aspects. The first aspect is the identification of the pattern of distribution of the disease among the ethnic groups and between men and women: who contracts what kind of diseases or health problems. The second aspect is the identification of the risk factors for poor health conditions among immigrant populations. For example, with the exception of the studies by Mellin-Olsen & Wandel (2005) and Wathne et al. (2013), all of the studies of lifestyle-related health problems have a biomedical approach to immigrants' health and use quantitative methods to analyse and present data. Some studies provide generalizations of the number of immigrants that have or are vulnerable to different kinds of lifestyle-related health problems. The study carried out by Mellin-Olsen & Wandel (2005) had a qualitative approach (focus group discussions) and explored immigrant women's experiences and understanding of their health and migration, including changes in their behaviour in everyday life, dietary habits, and perceptions of different foods. Wathne et al. (2013) explores the perceptions and experiences of young Pakistani girls and boys regarding obesity. Using interview methods, the authors unravel how obese children cope with the challenges of everyday life while trying to lose weight in cultural settings where they receive different signals about weight and food. The above-mentioned studies all attempt to answer the question of why the studied subjects had either CVD or obesity by exploring the subjects' perceptions of their experiences and behaviours.

In addition, research on mental health of immigrants in Norway falls within the positivistic framework that uses quantifiable data to generate conclusions. Mental health studies primarily focus on identifying the risk factors for mental health conditions among different immigrant groups. Most of the studies use the Hopkins Symptom Checklist to identify the risk factors and to measure psychological distress. They provide general conclusions such as, 'exposure to war and conflict environments' and 'individual's lack of integration into the host society' are the main risk factors for mental health problems among non-Western immigrants in Norway, but hardly explore the

subjective experiences of immigrants with mental illness and how their illness affects their everyday life.

With regard to studies of health care services for immigrants, the main focus is on the use of health care. Within this category, the use of mental health care and the use of emergency care as opposed to care provided by a general practitioner (*fastlege*) are exclusively researched. Most of these studies have a quantitative approach and thus describe which and how many immigrants use certain kinds of health care services. Also, research on screening, treatment, and preventive strategies has a biomedical approach to address various health issues.

Several studies have a humanistic approach and focus on addressing the questions of why people behave in such manner and how they perceive their ill-health situation. Using qualitative methods, these studies explore immigrants' subjective understanding of being sick and their health behaviours, experiences, and perceptions of health care personnel during their encounters with immigrant patients, and conversely the immigrants' experiences and perceptions of the health care services available to them. For example, Erdahl et al.'s (2011) study of attitudes towards depression and the treatment of depression explore the experiences and perceptions of individuals diagnosed with the illness, of laypersons, and of health care professionals. A study by Sagbakken et al. (2010) explores individual's perceptions of being diagnosed with tuberculosis. Johansen (2006) studies the experiences of health care personnel when assisting infibulated women in labour. Her findings suggest that a combination of taboo, silence, limited knowledge, and emotional difficulty, along with a wish to be culture-sensitive may at times prove counterproductive to giving the best help. According to Johansen (2006) Health care workers often seem to impose 'imagined' cultural values on infibulated women, rather than clarify them through personal communication. Further, using qualitative methods such as semi-structured interviews and in-depth interviews, Goth et al. (2010) and Høye & Severinsson (2008) study the experiences and perceptions of health care personnel during their encounters with immigrants with multicultural backgrounds. Berg (2012), Sajjad (2012), Berg et al. (2009), Goth & Berg (2011), and Høye & Severinsson (2010) exclusively examine immigrants' experiences and perspectives related to the health care available to them and explore the challenges immigrants encounter when accessing the Norwegian health care system.

Although international studies highlight the positive relationship between migration and health by using the theory of selectivity of migration, studies in Norway do not reflect immigrants as a group of healthy people. The research review revealed evidence that the significance of acculturation and the negative effects of migration are higher than the 'healthy migrant effect' for the health of immigrants in Norway. For example, the non-Western immigrant populations are mainly work migrants, refugees, or asylum seekers. Although work migrants are supposed to be healthy initially, they ultimately experience a worsened health status as a consequence of engaging in types of employment with negative health impacts in combination with poor acculturation.

Most of the studies point out that individual's lack of social integration and/or acculturation (mental health studies) and their behaviours in everyday life such as their dietary habits, exercise, and communication and social networks (lifestyle-related health studies) are the cause of immigrants' poor health status. Hence, research implicitly blames the victims and blames immigrants' cultural practices for exposing them to risk factors. The complexity of migration, the adaptation process, and the roles of institutions in the host society (e.g. neighbourhoods, health, and education institutions) on the health of immigrants are not taken into account. However, a study by Grønseth (2001 & 2010) has explored the health and well-being of Tamils as a combination of experiences of their home country, the migration process, and adaptation to and relationships with the host society.

<u>Research gaps and future research areas</u>

As shown in the section above, research on immigrants' health in Norway covers different groups. However, I consider that more research should be focused on four immigrant groups:

irregular/undocumented immigrants, work migrants, elderly immigrants and immigrants living in Norway as a whole (other than Oslo).

Health of irregular/undocumented immigrants

Relatively little is known about the group of immigrants comprising persons without legal residence (i.e. unregistered or irregular). The group includes asylum seekers who have been rejected, people who have remained in Norway illegally and without immigration authorities knowing about them, and tourists that have not returned home after their visa has expired. According to Shuja (2007), it is not known exactly how many people are living in Norway illegally, but it is estimated that there may be c.5000–10,000 in Oslo alone. Further, a significant number of children are included in this group. Currently, it is somewhat unclear what health benefits can and should be given to people residing illegally in the country. They are not counted as belonging to the immigrant population in Norway. However, it is clear that undocumented immigrants as a group are very complex. People in this group may need medical care, but face significant barriers if they attempt to access help.

Studies of irregular immigrants' health have only focused on one disease, namely tuberculosis (Heldal et al. 2008, Winje et al. 2008). Few studies have concerned access to health care as a legal right of irregular migrants or the availability of health care facilities to this group (Aschehoug 2010, Hjelde 2010). Research should focus on mental health of asylum seekers and illegal or irregular migrants. These groups are more vulnerable to mental health problems than those that have permanent resident status because their everyday life is fill with dreams of an uncertain future, thus their mental condition is worse off compared to legal immigrants (Willen 2012).

Health issues of work migrants

Several media reports have revealed the alarming conditions of the living and working environments of work migrants. The concept of 'social dumping' is often used to describe the situation of work migrants. However, the health impacts on work migrants have not been thoroughly scrutinized or have not yet been published, with the exception of the studies by Czapka (2009) and Guerin (2005).

Hence, there is a need to study the health impacts of migration for work, which differs significantly according to the migrants' country of origin, expertise, and the type of work they engage in.

Health issues of elderly immigrants

With regard to the health of elderly immigrants, there is a need to conduct research on health problems, perceptions, and expectations related to aging in Norway as well as the experiences of elderly immigrants regarding the care provided to them. Further, in order to provide better care systems for future elderly immigrants, there is a need to make a prognosis on their needs and design appropriate strategies.

Health of immigrants living in Norway as a whole

As most of the research to date has been based on the findings of the Oslo Immigrant Health Study (Innvandrer-HUBRO), it cannot be assumed that the findings extend to the entire immigrant population living in the country. As I discussing below (in 'Limitations of acculturation theory and blaming the victims'), living environments, including neighbourhoods, social networks, and physical conditions, affect immigrants' health status. For example, an immigrant living in the capital city with better access to health care (with interpreters) and living with other members of their ethnic-cultural community probably experience the same disease conditions differently than immigrants living in

rural Norway, with limited contact with Norwegians and their own countrymen. Research should be conducted on immigrants living in other parts of Norway and compare their conditions with immigrants living in Oslo and other larger cities.

Gender-based violence as a health issue

With the exception of FGM, most gender-based violence among immigrant populations is understood as a social issue. Hence, there is a need to look beyond the social costs of such violence and identify the health impacts of gender-based violence. I identify two aspects of gender-based violence related to migration and health. The first aspect is the effect of harmful cultural practices, such as FGM, forced marriage, child marriage, honour-related violence, on the health of individuals (Johansen 2006, Fangen & Thun 2007; IMDI 2013). Studies should focus on both the physical and mental health impacts of such harmful cultural practices. The second aspect is the health impacts of domestic violence and/or intimate partner violence related to marriage migration. Several studies have been conducted on women from Thailand and Russia who came to Norway as marriage migrants and their living conditions due to oppressive husbands (Lotherington & Flemmen 2007, Skilbrei 2007). It is important to study their health status as they are in a more vulnerable position than immigrant women married to a partner from their own ethnic background.

With regard to research approaches, I identify the following limitations to research on immigrants' health in Norway.

Lack of a gender approach to immigrants' health problems

As I mentioned in the section headed 'Research focus groups', gender is just used as a variable (men and women) in the research on immigrants' health in Norway. Studies describe the difference between the incidences of disease in men and women but do not analyse in-depth the effects of the socio-culturally determined roles of men and women (i.e. gender) on their health problems. The few mental health studies that focus on gender only briefly mention the differences in gender expectations between own and host cultures as one of the reasons for lack of acculturation, but those studies also lack in-depth analyses of how gender roles and identities vary between the host society and immigrant groups.

A gender approach is useful for understanding three different aspects of health. The first aspect is that individual's *subjective understanding of health* varies according to their gender, and therefore men and women perceive and react to illness and disease differently. The second aspect is that men and women's *responses to acculturation process* vary. In general, researchers have concluded that immigrant women's poor health status is a consequence of their low level of acculturation, including communication skills and unemployment. If analyses were to be conducted using a gender lens, it could be argued that the level of acculturation varies between men and women due to gender differences within immigrant groups. This approach is also suitable for studies of *gender-based violence* arising from harmful cultural practices such as FGM, forced marriage, domestic violence, and intimate partner violence, and to study alcohol and substance abuse among immigrant populations.

Limitations of acculturation theory and blaming the victims

The health of non-Western immigrants in Norway cannot be explained using the theory of selectivity of migration and the 'healthy migrant effect', since research to date has identified that immigrants have poorer health conditions than the native Norwegian population and Western immigrant population. This situation differs from the research findings of studies of immigrants' health in other

countries, particularly the USA, where first-generation immigrants experience better health conditions despite their poor social and economic status (Viruell-Fuentes 2007). Based on acculturation theory research conducted on immigrants in Norway opts to 'blame the victims', - non-western immigrants' culture and behaviours - for their poor health status.

Guided by international studies, I argue that the research needs to look at the explanations beyond the acculturation issues (Acevedo-Garcia et al. 2012, Viruell-Fuentes et al 2012, Salant & Lauderdale 2003). Health status of immigrants should be understood as a complex situation – a combination of several factors. The research needs to look at the socio-historical contexts of migration, the racialization of contemporary migrants in Norway (Africans, Asians, Muslims, and Western versus non-Western migrants), and the role these factors play in the differential social integration of immigrants. Further, the impacts of social contexts, such as neighbourhoods, social networks, and institutions, as well as the level of discrimination experienced by individuals also affect immigrants' health status (Viruell-Fuentes et al 2012). Although some studies of the health of immigrants in Norway have examined the level of acculturation in relation to neighbourhoods, discrimination (contacts with Norwegians), and acculturation as a process, they have quantified the information (e.g. the number of visits to or from Norwegians, and immigrants' length of stay in Norway, age, generational status, and language proficiency). Such research with quantified acculturation data ignores factors such as the effect of residence on low-resource communities, low socio-economic status, the social construction of cultural and/or ethnic identities, and institutional patterns of unequal treatment, all of which contribute to health disparities (Viruell-Fuentes et al. 2012).

Furthermore, studies identify immigrants' low level of physical activities in comparison to Norwegians. In other words, they lack of acculturation as one of the main causes of lifestyle-related health problems. However, immigrants in Norway are not necessarily are physically inactive due to their culture. Severe environmental conditions that differ from those their own countries and the costs linked to physical activities (e.g. clothes and fees) are possible explanatory factors (Attanapola unpublished data). More research should be conducted to disprove the myths of a relationship between immigrants' cultures and their health problems.

As I have mentioned in section 'Health of immigrants living in Norway as whole', geographical location (urban versus rural) and living in ethnic and/or immigrant enclaves have significant effects on immigrants' health status. Some studies show that living in an urban environment with low-quality housing and poor services provision results in a high risk of mental health problems (Bhugra & Gupta 2011), whereas other studies show the positive health impacts of living in ethnic enclaves (Viruell-Fuentes 2007) and practising cultural traditions (Dyke & Dossa 2007). Future research should not highlight immigrants' culture as a problem (i.e. a source of dysfunction) for attaining positive health status, but should treat their culture as a therapeutic arena that provides acceptable levels of care, advice, and alternative medicines that are not always harmful but promote health.

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5. CONCLUDING REMARKS

A substantial number of studies have been conducted on immigrants' health in Norway and most of them are based on data from the Oslo immigrant health study (Innvandrer-HUBRO). This literature analysis has identified eight crucial health issues: mental health problems, lifestyle and diet-related health problems, infectious diseases, reproductive health problems, access to and use of health care services, disability, gender-based violence, and care for elderly immigrants. Based on the acculturation theory, most of the research blames the immigrants' culture for their health problems.

Prospective studies are needed to understand migrant health better and to inform interventions for immigrants' health maintenance. The focus should be on vulnerable immigrant groups such as asylum seekers, irregular migrants, work migrants, and marriage migrants. Further, care for the elderly immigrant population is an emerging issue.

The intersectionality theory has been recently adapted to study immigrants' health problems and to identify why some immigrant groups are worse off than others in terms of their health. This approach provides a richer understanding of immigrants' health patterns by shifting the focus from individual-level cultural explanations to research that provides a broader, more in-depth analysis of ethnicity and/or racism as a structural factor that intersects with other dimensions of inequality such as gender and class and impacts the health outcomes of immigrants (Viruell-Fuentes et al. 2012).

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Dragvoll allé 38 B
7491 Trondheim
Norge

Tel: 73 59 63 00
Web: www.samforsk.no