JOINT ACTION on HEALTH EQUITY EUROPE
Work Package 7 Migration and health

Country assessment
NORWAY

Phase 1: Migration and health
Phase 2: Suggested actions based on assessment

Prepared by:
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PHASE 1: COUNTRY ASSESSMENT NORWAY

INFORMATION ABOUT COMPLETION OF THE QUESTIONNAIRE

COUNTRY/REGION: NORWAY

1.2 INFORMATION ON COMPILER

Name: Charlott
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Country: Norway
Occupation: Advisor

Describe the process used to fill in the country

Consultations with other colleagues at NIPH
Data collected by Charlott Nordström, advisor NIPH
Sections filled by Harald Siem, advisor NIPH, Yasmin El-Hage, intern NIPH, and Anand Bhopal, advisor NIPH. Furthermore, other colleagues have provided input on sections relevant for their speciality. Reviewed and final version approved by Bernadette Kumar.

State other relevant information:

The compilers are based at the Norwegian Institute for Public Health, within the Unit for Migration Health (formerly known as NAKMI, the National Competence Centre for Migration and Health, which was established in 2003, became part of NIPH in 2018).

The aim of the unit remains consistent with the original goal of NAKMI: to generate and disseminate research-based knowledge that promote good health and equitable health care for people with a migrant background.

AVAILABILITY OF DATA AND RESEARCH

BACKGROUND INFORMATION

Checklist 1.1 Availability of data and research

	Data and Research	Comment
1.	☒ Socio-demographic (SD) data on migrants is available for our country.	Statistics Norway (SSB), National Bureau for Statistics
2.	☒ The SD data is available at national level	By SSB
3.	☒ The SD data is collected routinely	By SSB
4.	☒ The SD data is available by age, gender, migrant / ethnic group	By SSB
5.	☒ We have data on the health of migrants	By SSB, research by independent research institutes, universities and other governmental institutions.
6.	☐ The health data from hospitals is available by migrant group/status* (explanation in glossary)	Not readily available. Hospital data can be obtained through the Norwegian Patient Registry, which can be linked with data from SSB.
7.	☒ Health data from registries are available by migrant group/status	Registries can be linked to produce such data. Researchers are able to apply for permission to linking several health registries with country background/migration background or legal status for research projects. It is a costly and time-consuming process to gain permission and access to do this. Registry linking registries for surveillance purposes is illegal. SSB information on data for research.
8.	☒ Health data from studies and surveys are available by migrant group/ status	This varies with the study, but is possible. SSB collects data for their report on living conditions every 10th year, using a selection of 12 groups in the migrant population.
9.	☒ It is easy to access data on migrant health as it is available online	Data is largely accessible online, however, no comprehensive overview is available and information will have to be collected from different sources. Most population data is updated annually at www.SSB.no. Otherwise, most data is available from the institute/organisation of origin through their search engines.

10.	☒ There are specific research programs that offer funding for either migration or migration health	There are no specific research programs on migration and health. NFR have many programs that target development of the health and care services, public health and social inequality (i.e. VAM). Other organisations sometimes call for proposals on migrants/ migrant health. In 2018, NordForsk announced a call for research on migration and integration.
11.	☒ There's a national/regional research Centre or agency that is responsible for migrant health	Until January 2018, there National Competence Centre for migration and Health (NAKMI) was a standalone institute. Now it is called the Unit for Migration and Health and is part of the Norwegian Institute for Public Health. Despite the organisational change, the unit still has mostly the same agenda and field of work. Combining research, dissemination to health personnel and policy advice to the government. Despite now being a unit within NIPH, duties regarding migration health are described in the annual state budget along with specific funding.
12.	☒ A literature review of the health of migrants is available in my country	The last comprehensive literature review published was by Dawit in 2010. An updated comprehensive literature review is in the making at the unit for migration and health.
13.	Other Relevant Sectors have data on migrants and ☒ Education ☒ Employment/labour ☒ Housing/Healthy Living Environments	SSB regularly provides general statistics on migrants and level of education, participation in work life and housing among other things. Most other sectors have available data on migrants. For example, the Ministry of Education, the Ministry of Children and Families, the Ministry of Justice, the Ministry of Culture and Equality, and the Directorate of Integration and Diversity (IMDi). Independent research institutes like The Work Research Institute (AFI, part of the Centre for welfare and Labour Research at Oslo Metropolitan University), The Fafo Institute for Labour and Social Research and Norwegian Social Research (NOVA) provide reports on migrants and other topics beyond health.

Explanations and additional comments to the checklist above.

Disaggregation of data is normally possible by age, gender, country of origin, length of stay, residence status. Overall, there is a large amount of information available on immigrants and their children, and their health. The data is not always readily available and not always comprehensive.

TABLE 1.1 Key indicators migrant population

	Indicator	*Number or percentage*	*Data Source 1.1.2019*
1	Total National Population	5 328 212	SSB.no
2	Total international migrant population	944 402	See clarification below SSB.no
3	Percentage of migrant population	17.8%	SSB.no
4	Percentage non-EU/EFTA migrants among foreign-born population	47%	SSB.no
5	Non-EU/EFTA citizens as percentage of non-national population	10.7%	SSB.no
6	Percentage of asylum seekers/ refugees	4.4%	SSB.no (percentage of migrant population)
7	Inhabitants per asylum applicant	2007	2 655 asylum applicants in 2018
8	Percentage of positive asylum decisions at first instance	72%	UDI.no (2018)

Additional comments to the table above:

Clarification of terms: Migrant population SSB uses the terms “immigrants” and “children born in Norway by immigrant parents”. As of 2018, they do not use the combining term “immigrant population” to describe both.
Immigrants: 765 108 (2019). 14,4%
Norwegians born with immigrant parents (two immigrant parents and four foreign born grandparents): 179 294 (2019), 3,4%

We have used SSB data as this is the most up to date and is the primary data, which feeds into the EUROSTAT, UNDESA, which is therefore normally older.

TABLE 2.2 Migrants socioeconomic position

	Indicator	*Category*	*Number or percentage*	*Data Source*
1	Education	University/college > 4 years	16.1%	SSB.no
		< 5 years of primary school	1.8%	
		Illiterate		
2	Employment	Unemployed	5.8%	SSB.no (Q1, 2019)
		Employed (15–74 years)	66.6%	SSB.no (20-66 years)
3	Income	Top percentile		SSB.no

		Migrant at risk of poverty Migrants below poverty	37%	Percentage refers to immigrants with four or more financial problems, and lasting low income below 60% of median in population.
4	Disability	On disability pension	4.9%	SSB.no (2018)

Additional comments to the table above:

All these topics will be addressed further later in the document.
Education: We do not have data on number of illiterate immigrants. General literacy rate reported as N.A on the UNDP Human Development Index.
Disability pension: Immigrants on disability pensions add up to 4, 9% of the total population. In the rest of the population 10, 9% are on disability pension. The number of people on disability pensions increase with age in both immigrants and the general population.

Availability of data

Data on migrant status is available through the national registry, which contains information on everyone who resides in Norway. Newly arrived immigrants' data are first available in the national registries after approximately 6 months of stay in Norway. The data is available online through the National Statistics Bureau (SSB.no) and Directorate for immigration (UDI .no). SSB population data including immigrants has been available since 1968. UDI provides updated data on immigration monthly.

Information on immigrant background is considered sensitive information. Health registries can be linked to information on country background/ reason for migration (child of immigrant, adopted etc.). Research projects that are regulated by the Health Research Act have to apply for advance approval from the Regional Committees for Medical and Health Research Ethics (REC). In some cases, it is also necessary to get a licence from the Data Protection Authority. Furthermore, you have to apply to the owner of the registry (I.e. SSB and NIPH). This can be costly and is a thorough application process to ensure data security. The process can take up to two years.

Independent research institutes and national competence centres, NIPH and Universities all do research on the migrant population on many different health related topics. Articles and reports are found in international and national peer-reviewed journals, written in English or Norwegian. Searching in the respective organisations own databases is crucial to locating grey literature. There is a mix of registries, quantitative and qualitative studies available. There is a lack of quantitative data on irregular migrants; numbers regarding this group are only uncertain estimates.

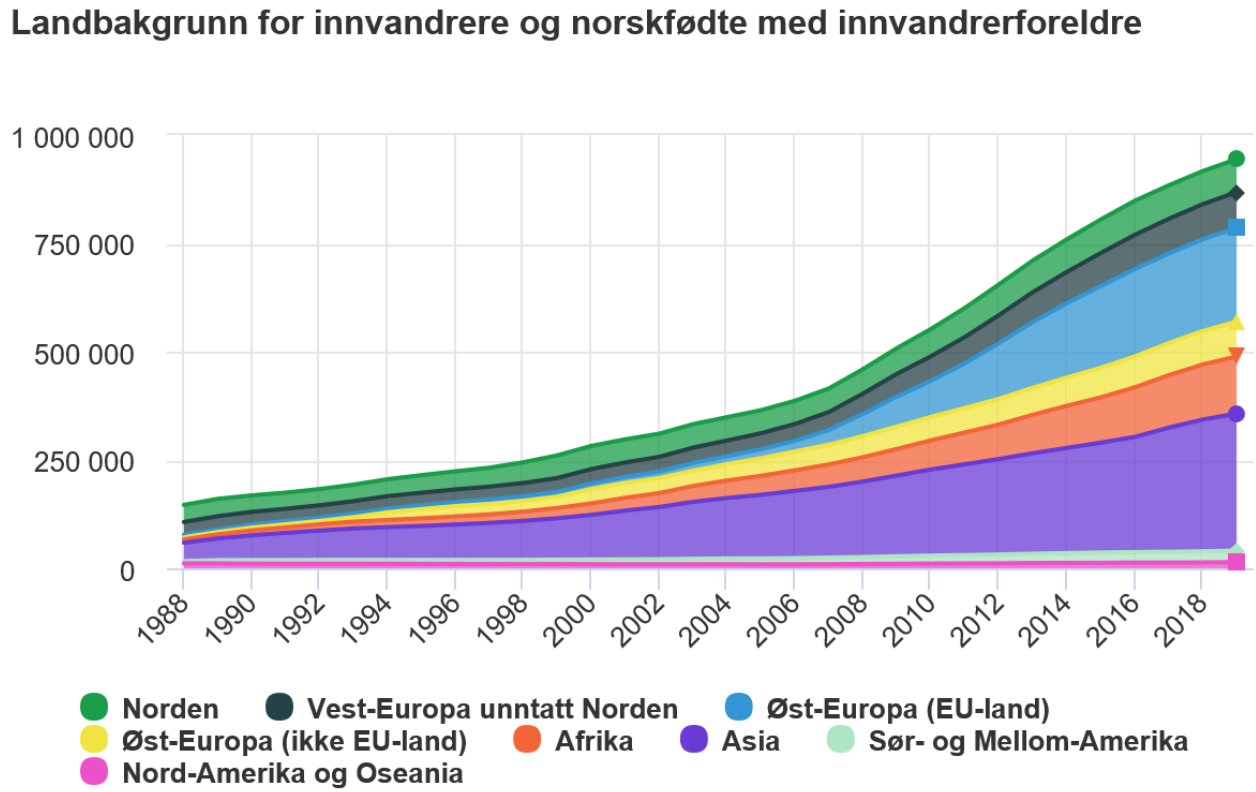
History of migration

Prior to 1945, migration to Norway was low with most migrants coming from other Nordic countries and mainland Europe. Hungarian refugees were the first larger group migrating to Norway in 1950s, followed by refugees from Chile and Vietnam in the 1970s. Around the same time, we saw

an influx of labour immigrants from Yugoslavia, Turkey and Pakistan. In 1975, immigration to Norway became regulated and limited. In the late 1970s and 1980s, a number of "boat migrants" from Vietnam were admitted as refugees (ssb.no, 2017).

Since 1990, immigration policy has focused on the resettlement of asylum seekers and refugees from conflict zones including Somalia, Sri Lanka, Former Yugoslavia, Afghanistan, Iraq and Syria. With the admission of new members to the EU, there has been a rapid growth in labour migration from Poland, Latvia, Lithuania and other Eastern European countries. In 2015, Norway, as with the rest of Europe, had a rapid increase in asylum seekers to the country (SNL.no).

The graph below shows immigrants regional background from 1988-2018 (SSB.no). In order from left; Nordics, West-Europe without Nordics, Eastern Europe (EU-countries), Eastern Europe (non EU-countries), Africa, Asia, South- and Central America, North-America and Oceania.



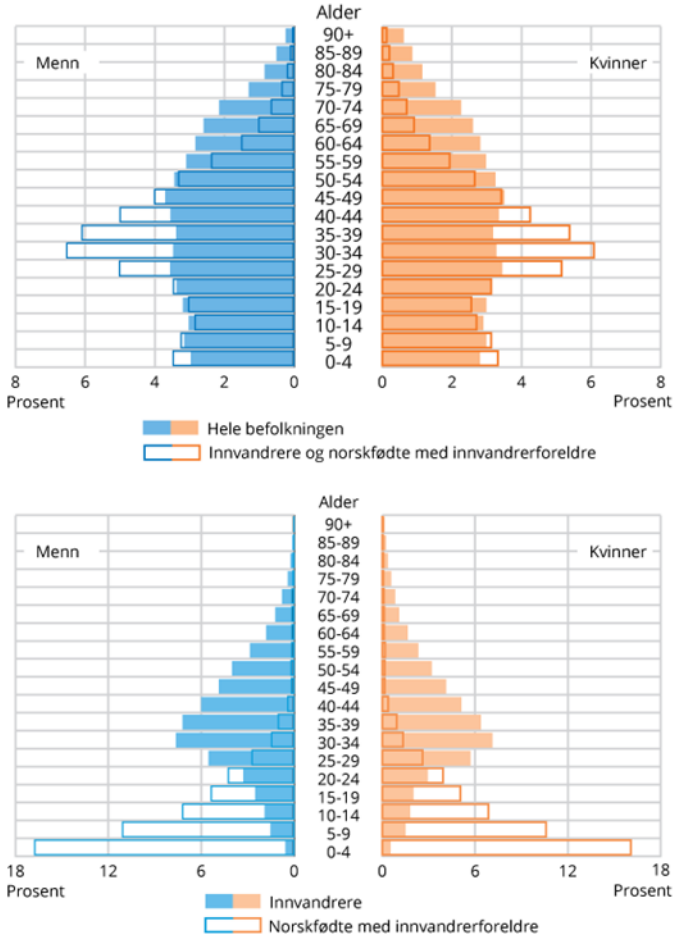
Kilde: Innvandrere og norskfødte med innvandrerforeldre, Statistisk sentralbyrå

Socio economic background of migrants

AGE AND GENDER

The figures below compare demographics of immigrants, Norwegian born to immigrant parents and the general population, by gender and age (SSB.no). Men are to the left and women to the right.

Befolkningspyramider. Hele befolkningen og personer med innvandrerbakgrunn samt innvandrere og norskfødte med innvandrerforeldre. 1. januar 2017



Kilde: Befolkningsstatistikk, Statistisk sentralbyrå.

The first pyramid compares 1) immigrants and born of two immigrant parents (bar chart outline only) with 2) the total population (bar chart filled). This shows that the immigrant and those Norwegian born with two immigrant parents (1) are younger and mostly of working age. This means that in 20-30 years' time, a large part of immigrants will reach retirement age and their health profile will change. The second pyramid compares 1) immigrants (bar chart outline only) with 2) Norwegians born to two immigrant parents (bar chart filled). This shows that the majority of Norwegians born to immigrant parents are under 15 years old.

EDUCATION

109,938 (16%) immigrants have 4 or more years of higher education, compared to 315 234 (9%) of the total population. 220 088 (31%) immigrants have 5 years of primary school, compared to 869 626 (24%) people in the total population. 11 795 (2%) immigrants are listed as having no education, compared to 2 305 in the host population (<1%) (SSB, 2018).

The level of education in immigrants does not differ vastly from the total population, however; there are larger differences between different immigrant groups. Immigrants are both more and less educated than the total population, with more people having university or college degrees as well as more people who have primary education or no education at all. In the group of people with no education, women are overrepresented and a majority of from Pakistan, Afghanistan and Somalia. Seen as one, the immigrant population have more education than the host population, primary explanation being that they are younger (SSB, 2018).

Keeping in mind that information on education level is unknown for 26.4% of migrants older than 16 years; SSB calculates estimations for this part of the immigrant data aiming to correct the data (SSB, 2017). Furthermore, information on asylum seekers education is not available as this information is only collected after the application for asylum has been granted (SSB, 2016).

INCOME

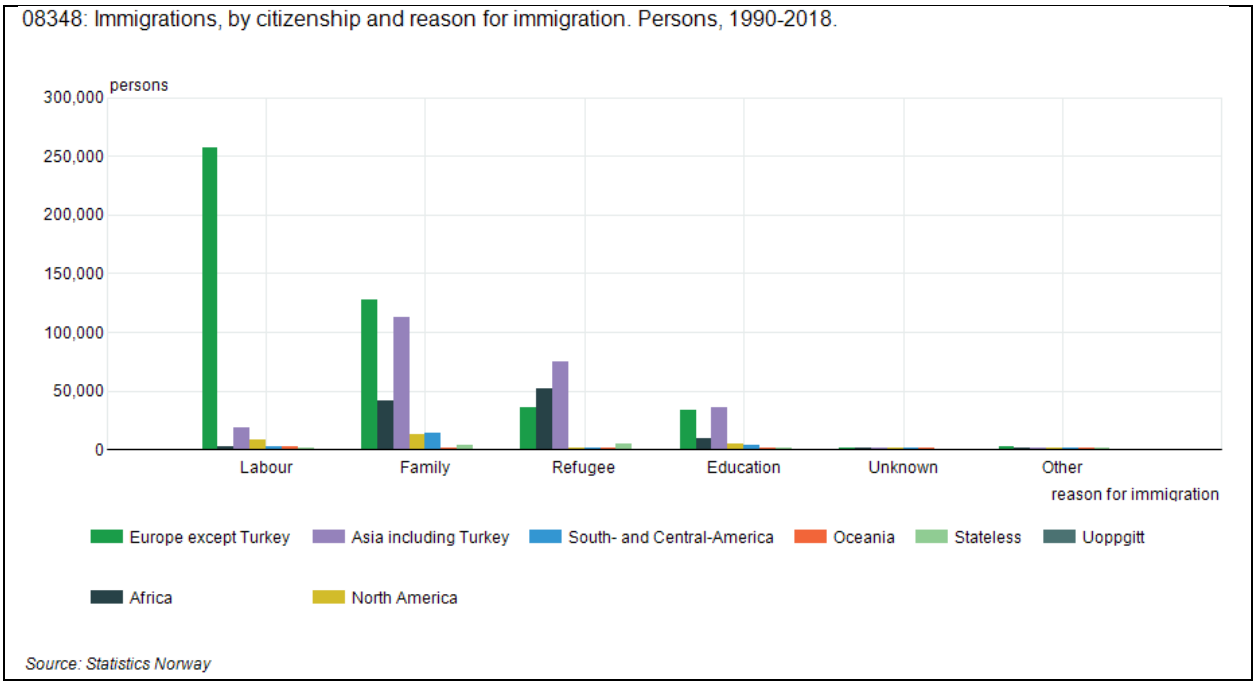
Reason for migration and length of stay explain much of the variation between immigrants' income. While length of stay tends to increase earnings over time, there is also evidence of discrimination in the labour market and a challenge for immigrants to use their professional education in protected vocations such as medicine and psychology, limiting social mobility (SSB.no, 2017).

In Europe, 'low income' (or 'relative poverty') is defined as earning less than 60% below the median income in the country. In the last publication from SSB on living conditions, immigrants on average had a 23% lower median income than the total population. While migrants from Somalia and Eritrea on average earn almost 50% less than the total population, immigrants from Iran, Poland and Kosovo earn 75% of the income in the total population. Immigrants from Bosnia-Hercegovina, Sri Lanka and Vietnam are the top earning immigrant groups, earning more than 80% of the median of the total population.

Reasons for migration

Labour migration is the primary reason for migration in Norway today. Since 1991, seeking asylum has only twice been the largest reason in a single year. The first time was in 1993 primarily due to conflicts in Bosnia and the second time was in 1999 primarily due to the Kosovo-conflict. In order, the main reasons for migration to Norway today are 1. Labour 2. Family reunion 3. Asylum (SSB.no, 2019).

The graph below shows reason for migration by region, from 1990-2018 (SSB.no). As can be seen, labour migration, followed by Family, is the main reason for migration for people from Europe. Refugees come primarily from Asia (ink Turkey), Africa and Europe.



Countries of origin

The largest groups come from Asia, followed by eastern Europe. According to registered citizenship, the top five countries migrants come from today are in following order: Poland, Lithuania, Sweden, Syria and Germany (SSB.no, 2019). Among Norwegian born with two immigrant parents the top five nationalities are Pakistan, Somalia, Poland, Iraq and Vietnam.
Title translation: Migrants by country background and age, 30 largest groups. 1 January 2017.

Innvandrere, etter landbakgrunn og alder. 30 største grupper. 1. januar 2017

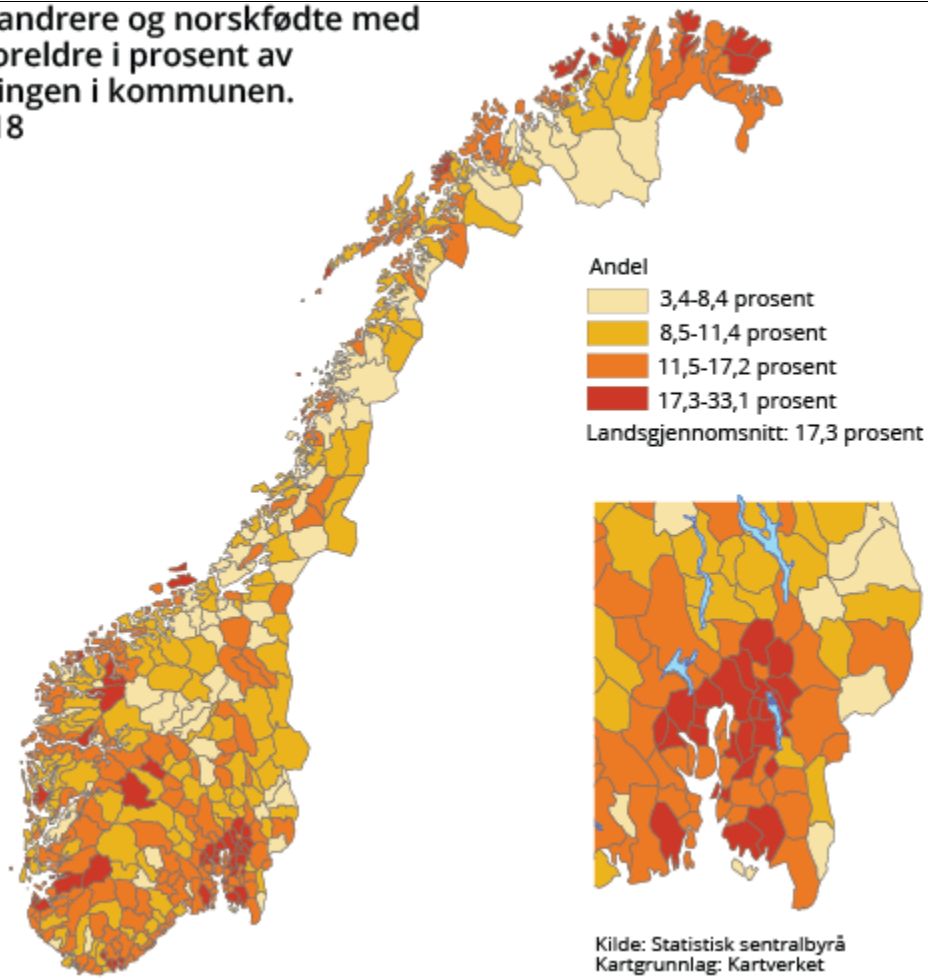
Landbakgrunn	I alt	Alder					Tidliginnvandrede (kommet til Norge før fylte 6 år)	
		0-5 år	6-15 år	16-19 år	20-66 år	67 år og eldre	Absolutte tall	Prosent
Innvandrere i alt	**724 987**	**11 259**	**51 038**	**27 126**	**599 480**	**36 084**	**59 206**	**8,2**
Polen	97 196	1 384	7 046	2 610	85 224	932	6 189	6,4
Litauen	37 638	533	3 229	1 128	32 683	65	2 410	6,4
Sverige	36 315	320	939	323	31 131	3 602	1 860	5,1
Somalia	28 696	256	3 822	2 523	21 608	487	3 063	10,7
Tyskland	24 601	273	1 497	1 014	19 256	2 561	1 958	8,0
Irak	22 493	132	1 240	1 246	19 375	500	2 671	11,9
Syria	20 823	1 625	4 296	1 543	13 239	120	2 403	11,5
Filippinene	20 537	114	1 243	643	18 030	507	918	4,5
Pakistan	19 973	178	626	377	17 096	1 696	2 755	13,8
Eritrea	19 957	224	2 380	1 822	15 350	181	1 310	6,6
Danmark	19 494	199	635	246	13 443	4 971	1 347	6,9
Thailand	18 634	81	1 550	1 291	15 566	146	961	5,2
Russland	17 225	109	1 327	830	14 307	652	1 577	9,2
Iran	17 169	79	921	609	14 851	709	1 386	8,1
Afghanistan	15 986	156	1 770	2 464	11 321	275	1 244	7,8
Storbritannia	14 330	269	625	141	10 521	2 774	1 016	7,1
Romania	13 889	192	974	289	12 304	130	749	5,4
Vietnam	13 750	71	186	131	12 276	1 086	1 236	9,0
Bosnia-Hercegovina	13 591	58	171	135	11 776	1 451	1 349	9,9
Tyrkia	11 330	164	231	162	10 275	498	1 087	9,6
India	11 022	411	579	111	9 270	651	1 060	9,6
Latvia	10 052	161	973	268	8 602	48	715	7,1
Kosovo	10 034	32	192	364	9 207	239	1 528	15,2
Sri Lanka	9 109	21	148	95	8 379	466	516	5,7
Kina	8 475	84	298	186	7 429	478	415	4,9
USA	8 446	168	427	197	6 173	1 481	634	7,5
Etiopia	7 888	173	781	434	6 446	54	827	10,5
Island	7 883	234	1 050	361	5 878	360	1 224	15,5
Nederland	7 713	105	679	341	5 772	816	772	10,0
Bulgaria	6 726	128	559	207	5 714	118	397	5,9

Kilde: Befolkningsstatistikk, Statistisk sentralbyrå.

Geographical distribution of migrants

The immigrant population of Norway is around 750,000, comprising 14.3% of the total population. Migrants live right across the country, with some concentrations around the bigger cities and the western coast of the country. As a proportion of the total population, most immigrants living in the capital city, Oslo. In 2018 there were 169 000 immigrants (25%) and 54 000 people born to immigrant parents (8%) (Oslo.kommune.no, 2019). This is illustrated in the heat map below which shows the population of immigrants and children born to immigrant parents as a percentage of the total population, by municipality, with the darker shades corresponding to a higher concentration (SSB.no, 2018).

Figur 3. Innvandrere og norskfødte med innvandrerforeldre i prosent av totalbefolkningen i kommunen. 1. januar 2018



HEALTH STATUS OF MIGRANTS

Data sources on health status of migrants

There are many health registries, owned or administered by different institutes like SSB, NIPH and the Norwegian tax administration. Sources of knowledge on migrants and health are available through state organizations like SSB, The National Institute of Public Health and The Directorate of Health who are all mandated to provide data analysis on a regular basis and inform policy makers and the public.

Linking national registries, particularly SSB administered registries combining migrant health data, is a valuable tool in Norwegian migrant health research. The Statistics Act (1989) tightly regulates the official statistics in Norway. Gaining approval to undertake such research can be an expensive and time-consuming activity, taking up to two year.

Health surveys and qualitative research among particular migrant groups or on particular health issues are also vital. Independent research institutes and the national universities and colleges contribute with a broad range of research on migrants' health.

Examples of relevant publications include:

- The annual public health report published by NIPH. The different chapters are updated routinely. The chapter on immigrants' health was last updated 14.05.2019. Based on this data The NIPH publish annual health profiles for the country and municipalities. Most of this information is not available aggregated from country background but can be linked with registries.
- SSB Reports on Living conditions among Immigrants in Norway from 2005-2006 and 2017 contains a chapter on health. The sample consisted altogether of immigrants aged 16 years and older from Poland, Turkey, Iraq, Iran, Afghanistan, Pakistan, Sri Lanka, Vietnam, Eritrea, Somalia, Bosnia – Herzegovina and Kosovo.
- Youth, Culture and Competence (UngKul) by NIPH is an umbrella name for several studies that look at the meaning of ethnicity, adaption and mental health. They are longitudinal studies following both children and youth that are born in Norway or have an immigrant background.
- Ungdata is an annual cross-national study of growing up, living conditions and health among youth on municipal level. The study is done by NOVA. For data on immigrant youth the results from Oslo municipality is most relevant. The study does not necessarily report on country background, but it is possible to apply for access to the data.
- The health survey in Oslo 2000–2002 (HUBRO) by NIPH. Samples of immigrants from Turkey, Iran, Pakistan, Sri Lanka and Vietnam. The next one will be in 2020.
- The health survey among youth (UNGHUBRO) was performed in Oslo 2000-2002 among 10th graders, and later on in the rest of the country.
- The NIPH is responsible for the Norwegian Surveillance System for Communicable Diseases (MSIS), which includes the tuberculosis registry and gives advice about measures to prevent and limit infectious diseases.
- Vaccinations and any unwanted effects are registered in the Norwegian Immunisation Registry (SYSVAK).
- Based on the SSB-report data mentioned above, NIPH has just published a report on immigrants living conditions and health (fhi.no, 2019).
- Mental Health Challenges of Immigrants in Norway- A literature review (Kale, 2017).
- Dementia, Ethnic Minorities and Migrants. A Review of the Literature (Kumar et al, 2017).

We have data on specific topics such as pregnancy, dietary and lifestyle diseases including nutrition, obesity, physical activity and diabetes, mental health, mortality, vitamin-D, cardiovascular disease and cancer. Examples of studies include:

- The STORK Groruddalen research programme: A population-based cohort study of gestational diabetes, physical activity, and obesity in pregnancy in a multi-ethnic population. This large project is an umbrella for several studies. Over the past years, since 2011, several PHDs have been published on the different topics mentioned above.
- Ahmed SH, et al. (2018) Prevalence and Predictors of Overweight and Obesity among Somalis in Norway and Somaliland: A Comparative Study.
- Hjellset VT et al. (2011) Health-Related Quality of Life, Subjective Health Complaints, Psychological Distress and Coping in Pakistani Immigrant Women With and Without the Metabolic Syndrome.
- CHART study by The University of Bergen. "Changing Health and health care needs Along the Syrian Refugees' Trajectories to Norway" (CHART) study health, health care

needs and quality of life among Syrian refugees during migration and the first year after arrival to Norway. It is an on-going longitudinal study and the first results are currently being published.

Overview health status of migrants

Although the data are fragmented, the available evidence indicates that the health of migrants reflects their heterogeneity. There are significant variations in disease prevalence and risk factors across gender, ethnic and age groups. In general, immigrants are healthier than the host population (Syse et al., 2018). However, among certain immigrant groups there is a higher burden and greater risk of lifestyle- and diet-related disorders, mental health problems, infectious diseases and complications of reproductive health. Immigrants from low- and middle-income countries have poorer health compared to immigrants from Western countries and Norwegians. Refugees have a poorer health profile compared to those who came to Norway for family reunion, work or studies, but still very close to non-immigrants. Country of origin, reasons for migration and length of stay in Norway all influence health service use and health status (Diaz et al, 2015).

Key areas highlighted in the Norwegian Institute for Public Health immigrant health overview:

- Diabetes is common among immigrants from Sri Lanka, India and Pakistan. In these groups, 20-24% of adults 30-59 years old have diabetes, compared to 3-6% of the host population. Immigrants from Turkey, Iraq, Pakistan, and women from Somalia are frequently overweight (20-25%).
- Cardiovascular disease is more frequent among immigrants from South-Asia and the Balkans than in the host population.
- Cancer is less frequent than in the general population, but the risk varies with country background and type of cancer. Immigrants participate less than Norwegian born do in screening programs for cancer.
- Vitamin D deficiency is frequent among immigrants from outside Europe; in particular from the Middle East, Africa south of Sahara and South Asia, where three out of four have vitamin D deficiency.
- Despite having access to the same health care services and access to give birth in low-risk maternity wards, obstetric outcomes observed were generally worse amongst immigrant women as compared to the ethnic Norwegian population (Bakken 2016). Immigrant women had a lower risk of pre-eclampsia relative to Norwegian women, this risk however increased with years of residence in Norway (Naimy et al 2015). Thai, Afghan and Vietnamese women had the lowest risk.
- Reports on migrants' mental health problems vary from study to study, depending on which population studied and in which setting they are studied (what groups they are compared to). Adult immigrants from conflict zones, and children and adult refugees report mental health problems at a higher rate than the host population (Jakobsen, Demott & Heir, 2014).

Topics we lack data on: Elderly immigrants, working migrants (especially male), long-term consequences of migration (longitudinal studies), children of migrants, and health on arrival for asylum seekers.

Specific factors affecting health status of migrants

People with high education, are employed or have good personal finances, generally have better physical and mental health.

A higher proportion of immigrants report mental health problems, especially from countries outside of Europe (Straiton et al, 2018). Refugees and asylum seekers have a high burden of mental health problems, such as post-traumatic stress disorder.

Diabetes is widespread among immigrants from Sri Lanka and Pakistan, with 20–24 per cent of adults aged 30–59 affected, compared to 3–6 per cent in the rest of the population (Jenum et al, 2012a). Cardiovascular disease is more widespread among immigrants from South Asia and former Yugoslavia than in the general population (Rabanal, 2015).

Some immigrant groups, whose country of origin have a higher infection incidence rate, have a higher incidence of certain infectious diseases than the general population. Most of the new annual cases of tuberculosis and hepatitis B occur among immigrants. The same also applies to one half of new HIV cases (NIPH, 2019).

Health status of migrants on arrival

This data is not routinely collected and surveys are not systematically conducted on newly arrived migrants. For all migrant groups, health status largely reflects country of origin, disease pattern and prevalence in country of origin, conditions on the journey to Norway, and availability of health care services before, during and after migration.

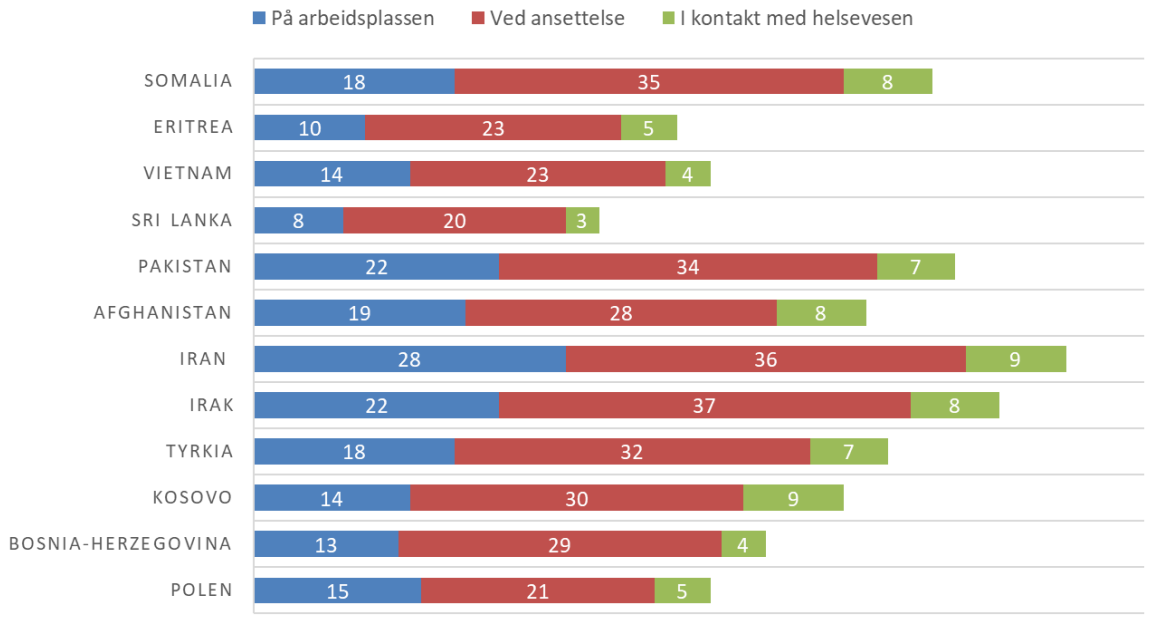
REFUGEES
All asylum-seekers and refugees are tested for tuberculosis within two weeks upon arrival. Other immigrants with a planned stay of more than three months have a duty to be tested for tuberculosis if they come from a high-endemic country of origin. The Norwegian Institute of Public Health record between 350-400 cases of tuberculosis diagnosed each year (NIPH, 2019).

All asylum-seekers are supposed to be offered a health- consultation with a GP within three months to identify their health needs. This is a voluntary consultation. This usually takes place after the asylum seeker has been placed in an asylum centre; however, there has recently been a pilot-project to assess offering this at arrival reception centres. Migrants that come through the resettlement schemes will have had a health assessment prior to arrival, undertaken by IOM.

Factors negatively effecting health status of migrants

SELF-REPORTED DISCRIMINATION
The graph below (SSB, 2017) show self-reported experiences of discrimination, by country of origin, at the workplace (blue), when being hired (red) and in contact with the health services

(green).



Berg et al (2011) found that about 10% of the variance in depression/anxiety symptoms could be explained by perceived discrimination. A more recent study found that migrants that experience perceived discrimination are twice as likely to have mental health problems compared to migrants that have not experienced perceived discrimination (Straiton et al, 2019).

ATTITUDES TOWARDS MIGRANTS

We have two different surveys on the populations' attitudes towards migrants. The information is not conclusive, and there are many different attitudes coexisting in our society. On the one hand, people have become more positive towards migrants, but on the other hand, people are sceptical towards certain groups, and describe feeling apprehensive in certain situations where they would meet migrants. Annually, SSB (2019) publishes a study of attitudes towards immigrants. The most recent state that negative attitudes to refugees to Norway («Should it be more difficult to be resettled in Norway? ») have been reduced from almost 55% in 2002 to 29% in 2018. 72 % of respondents state that immigrants are useful at work in Norway, and 71% state that they enrich the cultural life in Norway. However, 25% of respondents felt that immigrants abuse social benefits.

FAFO (2019) recently published a study of «Norwegians' attitudes towards gender equality, hate speech and the instruments of gender equality policy». They found consistently higher levels of support for equality policies and punishment of hate speech and discrimination directed towards women and people with disabilities, than for victims that are gay, transgender, religious or from ethnic minorities. At the same time, respondents though women and people with disabilities experience less hate speech and discrimination than the other groups. Furthermore, one in six Norwegians still describe not wanting a Muslim as their neighbour. While attitudes towards immigrants appear to have improved, there are still negative attitudes towards migrants that needs to be addressed.

MIGRANTS' INTERACTION WITH THE HEALTH SYSTEM

Health service utilisation

Migrants' use of health services varies across primary, emergency and specialist care. We have varying and limited information on migrants' interaction with the health system.

PRIMARY HC

In general, immigrants use primary health care services less than the ethnic Norwegian population (Fadnes & Diaz, 2017; Diaz & Kumar, 2014); however, we do not know if this is because of better health or barriers to health care provision. A comprehensive registry-based study found that amongst immigrant groups who do use GP services, those under 65 years used services at a higher rate while those over 65 years used services at a lower rate. For all immigrants, utilization of PHC increased with longer stay in Norway and was higher for refugees and lower for labour migrants (Diaz & Kumar, 2014).

EMERGENCY HC

In Norway, emergency health care is divided between primary health care ('out of hours GP') and the secondary care ('the emergency room'). A registry-based study found emergency primary care service use is generally higher amongst immigrant groups, although significantly lower amongst immigrants from high-income countries (Diaz et al, 2014). Research on emergency room by immigrants is more limited. A single study based in Oslo found a higher rate of emergency room attendance amongst 1st and 2nd generation immigrants. They also found only 71% of 1st generation immigrants registered with a regular GP (vs. 96% of those born in Norway) which may have explained some of the difference (Ruud et al, 2015).

SPECIALIST HC

The Research Council funded a registry study on "Health Care Utilization among Immigrants in Norway" done by NOVA. Their final report was based on public registry data from 2008 (Elstad, Finnvold and Texmon, 2015), it is unclear if the information is informative for the situation in 2019. The register study found high levels of variation, relating to geographical variation, reason for migration and length of stay. Admissions vary with country of origin, which largely corresponds with reason for migration. Recent labour migrants had lower admission rates while admission rates were higher for recent refugees. Admission rates in all immigrant groups tended towards the same level as the ethnic Norwegian population with length of stay (Elstad, 2016).

There is also some information on mental health and immigrant children and youth, one study had lower use of specialist mental health care compared to the Norwegian born population (Abebe et al, 2017). Children from Iran and adults from Iran and Iraq had significantly higher utilization rates than the white Norwegian group. Adults from Poland, Somalia, Sri Lanka and Vietnam had lower utilization rates.

PHARMACEUTICAL USE

Overall, immigrants in Norway tend to consume fewer pharmacological drugs than the host population. There are some differences among groups, varying by country background, reason for migration and length of stay (Gimeno-Feliu et al 2016).

Adherence to treatment

There is limited research on this topic in Norway. Low general literacy and lack of knowledge of the Norwegian language is a barrier to accessing and using information about medicines for immigrants. Switching from branded medications to generic drugs was found to impact drug adherence in 1st generation Pakistani immigrants, due to a combination of misconceptions and inadequate information (Håkonsen H. & Toverud E, 2011). In a separate study of Pakistani immigrants living in Norway ten years or more, half the participants were found to lack basic knowledge about their medicines although 93% felt it is important to take their drugs every day (Håkonsen H. & Toverud E, 2012).

A specific public health concern is adherence to medications for communicable diseases which have a risk of transmission if not properly adhered to. A qualitative study of experiences of tuberculosis treatment for immigrants in Norway found directly observed therapy to be perceived as a means of control and more disempowering than caring (Sagbakken et al, 2012).

Community pharmacists have an important role in providing patients with information on their medications. One study found that although community pharmacists recognize the need of immigrant patients for drug counselling there are large differences in the effort expended due a lack of cultural competence and language barriers (Håkonsen & Toverud, 2012).

Health Literacy: Awareness of rights and entitlements

There are mechanisms in place in Norway to ensure that all patients' rights and entitlements are respected, and to help patients get the health care they need. The Equality and Antidiscrimination Ombudsman (LDO) and the Ombudsman for Children supervise and advocate for the rights of the groups within their jurisdiction. There is also the Ombudsman for Health and Social services, available in every county, responsible for helping patients and clients to get the care they need. Information can be found at helsenorge.no. The Ombudsmen supervise implementation of the respective rights conventions, enshrined in Norwegian law, falling under their jurisdiction. To what extent migrant patients know their rights and further know of the Ombudsmen mechanism is unclear.

Health literacy: Ability to seek help from the right health service

There is limited research on this topic in Norway, as we know. One study on Somali women access to diabetes preventative services found participants had a good knowledge of diabetes but a combination of social, cultural and economic barriers mean that these women do not seek out or engage with these services. They are also less interested in a written material and preferred oral communication (Gele et al, 2015).

Health literacy: Ability to understand health information

There are still many gaps in assessing and addressing gaps of health literacy among migrant communities in Norway. According to Gabrielsen & Lundetræ (2014), immigrants are more likely to have lower health literacy due to lower reading skills. Not understanding health information and/or struggle to keep up with a new complicated health system can reduce their ability to take care of their own health. Another study found that 71 % of Somali women in

Oslo lack the ability to obtain, understand and act upon health information and services, and to make appropriate health decisions. (Gele et al, 2016).

HIGH-LEVEL POLICIES, GOVERNANCE AND LEADERSHIP

CHECKLIST 2.1 High-level policies, governance and leadership

	HIGH-LEVEL POLICIES, GOVERNANCE AND LEADERSHIP	Comment
1.	There are health policies specifically on migrants in my country	Partially only. The Directorate of Health publish national guidelines for providing health care services to asylum seekers, refugees, and family reunified persons.
2.	☐ There are migrant health strategies and/or action plans in my country	Partially only. From 2013-2017, there was a dedicated migrant health strategy - "Equitable Health and care services – good health for all". Whilst this strategy has not been continued, migrant health has been pursued in a different form (e.g. 2019 it was mentioned in the government budget). Different government tools of influence include white-papers, green papers, guidelines, standards, working plans, manuals and handbooks, training, and supervision.
3.	☐ Recommendations and/or actions from strategies and/or action plans have been implemented	Recommendations from the "Equitable Health and care services – good health for all". The National Strategy for migrants' health 2013-2017 has been implemented and is continuing to be implemented since it finished. "Meld. St. 13 (2018–2019) Muligheter for alle — Fordeling og sosial bærekraft" on social inequality is being implemented.
4.	☐ Implemented recommendations and/or actions have been evaluated	Not systematically as we know. Some research projects/interventions have been evaluated.

5.	☒ The key health policies in my country refer to migrants	Partially only. The "whole government" approach ensures mainstreaming on the migration health issue (MIPEX report Norway). There are several policies aiming for the social determinants of health that refer to migrants in particular. One of the newest being the strategy to increase health literacy in the population. Several patient organizations have developed policies for improving immigrant health.
6.	☒ The key health policies in my country have specific actions/ interventions to address the needs of migrants	Partially only. The Health Personnel Act state that health personnel have to ensure an interpreter when patient knows "little Norwegian" and expenses for such services fall under the financial responsibility for health services. As mentioned above, there are national guidelines in place for providing health care services to asylum seekers, refugees, and family reunified persons.
7.	☐ The national budget has resources specifically allocated to migrant health	Partially, previously the National Competence Centre for Migration and Health received funding over the state budget. While there is no specific earmarked funding for research on migrant health, this is now part of broader FHI funding. It was said in the budget that NAKMI is now part of FHI and this work would continue there. NKVTS (The National Centre for Violence and Traumatic stress Studies) is funded over the state budget, and does research, amongst other things, on migrants' health. Funding is allocated to asylum seeker and refugee health through the immigrant direc-

		torate and through the health directorate the municipality provides the primary health services.
8.	There are dedicated persons/divisions that deal with migrant health within ☐ The Ministry of Health ☒ Directorate of Health	The Directorate of health has recently been reorganized. There are no longer a division for Migrant Health, but two dedicated persons.
9.	☒ There are technical advisory groups/committees that advise government on migration and health in my country	SOHEMI («fagrådet for likeverdig-helse og omsorgstjenester til innvandrerbefolkningen»), an advisory board to the Directorate of Health. Participants give advice on equitable health care for immigrants and have background from working with different aspects of health equity for immigrants. In the Oslo Municipality, the *Unit for Diversity and Integration* (EMI) cooperates with the municipal government in a structured process on issues affecting health. They are not directly involved in the planning of health care services.
10.	☒ Migrant Health experts are represented in positions of decision making; on key councils, committees, boards on health in my country	Partially only. SOHEMI, see explanation above.
11.	☒ There are declarations/statements, by Government, NGOs, professional bodies or other, on migrant health in my country	"The Bergen-declaration" from the 2018 migration and health conference.
12.	☒ My country has adopted international strategies and declarations on Migrant Health	"Health in all policies" and "Universal Health Care" are policy strategies implemented by the government. The international convention on human rights is integrated in the Norwegian constitution; the right to health is included in the convention as well as in the 1966 International Covenant on Economic, Social and Cultural Rights. Norway has ratified the 1951 Ref-

		ugee Convention, The United Nations Convention on the Rights of the Child, and the Optional Protocol to the UN Convention against Torture, amongst other international conventions. Specifically, regarding migrant health, Norway has ratified several important conventions and declaration. This includes supporting the UN development goals (MDGs and SDGs), and the New York Declaration for Refugees and Migrants and the UN Global Compact for Safe, Orderly and Regular Migration. The International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) are enshrined in Norwegian law.

Explanations and additional comments to the checklist above.

2.2 General responses to the needs of migrants (over the last five years)

Implementation of measures/interventions

Many interventions and measures in the strategy for immigrant health from 2013-2017 have been implemented in the past 5 years, but overall, they are limited in scope and impact and there is no systematic evaluation of implementations in place. National, regional and local level implement measures, in different sectors, often in cooperation between the health care and social services, academia and volunteer sector. The Unit for Migration Health at the NIPH (previously called National Competence Centre for Migration and Health), has provided teaching for health personnel for many years. Topics include how to use and interpreter, physical and mental health of migrants in Norway, entitlements for migrant groups, different understanding of health, health care services and treatment, as well as communication barriers and prejudice. The centre also runs four networks for people working within the field across different areas: migrant friendly hospitals, municipalities, the volunteer sector and research. The first three has existed for many years, while the latter was established this spring.

On regional level, the biggest hospitals have strategies for equitable health care and implement different measures to give good health care to this diverse population. One example is the interpretation service at Oslo University Hospital, which trains health personnel in using interpreters, and manages quality control of the interpreters used at the hospital. Municipalities implement measures ranging from the social services sector to the health sector.

Intervention projects from academia cover a range of areas. Some examples are Innvadiab on preventing diabetes typ2, a community based intervention to increase participation in cervical cancer screening, MIPREG aiming to improve health outcomes among pregnant immigrant women in Oslo.

Many implemented measures come from the volunteer sector, from organisations or citizens. One initiative is "Bydelsmødrene", giving immigrant women a broad course in mental and physical health, enabling them to be resources for other immigrant women.

Effect on migrants' health

Many organisations and actors maintain that the strategy on immigrant health was a milestone for migration health work in the country. The strategy had ambitious goals with relatively few resources designated to the work, affecting its impact. At this time, it is hard to conclude on the effect it has had on immigrants' health.

There has been little systematic measurement of effect of measures in field (FHI.no, 2018). Some particular projects and strategies have been evaluated; however, it is not always easy to know the full impact of interventions or measures. Currently we do not have much data that can give broad summary of the effects of interventions on migrants' health.

Furthermore, the last survey on living conditions by SSB has not been fully comparable with previous surveys as the questions have been changed since the last survey, and new countries have been added. Data are collected every 10 year, and the next survey will be undertaken in 2020.

Attention to migrants' health

There has been a lot of attention to migrants in the public domain, but not necessarily positive and not necessarily to do with migrant health. Over the last five years, we saw a large increase in refugees to the country, which contributed to a greater awareness of the importance to meet their health needs.

Health personnel and researchers have worked consistently on migrant health over time and generated more awareness and interest for the field. Whereas previously health research on migrant health was fragmented, it is increasingly brought into the mainstream. Events such as the EUPHA MEMH conference in Oslo 2016 and the first national conference on migrants' health last year helps in bringing a more holistic view to the field.

Among clinicians, the idea that migrant health merits attention has grown dramatically. This is likely due to a combination of several factors: greater exposure of health professionals, broadened definition of migrants (i.e. not only some specific people from far away countries,

but including Poles and other groups closer to home); training courses; and a greater body of high-quality research to draw upon.

Drivers of change

On the one hand, awareness of immigration over the past 5 years has increased due to the increase in refugees and media coverage of the war in Syria, as well as consistent work undertaken by health professionals and NGOs to draw attention to the importance of this topic. As migrants reside all over the country, migration is no longer seen as an "Oslo phenomenon". Health personnel and researchers specialised in the field are based in cities and institutions across the country.

On the other, an increasing population of people from overseas who are residing/citizens in Norway means there is a larger group of people who needs to be cared for. The longer people stay the more they learn how to use the health services, rely upon the health services and are more aware of, and willing to ensure their entitlements.

The role of civil society and NGOs

There are a number of migrant-led NGOs and other non-profit organisations, like the Church City Mission (Kirkens bymisjon), CARITAS, the Norwegian Red Cross, the Norwegian Peoples Aid, The Norwegian Women's Public Health Association and many others, that voice concern and provide support to migrant groups. Professional organizations, like the Medical Association have voiced concern for human rights neglect with regard to irregular migrants' access to services. Patient organisation like the Diabetes Association, Cancer Society, LHL (National organisation for heart and lung diseases) have taken an interest in high rates of lifestyle diseases in certain immigrant groups. Many of these also collaborate with the research institutes and universities, developing programs and interventions.

Changes in governmental commitment to migrants' health

The present government (Spring 2019) is a conservative alliance of four parties. The government has leaned towards a stricter immigration policy. Governmental commitment to equitable health policies is relatively unchanged, continuing the tradition of systematic, long term public health work. Public Health reports are made in a 4-year cycle on status, development of measures and evaluation (www.regjeringen.no, 2019).

Awareness of migrants' health in the public

Migration and integration is frequently on the political agenda and mentioned in the press, however, migrants health is often not given as much attention. Particular topics that are very important, but affect a limited part of the migrant population, such as female genital mutilation and social control have historically been given a lot of attention, while other important topics, like chronic/lifestyle diseases, that affect a larger proportion of the population, have not received as much coverage. Refugees and mental health issues frequently receives attention. Overall, attention and awareness in the public sphere has often been misaligned with evidence and the burden of disease.

2.3 Migrant health policies

Migrants and general health policies in your country

The "whole organization" approach entails that measures implemented to combat inequities are mainstreamed in the health services. Not all health policies refer to, or specifically address, migrants or their health needs. Migrants with a permit to stay in the country are included in the welfare system, thus general health policies apply to migrants. In 2019, a strategy to increase health literacy in the general population was adopted. This represents an example of a general strategy that will benefit migrants in particular.

In 2015, The Office of the Auditor General monitoring the public sector assessed public health work in the municipalities and counties (riksrevisjonen.no). According to the audit, the municipalities are not doing systematic public health work, and many find it hard to know what measures that will work. Only 15% of municipalities had implemented measures to target living conditions and social inequalities, despite nearly half of the municipalities citing these as the some of the biggest challenges for public health.

Migrants' exclusion from health policies in your country

Not all health policies refer to or specifically address migrants or their health needs. For example, the Strategy for Social Inequalities in Health does not address migration specifically as a determinant of health.

Health policies specifically addressing migrants in your country

Norway's first National Strategy on Immigrant Health 2013-2017 was based on White Papers to the Norwegian Parliament (Meld. St.16, 2010-2011; Meld. St. 6, 2011-2012). Emphasis was on addressing the social determinants of health, such as: employment, good education, better housing and better living conditions, in order to reduce inequality in health for migrants.

Implementation of health policies specifically addressing migrants in your country

National strategies and policies are implemented at different governmental levels and across sectors.
National level: The ministry of education, ministry of justice and ministry of culture have different responsibilities that affect integration and health of migrants.
Regional/county level: The hospitals are organized under the Ministry of Health but operate independently. Most hospitals have strategies for equitable health care, some mentioning migrants particularly. Some have measures in place to secure proper use of interpreters, and where needed, measures to meet special needs of certain migrant groups (e.g. clinics for women ensuring proper care concerning female genital mutilation).
Local/municipality level: Municipalities are responsible for securing housing and ensuring access to the workforce and social support for families, as well as access to well-functioning health services.

Intersectoral action on social determinants of migrants' health

See also section 5 WP4 CA: Please note that this section might overlap with section 5 in the CA template for WP4. Please coordinate with the person filling in that CA as the responses should be consistent.

TABLE 3.1 Intersectoral action

	Intersectoral action	Comment
1.	☐ There are intersectoral migrant health policies	Only partially. "The health in all policies" approach combined with the "whole organisation" approach entails that most policies aim to address social inequalities in health and mainstream migrants as total population.
2.	☐ There are intersectoral migrant health strategies	No. The migrant health strategy lasted until 2017. The strategy was had intersectoral approach. In the governments' integration strategy 2019-2022 "Integration through knowledge", the government aim for increased participation in labour market and local communities. They have four goals; Increase education and work qualification among young migrants and adults, more migrants in the work force, increased sense of belonging and participation in communities, and prevent negative social control and reduce barriers for the individuals' freedom. Some measures are implemented by changing laws and regulations. Most measures are implemented on a municipality level and several tasks are transferred from a national level to the county level.
3.	☒ Recommendations and/or actions from these strategies/policies have been implemented	Yes, and ongoing.
4.	☐ These implemented recommendations and/or actions have been evaluated	Only partially. The Directorate of Integration and Diversity (IMDi) has released a report on effect evaluation of actions in the field of welfare measures. Planning

		evaluation into the implementation of interventions remains rare. However, we do have some experiences from the intersectoral migrant health field. One example is effect evaluation of a measure called "Raskt I Jobb (Quick inclusion in the workforce) which aims to help refugees enter the work force through Individual Placement Support (IPS). Effect evaluation from a previous project showed positive effect of IPS. This study showed that it also had a positive effect for integration. There have also been a few experiments to increase voter participation in national elections, including people with migrant background.
5.	☐ Intersectoral Health Policies (such as on NCDs) include/ refer to migrants specifically	Only partially. For example; The strategy on integration of migrants emphasize the importance of good health for participating and integrating in society. Thus, "good health among immigrants" is one of the aims of the strategy.

Additional comments to the checklist above:

Intersectoral response to migrant health

Many health policies in Norway attempt to address the social determinants for health, some are aimed specifically at migrants though they are not always intersectoral in approach, the different measures can have a similar aim. Examples include the labour inspection administration monitoring the labour market aiming to limit exploitation and ensure safety in the workplace. IMDI is ensuring that migrants can have easier access to the labour market and ensure availability of qualified interpreters. Ministry of Children and Families have responsibility to ensure safe environments for children to grow up, supporting cultural and welfare-projects in communities with high migrant density. The Ministry of education ensures access to quality education and adaptation for newly arrived migrants. They also support projects related to water safety, ensuring that newly arrived receive swimming training.

The Directorate of Health and The Directorate for immigration and diversity are officially co-operating to coordinate their measures that are beneficial to the wellbeing and good health for immigrants in the country. A NIBR-report (2017) looking at the two fields contribution to

health and participation, highlighted important implemented areas or measures falling within both directorates jurisdiction; such as free day care, measures against child poverty and the importance of the volunteer sector.

The Directorate of Health Public Health Policy Report from 2017 describes indicators developed for the intersectoral public health work. Immigrants are mentioned throughout the report, while the indicators are relevant for migrants only a few are specifically for migrants. In their working period 7 intersectoral working groups was established; 1. Financial living conditions 2. Adolescence 3. Working life 4. Healthy choices 5. Safe and health promoting environments 6. Social support, participation and contribution 7. Local public health work.

Access to the labour market

STATUS ON THE LABOUR MARKET

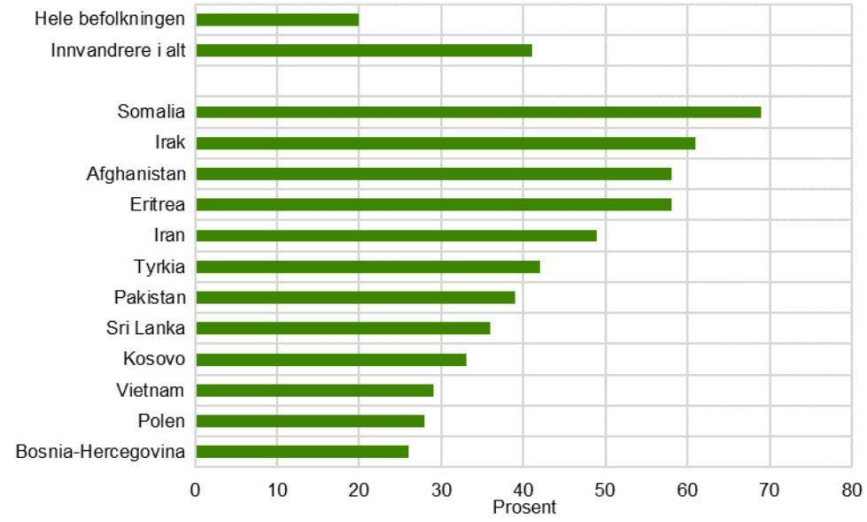
Most migrants in Norway are employed. Access to the labour market is restricted by factors like language barriers and discrimination. For some, getting an occupation that corresponds to their education level can be difficult. Immigrants' employment rates varies with country of origin, which largely corresponds with reason for migration and length of stay. Thus, Immigrants from Africa and Asia have lower employment rates than the average, while Nordic immigrant have a higher employment rate than the host population. Immigrants from Africa have the largest population "in education" (ssb.no,2017).

Immigrants more likely to work in conditions that contribute to physical strain and to have low levels of job security (SSB.no, 2017). Negative stress is often accumulated by low levels of job security. Entitlements to governmental support and pension is based on your participation in the work force, with improved benefits for permanent employees. However, low payed jobs in the private sector may not give the benefits that are routinely received in higher payed/more secure jobs. Immigrants are at greater risk of exploitation because they don't necessarily know their rights and they have limited possibilities to argue for their rights due to language barriers and lack of job security. Regardless of nationality, employees in industry and construction sectors face the highest risk for work-related accidents.

INCOME

In general, immigrants have lower incomes than the rest of the Norwegian population. More migrants than host population find it hard to make ends meet; they face problems paying rent and will have trouble paying unforeseen bills. Amongst immigrants, there are great disparities in income level attributable to reason for immigration, the characteristics of their home country, and their length of residence in the new country. (SSB.no, 2017)

Figur 18.4 **Ikke mulighet til å klare en uforutsett utgift på 10 000 kroner. Etter opprinnelsesland, 18 år og over**

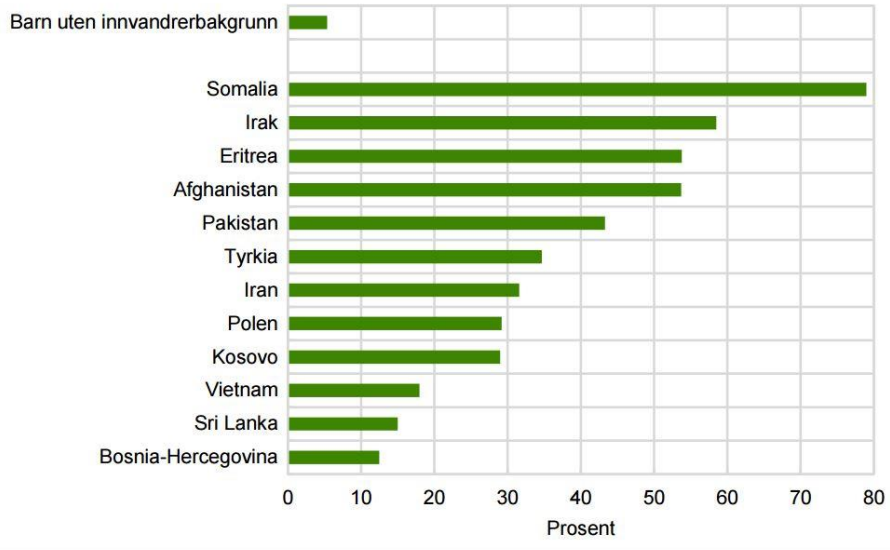


Kilde: Levekårsundersøkelsen blant personer med innvandrerbakgrunn 2016 og Levekårsundersøkelsen EU-SILC 2015.

The graph to the left show the percentage who responded "Not possible to pay an unplanned bill of 10 000kr" for migrant groups (categorized by country) compared to total country population ('hele befolkningen' = general population; 'Innvandrere I alt' = immigrant population)

The graph to the left shows percentage of children living in long-term low income families, by country of origin, from 2013-2015. The top bar shows the percentage of "children without an immigrant background" for comparison. Below are the different origin countries and percentage.

Figur 18.9 **Andelen barn i husholdninger med vedvarende lavinntekt etter opprinnelsesland. 2013-2015**



Kilde: Inntekts- og formuesstatistikk for husholdninger. Statistisk sentralbyrå (Epland og Kirkeberg, 2017)

Access to education/ skills building

Immigrants have full access to further education in Norway. However, there are rules regarding the time limits for completion of education, and the financial support during and after completion of high school and university.

For licensed occupations, immigrants with foreign degrees might find it hard to access jobs lack of international agreements between countries can be a barrier (Alecu & Drange, 2018).

Some may be asked to do extra courses or internships before they can apply to have their education accepted. There is ample anecdotal reporting of difficulties with Norwegian authority when it comes to recognition of skills and education prior to arrival in the country.

Access to society/ local communities

In summary, it is noted that immigrants state that they have a strong sense of belonging both to Norway and their country of origin. Almost 50% have Norwegian citizenship. The main reasons for wanting to become a citizen are to improve their prospects in Norwegian society and to feel a greater sense of belonging (SSB, 2017).

Immigrants in employment have higher level of Norwegian skills than other migrants and are often more integrated in society. This is particularly the case for women. However, those who meet the general population more often are also at greater risk of being exposed to discrimination. Immigrants generally experience more violence and threats than the population in general, but they rarely state that there are problems with crime, violence and vandalism where they live.

Access to healthy living/ enabling environments

In Norway, 82.3% of the population live in housing that they own. The corresponding rate for total immigrant population is 58.1%, with wide variation as to country of origin. As expected, ownership of the home increases with the time of residence in Norway, from 20% after 2-4 years to 70% after 20 years. There are also large differences; Africans are less likely to own a home than other groups (ssb.no, 2017). Migrants live in smaller spaces than the host population, but they are subjectively more satisfied with the size of their living space compared to the host population. Having resided longer in the country does not necessarily indicate that migrants have more space. Pakistanis, a group which has lived in Norway the longest, are one of the groups that live in "narrow space" (SSB.no, 2017), numbers are updated for 2018, ssb.no). 8% of immigrants find their living space to be of low standard (vs. 4% for total population). 3% (vs. 2%) are bothered by noise, and the overall full satisfaction with their living space is 40% (vs. 51%). Norway's geography entails that most people have direct access to green spaces and nature. Roads are considered safe, and traffic regulations promote health and safety.

Migrant status and health (Link A, See chapter 3 technical guidance)

Needs further elaboration
Reference: Kumar, B. (2018). Chapter 9: Migration and Health: Current status in Norway. In Migration and Health: what we know so far, what is lacking in our understanding, and how to move forward? (pp. 131-141). Coimbra: Almedina.

Migrant status and socio-economic position (Link B, see chapter 3 technical guidance)

Needs further elaboration
Reference: Kumar, B. (2018). Chapter 9: Migration and Health: Current status in Norway. In Migration and Health: what we know so far, what is lacking in our understanding, and how to move forward? (pp. 131-141). Coimbra: Almedina.

Differential exposure/vulnerability (Link C, see chapter 3 technical guidance)

Needs further elaboration Reference: Kumar, B. (2018). Chapter 9: Migration and Health: Current status in Norway. In Migration and Health: what we know so far, what is lacking in our understanding, and how to move forward? (pp. 131-141). Coimbra: Almedina.

Migrants' access to health services

Access to health care services for migrants - overview

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All immigrants, including asylum seekers and accepted refugees, have the same rights as the host-population to primary health care (municipal health services). There are defined deductibles for medical consultations and drugs. Antenatal care and newborn and child preventive services at the health stations are free, as are consultations, treatment and medication in relation to serious communicable diseases, condoms and oral contraceptives for youth between 16 and 18 years, psychiatric treatment for patients under 18 year, and Hepatitis B-vaccines for men who have sex with men. Dental services are usually not included for adults and can generate high out of pocket payments. The entitlements for irregular migrants are limited to treatments that cannot wait, childbirth and some communicable diseases.

Refugees, asylum seekers and family reunified persons are entitled to a free and voluntary health examination within their first three months of stay. The examination covers information about the health system, help to choose/apply for a GP, blood samples and blood pressure measurement, as well as talking about their health and referring to a specialist if needed. Municipalities should have appropriate information about this in English on their webpage.

Access to health care services for migrants

"Out of pocket" (OOP) payments are the same for documented migrants, asylum seekers and the majority population. Co-payments for GPs and specialists are considered to be relatively low. There are exemptions and ceiling schemes, regulated by law, in place to reduce inequities in health for poorer patients and those with greater healthcare needs. Larger fees are generated by the costs of the type of treatment required (i.e. specific tests, scans or vaccines). The patient will receive an exemption card and further costs of health care will be reimbursed for the year. Prescription medicine is included in the ceiling scheme as well. Depending on the category of disease, some medication is free, and some requires a small fee until the "ceiling" is reached. As OOPs are the same for documented migrants as the wider population, migrants that are under the age of 16 or on a minimal pension do not pay OOP for health care services. Migrants who have a communicable disease, immunodeficiency or need palliative care at the end of their life, do not pay OOP for the services or medication they need. (MIPEX report Norway, 2016).

Main barriers to access to health services

Despite rights and entitlements for the immigrant population, there are a number of barriers to access. Outright discrimination in the health services is reported to be low (SSB, 2017). However, the system might be complicated and difficult to navigate.

A literature review on mental health (Kale, 2018) found that language barriers severely hamper health personnel's ambition to give patient centred, equitable healthcare. The study found an underuse of interpreters, and where used, patients often continued to experience barriers to expressing their worries due to lack of trust. A recent study of patients' experi-

ences with GPs found that of patients in need of an interpreter, 72% was not offered an interpreter when they last needed it (fhi.no, 2019). A significant amount of patients in this group came from Asia, Africa, South-America or Eastern Europe.

A study of immigrant women's' participation in a national screening program and barriers found lower attendance to cervical cancer screening (CCS) among immigrant women compared to the general population (Møen et al. 2017; Leinonen et al. 2017). One way of grouping the barriers faced in participating in the Health cervical cancer screening is dividing them into individual-related, healthcare provider-related and healthcare system-related (Ferdous et al. 2018; Gele et al. 2017). Individual barriers could be language, low health literacy, limited awareness of the disease, lack of knowledge about how to navigate the health care system, cultural differences between the women and provider, dissatisfaction with patient-provider interaction, financial barriers, fear of stigma and lack of time or procrastination. Some of the health care provider-related barriers can be long waiting time/lists, heavy workload or time constraints, cultural differences between patient and provider and lack of cultural competency. Health care system-related barriers are lack of information about how to access health services, transportation, lack of female health care providers, inconvenient hours of health services and lack of appropriate services or referral patterns.

Responsiveness (quality) of health services

Health services responsiveness to migrants' needs

There is some literature on adapting health services to migrants' needs and implementation orientated policies. However, we lack thorough coordination and evidence that implemented measures reach the target audience and overall goal of equitable health care for migrants (MIPEX report Norway, 2016).

Hdir together with IMDI, recently ordered a systematic review of tools health services can implement to improve equitable health and care services for immigrants. The review found only one study fitting the inclusion criteria and found that it had too low quality to make any recommendations. Finally, they expressed a need for further exploration of how inequities are measured and what the best way to measure this is (FHI.no, 2018).

Many health and care services do adapt to a diverse population implementing measures to respond to migrants' needs. There is great variation, and many do not manage to adapt to the needs of migrants, consequently giving them lower quality health services (Lyberg et al, 2012). Some might be due to lack of will, while others because of the nature of the service or structural barriers. For example, health personnel might not fully know the rights of migrants or interpret the rights differently than intended by lawmakers. It can be difficult for health personnel to create sustainable changes on their own, if their leaders are not supportive. Specifically, mental health services struggle to adapt to the needs of migrants, as stated by some health professionals struggling to communicate the use of the mental care they are offering (Buvik og Baklien, 2017).

Examples of responsiveness on national level:
The Directorate of Health have issued several relevant guidelines and guidance documents for health personnel. Two good examples are the guidelines for provision of health services to asylum seekers, refugees and family reunified people IS-1022 and a policy document (a guiding-document) advising on good communication via interpreter.
The Directorate of Integration and diversity (IMDI) administers a national registry for interpreters with formal competence, and e-learning resources for using interpreters, through a webpage www.tolkeportalen.no.
The «Cultural Formulation Interview» (CFI) by the American Psychology Association has been translated to Norwegian and is an available tool to help contextualize the mental disorders (NAKMI & ROP, 2015).

Responsiveness in municipality: Many municipalities have refugee health teams or corresponding resources for helping refugees access health and care services in their local community. For example; the municipal service for refugee health in Trondheim (Flyktningehelseteamet). Follow-up of migrant families, giving free health care and providing assistance with communicating with other health and care services, and helping migrants navigate the health system.

Examples of responsiveness in hospitals:
The interpretation service "Tolkesentralen" Oslo University hospital ensures safe and effective access to qualified interpreters at the hospital.

The university Hospital in Bergen has hired a hospital Imam working together with the more traditional hospital priest, as the first hospital in the country. We are also aware that they are piloting a project called "the language bank" registering employees with multiple language skills who volunteer to help in acute situations where getting an interpreter might not be feasible. A report is anticipated fall 2020.

Health personnel responsiveness

Our general impression is that health personnel wants to do deliver good quality health care for their patients, and there are many good examples of responsiveness from health personnel. However, in a hectic work environment pressured by time restraints and rigid structures it can be difficult to see possibilities or have the capacity to be responsive to the differing needs of patients.

Many universities and colleges delivering health education provide different courses (mostly optional) touching on topics like language barriers and good use of interpreters, cultural sensitivity and cross-cultural understanding. However, there is no common strategy to ensure students are competent to be responsive to a diverse patient group.

Health information

Most written health information is given in Norwegian. However, translations are available online or through initiatives in the different health services or patient organisations. Much of the health information given in Norwegian is quite complicated, and thus complicated to translate increasing possibilities for misunderstandings. There is sporadic information available in different languages; however, we cannot say anything about the quality of the translation or language. There is no quality control of translated documents for health information.

Most governmental organisations have websites available in English, however the number of pages translated varies. Health information can be found on the webpages HelseNorge and NyiNorge. The chosen topics shared on Helsenorge can seem somewhat random, ranging from head lice to female genital mutilation, your right to an interpreter and free condoms, to information on exemption cards and ombudsmen.

Another Norwegian information webpage about health for health personnel, Helsebiblioteket, write about translations made to other languages in other countries and other translation tools for health personnel to use in blogs and articles. Some hospitals have made information brochures translated to many different languages combined with pictures to show procedures, these are available for staff to distribute at need. Many patient organisations provide important information to their target groups; some of these have available information in several different languages. One example is The Norwegian Diabetes Association.

VULNERABLE GROUPS

Vulnerable migrants – overview

These are some of the groups we consider vulnerable in our country;

- Irregular migrants are vulnerable not least because of limited access to health care. In our country they have access to emergency care but may not get treatment or dare to use it.
- Illiterate migrants are at risk to not understand health information given in writing, exclusion from major society, communication, labour. Most of the immigrants that lack education are women.
- Unaccompanied minors often lack network, safe adult relations, and difficult experiences at an early age.
- Migrants that are, or have been, subjects of trafficking
- Asylum seekers – Living in crowded and unpleasant living conditions, low income, passive lifestyle, risk of re-traumatization while waiting in reception centres.
- Migrants in detention centres. In 2018, 3070 immigrants have been kept at Trandum detention centre (politiet.no, 2018).
- Labour migrants are at risk of being exploited on the labour market and are at higher risk of work-related accidents than Norwegian counterparts are.
- LGBTI persons with migrant background

Rationale for vulnerability of migrant groups

Primarily, vulnerability is due to the context that they are which limits their possibility to have an effect their life situation. Lack of language and knowledge of the Norwegian system makes some migrants more dependent on others, and at greater risk of exclusion from society. They are at risk of not receiving, nor understanding, important information, and thus they are not be able to take advantage of their entitlements and likely will not have their needs met.

For unaccompanied minor refugees lack of a care persons for protection and guidance leave them at risk. Some of the important factors identified is how they are received in the country and that their basic needs are met, as well as their possibilities to form social bonds and create a social support network (Jensen, Skårdalsmo & Fjermestad, 2014). Association has been found between higher levels of psychological distress and low support during the asylum process, as well as with refusal of asylum for unaccompanied minors (Jakobsen et al., 2016). An explorative study on undocumented migrants found that having a family and work, factors that are normally associated with positive effect on mental health, did not necessarily have this effect for this group (Myhrvold & Småstuen, 2017).

Migrants in detention centres; Following the ratification of the Optional Protocol to the UN convention against Torture, the Parlimentary Ombudsmans' office established a National Preventive Mechanism (NPM). On 19th-20th of May 2015 the NMP visited the police immigration detention center. The center is run like a correctional facility, and some procedures appeared to be more intrusive than for detainees in prisons. The immigration detention center was not deemed a suitable psycho-social environment for kids and several weaknesses were identified with regards to health care services. (The Parliamentary Ombudsman Norway, 2015).

A recent study on lesbians, gays, bisexuals, trans and intersex persons (LGBTI persons) with migrant background (Eggebø, Helga, Elisabeth Stubberud og Henrik Karlstrøm, 2018) found this group vulnerable to discrimination based on their gender and sexual orientation, and migrant background, as well as the combination of discrimination on both grounds. Further they found that refugees were more affected by these forms of discrimination. Queer migrants may experience double stigma and difficulties belonging to several minorities. Despite this, most respondents said they were in good health and were satisfied with the health care services they received.

Responsive health policies to vulnerable migrants

LANGUAGE BARRIERS

To ensure equitable health care and patient safety migrants have the right to an interpreter in the health and care services (lovdata.no, 1999). The Directorate of Health have developed guidelines for use of interpreters for "communication through interpreters for leaders and personnel in the health and care services". The right to a formally qualified interpreter in all public sector interactions and formal education for interpreters to ensure safety and professionally is suggested in a new law on use of interpreters in the public sector, it has just been on hearing and is in process (regjeringen.no, 2019). There is a lack of policies responding to the needs of irregular migrants (MIPEX report Norway, 2016).

LABOUR MIGRANTS

Norway has enforced strict laws addressing workplace safety, as well as laws aimed at restricting exploitation in the labour market (arbeidstilsynet.no, 2019). The Norwegian Labour Inspection Authority (NLIA) ensures that employers follow the laws and regulations. Their webpage is available in English. Furthermore, NLIA provide businesses with an available "seal of approval" for organisations providing employees with health insurance and have contracts with occupational health care service agreement approved by the NLIA.

MIGRANTS IN DETENTION CENTRES

According to regulation of the polices' immigrant detention centre from 2008, an independent council is tasked with overseeing that the centres' activities are in compliance with national and international rules and regulations. Annual reports of their activity a published online (politiet.no, 2019), and improvements are made continuously. Following the Ombudsman's report, families with children are not sent to the centre and many other important changes has been made. The Ombudsman is still concerned with the use of isolation, particularly for people with serious mental illness or trauma (The Parliamentary Ombudsman Norway, 2015). The Red Cross are present with volunteers who visit the detainees regularly (rodekors.no, 2019).

Intersectoral response to vulnerable migrants

The ministry of education and research is responsible for the school sector and consequently following up students in their care. The social workers at schools are working closely with local mental health clinics for youth (BUP) and the child welfare services (Barnevernet). Through the student unions, student health care facilities are normally accessible on university campuses.

The Health Directorate and UDI lead different groups consisting of different actors in the field to address different important issues. UDI is redesigning the reception centre at Råde and the process for arrival for refugees and are involving all relevant stakeholders in the process. The Health Directorate are leading different intersectoral groups, like the group on psychosocial follow-up of refugees, consisting of representatives from different directorates, health research and services, volunteer organizations, relevant municipalities and others.

Interventions/ action to address the needs of vulnerable migrants

There are many projects and interventions in the field of vulnerable migrants. Through the "whole government" approach, services are mainstreamed and health personnel should be able to tailor their service to the need of the patient. There are several policies and interventions addressing particular groups of migrants at all levels, many have been mentioned through the document.

Here are examples of projects in the volunteer sector providing health care and other services for migrants in vulnerable situations.

- Health service for irregular migrants, and shelter for homeless migrants are run by The Church City Mission and the Norwegian Red Cross.
- Activities to engage migrants in learning Norwegian and preparing for work, including many different organizations and local initiatives.
- Caritas have many services for labour migrants in several cities, like Bergen.
- Rosa-help.no assists victims of trafficking all over Norway. They provide assistance, legal aid and safe houses.
- The Red Cross has phone-lines for people who needs someone to talk to about forced marriage or "honour related violence" and female genital mutilation.

Documentation/ evaluation of initiatives/interventions

We have this data only to a varying degree. There is more attention to evaluation and as mentioned before IMDI does effect evaluation of some of their interventions. Activities run by the volunteer sector are as far as we know rarely systematically evaluated or effect evaluated.

The MiMK (Mestring I mottak og kommuner) project has evaluated an intervention called "Teaching Recovery Techniques" (TRT) for unaccompanied minors. The project aims to reduce trauma related psychological stress and illness for youth that are seeking asylum or have been granted legal stay in the country, empowering youth and their caregivers with tools to handle their responses to traumatic experience. The results to date indicate that the program is effective and useful for the target group.

A study by Buvik & Bergljot (2017) evaluated focus group discussions for asylum seekers in asylum centres, by volunteer psychologists. They found that the measure was less effective because the participants and the helpers did not have the same understanding of the problem that needed solving, and the solution.

A recent systematic review of language education for adult immigrants found little documentation of evaluation of effectiveness of techniques (Flodgren, Nøkleby & Meneses, 2018). The review was ordered by IMDI. Our impression is that the Directorate is interested in implementing effective measures to help migrants more effectively learn Norwegian.

PHASE 2: Analysis and recommendations

To be completed after the Country Assessment, before 15th of august.

The central question that the CAT must cover and should be borne in mind when addressing this section is ; What are the main issues that need to be addressed in order to make your country's health system more equitable for migrants in respect of [data & research, governance, intersectoral action, access, quality, vulnerable groups]"? .

Short analysis of Country Assessment – addressing policy practice gaps

Summary

Migration to Norway is not new and in the last two decades the numbers and diversity among migrant groups has grown.

In Norway, sociodemographic, health status and living conditions data is readily available. Migrant status, country of origin and ethnicity are not routinely registered in medical databases or clinical records. It is possible to obtain data on health and the use of health services by linking databases on health with other databases using the personal identification number. Although this approach overlooks undocumented migrants, routine linkage of databases could have an important impact through improving our knowledge of the health of migrants and use of healthcare services. However, the process of gaining access to data could be time consuming and cumbersome as data are not routinely collected by ethnicity or migrant background. Data are not always comprehensive and there is a lack of longitudinal data. In addition, a substantial amount of data comes from individual projects that cover only a few migrant groups, thereby not providing adequate information. We also require different types of data; for example, while we know that service utilization was found to be lower amongst migrants, it is unclear why this is - whether due to barriers to access or better health. Migrants are often excluded from population health studies due to insufficient numbers. There is limited research on health literacy, in particular the ability to understand information and seek help from the right service. So an 'intersectional' approach is recommended, focusing not only on the main effects of migrant status but also on its interactions with other variables such as gender and age. Recognizing the enormous diversity among migrants makes it possible to focus on the migrants who are most 'left behind' or likely to be excluded and most in need of supportive policies. Instead of recycling static notions about who is or is not vulnerable, the selection of groups should be evidence-based

There are few open calls or earmarked funding for research on migrants' health in Norway. Measures to achieve better coordination of research in the field are in the process of being implemented. Ear-marked funding and consensus agreement on involvement of migrants in population studies could improve this current situation.

High-level policies, specifically on migrants, are few in number. In 2013 a national strategy on migrant health was launched as a first step towards a systematic approach. Currently, policy approaches are focusing on mainstreaming migration health into broader health policies. While the "whole organization" and "Health in all policies" strategies aim at reducing inequities, a challenge is that these broader health policies often do not specifically mention or address migrants and their health needs. Norwegian policies on health do not only concern health services, but also include attempts to tackle the social determinants of migrants'

health, which involves issues outside the health sector itself. Policies on migration involve several sectors. However, there is limited inter-sectoral action on the social determinants of migrant health, although multiple agencies are engaged in attempts to address these issues, for example the Norwegian Labour Inspection Authority, Ministry of Education, Ministry of Children and Families. On directorate level, there is official cooperation between the Directorate of health and the Directorate of integration and diversity, and several good measures have been implemented at all governmental levels. At the municipal level, there is a great lack of long term and strategic public health work. Supporting the local/municipal level and strengthening inter -sectoral engagement is necessary. There is a lack of clear policies responding to health needs and rights of undocumented migrants. Most other vulnerable groups are receiving some policy attention, but the volunteer sector seem to carry a lot of the responsibility

Although the Norwegian system of health governance allows some room for regional and municipal variations, there does not seem to be obvious differences in policy between regions. The development of separate care facilities for migrants both within and between organisations have been discouraged, instead 'mainstreaming' of measures to combat inequities are given priority. The main advisory body on migrant health is The Unit for Migration Health based at the Norwegian Institute of Public Health (formerly NAKMI) which is regularly consulted on migration issues. The Health Ministry is also advised by SOHEMI (Council for Equal Health Care for the Immigrant Population), which consists of professionals with immigrant and Norwegian backgrounds who are experts in disease profiles in the migrant population, migrants' use of health services, and equality and discrimination. Several patients' organisations with migrant health expertise (e.g. Diabetesforbundet, Kreftforeningen) and government bodies such as OMOD (Organization against Public Discrimination) are regularly consulted. Further work to engage a wider array of stakeholders on a broader range of issues has an important role.

In the Oslo Municipality, the *Unit for Diversity and Integration* (EMI) cooperates with the municipal government in a structured process on issues affecting health. They are not directly involved in the planning of health care services. Across Norway, including on a national level, the contribution of migrants themselves in the policymaking process is largely ad hoc. Yet, making systems 'migrant-friendly' is not only a matter of imposing rules, however important that may be, but also "a battle for hearts and minds" – communities must be engaged and made to feel as though their interests are being protected. Moreover, strong input from migrants themselves is needed to ensure that the measures taken are appropriate. Many matters are well regulated on paper, but doubts are expressed throughout this report about the extent to which measures are actually implemented in practice. Greater engagement with migrants can help highlight these issues earlier in the policy process.

Migrants and ethnic minorities live, work, fall ill and die in the municipalities. In Norway, there are sporadic accounts of initiatives, interventions and good practices in Migrant Health at the Municipality level, but it is often ad hoc and dependent on individual champions or certain NGOs. While the structure and organization at the municipality level should enable inter-sectoral action (as all under one umbrella) there is a great lack of long term planning and strategy in public health. While there is a great drive to promote public health and primary health care in municipalities these initiatives, do not pay special attention to migrants.

Therefore advocating for and supporting the local/municipal level for inter sectoral action is highly relevant, timely and essential.

Explain the rationale for suggested feasible actions

Click here to enter text

Explain the rationale for suggested complex actions

Click here to enter text

Suggested action promoting equity in health for migrants

Name of action Establishing a National Data and Research HUB/Platform om migrant health to systematize the availability of evidence, identify research gaps and promote dialog re collection and use of data and research on migrant health.
Feasible/complex action Feasible

Brief describe the rationale for selecting the main actions.

In Norway sociodemographic data, health status and living conditions is readily available. There is good access to health data through linking registries, survey data and research. However, the process of gaining access to data can be cumbersome, data are not routinely collected by ethnicity or migrant background, data are not always comprehensive, cover selective topics and or migrant groups and there is a lack of longitudinal data. The CA indicates that it is not the existence of data or research that is a challenge for Norway, it is the gaps as mentioned above and the use of the evidence in policy and practice that continue to be a challenge. Measures to achieve better coordination of research in the field are being implemented but are in the start phase.

Norway will build on the past lessons learned successful implementation of the COST/EU project MIGHEALTHNET that partly addressed this gap. In addition the WHO/EU project MIKHMA, the Knowledge HUB will be an inspiration to develop this virtual platform.

We hope through this action to provide a virtual platform for stakeholders to readily access and build upon available evidence with an ongoing dialogue between the users and producers of data.

We propose the following steps in this action

1. National Dialog Conference with users and other stakeholders to understand their data needs and requirements
2. Advocacy meeting with owners of registries to discuss a common approach to variables/survey questions on migrants to ensure comparable data with regards to time and linking registries
3. Survey/ Delphi study National Researcher Network re requirements of such a HUB
4. Exploring the setting up of the HUB (costs/ technicalities)
5. Launch of the HUB at National Migration Conference
6. Evaluation after 6 months

Implementation level x National ☐ Regional ☐ Local ☐ Other **Click here to enter text**	Approach ☐ Comprehensive cross government strategy ☐ Isolated cross government action ☐ Comprehensive institutional strategy ☐ Isolated institutional action
Ministry(ies) /Department(s) involved ☐ Economy x Education (Universities)	Role of the health care sector ☐ Advocacy ☐ Coordination ☐ Evaluation ☐ Implementation ☐ Monitoring ☐ Planning

x Health ☐ Housing ☐ Labour ☐ Social policies/Welfare ☐ Transports ☐ Urban planning X SSB, NFR	☐ None ☐ Other Click here to enter text
Target ☐ Social Gradient ☐ Gap between highest and lowest SES ☒ Society as a whole ☐ Group Specific / vulnerable groups	Other inequalities considered ☐ Geographical ☐ Gender ☐ Ethnic ☐ Other Click here to enter text
If group specific, which one (or more)? ☐ Unaccompanied minors ☐ Elderly migrants ☐ Undocumented migrants ☐ Labour migrants ☐ Family reunification ☐ Children of migrants ☐ ROMA ☐ Unemployed ☐ Asylumseekers ☐ Other **Click here to enter text** ☐ Other **Click here to enter text**	Social inequalities in health ☐ Directly and explicitly addressed ☐ One of the objectives of the policy ☐ Considered as one of the outcomes of the policy ☐ Indirectly addressed through action on the SDH ☐ Not considered
Monitoring and evaluation ☐ Evaluation and monitoring on the impact on health inequalities ☐ Evaluation and monitoring on the impact on health without considering inequalities ☒ Evaluation and monitoring on the impact on SDH with an equity focus ☐ General evaluation without a focus on equity ☐ Action/Policy not monitored or evaluated ☐ Do not know	

Suggested action promoting equity in health for migrants

Name of action Advocate and Support the development of an Inter-sectoral action plan to reduce inequalities in health in one or two Municipalities in Norway
Feasible/complex action Complex

Brief description

Norway's commitment to equality has strengthened opportunities, for most immigrants, to fully participate in society (especially education, employment, social support and political participation). Recent changes have slightly undermined those strengths. Health systems are usually more 'migrant-friendly' in countries with a strong commitment to equal rights and opportunities and Norway is no exception. In order to achieve equity in health, besides rights and entitlements there is a need to respond to specific needs and to involve migrants and adapt services accordingly.

In Norway, strategy and action plans on migrant health have been developed at national level (2013-2017 national strategy on immigrants' health 'Equitable Health and Care Services - Good Health for All'). Migrant and ethnic minority health has received attention at National level (NAKMI, SOHEMI, Board of Health Supervision and Ombudsmen and new policies on migrant health in patient organisations, trade unions and NGOs). There is a wealth of data and research on migrant health compared to 10 years ago. Despite these gains migrant health has not yet been given due consideration in other policies beyond health. As migration policy is divided between several sectors, there is limited inter-sectoral action on the social determinants of migrant health.

Migrants and ethnic minorities live, work, fall ill and die in the municipalities. In Norway, there are sporadic accounts of initiatives, interventions and good practices in Migrant Health at the Municipality level, but it is often ad hoc and dependent on individual champions or certain NGOs. While the structure and organization at the municipality level should enable inter-sectoral action (as all under one umbrella) there is a great lack of long term planning and strategy in public health. While there is a great drive to promote public health and primary health care in municipalities these initiatives, do not pay special attention to migrants. Therefore advocating for and supporting the local/municipal level for inter sectoral action is highly relevant, timely and essential.

We propose the following steps to achieve this action

7. National Dialog Conference with stakeholders to launch and discuss inter sectoral action plan at the Municipality level.
8. Based on the discussion at the National Dialog Conference conduct Delphi to prioritize feasible actions for inter sectoral actions
9. Advocacy meeting with KS (Organization of Municipalities) and possible implementation municipalities (one or two) to discuss the possibility of the developing an action plan (as perhaps part of (Helse i Plan)
10. Workshops at the Municipality with different sectors to discuss the action plan
11. Support the Municipality with data and technical inputs to develop the plan

12. Support the Municipality with the endorsement and acceptance of the plan
13. Monitor the evolution of the plan within the municipality

Implementation level

- ☐ National
- ☐ Regional
- ☒ Local – Municipality level
- ☐ Other **Click here to enter text**

Approach

- ☒ Comprehensive cross government strategy
- ☐ Isolated cross government action
- ☐ Comprehensive institutional strategy
- ☐ Isolated institutional action

Ministry(ies) /Department(s) involved

- ☒ Economy
- ☒ Education
- ☒ Health
- ☒ Housing
- ☒ Labour Health
- ☒ Social policies/Welfare
- ☒ Transports
- ☒ Urban planning
- ☐ Other **Click here to enter text**

Role of the health care sector

- ☐ Advocacy
- ☐ Coordination
- ☐ Evaluation
- ☐ Implementation
- ☐ Monitoring
- ☐ Planning
- ☐ None
- ☐ Other Click here to enter text

Target

- ☒ Social Gradient
- ☒ Gap between highest and lowest SES
- ☐ Society as a whole
- ☐ Group Specific / vulnerable groups

Other inequalities considered

- ☐ Geographical
- ☐ Gender
- ☐ Ethnic
- ☐ Other Click here to enter text

If group specific, which one (or more)?

- ☐ Unaccompanied minors
- ☐ Elderly migrants
- ☐ Undocumented migrants
- ☐ Labour migrants
- ☐ Family reunification
- ☐ Children of migrants
- ☐ ROMA
- ☐ Unemployed
- ☐ Asylumseekers
- ☐ Other **Click here to enter text**
- ☐ Other **Click here to enter text**
- ☐ Other **Click here to enter text**

Social inequalities in health

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- ☒ Considered as one of the outcomes of the policy
- ☐ Indirectly addressed through action on the SDH
- ☐ Not considered

Monitoring and evaluation

- ☐ Evaluation and monitoring on the impact on health inequalities
- ☐ Evaluation and monitoring on the impact on health without considering inequalities
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- ☐ General evaluation without a focus on equity
- ☐ Action/Policy not monitored or evaluated
- ☒ Do not know

Suggested action promoting equity in health for migrants

Name of action Click here to enter text
Feasible/complex action Click here to enter text

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☐ Unemployed ☐ Asylum seekers
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