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The Health of Polish labour immigrants in Norway

A Research Review

NAKMI report 3/2010
Norwegian Center for Minority Health Research (NAKMI)

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NAKMI, September 2010
Elżbieta Czapka

Summary

Polish labour immigrants in Norway

Since Poland joined the European Union in 2004 and several job markets in Western Europe became accessible, great numbers of Poles have emigrated in search for work and higher income. Norway has become a popular destination for the Polish immigrants due to its demand for workforce. In Norway Polish men work mainly as construction workers, which involves a specific risk to their health. Women, on the other hand, are mostly employed as house cleaners, child minders or social care workers. They are often employed illegally without being officially registered, which leaves them with no access to social welfare benefits or health care services.

Research methods

The research is both qualitative and quantitative in nature. The data were gathered by means of a questionnaire survey consisting of 83 general questions and 14 factual profile questions. Additionally, ten individual interviews were conducted and five focus interviews were held in order to gain a deeper insight into a number of research issues. Since snowball sampling was employed as the method, the research results are in no way representative of the entire population of Polish immigrants in Norway. The report also uses data from several representatives of Norwegian institutions, collected during information meetings which were organized for the Polish people by Jerzy Gruca, a member of The Polish Club, and the report's author.

Immigrants' self-evaluation of health

Migration is not only connected with changing your position geographically but it also involves a shift in position within the social structure. Existing research has proven that shifts in an individual's social status are reflected in changes of their health. The research in question analyses health in its three dimensions: biological, mental and social. The Polish labour immigrants in Norway assess their health in a relatively positive way. 46 % admitted that certain changes in their health had occurred, of which 26 % described those changes as not beneficial. Most frequently the immigrants mentioned a feeling of fatigue and insomnia.

Regarding their mental health, they declared that a good emotional state was experienced more often in Poland than in Norway. This is attributed to their social isolation, an evident feature of the Polish immigrants' participation in social interaction. For a number of reasons the Polish people fail to integrate with the Norwegian community.

Immigrants' use of health care services

As declared by the immigrants, their access to the health care services was limited due to their incompetence in the use of the Norwegian language and insufficient information about the health care system. The immigrants admitted to using health care services in Poland more frequently than in Norway. Their future plans had a significant impact on the way they used the Norwegian health care system. People who intended to settle down in Norway were more eager to take advantage of the medical care available in Norway.

Immigrants' lifestyle

The lifestyle of the Polish immigrants in Norway differed significantly from their lifestyle in the native country. The changes are particularly visible in the initial stage of their life in the foreign country. That is when the immigrants tend to save money by cutting down on food, which consequently influences their health. The research results show that the most evident changes can be perceived when it comes to eating habits and nutrition, sex life and alcohol abuse.

This may be due to the fact that the immigrants seem to experience no social sanctions as a result of breaching certain moral norms which were part of the moral code that they used to observe in Poland.

Health-related moral code

The most vital value for the immigrants is their family. They are prepared to put their health at risk for the sake of the family. As declared by the respondents, they would not experience any negative internal sanctions (guilt, shame) or external sanctions (contempt) if they consciously risked their health in order to help their families. The vast majority of immigrants admitted that tending to one's own health is a moral duty of each individual. Their main motives include their family's well-being and caring for their health, which is considered to be a gift from God.

Implications The results of the research show that lack of knowledge of the Norwegian and/or English language is one of the most significant factors influencing the immigrants' health. Their communicative competence affects the immigrants' access to the health services as well as their participation in social relations. Furthermore, the immigrants are prepared to sacrifice their health for the sake of the family, which ranks the highest in their hierarchy of values. This has some specific implications on the lifestyle of Polish migrants living abroad. They lead frugal lives and buy the cheapest food products available so that they can send a significant part of their income home to Poland.

One way to improve the health of the Polish labour immigrants in Norway would be to take all of the necessary steps to encourage them to learn Norwegian or English. Besides that, it would be beneficial – both to the Norwegian state and the Polish immigrant community – if the immigrants were able to bring their families to stay with them in Norway.

An introduction

Europe is undergoing constant changes in the areas of culture and politics. The rapid pace of these changes has resulted in endless metamorphoses of Europeans' daily lives (Janicki, 2009). Migration can be regarded as both a reason and a consequence of such changes. It is unquestionable that for economic reasons Europe needs migrants. Moreover, most of the contemporary immigrants are labour migrants (Padilla, Pereira, 2007). New labour migration is a very specific phenomenon, because unlike before it is now much easier for migrants to move back and forth and keep in touch with their relatives back at home, even if they are on the other side of the globe.

Norway became a destination for labour migrants in 1967 when the first group of Pakistani migrants came to Norway to find work in the oil industry (SSB, 2009). Since the European Union's extensive development Norway has been attracting more and more labour migrants from the EU 8 every year (SSB, 2009), especially from Poland. According to estimates, about 2 million people left Poland, an ex-communist state, after joining the European Union in 2004, seeking better lives and wages in richer Western EU member states. Most of those who left were young people complaining about poor career prospects in Poland, which was battling unemployment levels of about 20 per cent and a worryingly slow economic growth.

New labour immigrants from the EU 8 work mostly as construction workers and they are exposed to work-related accidents.

1. Polish people in Norway

1.1. Historical background in brief

Poles arrived in Norway for the first time during World War II. They had been sent there to do compulsory work, mainly road and airport building. Some of them decided to stay and built the foundation for the Polish community in Norway. The second wave of Polish immigrants arrived in the 1980s when the political activists of the Independent and Self-Governing Trade Union „Solidarnosc" were accepted as asylum seekers and given residence permit by the Norwegian authorities (Olszewski, 1997). Owing to the fact that immigration networks had already been established, the 1990s Polish immigration was made relatively easier. Undeniably, the breakthrough moment for Polish migration to Norway was when Poland became an EU member state in 2004.

1.2. Contemporary Polish immigration – official statistics and unofficial estimates

According to the official data published by the Statistics Norway on 1 January 2010, there are 52,125 immigrants from Poland residing in Norway (SSB, 2010). It is a labour migration in nature[1]. Despite the economic recession, which consequences were to some extent experienced in Norway as well, the country has remained an attractive destination for the Polish immigrants. In 2009 3,618 immigrants left Norway, but as many as 10,511 new immigrants seeking employment and new sources of income arrived in the country. Only 5,074 Poles (9.7 % of the entire Polish population) have obtained a Norwegian citizenship. In 2007 most Polish immigrants resided in Oslo (6,581), Bergen (2,022), Bærum (1,442) and Stavanger (1,272). 93 per cent of Poles who immigrated in order to seek labour were men, while 56 per cent of those who immigrated as family immigrants were women.

The Polish population in Norway is highly diversified as far as the length of their stay abroad is concerned:

25 years and more (since 1984) – 1603
20-24 years (1985-1989) – 1361
15-19 years (1990-1994) – 1141
10-14 years (1995-1999) – 847
5-9 years (2000-2004) – 2558
0 – 4 (2005-2009) – 41,799

The data quoted above show a considerable increase in the immigrant mobility between Poland and Norway since 2004.

Compared with the period preceding Poland's EU membership, there are over four times more Polish immigrants with a work permit. Undoubtedly, the most important factor which

1 In the period between 1990 and 2008 in Norway there were 44,617 Poles, out of which 31,923 were labour immigrants. In 2008 14,116 more immigrants arrived, including 10,401 labour immigrants.

attracts immigrants to Norway is the country's considerable demand for foreign workforce and far higher wages offered to employees than those available in Mid-Eastern European countries. Even though Norway is not a member of the EU, the country has incorporated several EU legal regulations concerning the job market and social welfare benefits. Another factor which attracts the immigrants is the existence of employment and recruitment agencies. They act as in-betweens in arranging employment but also provide some sort of accommodation. Poles are willing to work in Norway as a consequence of the unsatisfactory situation on the Polish job market and relatively low wages.

It must be mentioned that since 1 October 2009 the Polish citizens are not required to apply for permission to stay and work in Norway (UDI, 28.12.2009). They are allowed to reside in Norway for three months without registration but are then required to register at the police. Once they become employed, they should register immediately. Those actively looking for work in Norway are also supposed to register. The registration in question is made for an infinite period of time.

It is impossible to establish the exact number of Polish immigrants in Norway because many Poles do not possess ID numbers and, consequently, work illegally. In particular, this is the case with female house cleaners. Thus, these have no rights to health care services, except for emergency services, a fact which seems to be somehow tolerated by both Norwegian employers and Polish immigrants. As Okolski claims, "there are no bases, apart from the intuition and bravery of some experts, to assess the dynamics of the illegal migrants" (Okolski, 2004). Hence, the author will abstain from quoting any numerical data to estimate the number of Polish illegal workers in Norway.

1.3. Poles on the Norwegian job market

In countries where immigrants are employed on a large scale, they are overrepresented in the field of services, mainly in the hotel and catering industries as well as housekeeping and construction. As a matter of fact, this sort of overrepresentation is not encountered in the field of administrative clerical professions and tends to be quite rare as regards education and agriculture. (Okolski, 2004).

The IMDI Research shows that more than eight out of ten people arrived in Norway to work (IMDI, 2008). Nearly 70 per cent of the Polish labour immigrants work as artisans. Over 50 per cent of men and almost 40 per cent of women claim that their profession corresponds to their qualifications and skills, which links directly to the Polish immigrants' educational background. According to the IMDI research, as many as 79 per cent of the immigrants claim to have completed a vocational school or training and hold the necessary qualifications. More than a third of the Polish workers state that they have received lower wages than Norwegians employed to perform the same duties or hold the same post. This reveals that the Polish people feel that they are treated unfairly on the job market in comparison to the workers from the Baltic countries.

2. Migration and health – the theoretical basis for the research

A huge body of research has documented that there is a strong relation between health and migration. However, there is no direct link between these two phenomena. Migration in the geographical space tends to be related to vertical mobility and leads to changes in the social status of an individual. More frequently it boils down to social degrading than to social advancement. As Nazroo highlighted, the social position is a very important factor in determining the health of migrants (Nazroo, 1998). Changes in health reflect the changes in the social position of the individual, which confirms the thesis that migration influences the social position of migrants. However, some researchers claim that ethnic inequalities in health are not related to socioeconomic inequalities (Wild, McKeigue, 1997), while others claim that it is necessary to consider factors such as culture, socioeconomic status and genetic characteristics in order to explain ethnic inequalities in health (Smaje, 1996).

Usually people who go abroad for economic reasons are quite healthy. This phenomenon is well known as the healthy migrant effect. Migrants are convinced that they will be able to cope with the new reality and adapt to the new circumstances. They assess their health capital positively as it enables them to work hard and, as a result, improves their economical situation. However, migrants are unable to predict all the obstacles they can encounter abroad even if they do have some worries[2]. According to some research results, new labour migrants feel healthy before going abroad but state that their health deteriorates during their stay abroad. When they retrun home they assess their health as better than it used to be during their stay abroad but worse than before leaving the country (Kawczynska – Butrym, 2008).

The changes in health may result from lower self-esteem and social degradation experienced by a migrant in a foreign country, especially when their work is of a lower status in the professional hierarchy and offers worse career prospects than the job they used to do back home. New labour migrants are mostly employed in the service sector, and some jobs, especially construction work, involve a high risk of accidents and permanent health damages. The kind of job being done is a very important factor influencing male migrants' health in its three dimensions: social, mental and physical. Considering health issues, labour migrants, especially unregistered ones, constitute a particularly vulnerable group. Limited access to the health care services for immigrants has attracted researchers' attention recently. Despite the right to use the health care services, immigrants encounter obstacles such as limited access to information, language incompetence, economic barriers, and cultural barriers which make it

2 According to Kawczynska's research results, young Polish migrants in Ireland and Great Britain had some worries concerning emigration but still, they decided to leave Poland. They were afraid of: family longing –63,3 %, speaking a different language –52,2 %, financial problems –34,4 %, difficulties with finding a job –67,8 %, failures at work –31,1 %, different customs – 15,6 %.

either difficult or impossible to take advantage of the health services in the destination country.

In contemporary society, information becomes a type of immaterial good, which is sometimes much more valuable than material goods. Accordingly, a lack of information can marginalize particular social groups. All people have equal rights to obtain the necessary information because the state authorities are obliged to use resources to ensure equality in social, cultural, political and economical spheres between the minority and the majority groups. In the age of globalization, the state still plays an important political role. Unfortunately, many governments have difficulties "to construct new forms of interaction with their citizens" (May, 2002) and instead rely on existing communication channels.

Migrants have the right to know what kind of medical help they are entitled to, what health care services are available and how to get the required help. However, it seems as if migrants and ethnic minorities with low education become increasingly disadvantaged and marginalized in the information/network society. Many have insufficient digital skills and lack dominant language competence. If nothing is changed "ethnic minorities will undoubtedly be among "the misfits" of the network society in both work and in social communications" (Van Dijk, 2006). Undoubtedly, advances in information and communication technologies somehow influence the type of information people have access to and the sources of the information (Dutton et al. 2006).

3. Research methodology

3.1. Problems and research hypotheses

The main aim of the study is to investigate whether the Polish labour migrants have experienced changes in their state of health since their arrival in Norway (according to their declarations) and to discover the main obstacles to using the health care services in Norway. Methodologically, it seems reasonable to compare the declarations concerning the immigrants' state of health before arrival in Norway with those during the period of time spent in the foreign country. If the aim is representative research, it would be useful to analyse the health condition of the Polish immigrants in comparison to their compatriots living in their native land. However, this objective cannot be reached in the case of the author's research. Moreover, due to the cultural, environmental and economical differences, I do not consider the comparison of the Polish immigrants and the Norwegian society as regards their health state to be scientifically justified.

The following research questions were formulated:

1. How do the Polish migrants assess their health state with regard to any changes experienced after their arrival in Norway?
   What is the immigrants' health (social health, in particular) like, on the basis of their declarations?
2. Do they declare any lifestyle changes (eating habits, leisure and sleep, sex life, physical activity, use of addictive substances) to have occurred?
3. Do they use the health care services in Norway or in Poland? What are the reasons behind using or avoiding the health care facilities abroad? What kind of obstacles did they experience when using the health care services abroad?
4. How does their health rank in the immigrants' hierarchy of values?
   Are there any circumstances under which the migrants would be prone to put their health at risk?
   Would that result in experiencing specific sanctions – both internal and external?
5. What socio-demographic factors have influenced the immigrants' declarations?

In reply to the research problems posed above, the following hypotheses were formulated:

1. Migrants declare that the state of their health is worse in Norway than it used to be in Poland.
2. They declare that their lifestyle has changed since their arrival in Norway.
3. They use the health care services mostly in Poland. The main reason is lack of information about the Norwegian health care system and language incompetence.
4. Their health ranks low in the migrants' hierarchy of values. The migrants will be prone to put their health at risk for the sake of their families and faith in God. In consequence, they will experience no external and internal sanctions.

5. The migrants' declarations concerning the state of their health vary depending on their age, gender, educational background, religion and occupation in Norway as well as the length of residence in Norway, their linguistic competence (knowledge and usage of the Norwegian language), their plans to stay in or leave Norway and the purpose of their emigration.

3.2. Research methods

The character and the specificity of the research required both quantitative (survey) and qualitative (semi-structured individual interviews, focus group interviews, observation) research methods to be employed in order to answer the research questions. The research was carried out in three stages:

a) A pilot study

The aim of the pilot study was to test the design and quality of the questionnaire. The survey was divided into five parts according to the research problems in question. It contained 76 close-ended and half–ended questions and 14 factual questions. There were a few filter questions that preceded the contingency ones. The questionnaire was distributed among 20 immigrants who were requested to fill it in and include their comments concerning the research tool.

b) Full-scale quantitative study

Prior to the full-scale quantitative study, the questionnaire underwent corrections and modifications in response to the findings of the pilot study. Snowball sampling was chosen and, consequently, it is not representative of the whole population of young Polish labour immigrants in Norway. Any generalizations occurring in this study refer exclusively to the researched sample. It was impossible to use random sampling because the number of unregistered immigrants is impossible to specify and the existing registers are thus incomplete. To ensure that the sample has certain parameters relevant to the researched population, the respondents from diversified backgrounds were recruited from a variety of places and surroundings (building sites, churches, language schools, a Polish association in Norway). The immigrants were given the questionnaires together with addressed and stamped envelopes. They were asked to distribute them among their friends and relatives, fill them out and return by mail. This procedure was to guarantee the anonymity of the research. Eventually, several questionnaires had to be rejected because a number of replies were missing, especially in the factual part including the personal profile data.

Some information used in the report was also collected during the information meetings for the Polish immigrants with representatives of The Service Centre for Foreign Workers. The meetings were organised by Jerzy Gruca, a representative of the Polish Club and the report`s author. Among the issues raised during those meetings were the problem of information deficiency among the immigrants in Norway and the barriers which limit access to the necessary information.

c) Complementary qualitative study
The semi-structured individual interviews and the focus group interviews were conducted to get a deeper insight into some research issues and investigate the ones that could not be explored by means of a survey. At this stage the informants were recruited with regard to some specific characteristics, such as educational background, occupation and length of stay in Norway. As a deputy leader of one of the Polish associations in Norway, the author was an active participant of the Polish immigrant community life in Oslo, which enabled her to observe the immigrants' lifestyle in a participatory manner. The research was conducted between 2008 and 2009.

3.3. Research sample characteristics

The questionnaire survey was filled in by 107 Polish labour immigrants in Oslo, and 32 immigrants participated in the interviews. The majority of informants were male (58 %). The group was differentiated with respect to age (17-25: 20 %, 26-30: 34 %, 31-40: 18 %, 41-50: 16 %, over 50: 7 %)[3], educational background (vocational education: 24 %, general secondary: 31 %, tertiary (BA): 17 %, tertiary (MA, PhD): 28 %) and length of stay in Norway (5-6 months: 21 %, 7-12 months: 22 %, 13-24 months 22 %, more than two years: 35 %[4]). 40 % of the surveyed immigrants came to Norway alone without any friends or relatives. Only 21 % of the immigrants arrived in Norway accompanied by their spouse, 20 % came with their partner and 11 % with their offspring.

The reasons for coming to Norway varied[5]:
- their own financial difficulties – 28 %,
- their parents' financial difficulties – 3 %,
- their need to earn money with a particular aim in mind, such as providing for their children in the future, buying a car, organizing a wedding, buying a flat, working in order to obtain retirement benefits in the future, reuniting with a partner, having a nomadic lifestyle, language learning, having no prospects for the future in the native country – 34 %,
- difficulty of finding a satisfying job in the native country – 17 %,
- difficulty of finding any job in the native country – 3 %,
- attempt to gain new qualifications – 19 %,
- undertaking studies – 4 %,
- getting married – 9 %.

It must be added that as many as 50 % of the immigrants mentioned the people who depend on them financially[6]: spouse – 32 %, partner – 5 %, child(ren) – 22 %, parent(s) – 6 %, sibling(s) – 2 %.

3 5 % refused to answer the question about age
4 2 % didn't answer that question
5 Informants could point to more than one answer
6 Informants could point to more than one answer

For 85 % of the immigrants who took part in the research, their stay in Norway was connected with legal employment (11 %: illegal work, 38 %: learning Norwegian, 7 % visiting family, 7 %: exploring Norway)[7]. 34 % decided to stay in Norway; 40 % wanted to return to Poland after some time (the date was not specified at that point) and 26 % definitely wanted to go back. It often happened that people went abroad to work with an intention to stay for a few months and then prolonged their stay for undefined stretches of time.

7 Informants could point to more than one answer

4. Immigrants' health self-evaluation

Long-term stay abroad influences our general well-being and mental activity. As a result of experiencing a variety of difficulties and failures in a new environment, negative emotions may accumulate and difficulties in solving problems successfully tend to generate frustration. Physical exhaustion and a long-lasting exposure to stress overburden the nervous system and decrease our mental immunity.

Kawczynska-Butrym's research, conducted in 2010 as part of a return migrants project, shows that health was the only one, out of 14 categories, which was described as deteriorating rather than improving. One in seven return migrants admitted a decline in their state of health[8].

In order to examine if migration had an impact on the state of health of the Polish immigrants in Oslo, they were requested to compare their health condition during their stay abroad and prior to their arrival in Norway.

4.1. Declared changes in the state of health

Not surprisingly, most immigrants assessed their health condition as very good (30 %) and good (49 %). Only 17 % declared that their health was satisfactory and 4 % defined it as bad or very bad. It was important to ask the immigrants whether their health had undergone changes since their arrival in Norway. It appeared that the health of 54 % had not changed. 20 % admitted that their health had improved and 26 % reported deterioration in their health (table 1).

Table 1. Changes in the state of health, as declared by the immigrants

Health components	Health improvement	Health deterioration
Physical	*Generally I am feeling better, I have better blood circulation, I spend more time outdoors (in the fresh air), I am not sick, I feel less pain in my back, I like the Norwegian climate, I have no problems with gastritis any more.*	*Accidents at work, permanent infections, diabetes, problems with my spine!!!, a pain in the legs, I am not fit enough, fatigue, tiredness, lack of energy, digestion problems, genital system problems, skin and nail problems*
Mental	*My mental health has improved because now I know that my family has everything they need except for the father and the husband, I am not stressed about providing for my family, I am in a better mood, experiencing lack of stress, no worries, a kind of stability, I am happy in my private life*	*stress!!!, family longing, working abroad demands more concentration and effort, bad mental condition, the weather affects me*
Social	*Nice work, new friends and new experiences, I work less than in Poland, the working conditions are better, I earn 8 times more than in Poland*	*Working in a specific environment (in the office), lack of friends*

8 The text is in the process of editing before going to print.

What is interesting, such variables as age, gender and length of stay in Norway did not differ among the immigrants' declarations with regard to their health change.

In order to learn what the informants meant by the health change, they were asked to point out what health problems they experienced more often in Norway than in Poland (Table 2).

Table 2. Health problems experienced by the Polish immigrants` when abroad and in their native land (%)

Health problems	Experienced, but only briefly, right after my arrival	Experienced less than in Poland	Experienced more than in Poland	Did not experience at all	Experienced in the same way as in Poland
Stomachache	4	5	5	60	26
Headache and dizziness	4	8	14	51	23
Fatigue	7	4	25	36	28
Frequent infections	2	9	10	60	19
Insomnia	6	1	10	63	20
Excessive sleepiness	3	1	14	65	17
Allergies	4	7	12	65	12
Back pains	5	6	16	51	22
Other	4	-	8	88	-

Very few immigrants stated that they had experienced the above-mentioned conditions in Norway less frequently than in Poland. Fatigue seems to be the biggest challenge. In Norway one in four informants experiences fatigue more frequently than they did in Poland.

At this point it is worth emphasizing the results of the research carried out by Kawczynska-Butrym among return migrants in 2007 and 2008. The return migrants were asked about the occurrence of specific ailments, taking into account the periods before they left the native country, during their stay abroad and upon their return. According to declarations, their state of health deteriorated during the stay abroad, except for diarrhoea and apathy. The return migrants claimed that they experienced far more frequent psychosomatic symptoms (fatigue, irritation, insomnia) as well as back pain and muscle pain during their stay abroad. The latter could have been a result from the effort they put in while doing highly demanding physical jobs. Most frequently, as declared by the return migrants, their health improved slightly on their return home but still it was regarded as worse than before they left the country (Kawczynska-Butrym, 2008).

4.2. Immigrants' mental health

The research conducted so far points to the fact that migration has an impact on the individual's state of health. (Peters, 1986; Bruijnzeels, 2004). The majority of migrants who took part in the research claimed that they found themselves in a good emotional state, both in Poland and in Norway (table 3). However, the informants declared to be in a very good emotional state while in Poland, more frequently than in Norway.

Table 3. Emotional well-being of the informants as experienced in Poland and Norway, according to their declarations (%)

Categories	Poland	Norway
Very good	20	10
Good	50	53
Average	20	26
Poor	6	5
Very poor	1	2
Difficult to say	3	4

In order to obtain more detailed information about their mental state, the informants were asked about the kinds of emotions they experienced while in Norway and their frequency. (table 4).

Table 4. Emotional states experienced by the immigrants during their stay in Norway, according to their declarations (%)

Emotions	Yes			No	Difficult to say
	Only at the beginning	Seldom	Frequently		
Anger	14	34	12	34	6
Irritation	5	38	15	32	8
Nervousness	6	46	14	22	12
Helplessness	11	32	8	37	12
Indifference	4	26	11	46	13
Low self-esteem	9	21	10	52	8
Mood swings	5	24	18	39	14
Overwhelming homesickness	13	17	29	32	9
Depression	6	17	7	61	9
Happiness	4	23	31	24	18

The immigrants often mentioned a feeling of overwhelming homesickness while 32 % did not experience it at any point during their stay in Norway. Nearly a third mentioned a frequent sensation of happiness. Among other frequently experienced emotions mentioned in the questionnaires were irritation, nervousness and mood swings.

Living as an immigrant is to some extent a crisis situation. All the definitions of crisis emphasize that it is necessary for an individual to adapt to a new situation, which requires an efficient coping strategy. (Czapka, 2001). The comparison of coping strategies used by the immigrants in Poland and in Norway proved interesting. (table 5).

Table 5. Immigrants' coping strategies employed in Poland and in Norway (%)

Strategies	Poland	Norway
Waiting for the problem to be solved, trying to survive	28	30
Talking to friends, asking them for advice	53	47
Eating sweets or other comfort foods	10	12
Seeking a psychologist's help	4	2
Trying to sleep a lot in order to forget about things	6	9
Drinking alcohol in order to forget about sorrows at least for a while	5	4
Talking to relatives and asking them for help	40	32
Crying out of helplessness	8	15
Turning to a priest for help	3	3
Praying	36	36

Table 5 shows that, according to their declarations, while in Poland, the immigrants took advantage of such external coping strategies as talking to relatives, friends or a psychologist, slightly more often than in Norway. This is due to the fact that they have a more extensive network of family and social relations in Poland than in Norway. It must be mentioned that in Poland a family is the most important source of emotional support for its members and hence in an emergency situation people turn to their family for help. As many as seven per cent more admitted that they cry out of helplessness in Norway than they used to in Poland. Quite importantly, the immigrants turn to the most dysfunctional coping strategies (waiting for the problem to disappear, overeating, escaping problems by excessive sleeping) only a bit more frequently than they would in Poland.

4.3. Immigrants' social relations

According to the WHO definition of health, one of the criteria used to measure health is an individual's participation in social relations. For the labour migrants residing abroad, income-providing work is the most important area of their social activity. It is of significance how the immigrants evaluate the work they do in Norway (table 6).

Table 6. Evaluation of the work done in Norway, as declared by the Polish immigrants. (%)

Evaluation of work	Fully	Partly	Not at all	Below expectations/ possibilities	No reply
Financially satisfying	27	56	2	9	6
Relevant to my qualifications	33	22	31	5	9
Health-friendly	24	30	33	4	9
Providing me with a sense of security	29	45	12	5	9
Providing me with a sense of respect	37	33	16	4	10
Providing me with promotion prospects on return to Poland	18	16	47	6	13
Providing me with promotion prospects here in Norway	20	27	38	4	11

The way the immigrants assessed the jobs done abroad varied. A third of them described the work they do abroad as not health-friendly. This was further confirmed in the interviewees' comments:

„Well, my health has deteriorated a tad because of the work I did for one of the companies. I won`t be mentioning its name. I did a lot of demolishing of plenty of concrete blocks, knocking down walls and what not. I have a bad back these days, because it is hard work."(A.);

„I could have ended up in this warehouse at minus 25 degrees centigrade but I had a feeling there was something wrong with it and I gave it up, especially since my mate wanted the job. Then Pawełek suffered from a testicle inflammation and a fever of 40 degrees. My mates who still work there keep complaining about kidney pain."(D.).

The interviewees tried to explain why their work often involves putting their health at risk:

***"P1:** When I first came here I sat at home for three months. You know, this sort of accommodating to Norway. And I realised it is not natural to work so f...ing hard, work non stop. It just ruins your health.*

***P2**: But there`s no choice.*

***P3**: We have to reach a certain status, minimal security, feel relaxed to some extent.*

***P1**: But the more you get, the more you want and this is the problem. The more money you earn, the more you expect.*

***P3**: But at a certain age you can't do so much any longer. You come to realise that you can't work that hard anymore.*

***P1**: Some of us reach this conclusion a bit earlier, others need more time. Personally, I guess I have realised I`m overdoing it a bit and that you mustn`t do that."*

The immigrants who filled out the questionnaires believed that their work did not guarantee future promotion prospects, neither in Norway (38 %) nor – even more so – in Poland (47 %). That confirms the thesis that the immigrants tend to do the jobs which are not

eagerly taken on by Norwegians but are also considered less prestigious in Poland. In literature they tend to be referred to as 3D jobs (dirty, dangerous and dull) (Favell, 2008).

The Polish immigrants do not participate actively in social relations. One piece of evidence is the fact that very few of them are involved in or interested in joining any association or organisation (table 7).

Table 7. Participation in organisations and associations, as declared by the immigrants (%).

Organisation/association	Yes	No	No, but I`d like to.	No reply
Church groups	15	60	3	22
Choir or music band	4	70	4	22
Sports club	10	53	16	21
Hobby club	5	62	10	23
Political party	3	72	2	23
Youth organisation	3	68	5	24
Polish association in Norway	12	57	12	19
Trade unions	17	55	6	22
Language school	44	34	11	11
Voluntary organisations	8	64	5	23

Such a low social activity may result from lack of time. Attending classes at a language school or joining trade unions are obviously highly instrumental in nature and as such more of a personal investment rather than a way of spending leisure time.

According to their declarations, as many as 80 % of the immigrants spend their leisure time in the exclusive company of other Poles. Simultaneously, 31 % spend their spare time with Norwegians and 18 % favour the company of other nationalities. Apparently, the most significant barrier is the language gap. A fraction of the immigrants speak neither English nor Norwegian. As a result, they find it very challenging if not impossible to integrate with the Norwegian community:

„Not until free lessons are available, will the Polish community cease to be pushed to the margin. Until then, we won`t blend with the Norwegian community, actually, standing no chance of doing that. "(K.)

The immigrants also mentioned other barriers they encounter in relations with Norwegians:

„If we want to understand each other, ourselves and Norwegians, there is one solution I can see: Poles would need to be more in control of themselves and Norwegians would have to drink some alcohol to feel more relaxed, and then there is a chance."(K.)

"We don`t really hang out with Norwegians because they keep us at bay, being far from friendship, from social life – as far as Poles are concerned. I mean, they prefer their own company. But they are

in such a good financial situation, so secure that they don`t tend to get in touch. As for the neighbours, they don`t keep in touch with you too much either."(Krz.)

Both the quantitative and the qualitative research show that the Polish live in a certain diaspora in Norway despite the fact that the Norwegian authorities make efforts to integrate new immigrants with the local community. Most immigrants who participated in the research and the Polish community activists maintained that the best solution would be Norwegian language courses available to participants free of charge. To establish what kind of relations exist between Poles and Norwegians, the informants were asked how often they interacted with Norwegians in specific places and situations (table 8).

Table 8. Frequency of contacts with Norwegians in specific places and situations (%)[9]

Situations/places	Frequency of contacts		
	Frequently	seldom	never
Offices and institutions	43	51	6
Shops	92	7	1
Church	20	38	42
Health care	21	45	34
Work	82	11	7
Social contacts (after-work meetings, cinema-going)	21	48	33
Neighbourhood	36	50	14
Closer friendship	13	32	55

The immigrants were also asked to specify – on a scale from 1 to 10 – how they felt in Norway (1 – in total isolation, 10 – fully engaged in the social life). As many as 31 % found themselves in the section between 1 and 4, which points to a relatively high level of social isolation. The most numerous section is that between 5 and 8 (59 %). Only 10 % declared their full engagement in social relations (the section between 9 and 10).

There are several distinct reasons behind the social isolation of the immigrants. As many as 10 % admitted that they themselves had decided not to maintain any social contacts. 12 % experienced a cultural barrier which did not allow them to participate fully in Norwegian society. However, the language barrier, which prevents integration in a new society for obvious reasons, seems to be the most important (39 %).

Some Poles (22 %) claimed to be treated unfairly or even discriminated against by Norwegians. The following forms of unfair treatment have been mentioned: *„when I was trying to rent a flat; while I was driving, they were trying to overtake and kept giving me the finger and showing other taboo gestures, it was like letting me know who rules here, who the master is.; generally, Poles are not treated by Norwegians as equals, at the same time it must be said that*

9 The table includes the results which were obtained by consolidating the following replies: frequently (very frequently + frequently), seldom (very seldom + seldom) .

Norwegians are very kind towards immigrants; some get irritated when you don`t know the language; discrimination at work – they tried to make me quit the job, they bullied me, I had to be on sick leave for six months, find another job; obviously not a single Norwegian treated me as their equal despite all the high qualifications I hold; at work a Norwegian always ranks higher than a Pole irrespective of the skills and preparation for the job; my employer treated me unfairly when it comes to money; they looked down on me; they are racists who treat Poles as machines; in a designer shop a shop assistant treated me badly because she assumed I couldn`t afford things".

Surprisingly, 20 % of the informants declared that they were treated unfairly by other Poles. They gave several examples of such treatment:

„ At work when they try to show off and prove that they are better and want to manage things; verbal abuse as a result of my positive outlook on life; having difficulties in retrieving the money I deserved for my work; showing contempt and superiority; insecurities; jealousy; I don`t want to have anything to do with the majority of other Poles abroad; they get on my nerves with practically everything they do; they refuse to accept my plans to settle down in Norway; discrimination at work because I do a painter`s job; they think they are superior just by the fact that they work here but, in fact, they have been and still remain brutes."

Only 7 % mentioned how they were treated badly by other foreigners (attempted fraud while shopping, vulgar behaviour, avoiding paying wages for illegal work).

4.4. Implications

The health problems mentioned by the immigrants must be seen in the context of their hard work and stress resulting from their separation from the family. Several symptoms mentioned by the informants point to the phenomenon of culture shock, especially at the beginning of their stay abroad. The mental health symptoms are rather disturbing as they show that the immigrants live under constant stress. At the same time, they are unable to use the same coping strategies that they took advanatage of in similar emergency situations back in Poland. Seemingly, a good solution would be to meet a counsellor or a psychologist who speak Polish in order to learn how to manage stress. In an ideal case scenario, immigrants should be prepared to deal with immigration-related stress prior to their arrival in Norway.

As regards the social dimension of health, the most alarming problem seems to be the feeling of social isolation. The best solution, often suggested by the immigrants themselves, would be the organisation of free Norwegian language courses. It would enable them to adapt to life in the Norwegian society better through more frequent and more direct encounters with Norwegian citizens. This would be beneficial because even though most migrants had come to Norway with an intention to earn enough money and then return to Poland, the research shows that the immigrants' plans evolve as they prolong their stay in Norway.

5. Immigrants' use of the health care services in Norway

"Increasing migration to and within Europe has confronted health care systems with the challenge of developing accessible, appropriate and effective services for migrants and ethnic minorities" (Ingleby, 2000)

Although in most EU countries migrants are granted the same treatment as nationals when they obtain work and/or a residence permit, their access to health care systems is still problematic (Mladovsky). Equal access to health care is one of the main characteristics of equity in health (Oliver, Mossialos, 2004). Although Norway is not a member of the EU, it is a member of EEA (European Economic Area) so most of the EU legislation is implemented in the country. Migrants that have been granted work and a residence permit are entitled to the same medical treatments as Norwegians and also subject to the same cost-sharing regulations.

Research on the health state of illegal immigrants is generally neglected. Illegal migrants have no rights to health care services in Norway, except for emergency services.

The issue of immigrants' use of health care services, often raised in literature, frequently refers to the existing barriers which limit their access to medical services. This theme has also been incorporated in the research under analysis. The following research problems have been formulated:

- Do the Polish migrants use the health care services in Norway?
- Where do they use them more often – in Poland or in Norway? Why?
- What kind of barriers do they face in accessing the health care services in Norway?

5.1. Use of health care services in Poland and in Norway

Because the cost of flights from Poland to Norway is relatively low, the immigrants often share their lives between the two countries. They perform some social roles in Poland, and others in Norway. Consequently, a question emerges: In which of the two countries do they function as a patient more frequently?

41 % of the surveyed migrants declared that they had used the health care services in Norway, mostly once or twice. They mainly visited a GP (66 %) but also mentioned emergency services, ear, nose and throat specialists, dentists, gynecologists, midwives, surgeons and opticians. Their reasons for using health care services were: pain (29 %), infection (26 %), worrying symptoms (26 %), accident at work (16 %), regular check-up (16 %), need of prescription drugs (16 %), chronic disease (11 %), need of sick leave (5 %).

The migrants were asked where they used the health care services more often, in Poland or in Norway. Other research conducted so far suggests that Polish immigrants working in

Western countries often return to Poland to undergo medical treatment in private surgeries, thus contributing financially to the Polish medical institutions (Kawczynska-Butrym, 2009). In the current research, 61 % admitted going to the doctor's more frequently in Poland, 10 % visited a physician in Norway more frequently than they used to in Poland and 29 % declared the same frequency of appointments with a doctor in both countries. The reasons for going to the doctor more often in Poland than in Norway is can be divided into six categories:

- language (*it is easier to communicate in your language, no language barrier*),
- cost (*it is much cheaper, I don't pay so much for a visit*),
- information (*I know where to go, it is much easier*),
- accessibility (*it is faster and more comfortable in Poland, medical services are more accessible in Poland*),
- trust (*I trust my Polish doctors, I trust Polish doctors' way of treatment, I know doctors in Poland*),
- lack of residence permit *(Being here illegally , I`m a bit afraid . That`s the reason.)*
- other factors (*I am usually sick when I go to Poland for holiday, I haven't been sick in Norway so far.*).

The immigrants were also asked what kind of coping strategies they use in both countries when they did not feel well (table 9).

Table 9. Coping strategies related to dealing with poor health

Coping strategies	Poland (%)	Norway (%)
I go to see a doctor	50	18
I try to invent a treatment for myself	58	67
I ask my friends for advice	14	18
I wait until I recover	20	28

According to their declarations, only 18 % of the informants went to see a doctor in Norway when they did not feel well, whereas it was 50 % in Poland. What is interesting, the migrants' preferred way of coping if they were not well was by treating the condition on their own. The country of living did not seem to influence that significantly.

43 % of the informants preferred to visit specialists in Poland, especially a dentist or gynecologist. The main reason for choosing dentists in Poland is the high cost of dental treatment in Norway. A theory of social distance helps explain why the female migrants prefer to seek help from a gynecologist in Poland rather than in Norway. These specialists has to "operate" in a very intimate environment, and it might be much more comfortable for women if their gynecologist comes from the same culture and speaks the same language.

29 % of the informants claimed that it does not matter if the doctor is Polish or Norwegian, as the quality of service is comparable. Interestingly, this opinion was expressed more frequently by the respondents who had used the Norwegian health care services before ($p \geq 0.000$). Nearly a fifth (17 %) agreed with the opinion that only a Polish doctor could

understand a Polish patient. 26 % considered access to the health care services in Poland to be better than in Norway, and 27 % were of the opposite opinion.

5.2. Obstacles limiting access to the health care services in Norway

In general, the patient-related barriers (such as language barriers, beliefs concerning health and treatment, lack of trust in the health care system of the hosting country) and the system-related barriers (legislations, lack of information) can be distinguished. Mladovski mentioned three groups of factors that explain why even the legal migrants may experience unequal access to the health care:

a) requirements for obtaining a permanent resident status can be very stringent,
b) literacy, language and cultural differences,
c) administrative and bureaucratic factors, lack of knowledge of the system and mistrust of health providers (Mladovsky).

The research conducted among the Poles in Oslo showed that there are three main barriers in accessing the health care services by the Polish immigrants: lack of information, lack of language competence and economical factors.

5.2.1. Lack of information

Most importantly, migrants, especially those from countries without a proper health care system, must learn how to get access to a "fastlege" (GP), who is the gatekeeper in the Norwegian health care system. All registered newcomers receive written information about the Norwegian "fastlegeordning" by post. Still, migrants usually do not understand this information because it is in Norwegian. The ones who have access to the Internet seem to be in a much better situation because they can find the information on the Norwegian health care system provided in many languages on the Norwegian Labour and Welfare Administration's (NAV's) website.

According to their declarations, 59 % of the informants would like to get more facts about the health care services. The main sources of their information are friends (34 %), the internet (31 %), church (10 %) and trade unions (9 %). It seems like migrants do not use NAV or other similar institutions, which are the most competent sources of information. The fragment from a focused interview describes the kind of problems that migrants experience:

„*P1: Here we are more alert, you know an individual is sort of more alert, right.*
P2: But why? Alert to what?
P1: Well, here you`re living under more stress. You have no family, you keep thinking about them all the time. You constantly think how to get by and get round things.
P2: Here your thinking is adjusted in a somewhat different way, so to speak.
P1: You keep thinking that you can`t afford to fall ill.
P2; That`s another story. A sort of block.
P1: Because you don`t know where to look for a doctor….
P2: When you fall ill, you find out.
P3: We know nothing about the health care system, nothing about where to go for help...

P2: But you have this doctor assigned to you by NAV, don`t you?
P3: That too, but it`s more about what this appointment should be like, whether you need to pay something and some other detailed info. From what I hear, you have to book an appointment in advance and wait for about two-three days.
P2: You have to wait until you get better and then you can see the doctor."
Another immigrant, a construction worker, aged 52, admits:
"Health? I always try to tend to it, but obviously here in Norway it`s kind of blurred. They have a different approach to these health care services. In Poland everyone has a medical centre, a family doctor and here it`s far less clear. Well, you get assigned some kind of area, some sort of a medical centre once you get your personal ID number. But I haven`t used it yet."
The immigrants possess rudimentary knowledge of the GP scheme and as a result are not certain how to use the health care services. Additionally, some immigrants do not have computers at home and are not familiar with the Internet. Even if they receive information from NAV by post, they still do not have access to it because they do not understand Norwegian ("*For us the language is a real barrier…*").

5.2.2. Foreign language incompetence
Language issues present significant barriers to many immigrants. Those who speak neither English nor Norwegian may have basic practical problems with accessing the health care services (making appointments, communicating with a doctor). According to IMDI's research, many migrants speak little or no Norwegian even after a few years` stay in Norway (IMDI, 2008).

Professional translators should be available and, more importantly, the immigrants must be informed about their right to have one. The population-based study conducted among immigrants in Sweden showed that their knowledge of language was related to their self-reported health status and their use of the healthcare services (Wiking et al., 2004). In a study conducted in England and Wales, language and communication difficulties appeared to be very important issues affecting the migrant worker's health and safety (Mc Key et al., 2006).

According to the present research, 29 % of the Polish immigrants did not speak English, 39 % did not speak Norwegian and 12 % spoke neither English nor Norwegian. They felt discriminated against because of the language:
"I was rejected when I spoke English. They demanded I speak Norwegian although I didn't understand a word."
"Some of them (Norwegians) get irritated If I don't speak Norwegian. If you don't speak a very good Norwegian they treat you worse at work, in a pub and in public offices"
"You have to be like the Norwegians in order to be accepted in the society. I am Polish and I think in Polish".
There is a strong correlation between language abilities and the immigrants' future plans. Those who did not speak Norwegian were more likely to plan their return to Poland ($p<0,01$). What is extremely important, they declared ten times less frequently that they went to a doctor in Norway when they felt unwell ($p\leq0,000$). Finally, they had the lowest self-

evaluation of their mental health condition (p<0,05) among all the immigrants. The informants had their own explanation for the importance of speaking Norwegian:
"You have to arrive here as a young person. Then it's so much easier to learn a language , especially if you have a talent to pick up the accent and speak well and, certainly, to work on improving the language in order to have a wide range of words to understand all they say. Not just 'hello' and all the survival stuff but everything including some jokes and things like that. It`s so much easier then. But, about the Poles who are arriving here these days and what I think of them, the Polish people in Norway have an extremely difficult situation, mostly because their access to language learning is highly limited. "

5.2.3. Economic barriers

The third barrier is of an economic nature. It is especially important in the case of the economically vulnerable groups of migrants (undocumented migrants, labour migrants and asylum seekers). In Norway patients must pay a patient fee for using health care services until they are allowed to receive an exemption card "frikort"[10]. Although the patient fee is rather symbolic for the Norwegian citizens, it can be a burden for some categories of immigrants. Migrants underutilize the health care system if they are excluded from the public health care insurance (undocumented migrants), cannot afford to pay for appointments (refugees, poor labour migrants) or do not want to spend money on the health care services (labour migrants who send money home).

Migrants often do not want to spend money on the patient fee because their main aim is to earn money in order to send it home or save. According to the Polish immigrants' declarations, 28 % spent only between 1 % and 10 % of their salaries on food (11-20 % -.27 %, 21-30 % – 16 %, more than 30 % – 9 %). The family was the most important value in the immigrants' hierarchy and – as the research shows – this did not change after their arrival in Norway:
"*Here if you are on sick leave, you still get 100 % of your salary, but when on sick leave you can't go to Poland and you can't do overtime*",
"You live under more stress abroad. Your family is far away, you think about your relatives all the time. We know that we can't be sick here, we have to be ready to deliver",
"I think that most of the Polish immigrants here want to save as much money as possible at the cost of their diet and health".
This shows that the immigrants' moral code concerning health partially explains why they do not use health care services in Norway as often as they do in Poland. This issue will be further developed in the following part of the report.

5.3. Implications

New labour migrants are usually employed as manual workers. As a result, their health is exposed to risks. They also need more medical care than the rest of the society. These

10 More information is available on: http://www.nav.no/page?id=355

migrants are not well educated and do not have the sufficient language skills, which makes their access to medical services quite difficult as multiple risks increase the possibility of multiple barriers. As it transpires, the migrants use the health care services in Poland more frequently than in Norway. Those intending to settle down in Norway declared that they used the health care services in Norway more frequently than those who planned on returning. Taking advantage of the health care services indicate an ongoing process of integration into the new society.

The main barriers in accessing the health care services are a lack of information and the corresponding language incompetence. It is also of importance that the immigrants arrived in Norway in order to work and looking after their own health was not their priority. A good solution would be to organize a series of information meetings for Polish employees in Norway. Those attending such meetings would become knowledgeable of the Norwegian health care system and could serve as a reliable source of information for other immigrants.

6. Immigrants' lifestyle

The concept of lifestyle is referred to both in social and medical sciences. It is mentioned when the health state of individuals and social groups, as well as the funds used to provide the health care system, are analysed. Research conducted in several countries has shown that an increase in the funds for medical care does not necessarily result in an improvement of the population's health. Researchers decided to explore which factors influence the health state of individuals as well as that of social groups and found lifestyle to be a significant factor. Ginzberg claims, "what we understand by referring to the concept of lifestyle is this orientation aimed at yourself, others and society, i.e. an orientation focused on values, which is developed by each of us" (Ginzberg, 1966: 145). Siciński defines lifestyle as, "a set of daily behavioural patterns specific for a particular group or a particular individual; in other words: a specific way of behaving which distinguishes a particular group or a particular individual from others." (Sicinski, 1988: 11). Usually an individual has a certain repertoire of behavioural patterns available and is able to make a choice. Consequently, individuals are capable of modifying their behaviour (Elstad, 2000). It is vital that an individual make these choices in a specific economic, historical, family, cultural and political context (Lynch et all., 1997). Lifestyles, including health behaviour, can be perceived either as a consequence of an individual's participation in a specific social stratum and the resulting limitations or as a way of living which has been developed more actively. Whether the former or the latter perception is taken into consideration, lifestyles are always connected in some way with the socio-economic strata system (Elstad, 2000).

Migration as a social factor generates social discrepancies and thus indirectly predisposes individuals to certain illnesses. Changes in lifestyle involving leisure time management, eating habits, sexual life, use of addictive substances (eg. alcohol, nicotine, drugs), physical activity and sleep are closely connected with migration. These changes are frequently accompanied by health deterioration due to an increase in the frequency of health-damaging behaviour among the immigrants.

One of the research problems posed here was related to the immigrants' declarations about the lifestyle changes they observed after moving to Norway. The researcher has been mostly interested in the lifestyle elements which directly or indirectly affect health (housing conditions, eating habits, use of addictive substances, sexual life, physical activity and leisure activities). The hypothesis that immigrants changes their lifestyle after arrival in Norway has thus been demonstrated to be true.

6.1. Housing conditions

Most informants live in rented accommodation (62 %). However, they admitted that renting a flat was not easy due to the fact that Norwegians were not willing to accept Poles as lodgers:

„It's difficult to find a flat. Recently I've been surfing the net, fishing for adverts and calling people. „Yes, of course, but where are you from?", „From Poland.", „ Oh no, it has been rented already. I'm sorry you're a bit too late." (Z.)

On the Internet one might find this sort of advertisements: "*Flat for rent, excluding Poles*" which is an example of ethnic prejudice and discrimination. The immigrants themselves tried to explain this phenomenon referring to the autostereotype of their own national group:

„It's well known what Poles are like. It's all about creating trouble and destroying things." (W.)

The immigrants mentioned the high prices of flats in comparison with the housing conditions offered by owners:

"I am a bit overwhelmed by all that. I mean, the housing conditions as compared to the prices are tragic." (K.)

"One kitchenette, no TV, come on. While one of us was asleep, the other would come and wake him up, because he had to get something to eat, take a shower, right?." (Z.)

15 % mentioned living in a workers' hotel, which usually meant a plastic housing unit with a low price reflecting the low living standards. Only 4 % stayed with a family, 3 % lived in their employers' house (au pairs, child minders) and 16 % mentioned other accommodation options which had not been included in the checklist (own flat, student dormitory). Interestingly, no more than 16 % of respondents were dissatisfied with their housing conditions. They gave the following reasons: *"cramped rooms, I`m looking for a bigger place, too few square metres"; "It's not a flat, it's a plastic container for survival, it reminds me of a labour camp"; „the owner is a dirty slough and for such conditions the price is too high"; „poor housing conditions"; „noisy neighbours"; „it's damp with mould appearing here and there"; „difficulty trying to make the flatmates bond"*.

6.2. Eating habits and nutrition

It is quite typical for labour migrants, the young and healthy ones in particular, to cut down on food for the sake of saving money , which the Polish immigrants themselves seem to notice:

" I think most Poles here are trying hard to save money. Food and health suffer as a result. You can see it when you look at some of them, who are malnourished and don't seem to care enough. They keep drinking, smoking cigarettes and saving on food, I'm afraid." (O.)

The data showed that nearly a quarter of the respondents spent less than 10 % of their income on food, which – considering the very high prices of food in Norway – proves the hypothesis that immigrants attempt to save money at the cost of buying less or worse quality food. The data presented in Table 10 show that nearly a third of the informants mentioned that some changes in the frequency of having meals occurred since their arrival in Norway. It was mentioned a bit more often that meals were eaten less frequently – as opposed to more frequently – and suppers in particular.

Table 10. Frequency of having meals in Norway (%)

	breakfast	dinner	Supper
Here I have it more frequently	17	12	11
Here I have it less frequently	13	19	21
The frequency has not changed	70	69	68

Some responses seem quite worrying considering that they revealed the fact that the immigrants' eating habits became highly irregular while they themselves remained fully aware of the negative consequences the situation had on their health:
"It used to be easier to look after your health in Poland… During the day I hardly ever find a spare moment to have something to eat … I eat huge amounts of food very late at night and it is in no way healthy but I have no time for eating … I realize it`s no good and that I`m doing harm to myself" (O.)
Many informants emphasized the fact that it was mainly during the first year of their stay abroad that they tended to reduce food expenses and paid little or no attention to the quality of the food they ate:
"At first it wasn't so important to me, it was like a preparation period. I eat anything just to avoid feeling hungry. But this time has already passed."(A.)
"At first I surely had that attitude. You would buy the cheapest products and somehow it must have had an influence on health, because I experienced it myself. Well, you have to pay for good food, as simple as that. It seems to me that the majority of Poles here have the same tendency to buy the cheaper stuff … Yes, I believe the first year is hard. The first year is a kind of for and against. You find answers to all the question marks in your head."(I.)
The respondents were also asked what they wanted to change in their eating habits. As many as 36 % wanted to eat on a more regular basis; 26 % wanted to change the food quality; 14 % were willing to eat less and 9 % wanted to eat more frequently. Only a third of the research informants wished for no changes in their heating habits.

6.3. Use of addictive substances

Both alcohol and cigarettes are far more expensive in Norway than in Poland. Consequently, it could be assumed that the immigrants likely wanted to limit their use of addictive substances. The research data show that:
- 26 % of the repondents used to smoke cigarettes in Poland and kept smoking in Norway;
- 16 % of the respondents quit smoking in Norway (*cigarettes are too expensive; there`s no place for smoking; in Norway being a non-smoker is trendy; willingness to give up smoking; in Norway the climate is so perfect that smoking here should be regarded as a sin; the fresh air makes me feel so good that I don`t feel like smoking*);
- 58 % of the respondents had never smoked.

It is worth emphasizing that none of the informants started to smoke while in Norway.

The situation looks slightly different as far as drinking alcohol is concerned. 76 % of the informants used to drink alcohol in Poland and continued drinking in Norway. Only 4 % quit drinking in Norway and 20 % had never drunk alcohol. According to the immigrants' declarations, 52 % drank less alcohol in Norway than they had in Poland (*alcohol is too expensive; there`s no time for drinking; it`s difficult to buy alcohol*). As few as 5 % admitted to drinking more alcohol than they used to in Poland (*alcohol helps me relax; in Norway I can afford alcohol; it is easier to stand homesickness when you drink*). The interviewees claimed that:
"When you drink, you forget all about your sorrows".(D.)
„You drink a little more here (everyone bursts out laughing). Because alcohol abuse is on the increase here." (A.)
When asked whether they wished to change something about their alcohol drinking habits, no less than 13 % of the respondents claimed that they wanted to drink less or quit the habit. This means that the people in question were aware of their alcohol abuse. Alcohol was most frequently drunk at home or at a friends' place. The immigrants who were temporarily out of work often reached for alcohol as there was nothing else they could do during the day. One informant said in an ironic tone during the interview: „The government in Norway should give us bonuses, money to spend on alcohol because we have nothing to do here and therefore we turn to drinking".

6.4. Sex life

Research conducted so far clearly shows that – considering the immigrants lifestyle in Poland and abroad – most changes occur in the area of sexual activity. According to Beck, in contemporary societies (risk societies) "it can be claimed, with a bit of overstatement, that: everything is acceptable… The marriage can be subtracted from sexuality and sexuality from parenthood. Parenthood can be multiplied by the divorce and all of these can be further divided by living together or on your own" (Beck, 1992, p. 116). In Norway no social sanctions occur towards people living together outside a legally binding relationship. This permission to live in a free relationship, have children outside the wedlock and get a divorce, which is granted by the society, can result in immigrants` adopting the new patterns of behavior. As one of the respondents noticed: *"Here when I have to face all sorts of situations, despite the fact that it used to be clear to me before, I start hesitating and wondering. If they all live here like that, then why, is that really wrong?"*

No less than 28 % of the respondents admitted to changes in their sex life after their arrival in Norway (*having a greater or a smaller number of sexual partners; initiating sexual life; sexual promiscuity; providing sex services*) Interestingly, 12 % moved in with their partner for the first time in Norway. A young female interviewee admitted:
"*Somehow it happened. He wanted it so badly and I finally agreed.* "(J.)
Another interviewee made a rather ironic remark that *'being abroad brings people closer to each other'* (R.), which made the other participants burst out with laughter.

One can claim that family disintegration as a consequence of migration remains the biggest problem from the sociological and pedagogical point of view. Back in the 1970s,

Znaniecki and Thomas's study of Polish boys drew our attention to the problem of divorces and sexual promiscuity among immigrants (Thomas, Znaniecki, 1976). In the interviews the majority of immigrants pointed to the problem of 'double' relationships, i.e. having a spouse or a partner in the native land and a new relationship abroad, which was usually kept secret from the person left behind at home:

„That's how these 'double' realtionships come to exist, just for a while. They're not supposed to be permanent. We just jump into a Norwegian bed at some point, we make the bed warm and then we fall out of it. And it happens whenever it suits us best. We don't think about the fact that we have a family, that we have children and a wife. We get into a sort of rhythm and we can`t, in fact, get out of it. There's no turning back. And that's the greatest danger later on."(M.)

„Leaving Poland is patological because if you have two little kids, a young and attractive wife back in Poland or a girlfriend, and you go abroad to earn money, and then three, five months pass and you will have a problem with it either way." (Ma.)

"Take our next-door neighbour. This girl has only just arrived. She came here, left her husband out there somewhere and she is living here. She goes to one, then to another, she keeps changing partners. Nothing to talk about. She doesn't have much, but she is here, she came here on her own and here we go." (T.)

It seems that the divorce is a natural consequence and the highest social price to pay for migration. This phenomenon can be explained when you consider a kind of 'extended freedom' connected with an immigrant's life. This freedom occurs due to lack of social sanctions, owing to a long-term separation of spouses or partners and results from an urge to share a life with another person. Prostitution should be mentioned at this point. As many as 16 % of the respondents had heard of Poles (mostly women) who worked as prostitutes in Norway. Two of the informants admitted that they had provided sex services in Poland and in Norway.

6.5. Leisure and sleep

15 % of the respondents declared a lack of free time and 28 % maintained they did not have enough leisure time. As many as 44 % of the informants admitted that in Norway they spent their spare time differently, as compared to Poland. However, it is difficult to point to some specific differences based on the analysis of the obtained data. Some immigrants declared that they had more acquaintances in Norway; others claimed the exact opposite, admitting to '*being out of touch with other people*'. The most frequent declarations revealed that the respondents used to spend more time with their families back in Poland.

During the focus interviews, Poles frequently mentioned that during the weekend in Norway most tended to have fun, spending most of their earnings on alcohol:

„Everyone knows what happens on Friday nights. The party begins. And it doesn`t stop before Monday." (W.)

A fifth of the informants admitted to a lack of sleep. The reasons varied: lack of time to sleep (13 %), sleeping as a waste of time (13 %), insomnia (7 %). In the interviews the last reason – insomnia – was mentioned most frequently:

„I suffer from insomnia. It became more serious once I had lost my job. But, generally, I wake up very early in the morning, at 4am."(Z.)
Insomnia can be one of the symptoms of intense stress experienced by the immigrants. Migration is always a crisis situation and each individual deals with the immigration stress in a different way.

6.6. Physical activity

Oslo is a city where – irrespective of the time of the day – gyms are crowded with people of different ages and parks are frequented by joggers. It seemed interesting to verify whether or not the young Polish immigrants shared this Norwegian enthusiasm for sports. The immigrants' opinions highly varied. Most of them assessed their fitness level as very good or good (76 %). No less than 31 % of the immigrants participating in the research claimed that they devoted more time to sports activities in Norway than in Poland. Several different reasons were mentioned to explain the situation: *better sports facilities, the majority of people here do sports, I feel like doing sports more here, I am in a better financial situation here, I work all day sitting in front of the computer so I need some physical activity later on*.

21 % of the informants who spent less time on doing sports offered the following explanations: *lack of time, excessive work and resulting lack of enthusiasm for sports, lack of money*. 13 % admitted to lack of any physical activity in their leisure time; among them there were mostly construction workers who did physically demanding jobs throughout the day and could not be expected to engage in even more physical activity after work.

Poles' opinions about the attitudes of Norwegians towards sports and active lifestyle were particularly interesting. Some people accepted this kind of lifestyle without any reservations. Others were sceptical or claimed that sport was a substitute for religion for the people of Norway. Some Polish people followed the example and spent more time doing sports. When asked to give reasons, they usually pointed to keeping fit and looking after their appearance (50 %), wishing to spend time in an enjoyable way (40 %), trying to prevent diseases (37 %) and having to release emotional tension (27 %). However characteristically, young people did not consider protecting their own health as a top priority.

6.7. Implications

Many immigrants who came to Norway from Pakistan, India or Turkey in the 1970s, retired at the average age of 50 and either obtained a pension or lived on some sort of welfare benefit. It could have been connected with the fact that they had difficult or health-harming working conditions (Bratsberg, Roed, Raaum, 2006) as well as with their unhealthy lifestyles. It cannot be stated for certain whether twenty years from now the new labour immigrants will be in a similar situation. However, for certain this category of immigrants poses a significant challenge for the health care and social insurance systems in Norway (if they decide to settle down there) and in Poland (if they decide to return to their native land). The immigrants who work illegally, with no right to the health care services or health benefits, are in

the most difficult situation. Should they become victims of an accident at work, they are left with no financial support.

The research shows that the Polish labour immigrants in Oslo lead a different lifestyle in Norway than they did in Poland. The first year of their stay abroad, when the immigrants saved by reducing food expenses, consequently losing their health, was when most changes occurred. The most significant changes can be seen in eating habits, sex life and alcohol abuse. With respect to the last two areas, the changes can be explained by the fact that an individual who is living abroad is not controlled by the Polish system of informal social sanctions. In addition, the other immigrants do not react to the fact that the moral code observed in Poland is violated. As one of the interviewees admitted after citing an example of a friend who had a wife in Poland and another partner in Norway: *„how can I protest if everyone else accepts the situation"*. When abroad it was also easier to break the rules which the immigrants would never dare break in Poland*: "We pretend not to notice that happening. In Poland that would be unacceptable."*.

When conducting further reasearch it is advisable to focus on the variables that influence migrants' lifestyle. It would enable researchers to single out the categories of immigrants who are predisposed to certain health-damaging behaviour and suffer from the resulting lifestyle-related diseases.

7. Health-related moral code of the Polish immigrants

Norms, knowns as moral rules, are part of the axio-normative system specific to the culture of a given nation. Axio-normative subsystems, including moral norms are relative in nature and undergo constant changes. O'Brien states that, „Moral norms are constantly evolving. At this time, certain norms exist but they are in the process of an ongoing transformation in order to adjust to the social, personal and physical environment" (O'Brien 1999: 27). Crisis situations can influence the moral code of an individual (eg. losing a job, death of a close realtive) as well as that of a social group (economic recession, political transformation). Undeniably, migration is an example of a crisis situation, a process where an individual changes their geographical, social and cultural location. The moral code of the Polish society has been shaped under the influence of the Catholicism. Sociologists have not yet explored sufficiently the issue of interdependency between health, ethnicity and religion (Ahmad, Bradby, 2007).

Based on the conducted research, the author wanted to find out if the immigrants believed an individual had a duty to look after their health and, if so, why; whether, as declared by the immigrants, their migration had an impact on how they ranked health in their value hierarchy; in what situations they would likely risk their health and what sanctions they would experience if they risked losing their health.

7.1. Health care as a duty according to the immigrants

Rules (both prescriptive and proscriptive in form) are regarded as the basic cognitive component of a norm. (Heywood 2002). The respondents were asked to specify to what extent they agreed with the rule that each person has a duty to look afer their health. As predicted, as many as 90 % of the respondents agreed with the statement (I disagree – 4 %, hard to say – 6 %).

The analysis of the answers to the question, "Why it is necessary to look after your health?" proved very interesting. For 51 % of the immigrants the greatest motivator was their family's well-being. Other answers included the following: it was God who gave us health and life (46 %), health is a factor underlying personal success (37 %), you have to look after your health to be useful for the society (24 %). The immigrants also mentioned some other reasons to look after their health: *„Life and health is the ultimate value"; „To avoid a situation when one disease leads to another, a more serious one"; "We are part of nature, which deserves care and protection."; "You ought to be responsible for your family"; "To feel better".*

7.2. Health as a value

In order to find out if the position of health in the immigrants' hierarchy of values had changed since their arrival in Norway, they were asked to determine how important the values mentioned in the questions were in Norway, as opposed to the situation back in Poland (Table 11).

Table 11. Importance („of great importance" and „of some importance") assigned to respective values (%)

Poland			Values	Norway		
Of great importance	Of some importance	In total		Of great importance	Of some importance	In total
52	34	**86**	**Family happiness**	62	27	**89**
47	29	**76**	**Health**	52	27	**79**
38	45	**83**	**Self-development**	40	36	**76**
35	39	74	Honour	35	40	75
36	26	62	Freedom and social justice	33	31	64
29	29	58	Professional success	28	34	62
28	33	**61**	**Education**	35	25	**60**
41	20	61	Love of your life	40	21	61
16	46	**62**	**Pleasures**	16	31	**47**
13	42	**55**	**Money**	16	44	**60**
20	30	**50**	**Faith**	26	24	**60**
13	27	40	Native land	19	24	43
6	8	14	Power	5	9	14

The results show that health, family happiness, education, faith and money were more important to the respondents in Norway than in Poland. As regards health, it is the difference of 5 percentage points when the response "of great importance" is taken into account. Interestingly, the number of people who assigned great importance to family life increased by 10 pp. So as to collect more information about the importance of health in the immigrants' life, the interviewees were asked whether health was the most important value in their lives. The majority of respondents admitted that this was the case but they presented varied arguments to support their answers:

– Fear of diseases *(„For me it's the most importanat value. I've always been terrified of illnesses which appear unexpectedly, like multiple sclerosis, cancer or suchlike. Terrified, terrified"(J.), „I do worry about this eye. I`d rather, you know, this little money I have, I`d rather give it all away but have this eye healthy again." (A.))*

– Health as the foundation for everything else (*"It goes without saying that health is the basis. Although we often don't realise that. There are so many other important things that we care more about. But it only lasts until something happens to us."(O.); "Health, most certainly. Without health, nothing matters and remains. Not even work, nothing."(D.),)*
– Health as an instrumental value ("*Health is not something we aim to achieve. We aim to reach different values, such as work, money, love. That`s what we aim at. We care about health but we don`t pay attention to it.*" *(O.), „Without it you can`t achieve many different things, things of great value." (O.)).*

Some young interviewees declared that health did not constitue the most important value for them:
"Health is not the most important value in my life, let`s not exaggerate." (M),
" … no, it`s more important for me to live according to the rules and have a rational outlook on the world" (M.).
It can be explained by the fact that an individual at a young age suffers from no major health problems and does not consider health to be a value that they could be deprived of:
"As far as I am concerned, I think you don't consider health important up to a point, it comes with age, for example what you eat and what consequences it has for your health. "(M.) „ There comes a moment in life when you start looking after your health. Until a certain age you don`t think about it. And then you start thinking that perhaps you won't wake up the next morning. Who knows? I may not live till the next day. Who knows? At a certain age you start to think about everything that is going on around you in a different way." (W.)

7.3. Health-related convictions and behavioural patterns according to the Polish immigrants

It is interesting how the Poles perceived and evaluated the convictions and health behaviour of Norwegians and whether coming into contact with a different culture influenced their own health-related convictions. As the research shows, the immigrants had differing opinions about Norwegians' attitudes to health. Some totally approved of the Norwegian approach to health:
"The fact that Norwegians try to live healthy lives had an impact on me … in Poland I didn't use to care about what I ate, here I'm trying hard … I try to eat well, and eat healthy. In Poland I used to eat white bread, here I only have the special one. I used to go to the gym and for walks here but I grew a bit lazy." (K.);
Others showed a degree of scepticism:
"They simply have a thing about going to the mountains and doing winter sports. Besides, there are so many gyms here and all of them are full of people. Everyone is working out. Norwegians are health freaks. They really are."(K.);
Finally, there were those who condemned the amount of attention paid to sports:

" To me this sport is a substitute for religion for them. They have this enormous spiritual emptiness because they have nothing spiritual, they don't think about it and this gym thing is filling up that empty space. Seriously." (M.).

Some remarked that Norwegians found it easier to look after health than Poles because they had no difficulty obtaining sick leave:

"Here in Norway they are in a better situation beause they will get sick leave if they have a runny nose or something. It's enough. They look after their health. " (A.);

"Here people are less afraid to go on sick leave than in Poland. In Poland you can get fired immediately. Here no one will sack you, they have no right to do so." (T.).

This group of immigrants seemed to place responsibility for the state of health on institutions rather than individuals. Others suggested that Norwegians took care of their health because *"... to go to hospital [in Norway] is not a good thing to happen because they basically only serve you medicines in there" (M.).*

One of the respondents expressed her dissatisfaction with the fact that her health was in a way controlled by institutions:

„I feel in the spotlight here, more than it was the case in Poland. Take medical issues for instance, as soon as I turned up here, got registered, obtained my personal ID number, I immediately received information that some of my medical examination results are not avilable in the database, and as a woman I should have certain things examined and that I ought to do it straightaway. And it was like immediately. They have all the info about me in the computer database, they know whether I`ve been ill or not." (A.)

What deserves attention is that the interviewees in each of the focus interviews expressed their negative opinions about child care in Norway, even though they were asked no questions about the issue:

"It is sick, abnormal! For example, with respect to kids. A well-educated, seemingly wise person told me this. She said that there were so many kids around at their place during holidays that they lived on sausages because she didn`t feel like preparing something else. To save on children, they would buy the cheapest sausages." (O.)

"Nobody here cares about children. They are always running around sniffling… Nobody seems to care. I couldn't stand the sight any more, came up to this girl with a tissue and helped her clean her nose. Everyone was so shocked, admiring how I looked after the child so wonderfully." (J.)

"But they really fail to look after children here. If the creature is ill, let it lie down before it gets better." (O.)

"They so don't care about the kids. But when an adult feels a bit of a pain in the leg they will rush to a doctor. That's what they care about." (A.)

The opinions expressed by the immigrants show that they were appalled by a lack of what they considered to be adequate care of the children. Probably the idea of what is adeqaute in terms of child care differs significantly between Poles and Norwegians.

Poles themselves admitted that in Norway they cared less about their own health than in Poland. Some gave examples of extremely hard work for long hours, which influenced their health in a negative way:

"It is all so stupid. I worked 12–13 hours per day. It turned out that I was neither relaxed enough nor able to work well. In fact, I sacrificed my mental and physical health at the same time. What for?" (M.);
„Surely, health is more important than work. Sometimes you have to give up work to look after your health, no matter what. " (D.)

Although Poles were envious of Norwegians because they could easily go on sick leave, the Polish immigrants hardly ever visited a doctor:
"I happened to be ill here only once, when I put a strain on my back, but then I used all sorts of ointments and off to work I went. " (J.)

Part of the reasons may obviously be rooted in the existing barriers, such as language incompetence, lack of information or financial difficulties, which limit access to the health care services and are the frequent subject of recent research. Constant efforts are made to eradicate these barriers. (Mladovski 2007: 9). During the interviews, it transpired that an individual's hierarchy of values is of great importance, especially for those immigrants who have a family in Poland:
"When you are on sick leave here, you get paid 100 % of your regular income but you won't go back to Poland, you won't do overtime." (T.),
"*When abroad you are more stressed out. There's no family around, you keep thinking about them all the time. You keep thinking how to get by and that you can't get ill.*" (Z.).
Clearly, the immigrants who took part in the research, declared their family was more important than their own health, which is further confirmed by the following analysis.

7.4. Readiness to sacrifice as declared by the immigrants

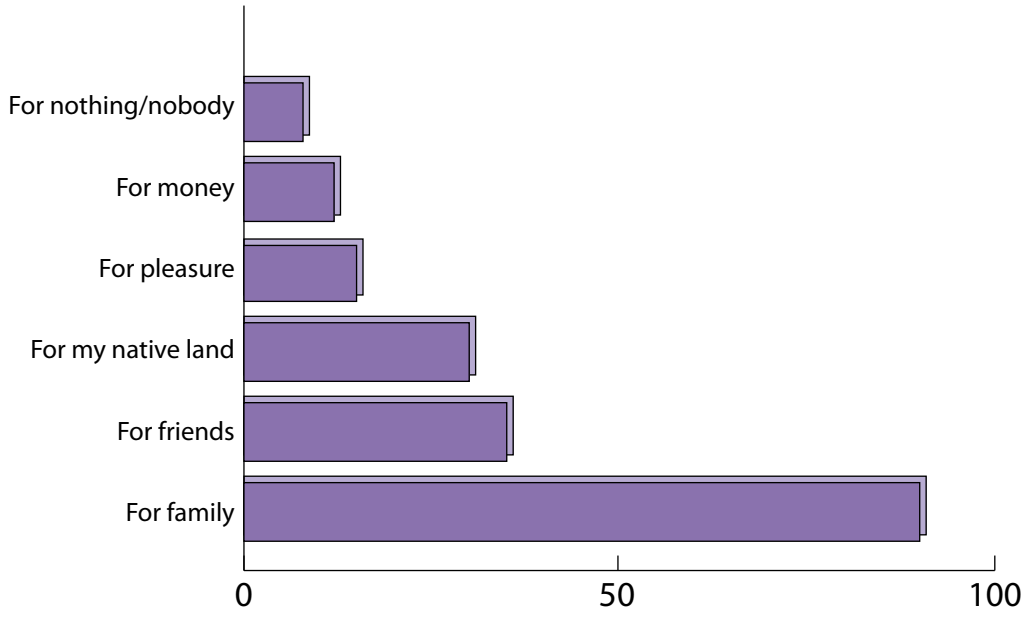
The majority of the interviewees admitted to an unhealthy lifestyle. Although they earned more than in Poland and could eat better quality food and work less, the immigrants lived frugal lives. The amounts they spent on food, as stated in their declarations, illustrate the situation:

1-10 % – 28 %,
11-20 % – 27 %,
21-30 % – 16 %,
over 30 % – 9 %.

No less than 38 % of the informants wished to have meals on a more regular basis and 28 % wanted to eat food of better quality. Diagram 1 presents the results to the question of why or rather for whom the Polish immigrants would expose their health to danger.

As many as 92 % of the informants were ready to expose their health to danger for the sake of their family. Curiously, statistically women declared their readiness in that respect more frequently than men ($p<0,05$). Far fewer respondents, only a third, were prepared to risk their health for friends (30 % for God, 23 % for their native land, 11 % for pleasure/ derived from doing sports, 9 % for money, 3 % for nothing/nobody). Men, on the other hand, admitted more readily that they would be willing to sacrifice their health for God ($p<0,05$). Those who claimed that it was important to look after their health as it guaranteed personal success, declared their willingness to sacrifice health for God's sake five times less frequently.

Diagram 1. Analysis of the replies to the question for whom or for what the immigrants would be ready to sacrifice their own health



Those interviewees who were married emphasized that they would not hesitate to sacrifice their health for the sake of the family, but they would have doubts if it were to happen for the sake of strangers:

„I'd expose my health to danger for someone, but not for an idea or something, in particular I would do it for my own family." (D.)

„Donating a kidney or something is a trend these days, so that would be easy. But to do it for a stranger is another issue." (A.)

„You always approach strangers in a different way. You might think there will be negative consequences, side-effects or something. And for the family, for the children or for the wife you just go for it and that's it – nothing to wonder about.". (T.)

„You'd think twice if it was for a stranger. Supposing you had some health problems or something as a result, then you would have to abandon your family. There would be nobody to provide for your family, to earn the living. For the family you'd just do everything without thinking." (D.)

The younger immigrants did, in fact, declare their willingness to sacrifice their health for somebody but admitted those were just declarations and, as a matter of fact, they could not predict what they would actually do in reality:

„I'd also like to add that I'd definitely want to sacrifice my health because that's a noble thing to do but what would come out of it I don't really know."(M.)

"I would really love to make a sacrifice for someone but I am afraid that at some point I would chicken out. At the moment I would love to sacrifice my health for someone, it would be a beautiful thing to do, but it would be difficult to do it right now. But I'd definitely consider that, I'm just afraid I wouldn't be able to do it there and then."(K.)

"What I will do depends on the situation I'll find myself in, whether I'll sacrifice my health or life. Right now I can make lovely little declarations that I will sacrifice my life, like St Maksymilian Kolbe did, but then I will be overwhelmed by fear."(M.)
It can be assumed that the differentiating variable in this case is not only age but also marital status. To confirm this assumption more quantitative research is essential.

7.5.Sanctions experienced in the case of putting health at risk under specific circumstances

As O'Brien justly said, „Morality, when deprived of the impact of intense emotions, could not exist. Strong emotions lie at its core. They give it the meaning and provide the dynamics for moral transactions" (O'Brien 1999: 109). Seemingly, these "unpleasant emotions" are our moral compasses and consitute an emotional component of a norm. When certain moral norms are breached, a specific system of sanctions, both internal and external, comes into play. The number of sanctions and the strength of the norm are interdependent. To quote Fein, "Norms are not 'moral' due to the unique differences in their content. They are 'moral' because they are approached differently" (Fein 1997: 17).

The respondents were asked how they would feel if their health was put at risk in the specific contexts of guilty/innocent, proud/ashamed, admired/condemned. In each case one of six replies had to be selected: very proud, proud, indifferent, ashamed, really ashamed, hard to say. The results show that the respondents answered this category of questions rather randomly, which seems quite meaningful. The lowest percentage of "no replies" was recorded in the case of the questions which dealt with experiencing sactions as a result of sacrificing one's health in order to provide for the family. The very fact of giving an answer to this question shows how important the family is for the respondents.

Almost three quarters of the informants would feel proud if their health was exposed to danger in order to provide for the family (45 % in defence of faith, 45 % in defence of their native land). The deepest shame, as declared by the immigrants, would result from putting health at risk in order to buy a better quality car/flat. (Table 12).

Table 12. Sense of pride or shame experienced in the case of risking health in the listed contexts, as declared by the respondents (the categories „very proud" and „proud" as well as „really ashamed" and „ashamed" were joined and treated as a whole) .

How would you feel if you put your health at risk in order to:	PROUD	INDIFFERENT	ASHAMED	HARD TO SAY	NO REPLY
Buy a better quality car/flat	15 %	20 %	**35 %**	19 %	11 %
Provide for the family	**73 %**	10 %	3 %	9 %	5 %
Defend your faith	**45 %**	19 %	9 %	16 %	11 %
Defend your native land	**45 %**	17 %	5 %	21 %	12 %
Do extreme sports	16 %	30 %	17 %	22 %	15 %

Men, more frequently than women, would feel proud if they put their health at risk to provide for the family. (p<0,05). People who believed that it was necessary to look after their health as it is a gift from God (p<0,05) as well as the believers and the practicing believers among them (p<0,000), claimed more frequently that they would be proud to sacrifice their health in defence of their faith. Curiously, the immigrants who replied that one ought to look after their health to be useful for the society, declared a sense of pride in sacrificing their health for the sake of their native land more frequently than others (p<0,05).

With reference to the question about a sense of guilt or innocence, the analysis of replies shows very similar results. As many as 70 % of the respondents declared no sense of guilt in the case of sacrificing one's health in order to provide for the family. The feeling of guilt resulting from exposing one's health to danger in order to buy a better car/flat would be experienced by the largest number of the immigrants (34 %). (Table 13.)

Table 13. Sense of guilt or innocence experienced in the case of risking health in the listed contexts as declared by the immigrants. (the categories „totally innocent" and „innocent" as well as „totally guilty" and „guilty" were joined and treated as a whole) .

How would you feel if your put your health at risk in order to:	INNOCENT	INDIFFERENT	GUILTY	HARD TO SAY	NO REPLY
Buy a better quality car/flat	19 %	23 %	34 %	12 %	12 %
Provide for the family	**70 %**	9 %	2 %	10 %	9 %
Defend your faith	**47 %**	18 %	6 %	14 %	15 %
Defend your native land	**47 %**	18 %	1 %	19 %	15 %
Do extreme sports	20 %	16 %	26 %	22 %	16 %

The replies given by the respondents varied in terms of the attitude to faith and religious practices that they declared. The believers and practicing believers declared that they would feel guilty if they put their health at risk in order to buy a new car/flat far more frequently (p<0,01). The same category of immigrants replied that they would feel innocent if they risked their health in order to provide for the family (p<0,05). Age, educational background and place of residence in Poland proved to differentiate the declarations related to the sense of guilt in the case of sacrificing health in defence of the native land. The younger respondents (aged 17-25 and 26-30) from smaller towns with a university or a college degree, as it transpired, would feel more innocent than others in this situation (in each case p<0,05).

The results obtained in response to the question about experiencing external sanctions (admiration or condemnation) in the case of risking health in the selected contexts seem quite interesting (table 14). In fact, a third of the immigrants would feel condemned only if they risked their health in order to buy a better quality car or flat.

Table 14. Sense of being admired or condemned experienced in the case of putting health at risk in the listed contexts, as declared by the immigrants (the categories „really admired" and „admired" as well as „totally condemned" and „condemned" were joined and treated as a whole) .

How would you feel if your put your health at risk in order to:	ADMIRED	INDIFFERENT	CONDEMNED	HARD TO SAY	NO REPLY
Buy a better quality car/flat	8 %	33 %	30 %	15 %	14 %
Provide for the family	**69 %**	10 %	-	11 %	10 %
Defend your faith	**36 %**	29 %	4 %	16 %	15 %
Defend your native land	**44 %**	21 %	1 %	18 %	16 %
Do extreme sports	20 %	23 %	17 %	23 %	17 %

The immigrants who found health worthy of care as it is a gift from God declared that they would be admired for sacrifacing their health in order to buy a better car/flat less frequently than the others($p<0,05$). Nearly a third of the respondents would experience neither admiration nor condemnation if they put their health at risk in defence of their faith, which seems an interesting observation. As regards internal sanctions, the fraction of people who declared indifference was much smaller.

7.6. Implications

In summary, it must be emphasized that for most Polish labour immigrants who participated in this research and had a family in Poland, the family was the reason why they decided to go abroad and it was for the family's sake that they were ready to sacrifice their health:
„[I miss] my family. If only I could earn enough at home… It's not that I want an incredible amount of money, just enough for the basic things. I don't believe someone would leave a family and depart from Poland otherwise." (Z.)

For the immigrants, health was a highly important value, ranking directly below the family. According to their declarations, the immigrants' opinions in that respect did not change much during their stay abroad. The family's well-being was the most frequently mentioned reason for looking after their health. The immigrants would be prepared to sacrifice their health first of all for the sake of the family and only later for their friends and for God. Most immigrants would experience positive sanctions (feeling of innocence, sense of pride, sense of being admired) only if they sacrificed their health for the sake of the family. Experiencing negative sanctions would most frequently result from buying a better car or a flat, as declared by the immigrants.

While conducting the research, one could come to a realization that it is enough to put the word 'family' in a question so as to obtain a predictable answer. "Can this case of obvious familism be regarded as amoral", questioned Banfield. It seems that familism is an irreplaceable element of the axio-normative system typical for the Polish culture and can in no way be

described as amoral. It results from the fact that one's care for the family in most cases leads to experiencing positive sanctions, whereas actions targeted against the family provoke very negative social reactions. It must be pointed out that one of the most significant family functions is maintaining the society's cultural continuity. The family has been and still is the most important value for Poles. In that respect, one's sacrifice for the family's sake does not jeopardize the interests of the larger community. Quite to the contrary, these interests are strengthened as a result. The family acts as a motivator for an individual to undertake actions in order to improve their life situation and most commonly the family remains the most important group of reference for the individual in question. Hence, it is vital that the immigrants should be encouraged to reunite with their families during their stay abroad. In Poland, women are the ones to look after the health of all the family members. That as well seems to have far-reaching health implications for the Polish men working abroad.

Final conclusions

Although the conducted research is not representative in nature, it allowed us to identify the most significant health problems concerning the Polish labour immigrants. It also provided an opportunity to specify the types of barriers which make the immigrants' access to the health care services difficult. The fact that the researcher herself could participate in the immigrant culture and experience enabled her to access the research population more easily but, most importantly, to understand the difficulties the immigrants might experience.

The research results show that the immigrants seldom use the Norwegian health care services, even if there is a need. That is due to their insufficient command of both Norwegian and English and lack of information about the Norwegian health care system. The immigrant's lifestyle, especially their eating habits, cannot be described as health-enhancing. In connection with hard work this can result in a serious deterioration of their health in the future.

What deserves special emphasis is a relatively common social isolation of the labour workers due to their poor command of foreign languages and their lack of free time. The most important practical implication would be to introduce free language courses in elementary Norwegian for immigrants, an idea which has been frequently mentioned in this report.

According to the statistics, an increase in the number of unemployed Polish labour immigrants was documented (Eldring, 2009). What is important, the return migration remains very modest. Unemployed immigrants use various strategies to cope with the situation. Some of them work illegally and the others try to survive a hard time and live on unemployment benefit. Even being unemployed, immigrants send remittances home which must affect their living conditions and health as a consequence. Further research is required because several problems have only been signalled in the report. It seems necessary to carry out qualitatative research in particular among the immigrants returning to Poland and those who decide to stay in Norway. This would allow us to assess in greater detail what impact labour migration may have on the immigrants' health

The contemporary labour migration, which was mentioned in the introduction to this report, has a very distinctive character as compared to the migratory movements which have been analysed up to now. The area of labour migrants' health remains open to further exploration.

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Appendix 1

QUESTIONNAIRE

I am a sociologist and I am working for the Norwegian Centre for Minority Health Research. Let me ask you to fill out this questionnaire concerning health issues. The questionnaire is anonymous and the data collected will only be used for the purposes of scientific analysis. It is of great importance that your answers are sincere and well thought-out. Please be so kind and read the instructions carefully as well. You may want to omit certain questions, which for some reason you do not want to reply to.

1. **How long have you been living abroad?** *(current stay, give the number of years or months)*
   For …… years.
   For …… months.

2. **What is the character of your *current* stay ?** *(use X to mark the right answers)*

The character of the current stay	LEGAL WORK	ILLEGAL WORK	LEARNING THE LANGUAGE	TOURIST VISIT	CAMP	FAMILY VISIT	STUDIES	IF OTHER, WHAT? / PLEASE WRITE/
main								
additional								

3. **Do you want to return to Poland?**
   □ Yes, I definitely don`t want to settle down here.
   □ Yes, but I have to stay here for some time (why?.....).
   □ Possibly yes, but I am still wondering.
   □ Rather not.
   □ Definitely not.

3a. **If you want to return, when?** (*give the number of years or months*)
   In …… months.
   In …… years.

4. **Who did you come with?** *(you can choose more than one answer)*
   - □ On my won.
   - □ With my spouse.
   - □ With my sibling(s).
   - □ With my parent(s).
   - □ With my friend(s).
   - □ With my partner.
   - □ With my aquaintance(s)/neighbours(s).
   - □ With a larger group of friends.
   - □ With my children (their number …… , their age: …… …… …… ……).
   - □ **If other, who with?** ……

5. **Where are you living now?**
   - □ In a rented flat (with how many people? …… in how many rooms? ……).
   - □ In a workers hotel (with how many people? …… in how many rooms? ……).
   - □ In a caravan (with how many people? ……).
   - □ At my friends` place.
   - □ With my family.
   - □ At my emlpoyer`s place .
   - □ Other ……

6. **Who did you live with at the beginning of your stay abroad and who are you living with now?** *(use X to mark the right boxes)*

	At the beginning of my stay abroad	**Now**
On my own		
With a family member (who? ……)		
With a partner		
With friends (how many? ……)		
At my employer`s place		
With strangers (how many? ……)		
Other? write ……		

7. **Are you pleased with your accommodation?**
   - □ Yes (why?. . . . .)
   - □ No (why?. . . . .)

8. How do you evaluate the state of your health now?

□ Very good.
□ Good.
□ Satisfactory.
□ Poor.
□ Very poor.

9. Has the state of your health changed since you left Poland?

□ Yes, it has improved.
(what kind of improvement is it?) . . . . . .

. . . . . .

□ Yes, it has deteriorated.
(what kind of deterioration is it?). . . . . .

. . . . . .

□ No, it has not changed.

10. After arriving in Norway did you or do you still experience – more than usually or less than usually – the following health problems?

Health problems	I experienced it but only right after arriving in Norway	I experience it less than in Poland	I experience it more than in Poland	I never experience it	I experience(d) it similarly to the situation in Poland
Stomach ache					
Headache and dizziness					
Fatigue					
Frequent infections					
Insomnia					
Sleepiness					
Allergies					
Back pains					
Other (what kind? ……)					

11. Has the frequency of your meals changed since you arrived in Norway? *(use X to mark the right answers)*

Meals	I eat them more frequently here	I eat them less frequently here	Nothing has changed
breakfast			
dinner			
supper			

11a. If you have meals less frequently in Norway, what are the reasons? *(underline the right answers):*

Losing weight, loss of appetite, lack of time, lack of money, oversleeping, food is not tasty here, indigestion (stomach ache), other (what kind?) . . . . . .

11b. If you have meals more frequently in Norway, what are the reasons? *(underline the right answers):*

More time, better appetite, higher income, more tasty food, other (what kind?) . . . . . .

12. Would you like to change your eating habits:*(you may choose more than one answer)*

□ Eat more frequently?
□ Eat less frequently?
□ Eat more?
□ Eat less?
□ Eat more regularly?
□ Change the kind or the quality of food (eg. eat more fruit, eat organic products) ?
□ I don`t want to change anything.

13. Do you smoke?

□ Yes, I smoke here and I used to smoke in Poland.
!!! I smoke here (***underline***) : less, more, the same
□ Yes, I started smoking here.
□ No, I quit smoking here.
□ No, I don`t smoke and I have never smoked. *(go to question 18)*

14. If you quit smoking in Norway, say why *(you may choose more than one answer).*

□ Cigarettes are too expensive.
□ There is no place to smoke.
□ At work non-smoking is promoted (income bonuses for non-smokers).
□ Non-smoking is trendy here.
□ Other reasons ……..

15. If you started smoking in Norway, say why *(you may choose more than one answer).*

□ Smoking helps me relax, eases tension.
□ There are many smokers around, that was encouraging .
□ I can afford cigarettes here, therefore I smoke.
□ Other reasons……..

16. How many cigarettes do you smoke per day? . . . . . .

17. If you smoke, do you want to quit?

□ Yes.
□ No.

18. Do you drink alcoholic drinks?

□ Yes, I drink here and I used to drink in Poland.
I drink here (*underline*): less, more, the same
□ Yes, I started drinking here.
□ No, I quit drinking here.
□ No, I don`t drink and I have never drunk. *(go to question 23)*

19. If you quit drinking alcohol in Norway, say why *(you may choose more than one answer).*

□ Alcohol is too expensive.
□ Being a teetotaller is trendy in this country.
□ I don`t have time for drinking alcohol.
□ I can`t find a place to buy alcohol.
□ Other reasons……..

20. If you started drinking alcohol in Norway, say why *(you may choose more than one answer).*

□ Alcohol helps me relax.
□ There are many drinkers around, I didn`t want to stand out.
□ I can afford alcohol here.
□ It is easier to stand homesickness when you have a drink from time to time.
□ Other reasons……..

21. If you drink, WHERE do you drink most often?

□ At a bar/pub.
□ At a restaurant.
□ At home.
□ At friends`.
□ In the street.
□ At work.
□ Other.....

22. If you drink alcoholic drinks, would you like to…

□ quit drinking altogether?
□ drink less?
□ drink more?
□ I don`t want any changes to happen.

23. Have you initiated your sex life yet?

□ Yes.
□ No. (*go to question 28*)

24. Do you have a steady sexual partner?

□ Yes.
- Where is he/she? Iin Poland, in Norway, in another country . . . . . .
- What is his/her nationality? Polish, Norwegian, other . . . . . .

□ No.

25. Has going to Norway changed anything in your sex life?

□ Yes. *(mark all the changes)*
  □ I initiated my sex life here.
  □ I have more sexual partners here than in Poland.
  □ I have fewer sexual partners here than in Poland.
  □ I have moved in with my partner for the first time.
  □ I happen to have one-night stands (eg. at a party).
  □ I provide paid sex services to earn my living .
□ No.

26. Has going to Norway changed anything in your use of contraceptives?

□ Yes.
- □ I started using contrceptives.
- □ I use contraceptives more frequently than in Poland.
- □ I use contraceptives less frequently than in Poland.
- □ I stopped using contraceptives.

□ No.

27.Do you want to change anything in your sex life?

□ Yes, I want to limit promiscuous contacts.
□ Yes, I want to have a steady partner.
□ Yes. Other changes, what kind? . . . . . .

□ I don`t want any changes to happen.

28. Have you heard of Polish people working as prostitutes in Norway?

□ Yes. (*underline*: women, men, both women and men)
□ No.

29. Do you know Poles who work as prostitutes in Norway?

□ Yes. (how many? ……, male or female? ……)
□ No.

30. Have you ever provided sex services to earn your living?

□ Yes, in Poland.
□ Yes, in Norway.
□ Yes, both in Poland and in Norway.
□ No .

31. How do you assess your fitness level?

□ Very good.
□ Good.
□ Average.
□ Low.
□ Very low.

32. Has anything changed in your physical activity since you arrived in Norway?

□ In Norway I spend more time keeping fit.
□ In Norway I spend less time keeping fit.
□ Nothing has changed. *(go to question 35)*

33. If you spend more time in Norway keeping fit, say why *(you may choose more than one answer).*

□ They have better sports facilities here.
□ I have more time.
□ I have more money to use the sports facilities (eg. swimming pools, tennis courts, gyms).
□ I feel like keeping fit more than in Poland.
□ In Norway most people are physically active and that is encouraging .
□ Other reasons . . . . . .

34. If you spend less time in Norway keeping fit, say why *(you may choose more than one answer).*

□ I don`t have enough time for sports as I work too much.
□ I don`t feel like doing sports as I`m too tired after work.
□ There are more enjoyable ways of spending free time here.
□ I don`t have money for that because I`m saving.
□ Other reasons . . . . . .

35. What are the reasons behind your physical activity? *(you may choose more than one answer):*

□ My willingness to prevent diseases.
□ My need to release emotional tension.
□ Looking after my appearance and keeping fit.
□ My willingness to spend time in an enjoyable way.
□ Other reasons (*what kind?*) . . . . . .

□ I am not physically active.

36. Do you take drugs?

□ Yes, I used to take drugs in Poland and I still do it here.
□ Yes, I started taking drugs here.
□ No, I quit taking drugs here .
□ No, I have never taken drugs. *(go to question 43)*

37. If you started taking drugs or you take them more frequently in Norway, say why *(you may choose more than one answer).*

□ It is easier to buy drugs here.
□ Drugs help me overcome stress.
□ Several people around me take drugs and that was encouraging.
□ I can afford drugs here.
□ Other reasons . . . . . .

38. If you quit taking drugs in Norway, say why *(you may choose more than one answer).*

□ Drugs are too expensive here.
□ Drugs are not easily available.
□ I can`t take drugs because I work.
□ Other reasons . . . . . .

39. Where do you usually have access to drugs?

Write your answer here: . . . . . .

40. If you take drugs, would you like to give up on drugs?

a) Yes.
b) No.

41. Do you have some leisure time during the day?

□ Yes. (*how many hours?* . . . . .)
□ No.

42. Is the amount of leisure time sufficient for you?

□ Definitely yes.
□ Rather yes.
□ Rather not.
□ Definitely not.
□ Hard to say.

43. How do you spend your leisure time in Norway?

. . . . . .
. . . . . .
. . . . . .

44. Has anything changed in the way you spend your leisure time since you left Poland?

□ Yes. (*what?*) . . . . . .

□ No

45. How many hours per day do you usually sleep?

. . . . . .

46. Is this amount of sleep sufficient for you?

□ Definitely yes.
□ Rather yes.
□ Rather not.
□ Definitely not.
□ Hard to say.

47. If you think you sleep too little, what is the reason? *(you may choose more than one answer)*

□ I lack time for sleeping.
□ Sleeping is a waste of time for me.
□ Insomnia.
□ Other reasons . . . . . .

48. Have you ever turned to a doctor for help when in Norway?

□ Yes. (*how many times?* . . . . .)
□ No. (*go to question 54*)

49. What was the reason behind your appointment(s) with a doctor?

Reason behind doctor appointment(s)	When did the appointment take place?		
	In the last six months	In the last three months	In the last month
Accident			
A cold			
Pain			
Chronic disease			
Medical check-up			
Worrying symptoms			
My need to get a prescription			
My need to get sick leave			
Other reasons ……			

50. What kind of doctors did you turn to for help?

. . . . . .

51. Was an interpreter present during the doctor appointment?

□ Yes.
□ No.

If an interpreter was present, were you pleased with his/her work?

□ Yes.
□ No. (*why not?* . . . . . .
. . . . .)

52. Why didn`t you turn to a doctor for help? (*you may choose more than one answer*)

□ It wasn`t necessary.
□ I didn`t have time.
□ I don`t have the insurance.
□ I don`t know the language and I was afraid of misunderstanding.
□ I didn`t want to go to a Norwegian doctor. (*why?*) . . . . . .
. . . . .)
. . . . .)
□ I didn`t have money.
□ Other reasons (*what kind?*) . . . . . .

53. Where do you go to the doctor more frequently?

□ In Poland. (*why?*) . . . . . .

□ In Norway. (*why?*) . . . . . .

□ As frequently in Poland as in Norway.

54. Do you agree with the statements below?

a) Whether you use the services of a Polish doctor or a Norwegian one doesn`t make a difference. The medical service quality is similar.

□ I fully agree.
□ I agree.
□ I disagree.
□ I fully disagree.
□ Hard to say.

b) Only a Polish doctor can understand a Polish patient.

□ I fully agree.
□ I agree.
□ I disagree.
□ I fully disagree.
□ Hard to say.

c) In Norway you have better access to the health care services than in Poland.

□ I fully agree.
□ I agree.
□ I disagree.
□ I fully disagree.
□ Hard to say.

d) In Poland you have better access to the health care services than in Norway.

□ I fully agree.
□ I agree.
□ I disagree.
□ I fully disagree.
□ Hard to say.

55. Are there any specialist doctors that you would prefer to go to in Poland?

□ Yes. (*which specialists?*) . . . . . .
□ No, I can`t see a difference.

56. What did you use to do in Poland and what do you do here when you feel ill?

Type of behaviour	Poland	Norway
I go to a doctor.		
I try to invent a treatment myself.		
I ask friends for advice.		
I tend to wait until the symptoms disappear.		
Other ……		

57. Mark how frequently you are directly in touch with Norwegians in the places/situations listed below.

Situations/places	Frequency of contact				
	Very frequently	Frequently	Seldom	Very seldom	Never
Offices and institutions					
Shops					
Church					
Health care services					
Workplace					
Social contacts (after-work meetings, going to the cinema, going for a drink, etc.)					
Neighbourhood					
Closer friendship					
Other ……					

58. Have you ever been treated unfairly in Norway?

a) Yes, *(mark by whom)*

□ by Norwegians *(describe the situation and say who treated you unfairly:* . . . . .)

□ by Poles *(describe the situation:* . . . . .)

□ by foreigners of other nationalities *(describe the situation:* . . . . .)

b) No.

59. Do you feel that you are treated as well as the immigrants of other nationalities in Norway?

□ Yes.
□ No, I feel I am treated in a better way.
□ No, I feel I am treated in a worse way.
□ Hard to say.

60. Do you think that all the immigrants are treated in the same way in Norway?

□ Yes.
□ No.
Those treated in the best way (name a nationality) . . . . . .

Those treated in the worst way (name a nationality . . . . . .

61. Put „x" in the right box to show how you feel in Norway. *(0–in complete isolation, 10–fully involved in the social life)*

0 □ □ □ □ □ □ □ □ □ □ **10**

62. If you feel isolated, what are the reasons? *(you may choose more than one answer)*

□ It is my decision, I simply don`t want any social contacts.
□ I experience a linguistic barrier (I don`t speak Norwegian or English well enough).
□ I experience a cultural barrier, I can`t adapt .
□ I experience unfair treatment *(underline)*
a) by Norwegians, who keep me at bay.
b) by Poles.
c) by people of other nationalities.
□ Other reasons (*what kind?*) . . . . . .

63. Who do you spend your leisure time with, who do you keep in touch with socially?

□ With Poles.
□ With Norwegians.
□ With people of other nationalities (*which ones?* . . . . .)

64. Who would you like to spend your leisure time with and keep in touch with socially?*(you may choose more than one answer)*

□ With Poles.
□ With Norwegians.
□ With people of other nationalities (*which ones?* . . . . .)
□ I can`t see a difference.

65. Do you belong to/attend...

Do you belong to/attend	Yes	No	No, but I would like to
a church group?			
a choir or a music band?			
a sports club?			
a hobby club?			
a political party?			
a youth organisation?			
a Polish association in Norway?			
a trade union?			
a language school?			
a voluntary organisation?			
Other, what kind? ……			

66. How do you assess the work you do?

I assess it as	fully	partly	not at all	below expectations /possibilities
financially satisfying.				
relevant to my qualifications.				
health-friendly.				
providing me with a sense of security.				
providing me with a sense of respect .				
providing me with promotion prospects on return to Poland.				
providing me with promotion prospects here in Norway.				

67. During your stay in Norway, have you gone through periods of time when you felt the following more intensely than usually:

Emotions	Yes Use the right letter: A – only at the beginning of my stay B – it happens quite frequently C – it happens but very seldom	No	Hard to say
Anger			
Irritation			
Nervousness			
Helplessness			
Indifference			
Low self-esteem			
Mood swings (sorrow-joy, etc)			
Overwhelming homesickness			
Depression			
Happiness			
Other, what kind? ……			

68. What is your present emotional state like?

- □ Very good.
- □ Good.
- □ Average.
- □ Bad.
- □ Very bad.
- □ Hard to say.

69. What was your emotional state like when you arrived in Norway?

- □ Very good.
- □ Good.
- □ Average.
- □ Bad.
- □ Very bad.
- □ Hard to say.

70. How do you try to cope in a difficult situation in Norway and how did you use to cope in Poland? *(eg. with difficulties at work, with homesickness, etc.)*

Coping startegies	Poland	Norway
I wait for the problem to disappear, I simply try to survive .		
I talk to friends, ask them for help.		
I eat sweets and other comfort foods.		
I turn to a psychologist for help.		
I try to sleep as much as possible to forget about the problem.		
I drink alcohol to forget about the sorrows at least for a while.		
I talk to my family and ask my family for help.		
I cry out of helplessness.		
I turn to a priest for help .		
I pray.		
Other, what kind? ……		

71. How important were the items listed below to you before you came to Norway ?

		Of great importance	Of importance	Of some importance	Of little importance	Of hardly any importance	Of no importance
A	Power, a possiblity to manage or control people						
B	Faith, religious values						
C	Pleasures, a possibility to enjoy life						
D	Native land, patriotic values						
E	Money, a possibility to possess material goods						
F	Honour						
G	Self-development, shaping your character						
H	Family happiness						
I	Education, developing your professional competences						
K	Love of your life						
L	Freedom, social justice						
Ł	Professional success						
M	Health						

72. How important are the items listed below to you at the moment ?

		Of great importance	Of importance	Of some importance	Of little importance	Of hardly any importance	Of no importance
A	Power, a possiblity to manage or control people						
B	Faith, religious values						
C	Pleasures, a possibility to enjoy life						
D	Native land, patriotic values						
E	Money, a possibility to possess material goods						
F	Honour						
G	Self-development, shaping your character						
H	Family happiness						
I	Education, developing your professional competences						
K	Love of your life						
L	Freedom, social justice						
Ł	Professional success						
M	Health						

A) Choosing from the items listed in question 75, pick up <u>no more than three</u> which you value the most (*order them by the level of importance: 1 – the most valued, by filling in the right letter)*

1 ..... 2 ..... 3 .....

B) Choosing from the items listed in question 75, pick up <u>no more than three</u> which you think Norwegians value the most (*order them by the level of importance: 1 – the most valued, by filling in the right letter)*

1 ..... 2 ..... 3 .....

73. Who/what would you be ready to put your health at risk for? (*you may choose more than one answer)*

□ For the sake of my native land.
□ For the sake of my family (who? parents, children, siblings,spouse, another person. . . . .)
□ For God (in defence of faith).
□ For the sake of friends.
□ For money.
□ For the pleasure derived from doing extreme sports.
□ Other. . . . . .

74. How would you feel if you consciously put your health at risk in order to do the following (*put „x" in the right boxes*)*?* **Would you feel…**

a) proud or ashamed?

Aim	Very proud	Proud	Indifferent	Ashamed	Really ashamed	Hard to say
Obtain money to buy a better quality car/flat						
Provide for the family						
Defend your faith						
Defend your native land (eg. going to war)						
Do extreme sports						

b) condemned or admired?

Aim	Really admired	Admired	Indifferent	Condemned	Totally condemned	Hard to say
Obtain money to buy a better quality car/flat						
Provide for the family						
Defend your faith						
Defend your native land (eg. going to war)						
Do extreme sports						

c) guilty or innocent?

Aim	Totally innocent	Innocent	Indifferent	Guilty	Totally guilty	Hard to say
Obtain money to buy a better quality car/flat						
Provide for the family						
Defend your faith						
Defend your native land (eg. going to war)						
Do extreme sports						

75. Do you agree with the following statement?

It is every person`s duty to look after his or her health.

□ I fully agree.
□ I agree.
□ I disagree.
□ I fully disagree.
□ Hard to say.

76. If you believe everyone should look after their health, why do you think so?

□ God gave us life and health and we are supposed to take care of it.
□ We have to take care of our health in order to be useful for the society.
□ Health is a necessary element of your personal success and an enjoyable life.
□ You have to take care of your health not to be a burden for the family, to provide for the family.
□ Other . . . . . .

1. **You are:** a. female b. male
2. **Age** .....
3. **Education:**
   - □ primary
   - □ lower secondary
   - □ higher secondary
   - □ vocational, **what kind?** .....
   - □ BA degree, **in what field?** .....
   - □ MA degree, **in what field?** .....
   - □ postgraduate studies, **in what field?** .....
   - □ PhD degree, **in what field ?** .....
4. **Province where you live permanently in Poland** .....
5. **County where you live permanently in Poland** .....
6. **Place of your permanent residence**
   - □ City with a population of over 100 thousand inhabitants.
   - □ Town with a population of over 50 thousand inhabitants.
   - □ Town with a population between 20 and 50 thousand inhabitants.
   - □ Housing estate in the countryside, former State Agricultural Farm (PGR).
   - □ Village, settlement.

7. How would you describe your faith and religious practices before your arrival in Norway and at present?

My beliefs	In my native land, before arrival in Norway	Here, abroad
I am a believer and take part in religious rituals on a regular basis.		
I am a believer and take part in religious rituals from time to time.		
I am a believer but I don`t take part in religious rituals .		
I am a non-believer but I perform some religious rituals eg. praying when in difficulties, attending a wedding ceremony at church, attending a funeral service, other, what kind? ……		
I am a non-believer but I observe some tradtions eg. Christmas Eve celebrations, food blessing at Easter, other, what kind? ……		
I am a non-believer and I neither observe religious traditions nor perform religious rituals.		
I have a hostile, rebellious attitude towards faith.		

8. How do you keep in touch with your relatives in Poland?

- □ By ordinary mail (**how many letters per month do you send?** ……)
- □ By phone (**how many times per week do you call your relatives in Poland?** ……)
- □ By text message (**how many text messages per week do you send?** ……)
- □ By e-mail (**how many e-mail messages per week do you send?** ……)
- □ By instant messaging (skype, gg, tlen, etc). (**how many times per week do you use instant messaging to get in touch with your relatives in Poland?** ……)
- □ I don`t keep in touch at all.

9. Are you *(choose all the relevant options)*

□ in a legally binding relationship with someone from Poland?
□ in a legally binding marital relationship
□ with a foreigner (immigrant)?
□ with a citizien of the country where you are staying?
□ in an informal steady relationship with someone from Poland?
□ in an informal steady relationship
□ with a foreigner (immigrant)?
□ with a citizien of the country where you are staying?
□ in an informal temporary(lasting for the duration of your stay)relationship with someone from Poland?
□ in an informal temporary(lasting for the duration of your stay)relationship
□ with a foreigner (immigrant)?
□ with a citizien of the country where you are staying?
□ single?
□ divorced?
□ widowed?
□ in separation?

10. What part of your income (roughly) do you:

a. spend on food. ……%
b. spend on accommodation. ……%
c. send home to Poland. ……%
d. save (eg. on a bank account) ……%
e. spend for pleasure. ……% (*what in particular?* ……)
f. Other expenses ……% (*what kind?* ……)

11. What kind of work do you do in Norway? (*you may choose more than one answer*)

□ I work legally (what kind of work? . . . . .)
□ I have an illegal permanent job (what kind? . . . . .)
□ I work legally and have a temporary job (what kind? . . . . .)
□ I have an illegal temporary job (what kind?. . . . .)
□ I don`t work.

12. Name the reason behind your going abroad. *(circle the right answer or write your own)*

□ My own financial problems.
□ My parents`/siblings` financial problems.
□ My need to earn money to achieve a particular goal (**what kind?** . . . . .).
□ Difficulty finding a satisfying job in Poland.
□ Difficulty finding any job in Poland.
□ My willingness to obtain new qualifications.
□ Undertaking studies.
□ Getting married.
□ Other resaons – **what kind?**. . . . . .

13. How do you assess your command of English and Norwegian?

	English		Norwegian	
	Before my arrival in Norway	**Now**	**Before my arrival in Norway**	**Now**
Very good				
Good				
Poor, but sufficient for communication purposes				
Poor, insufficient to communicate				
None (I don`t know the language)				

14. Mark the people who are dependent on your income:

□ Spouse
□ Partner
□ Children (how many? ……)
□ Mother
□ Father
□ Siblings (how many? ……)
□ Others (who? ……)

Thank you!!!

Appendix 2

The interview questions

- Has your arrival in Norway changed anything in your approach to health?
- Where do you look after health more and why?
- Would you be ready to put your health at risk in a specific situation? What kind of situation?
- Who do you think values their health more, Poles or Norwegians? Why?
- Do you regard health as the most important value or are there any other more significant values for you?


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