Public health challenges among immigrants in Norway

A content analysis of health policy documents

Ragnhild Storstein Spilker
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På mange områder er det likevel ikke mangel på kunnskap, men mangel på handling som er problemet.

Stmeld.nr.16 (2002-2003) Resept for et sune Norge

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Trykk: Nasjonal kompetanseunhet for minoritetshelse - NAKMI
To Maria and Akie,
I love you so much

In remembrance and gratitude to Liv, Ole and Ragnhild,
You are always with me
Abstract

**Background:** In Norway several epidemiological studies have documented that immigrants have a higher burden of and are at greater risk of lifestyle- and diet-related disorders, mental health problems, infectious diseases and complications of reproductive health compared to the ethnic Norwegian majority population. Furthermore the Government’s National Strategy to reduce social inequalities in health and other reports from institutions like the Directorate of Health, the Public Health Institute and the Norwegian Medical Association have underlined these health inequalities. However despite the existence of the evidence, these public health challenges to a large extent have not been translated into policy.

The report no.47 (2008-2009) to the Parliament, The Coordination Reform (Samhandlingsreformen) lays great emphasis on prevention and early intervention in the course of illness and states that “creating a framework in which the public must take responsibility for its own health will become a more prominent component of health policy”. The Ministry states that it “will attach importance to dialogue with all relevant stakeholders in order to reach a mutual understanding of the challenges we face in implementing the Coordination Reform”. This should apply to all users including the most vulnerable groups, like immigrants.

In Norway there is a growing body of epidemiological research of immigrants’ health, but research on access and utilization of health services for migrants and whether the services are appropriate and relevant is scarce, and on policy development non-existent. There is a great need for appropriate preventive and promotive measures. Despite existing gaps in the evidence base with regard to immigrants’ health status the evidence is nonetheless substantial for immediate action.

Other European countries have already studied and reviewed national health policies with regard to inequity and migrant health. These studies will provide a good basis for comparison with Norway and could provide direction with regards to the recommendations for the future.

**Methods and materials:** The main objective of this study is to analyse if the evidence-based knowledge on the public health challenges of immigrants in Norway has translated into concrete actions in the national health policies, strategies and plans. This has been done by conducting a content analysis of 10 white papers and 18 strategies and action plans.

**Results:** In Norway, health policies that govern the health and care services are explicit about equity in terms of availability, utilization and results. The documents which have been analysed emphasise equity as the overall value of the Norwegian health care system, reduction of social inequalities as a main goal and that vulnerable groups should be prioritised.

In several of the reports challenges of the health status of immigrants are adequately described, but when it comes to the formulation of concrete measures in action plans and national strategies it is rather diffuse and non-committal. The ten white papers have sections on immigrants as a specific group describing the immigrant population, health inequalities and challenges of health care provision. Suggestions and proposed actions are not comprehensive, and formulated in a general and normative manner. There are few explicitly stated measures and they are not in concordance with the situation analysis.

Action plans and strategies are tools for implementing decided policy. Five of the documents did not mention immigrants as a group while five ‘barely’ mentioned. Eight action plans or
strategies on essential areas like mental health, nutrition, physical activity, drugs and alcohol use, HIV and sexual health had a ‘broader’ approach to immigrants and their specific challenges. However the documents vary a lot when it comes to specification of measures and it is difficult to see which concrete actions should follow.

There is no doubt that a lot of the public health challenges of immigrants are known and recognised, but whether appropriate, relevant actions are being taken is more uncertain. The results show that there is a huge gap between the described challenges, proposed actions and the explicitly stated measures.

**Conclusions:** Despite a solid body of evidence on immigrants’ health status and the recognition of these challenges in various reports to the Parliament the last decade, the attempts to meet and incorporate the health needs of migrants and ethnic minorities into the Norwegian Health Care Services are still fragmented and uncoordinated. The measures described are on a small scale but mainstreaming these measures has yet to happen. There is a lack of an overall strategy and policy from the national health authorities and Norway could learn from work done in other European countries like Scotland and Spain. Greater attention needs to be paid to research and policy implementation in order to address ethnic inequalities in health. Analysis of health policies needs to be continued to identify gaps both in research and implementation in order to support governments in developing more structured, comprehensive and coordinated policies when it comes to migrant health.
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List of tables

Table 1: Immigrant population in Norway by 01.01.12 (Statistics Norway 2012) .................. 6
Table 2: Framework for analysing migrant health policies. (Mladovsky 2009) ..................... 26
Table 3: Overview of documents included in the study ......................................................... 32
Table 4: Search words ........................................................................................................... 33
Table 5: Overview of identified pages in documents. ......................................................... 38
Table 6: Action plans and national strategies. ................................................................. 45

List of figures

Figure 1: Study design ......................................................................................................... 30
Figure 2: Action spectrum on inequalities in health (Whitehead, 1998). .......................... 56


1 Introduction

In Norway, health policies that govern the health and care services are explicit about equity in terms of availability, utilization and results. This is stated as the overall goal for the health care services and is reflected both in the comprehensive health legislation and in national health policy documents.

Several epidemiological studies have documented higher prevalence of both somatic and mental health problems among immigrant groups compared to the ethnic Norwegian majority population. Furthermore the Government’s National Strategy to reduce social inequalities in health and other reports from institutions like the Norwegian Directorate of Health, the Public Health Institute and the Norwegian Medical Association have underlined these health inequalities (The Ministry of Health and Care Services 2007, Norwegian Medical Association 2008, Norwegian Directorate of Health 2009, National Public Health Institute 2010).

The report no.47 (2008-2009) to the Parliament, The Coordination Reform (Samhandlingsreformen) lays great emphasis on prevention and early intervention in the course of illness and states that “creating a framework in which the public must take responsibility for its own health will become a more prominent component of health policy”.

In 1975 ‘Health service for immigrants’ was established in Oslo by the then existing Oslo Health Council and the social services. The purpose was stated in a white paper on immigration, Report to the Storting 107 (1975-76). This health service was to function as a gateway into the mainstream health services and also ‘through systematic collection on immigrants’ needs for health services create a basis for integration of guest workers into the ordinary municipal health services’. The clinical symptoms presented by the patients were related among other to nutritional problems like anemia and vitamin D deficiency, diabetes, genetic diseases, post-traumatic stress disorders and injuries from torture and complex medical conditions. The service was closed down in 1988 after public ideological discussions on special care and arrangements for immigrants and other vulnerable groups (Austveg 2005).

In a white paper fifteen years ago, Report to the Parliament nr.17 (1996-97) ‘on immigration and the multicultural Norway’, the Government stated that ‘a multicultural society means that services must be adapted in order to provide equitable health care to a more diverse user group’ and that there is a need for adapting services and public health to immigrant groups.
Health issues of concern that are mentioned are mental health, nutritional problems; iron and vitamin D deficiency, type 2 diabetes, cardiovascular diseases, obesity, high blood pressure and high cholesterol, infectious diseases like TB and HIV and female genital mutilation. The Government formulates knowledge on immigrant children and adolescents’ health and need for services and as an area of primacy. Research and documentation on disease incidence and use of health services among immigrants in general should also be prioritised (St.meld.nr. 17 (1996-97)).

A review of the research literature undertaken in 2010 documents that immigrants have a higher burden of and are at greater risk of lifestyle- and diet-related disorders, mental health problems, infectious diseases and complications of reproductive health. Significant variation across gender, ethnic and age groups exists, but this review confirms that immigrants have poorer health and a lower socioeconomic status, particularly those from low- and middle-income countries compared to immigrants from Western countries and Norwegians (Abebe 2010).

In 1975 1,5% of Norway’s population were immigrants and in 1997 this number was 5,5%. Today 655 000 persons or 13,1 % of the total population constitute the immigrant population (Statistic Norway 2012). Despite still existing gaps in the evidence base with regard to migrants’ and ethnic minorities’ health status the evidence is nonetheless substantial for immediate action. There is a great need for appropriate preventive and promotive measures.

General practitioner and researcher A.K.Jenum said in an interview in 2009 with Dagens Medisin (‘Medicine of Today’) that after having worked as a doctor for 20 years in the east part of Oslo, she was rather disillusioned by the inaction of central health authorities when it comes to the demographic and epidemiological situation and the health challenges of the immigrant population living there.

Nå har jeg jobbet i øst i tyve år og må si at jeg er ganske oppgitt over passitiviteten til sentrale helsemyndigheter i forhold til å gi oss verktøy å jobbe med i denne demografiske og epidemiologiske situasjonen. I STORK-prosjektet finner vi, ikke overraskende, mye mer svangerskapsdiabetes enn det man har antatt, og mange av de gravide har alvorlig D-vitaminmangel.

Dagens Medisin 21/09
The question is how the public health challenges of immigrants are attended to by national health authorities and if and how the evidence-based knowledge on the public health challenges of migrants and ethnic minorities have translated into national health policies in Norway.

The main objective of this study is to identify, analyze and discuss national health policies with regard to immigrants’ health. This is done by conducting a content analysis of governmental health policy documents.
2 Background

2.1 Migration and health

Migration is a complex and dynamic process and there are a number of individual, social and environmental factors which can affect health in complex ways, both negatively and positively. It is a process of change for the individual moving from one social and cultural setting to another. Immigrants’ health is influenced by pre-migration factors as socioeconomic and ethnic backgrounds, health status and access to and quality of care in country of origin, the migratory history and trajectory and post migrations determinants as working and living conditions, social network and social inclusion, experiences of racism and discrimination and access to health and welfare services (Kumar 2011).

Today more than 200 million people live outside their country of birth and therefore migrant health is a global issue. For many individuals migration brings about enormous changes; moving from a low or middle income country to an industrialised and from rural to urban areas. Immigrants must settle and in one way or another come to terms with the new culture they moved to, at the same time carrying with them their particular culture, traditions, language and history. Immigrants from low and middle income countries coming to a country like Norway are going through demographic, epidemiological and nutritional phases of transition. Moving from areas of higher fertility, mortality and prevalence of infectious diseases and under nutrition to higher prevalence’s of chronic diseases can change and increase risk for diseases. Susceptibility to ill health can be reinforced by living conditions in the new country (ibid.).

Migrant health as a field addresses the state of physical, mental and social well-being of immigrants. Many immigrants experience structural inequalities which can have a substantial impact on health and well-being. Immigrants are often affected by poverty, unemployment and social exclusion. Poor economy, less autonomy and control over own life influence the possibilities to make healthy choices and increase vulnerability for life-style related disorders. Many immigrants have harsh working conditions and are more vulnerable to work-related injuries and conditions (Davies et. al 2010).
Availability and accessibility of health care and quality of services are important aspects for improving immigrant’s health. Many immigrants experience structural, social, cultural, financial and linguistic barriers in accessing health care services and combined with low health literacy these factors can have a deteriorating effect on health. It is therefore important to respond to the health challenges of immigrants through evidence-based policy and better adaptation, planning and provision of health services (ibid.),
2.2 The Norwegian Context

2.2.1 The immigrant population

The immigrant population of Norway as in all other western European countries have been steadily increasing, and especially since the beginning of the 1990’s. The immigrant population is now nearly 655 000 persons and accounts for 13.1 per cent of the total population. 547 000 of these person are immigrants while 108 000 are born in Norway to immigrant parents. Projections by Statistics Norway show that it will increase considerably in the coming years – from the current level to somewhere around 1,5 million or 24 per cent of the population in 2040 (Statistics Norway 2012).

Table 1: Immigrant population in Norway by 01.01.12 (Statistics Norway 2012)

<table>
<thead>
<tr>
<th>Year</th>
<th>Immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>58 000</td>
</tr>
<tr>
<td>1980</td>
<td>100 000</td>
</tr>
<tr>
<td>1990</td>
<td>150 000</td>
</tr>
<tr>
<td>2000</td>
<td>200 000</td>
</tr>
<tr>
<td>2012</td>
<td>300 000</td>
</tr>
</tbody>
</table>

294 000 of the immigrants have a European background, 163 000 come from Asia, 60 000 are of African origin, 18 000 from South- and Central-America and 11 000 from North America and Oceania. Of those born in Norway to immigrant parents do 57 100 have an Asian background, 29 000 have parents from Europe, 19 500 are of African background and 2 600 have immigrant parents from South- and Central America (ibid.).
The immigrant population consist of people from 219 different countries and independent regions and they have come as refugees, labour migrants, and students or to be reunified with family living in Norway. Poles are by far the largest immigrant groups followed by immigrants from Sweden, Pakistan, Somalia and Iraq. Immigrants are represented in all Norwegian municipalities, but most immigrants and their descendants live in the South and East of Norway, and in Oslo as much as nearly 30 per cent of the population have immigrant background. 4 in 10 immigrants have lived in Norway for 4 years or less, while 2 in 10 have lived here for more than 20 years (ibid. 2012).

2.2.2 Public health challenges among immigrants in Norway

There are significant health inequalities in the Norwegian population as a whole, and there is a great variance in health status between different immigrant groups. However immigrants do in general have poorer health and a higher disease burden than the majority population (Kumar and Viken 2010).

Diseases and conditions like diabetes type 2, HIV, hepatitis B, tuberculosis, vitamin D deficiency, musculoskeletal disorders and mental health problems are significantly more prevalent among immigrants. However there are differences between ethnic groups and between men and women. Incidence of cardiovascular diseases and cancer among immigrants in Norway is not known. Risk factors such as physical activity, obesity and to some extent smoking are more common in the immigrant population, but there is a great variance between groups and across gender (Spilker et al. 2009, Abebe 2010).

Immigrants and their descendants assess their own health as being worse than the population as a whole. More immigrant women than men report illness. Particularly immigrants above the age of 40 assess their health as considerably worse compared to the general population. Immigrants seem to be more affected by health problems and struggle more in coping in daily life with poor health (Spilker et al. 2009).

Ethnic inequalities in health are often explained by genetic, cultural and socioeconomic factors. Determinants of health like degree of social inclusion, support and integration, perceived racism and discrimination and other negative life events will also affect well-being. Access to
health services and quality of health care are important aspects in prevention of disease and health promotion (ibid.).

There are few studies on immigrants’ use of and access to health services, and the studies that have been done recommend that the health care services should adapt to the needs and health problems of immigrants (Abebe 2010).

It is beyond the scope of this thesis to describe the public health challenges of immigrants in Norway in more detail, but more information can be found on the Norwegian page of the European web resource Mighealthnet.

2.2.3 The Norwegian health care system

The Norwegian health care system is built on the principle of equal access to services. Regardless of social or economic background and location of residence all inhabitants have in principle the same rights and access to health care. The health system is structured in three levels; the national / state level, the four health regions and the municipalities. The state determines the national health policy, prepares and oversees legislation and prioritises and allocates funds. Specialist health care is provided by the regional health authorities and the municipalities are responsible for primary health care services. The parliament, Stortinget, is the political decision-making body and the Ministry of Health and Care Services has the overall responsibility for the health care sector (Roth Johnsen 2006)

Several important health reforms of financing, organisation and provision of services have taken place the last decades, but the overarching goals of solidarity and equality as fundamental values have remained unchanged. The main objective is to improve the health of the population as a whole, reduce health inequalities and distribute health services according to need (ibid.).

Municipalities have responsibilities for health promotion and prevention of illness and injuries and organise school health services, health centres provide midwifery services and child health care and provision of general practitioners through the GP scheme. The Norwegian Directorate of Health, National Institute for Public Health and the Norwegian Board of Health Supervision are important public health institutions and are professional and administrative bodies under the authority of the Ministry of Health and Care Services (ibid.).
According to Roth Johnsen (2006) there are several preconditions for successful health policy in Norway. The decision-making process is consensus oriented and most decisions are made through negotiations with interest groups, like professional associations, unions and patient and users organisations. The policy process is characterised by a combination of central command and control and freedom to local adaptations. Policy making is influenced by the ‘steer, don’t row’ principle where politicians are more concerned with strategy and less with implementation (ibid.).

2.3 Policy

2.3.1 Public policy and the policy process

In Michael Hill’s book The Public Policy Process (2009) several definitions or descriptions of policy emphasize courses of action and inaction and a range of decisions or actions: ‘A policy may usefully be considered as a course of action or inaction rather than specific decisions or actions’, ‘policy … consists of a web of decisions and actions that allocate… value’ and ‘the concept of policy denotes… deliberate choice of action or inaction, rather than the effects of interrelating forces’ (Hill 2009, p.15). These attempts to define the concept point out that policy involves a multitude of actions and decisions and also underline the importance of not only focusing on actions and decisions which produce change, but that attention also should be given to inaction and those which resist change. This can often be difficult to observe as these decisions are not traceable in the same way (Hill 2009).

The public policy process is both complex and multi-layered involving many actors: politicians, pressure groups, bureaucrats (civil servants and publicly employed professionals) and sometimes also the recipients of policy. Policy is not a very specific and concrete phenomenon and therefore challenging to define precisely. Sometimes it can be identified in terms of a decision, but most often it constitutes a set of decisions or it can be seen more as an orientation or a course. A former British civil servant argued that “Policy is rather like the elephant – you recognise it when you see it but cannot easily define it” (Hill 2009, p.15).

Public policy is often defined as “decisions taken by the government or on behalf of it”. That could be an action or a decision not to act. Only governments have the authority and legitimacy to make binding decisions which are carried out on behalf of the people. Other organisa-
tions and actors might make decisions that can have an impact on individuals, systems and parts of society or influence government policies, but these decisions are not binding by force of law (Blank and Burau 2007).

2.3.2 Health policy, health care policy and health care politics

Health policy can be defined as the actions taken by the government which affect the health of the population. Economic, social welfare, employment and housing policy among others can be seen as part of a government’s health policy meaning any action that can influence health. Health care policy is limited to actions concerning the financing, provision and governance of health services. Finally health care politics is understood by Blank and Burau as “the interactions of political actors and institutions in the health care arena” (Blank and Burau 2007, p 2).

Health care and health care policies are some of the most debated fields in the public policy domain. Ageing populations, advances in medical treatment due to new knowledge and new technologies and high public expectations are some of the factors that put health care high up on the political agenda. The fact that health policy deals with matters of life and death and huge resources, policymaking involves both emotional and economical concerns. Health policy differs from other policy areas because the health care professionals possess specialised knowledge which gives them a specific power in shaping and constraining policy. Without support from the medical community policies could easily fail (Blank and Burau 2007).

2.3.3 Comparative health policy

Availability and dissemination of data across countries as a consequence of the advances in information technology has made comparative policy analysis an important and increasing part of policy research. The awareness of shared challenges in modern welfare states has brought up interest in policies in other countries. Comparison of policies among countries can demonstrate similarities and differences in approaches to problem solving and is useful in developing policy options and looking at a range of different experiences. Comparative health policy can also show how countries vary in the policies they choose, provide an understanding of why differences exist, and assist in identifying characteristics of policies that succeed (Blank and Burau 2007).
Against a backdrop of shared policy challenges several comparative health policy studies have pointed out the importance of *policy convergence* for understanding how health care policies are being made. The notion of health policy convergence proposes that there are global trends in the shaping of health policies and that goals and activities of national health systems are developing more and more in the same directions. Some scholars argue that health system reforms have contributed to a universal paradigm for the structuring of health care despite ideological lines and conceptual frameworks, while others see medical knowledge and technological advances as the main contributors to health policy convergence (Blank and Burau 2007).

The convergence thesis implies that as countries develop they have a tendency to converge towards similar policies, and because of new expensive technologies and comparable demographic changes the drivers for convergence are reinforced. Convergence is in addition strengthened by globalization and the international health community developed through the internet. Furthermore, the work done by international organisations such as WHO, OECD and the EU have set the foundation for what has been called “ideational convergence” (Blank and Burau 2007).

Convergence is appealing because comparable challenges, in theory, make for similar solutions and it is also inspired by the fact that all health systems must fulfil the same type of functions. But critics of convergence theories claim that the advocates overgeneralise the development process and underrate important variances between countries. Convergence of health systems and policies has become a focus in health policy research, but the underlying theoretical framework used is often imprecise and characterised by forms of “soft determinism” which presume that “comparable conditions produce comparable problems which result in comparable policies” (Blank and Burau 2007, p.11).

The idea of convergence in health policy research is of great significance because the internationalisation of the health policy arena can influence policymakers to converge in areas where it might be in conflict with the needs of the specific countries. Believing too strongly in policy convergence may lead to the damage of health care programmes in some countries (Blank and Burau 2007).


2.3.4 Policy analysis

When studying and analysing public policy many different approaches can be adopted (Hill 2009).

Policy analysis is a sub discipline which is influenced by and uses concepts from different disciplines: economics, political science, sociology, public administration and history. A range of definitions are used by various scholars, based on heterogeneity of theories (Walt and Gilson 1994).

There are several definitions when it comes to policy analysis and a distinction is made between analysis of policy and analysis for policy; where analysis of policy is analytical and descriptive and attempts to describe and explain policies and their development, whereas analysis for policy is normative and prescriptive and involved with formulating policies and proposals. However, it is not always easy to distinguish clearly between analysis of and for policy (Hill 2009).

2.3.5 Frameworks and theories

There are frameworks and theories of the public policy process that have been extensively applied in published literature. The most recognised framework is the stages heuristic which splits the public policy process into four stages: agenda setting, formulation, implementation and evaluation. It has been criticised for assuming a linear relationship which does not exist, for claiming well-ordered limits between stages that often are unclear, and not offering causal explanations. On the other hand this framework can be a useful and simple tool when looking at the public policy process as a whole and may help researchers to place their own research within a broader framework (Walt et al. 2008).

A policy analysis framework specific to health was developed by Walt and Gilson. Their main argument was that health policy research focused too much on the content of policy neglecting the actors, the processes and the context. Their policy triangle framework is a simple analytical model which takes into consideration how these elements are interrelated in the policy-making process. In short it claims that actors (both individuals and groups) are affected by the context (both on macro and micro level) wherein they live and work. Context is in turn influenced by different aspects as political changes, ideologies, historical experiences and
cultures. The process of policy-making; how issues are put on the political agenda and how they are dealt with, is again influenced by the actors. The content of policy is in reality reflecting all these dimensions. However, a sole focus on health policy content without understanding the role of the actors, context and processes can lead to ineffective policy choices and implementation (Walt and Gilson 1994). A lot of literature has looked at the mismatch between policy objectives and actual implementation (Walt et al. 2008). Some argue that discussions of implementation do not sufficiently take into account that several layers of government are involved in the policy process and have identified what they call a” multi-layer problem” in the literature on implementation (Hill and Hupe 2003).

2.3.6 Research designs in health policy studies

To the analysis of health policy a range of approaches can be applied when it comes to research design. Most studies in this field are case studies, understood as “in-depth investigations of a single instance of a phenomenon in its real-life context” (Walt et al. 2008, p.312). The first question to ask is what is it a case of? It could be an implementation failure, policy transfer between countries, network influence on agenda setting or political factors influencing policy evaluation. At times the case appears clear from the start of investigation other times it will be constructed and re-constructed as the analysis proceeds. Secondly one has to ask why it is important and useful to study this case. Will it offer insight to theory comparison and development? Can it demonstrate effective policies? Can results offer insights that will impact policy development? All these questions should be considered in order to help the researcher in framing the study and choosing methods (Walt et al. 2008).

2.3.7 Researcher’s positionality

In their article on ‘doing health policy analysis’, Walt and colleagues dwell upon researchers’ positionality. How researchers are perceived; their institutional connection, their legitimacy and eventual attachments to political communities are essential to the accessibility to the policy environment and its actors, especially when researching policy elites and delicate issues and ‘high politics’. According to the authors there has been a lack of focus and reflections regarding this issue and its possible effects on the research process in health policy analysis (Walt et al 2008).
The concept of positionality is often separated into ‘insiders’ and ‘outsiders’. An insider is often seen as both a participant and researcher, also called a participant-observer. When investigating complex policy environments and processes an insider will see and understand things in a different way than an outsider who probably affects both how and what data are collected and the interpretation of findings. An insider normally will have easier access, be able to ask the important questions and have a deeper understanding of the actors and the culture that are being studied. In contrast to the ‘biased’ insider, an outsider will be curious in another way and be able to ask other and more taboo questions, and thereby get more explanatory and substantial answers. However this dichotomy has proven to be far too simple. Factors such as class, caste, gender, age, ethnicity and profession are important and a researcher can be an insider and an outsider at different levels and different times during the research process (Merriam et al. 2001).

The researcher’s position, how he or she is ‘situated’ in the field of investigation will influence the research agenda, i.e. the issues in focus and the questions asked. Researchers that are connected to specific policy settings will naturally have their focus on particular topics of that policy space rather than more universal issues and will most likely be inclined to formulate policy-relevant conclusions instead of adding to new theoretical or methodological knowledge. Another challenge with regard to positionality is the fact that funding of health policy research often requires research translation, thereby pushing researchers to become policy actors. There are also researchers actively engaged in policy-making facing both open and closed doors in the research process (Walt et al. 2008).

It is important to the development and quality of health policy analysis that researchers reflect on and are explicit about their own positionality and how this impacts on the research agenda and knowledge generation (Walt et al. 2008).

### 2.3.8 Content analysis of health policy

Michael Hill distinguishes between analysis for policy and analysis of policy and the latter is divided into studies of policy content, policy outputs and policy process. Studies of policy content seek to ‘describe and explain the genesis and development of particular policies’ (Hill 2009, p.5). The main emphasis in content analysis is ‘the substance of policy’. In content analysis one seeks to investigate a specific policy issue and the alternatives for tackling it. The
central points are the outcomes of policies and the effects they have on people. Governmental policy objectives and goals as stated in official documents are not always translated into policy implementation. Policy statements exist in writing, but are not supported by policy actions such as regulations or programmes. When existing policies are not successful the challenges should be addressed through analysis and thereby raising awareness on the importance of that specific policy area (Collins 2004).

2.4 Migrant health policies in Europe

2.4.1 Introduction

The issue of migrant health has gained increased attention and recognition as an important health policy issue in Europe, due to its significance to migrants’ integration and contribution to society, public health and health. Migrant health is regarded by many stakeholders and experts as a central and overdue matter in the EU health agenda (Peiro and Benedict 2010).

Research can be transformed into policies as recommendations, plans of action, strategies, decisions on statutory duties and rights or new institutional bodies (Lorant and Bhopal 2010). Migrant health policies can concentrate on particular groups, such as asylum seekers or undocumented migrants. They can also have a broader focus on migrants in general or vulnerable groups including migrants and ethnic minorities (Mladovsky 2011).

The use of law and policy provides an essential foundation for achieving progress in the field of migrant health. To adapt health care systems to the challenges of multi-ethnic societies and to follow up the recommendations from researchers and stakeholders countries need policies and plans in order to take the necessary actions (Bhopal 2012).

The European Union, European institutions, different levels of government, policy forums and communities have put migrant health in focus both by highlighting the existing health inequalities and by recognising the importance of healthy migrants for the economy and society. Especially in the latter part of the first decade in the new millennium one has seen important progress in the field of health inequalities and migrant health in Europe. Substantial policy development and high-level conferences and consultations have taken place, above all
on the ‘supranational’ level (IOM 2009). In addition to this, some EU countries have begun developing their own national migrant health policies (Mladovsky 2011).

2.4.2 The supranational level

There are few legal references in the EU with regard to health which is a new and limited competency within the union. A new health strategy was adopted by the European Commission (DG Sanco) in 2007: “Together for Health: A Strategic Approach for the EU 2008-2013”. The aim of this strategy is to formulate future objectives concerning health and health care in the EU, and how to effectively develop and implement this work in national health policies. The strategy is meant to provide “an overarching strategic framework covering core issues in health as well as ‘health in all policies’ and global health issues” (IOM 2009, p.9). However, the strategy does not address migrant health in a comprehensive manner (ibid.).

During the Portuguese EU Presidency in 2007 health and migration was the main theme of its health programme, with the aim of creating a European network of national experts on migrant health. This was done to foster exchange platforms for information sharing and to promote advances and strategic approaches in the field of migration and health. An Advisory Group on Migration and Health was formed with the support of the European Commission and WHO. The Council of Europe, the European Centre for Disease Prevention and Control (ECDC) and the IOM (International Organization for Migration) also became members (ibid.).

The conclusions of the conference ‘Health and Migration in the EU’ during the Portuguese Presidency were adopted by the Employment, Social Policy, Health and Consumer Affairs (EPSCO) Council of the EU, highlighting cross-sectorial approaches and calling for the integration of migrant health issues into health, social, employment and other national policies of the member states and EU institutions. The EU Council asked member states to include, in the implementation of the new health strategy, Together for Health, aspects “aimed at improving knowledge of migrant health and developing health promotion, prevention and migrants’ access to care”. Furthermore, the EU Council called for the 7th Research Framework Programme and other EU programmes to support research and interventions in the field of migrant health (Peiro and Benedict 2010, p.2).
The Portuguese Presidency set the scene for further development of migrant health initiatives and as a result other important events followed. The Council of Europe prepared the Bratislava Declaration on Migration, Health and Human Rights, which was adopted during the 8th Conference of the Ministers of Health of the Council of Europe in November 2007, and a committee of experts on health and migration was established (IOM 2009 and Peiro and Benedict 2010).

The WHO issued a Resolution on the Health of Migrants at the 61st World Health Assembly in May 2008, urging its member states to protect migrants’ health and promote its inclusion in health strategies. The WHO European Region Ministerial Conference on Health Systems in June 2008 resulted in the Tallinn Charter, which included the recognition of the right to health, the need for tackling inequalities in health and a focus on ‘health in all policies’. The WHO Commission on Social Determinants of Health and their report Closing the Gap in a Generation contributed to another WHO resolution at the 62nd World Health Assembly in May 2009; The Resolution on Reducing Health Inequities through Action on the Social Determinants of Health. This resolution urged the WHO member states to address health inequities affecting vulnerable and mobile groups within and across countries (Peiro and Benedict 2010).

The Spanish EU Presidency in 2010 had an overarching focus on equity in health and their “Conclusions on Equity and Health in All Policies: Solidarity in Health” were adopted by the EPSCO Council in June 2010, expressing concern in the health inequalities persistent within and across EU countries, particularly among vulnerable groups including migrants and ethnic minorities. The Council conclusions call upon member states to strengthen public health interventions and promote equity in health through multi-sectorial policy approaches (ibid.).

The WHO Resolution on The Health of Migrants (2008) mandated a review of progress within two years and in Madrid, in May 2010, WHO and IOM co-convened the Global Consultation on Migrant Health, hosted and supported by the Spanish EU Presidency. Representative from all five continents were present together with concerned UN agencies. The Consultation conclusions were jointly presented by the Spanish and Portuguese governments later the same month at the 63rd World Health Assembly in Geneva. The Consultation developed an outline for an operational framework, which identifies priorities to address key actions within the following four areas 1) monitoring migrant health, 2) policy and legal frameworks, 3) mi-
grant-sensitive health systems and 4) partnership and multi-country frameworks (WHO 2010).

In November 2011 the Committee of Ministers of the Council of Europe adopted 14 recommendations on mobility, migration and access to health care. The committee recognises that managing diversity and integration of migrants should be driven by fundamental values as human rights and that both migration and public health are global issues, calling for global responses. Migration itself is not necessarily a risk to health, but conditions surrounding migration can increase vulnerability for ill health (Council of Europe 2011).

2.4.3 Policies on national levels

Policy developments on migrant health in EU countries have been sporadic and uncoordinated. Certain diversity in policy approaches and responses is to be expected, dependent both on type of immigration in different countries and on different welfare systems. In countries where migrant health policy has been elaborated, this may not be reflected in implementation and action on the ground (Mladovsky 2007).

In Mladovsky’s article Migrant health in the EU (2007) a consultation with country experts in health policy is referenced. This consultation showed that France mainly had its focus on prevention of infectious diseases and that analyses on ethnic inequalities were not carried out both on cultural and administrative grounds. In Ireland and Germany migrant health and access to health care had not emerged as a policy issue on the national level, but there had been a growing interest in addressing inequalities in health. While in Italy migrant health policies were rather developed and had been recognised as a policy issue at the central level since the 1990s. However, it was not evident whether the implementation of policies had been successful (Mladovsky 2007).

According to the author the Netherlands stands out in Europe for the continuous and systematic way they have attended to migrant health issues. Already in 1997 they organised a working group on culture and health and launched a programme to foster research and innovations in care. Unfortunately, the initiatives seemed in danger of stagnating. In Spain, migrant health and health care concerns were starting to be highlighted in national and regional plans. In Sweden, the general national health policy had a focus on social inclusion and good health for the entire population. There was a special emphasis on vulnerable groups, such as migrants,
and the government had created a multi-sectorial coordination of services that promoted the health of newly arrived immigrants. In the UK, migrant health policy was, to a great extent, found to be integrated into policies addressing inequalities in health in general and in BME (black and minority ethnic) groups particularly. The Department of Health (DH) in England had taken the initiative to generate knowledge on good practices concerning race equality issues. However, in most countries the scarcity of good baseline data makes evaluation on policies, programmes and practices difficult (ibid.).

Results from a survey done in 2008 among health policy experts in 19 European countries, and with additional information on six other countries, suggest that in most countries migrants’ health and access to services are not addressed through targeted policies. Only in eleven of the 25 countries one found national policies with the aim of improving migrant health. These countries are: Austria, England, France, Germany, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and Switzerland. In the book *Migration and Health in the European Union* (2011), Philipa Mladovsky provides an overview on migrant health policies in these eleven countries along four different components: 1) population groups targeted, 2) health issues addressed, 3) provider or patient focus of interventions and 4) policy implementation (Mladovsky 2011).

Different approaches have been taken by each of the eleven countries; some have developed detailed policies while others, such as Germany, only have formulated a few objectives as part of a more comprehensive integration policy. All countries have addressed legal regulations and screening with regard to asylum-seekers. Apparently, there is a tendency to either have a focus on newly arrived immigrants or more established minority groups. It seems that sexual and reproductive health has had a greater focus in Italy and Germany, whereas mental health has been prioritised in England, Spain and the Netherlands. There is a mix of interventions both targeting the supply and demand side in all countries. There are substantial differences both across and even within countries along the different policy dimensions investigated and Mladovsky sees opportunities for policy dialogue and learning (ibid.).

Migrant health policies in England, Ireland and the Netherlands are incorporated in wider policies that also include ethnic minority groups. In England migrant health policies are part of policies concerned with ‘race’ and BME groups and do no separate between different migrant groups and their offspring. As a result, the needs of newly arrived migrants may be ignored. Ireland’s Health Service Executive launched a National Intercultural Health Strategy
(2007-2012) which covers different migrant groups, in addition to travellers, other ethnic minorities and children of migrant parents. It has its main focus on anti-discrimination and ‘interculturalism’ in service provision. In the Netherlands migrant and ethnic minority health inequalities have been addressed under the wider concept of “cultural differences”. Two reports underlining migrants and ethnic minorities’ health needs and challenges in accessing services were issued by The Council of Public Health and Health Care. As a response, The Minister of Health put down a project group in 2001. After having created a strategy for intercultural health care, the group stepped down in 2003 as “the new Minister of Health announced that he saw no role for the government in this area” (Mladovsky 2011, p.187).

In the other countries (i.e. Austria, France, Germany, Italy, Portugal, Spain, Sweden and Switzerland) policy and programme approaches have a more narrow emphasis on migrants. In Austria an expert working group was set up to analyse migrant health issues which in 2005 delivered a report on intercultural competence in the health sector. The Germans established a working committee on public health and migration in 1997 and ten years later a handbook of Health and Integration was issued. Same year, in 2007, the National Integration Plan was issued, not primarily focusing on health, but asking state governments to take initiative to reducing barriers to access and developing migrant-specific health services and health information. The Italian Ministry of Health formed a ‘national reference centre for health and immigration and the fight of disease due to poverty’ within the scientific research institute, Istituto San Gallicano in Rome in 2006 (Centro di riferimento nazionale per la promozione della salute delle popolazioni migrant e il contrasto alle malattie delle poverta). In Sweden, a multi-sectorial approach was taken in 2004 by several government agencies within health and welfare, education, employment, integration and immigration services in a common policy document; “Nationell samsyn kring hälsa och första tiden i Sverige” (National agreement on health and the first years in Sweden). The aim was to promote health through the coordination of services for migrants (asylum-seekers and others) during their first years in the country. In Sweden migrants’ right to an interpreter is guaranteed by law (ibid.).

In 2004, Portugal established the Health Office of the National Centre for the Support of Immigrants with the aim of improving access to services, both for regular and irregular immigrants, and disseminating information on immigrants’ rights to health care. Through the Portuguese EU Presidency in 2007, migration and health became policy priority. The “Plan for the Integration of Immigrants 2007-2009” focused on several barriers to migrants’ access to
the national health services and the quality of services therein. Spain, already in 1994, adopted an Immigrant Social Integration Plan, serving as a reference framework for the national government and as a proposition for the regions to act. The Global Programme for Regularisation ad Coordination of Foreigners and Immigration was subsequently approved and, in 2005, interactions between employers and irregular foreign workers were regularised. The Strategic Plan on Citizenship and Integration 2007-2010 was adopted with the health-related objectives of guaranteeing migrants’ right to protection of health, identifying the health and social needs of migrants and training of health professionals. In 2008, 15 out of 17 autonomous communities had created regional plans on immigration with detailed migrant health policies (ibid.).

Switzerland with a quite decentralised health system envisioned, with its “Migration and Public Health Strategy 2002-2006”, that policy approaches and measures to raise awareness on migrant health issues would be taken in all health institutions. The follow-up responsibility is placed within a small unit at the Federal Office of Public Health. Following an evaluation of the first strategy, a new strategy has been formulated aiming at continuing and consolidating the objectives of the former one (ibid.).

Developing and implementing migrant health policies is according to Mladovsky a challenge to most governments because of “the highly contested and political nature of any public policy related to immigration in many European countries” (Mladovsky 2011, p.196). There are many elements that influence policy implementation, i.e. structures of the public administration and health care system in a country, immigration patterns, political elections and the parliamentarian system, availability of data, collaboration with other sectors, budgetary restraints and sustainability of policies and programmes. There is generally very little evidence on the implementation of migrant health policies in different countries. It is therefore difficult to evaluate the accomplishment of different policy approaches (ibid.).

Mladovsky underlines the importance of acknowledging that countries are different with regard to their welfare systems and that “there can be no ‘one size fits all’ approach to migrant health policies” (Mladovsky 2011, p.198). Analysis of migrant health policies is a new research field and there is a need for developing frameworks and methodology, evaluations of effectiveness of existing policies and getting a better understanding on how such policies can be developed in different countries (ibid.).
Lorant and Bhopal (2010) compared policies to tackle ethnic inequalities in health between Belgium and Scotland. They found that Scotland has developed a much more complete policy response than Belgium. Scotland has acknowledged the challenge of ethnic inequalities in health, including the need of better data collection and has come up with a confident strategy which has led to significant changes in service planning and provision. Belgium has not been able to monitor ethnic inequalities in health and in addition there is no clear commitment on the national level to tackle the issue and moreover there is no understanding of inequities in health and health care and that health needs of migrant may be different (Lorant and Bhopal 2010).

Vázquez et al. (2010) did a comparative analysis of health policies for immigrant populations in three European countries: England, Italy and Spain. They found that all three countries have national health care systems of universal access, but still had developed specific health policies with regard to the immigrant population and that this could indicate that “it is not enough to grant a right to health care but in order to guarantee that right it is necessary to modify services so that access to quality care becomes a reality” (Vázquez et al. 2010, p.6).

Different immigration and integration history seems in some ways to have conditioned approach to and development of policies. England, a country with a longer tradition of immigration has developed policies aimed at reducing health care inequalities, acknowledging society’s diversity. While in Spain and Italy where immigration is a more recent phenomenon, immigrants are regarded a population group with special characteristics and needs in risk of exclusion from health services. Despite of different policy objectives the authors found no major differences regarding types of action and implementation. The actions developed at both national and regional levels in the fields of improving health, access to services and quality of care appear to respond to identified challenges. However there are differences between the countries when it comes to focus on health issues and emphasis put on improving access and services. Vázquez et al. conclude that policies have developed alongside with increase of immigrants in all three countries, but seem more comprehensive and targeted in England and Spain than in Italy where specific migrant health policy approaches are rare in current plans (ibid.).
3 Methods and materials

3.1 Objective of the study

The main objective of this study is to analyse if the evidence-based knowledge on the public health challenges of immigrants in Norway has translated into concrete actions in the national health policies, strategies and plans.

3.2 Method

The method chosen to achieve the above objective is to review 10 white papers and 18 strategies and action plans of relevance by the means of a content analysis.

3.2.1 Definitions

Public health – is the health status of the population and how health is distributed in a population (The Norwegian Public Health Act 2011).

Public health work - efforts by society to influence factors which directly or indirectly promote the health and wellbeing of the population and prevent mental and somatic illness, harm or suffering, or protect against health threats, as well as efforts seeking a more equal distribution of factors that directly or indirectly affect health (The Norwegian Public Health Act 2011)

§ 3. Definisjoner

I loven her menes med

a) folkehelse: befolkningens helsetilstand og hvordan helsen fordeler seg i en befolkning

b) folkehelsearbeid: samfunnets innsats for å påvirke faktorer som direkte eller indirekte fremmer befolkningens helse og trivsel, forebygger psykisk og somatisk sykdom, skade eller lidelse, eller som beskytter mot helsetrusler, samt arbeid for en jevnere fordeling av faktorer som direkte eller indirekte påvirker helsen.

LOV 2011-06-24 nr 29: Lov om folkehelsearbeid (folkehelseloven)
Immigrants - persons who are born abroad to two foreign-born parents, and who have moved to Norway, and those born in Norway with two immigrant parents are defined as pertaining to the immigrant population and thereby defined as immigrants in this study.

Health policy – a set of decisions or commitments to pursue courses of action aimed at achieving defined goals for improving health, stating or inferring the values that underpin these decision; the health policy may or may not specify the source of funding that can be applied to the action, the planning and management arrangements to be adopted for implementation of the policy and the relevant institutions to be involved (WHO 2011).

Governmental health policy documents – written documents that formulate health policies as defined above and issued by the Ministry of Health and Care Services or other ministries and subordinate governmental institutions.

3.2.2 Analysing migrant health policies

The analysis of migrant health policies is still in its early development. There has been little research and the scientific literature has hardly begun to tackle the issue of analysing migrant health policies (Vázquez et al. 2010). There is often a lack of explicitness in theories and methods employed in such analyses. How is the concept of policy defined? What does it consist of? Is it explicit policy documents and strategies or could it also be policy embedded in law and implicit in practices, rules and regulations? (Lorant and Bhopal 2010).

A surely debatable question is to what extent a government should develop specific migrant health policies, and if so what types of issues and policies should be considered? Philipa Mladovsky, in her article A framework for analysing migrant health policies in Europe (2009), tries to identify and present concepts and technicalities important in migrant health policies by use of a framework, which is then used to analyse the policies implemented in four different countries (England, Italy, the Netherlands, and Sweden). The author claims that the framework serves as a valuable instrument for systematic comparison of national migrant health policies. There has been little investigation on how to systematically translate research knowledge on ethnic inequalities and inequities in health and health care into health policy. The framework is organised into five categories of policy issues each of them with several different policy options:
<table>
<thead>
<tr>
<th>Policy issue</th>
<th>Policy options</th>
</tr>
</thead>
</table>
| Data collection                  | • Register data  
• Household surveys  
• Longitudinal surveys  
• Clinical records  
• Citizenship  
• Country of birth  
• Parents’ country of birth  
• Ethnicity |
| Population groups targeted       | • Migrants in general  
• Foreign students  
• Economic migrants  
• Asylum seekers  
• Irregular migrants  
• Displaced persons  
• Ethnic minorities  
• Vulnerable groups  
• Low socioeconomic groups |
| Health issues targeted           | • Smoking  
• Nutrition  
• Substance abuse  
• Communicable diseases (TB and HIV)  
• Accidents, injuries and violence  
• Mental health  
• Perinatal and maternal mortality  
• CVD |
| Part of the health system targeted| • Access procedures and rights  
• Removal of financial barriers  
• Information about the health system  
• Information and empowerment on health issues and rights  
• Training of providers |
<table>
<thead>
<tr>
<th>Health mediators, communicators or translators</th>
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</thead>
<tbody>
<tr>
<td>Language – and cultural- adapted programs</td>
</tr>
<tr>
<td>Increased multi-sectorial coordination</td>
</tr>
</tbody>
</table>

### Implementation

<table>
<thead>
<tr>
<th>Uniform or targeted implementation of policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeframe</td>
</tr>
<tr>
<td>Monitoring (data / indicators)</td>
</tr>
<tr>
<td>Evaluation</td>
</tr>
<tr>
<td>Incentives / penalties</td>
</tr>
</tbody>
</table>

### Table 2. Framework for analysing migrant health policies. (Mladovsky 2009)

Using such an analytic framework to organise policy information Mladovsky was able to identify some essential topics and alternatives in migrant health policy. When comparing several countries through the framework, according to the author, it can be used as a tool for policymakers in identifying areas in need of policy development (Mladovsky 2009).

In their article *Comparing policies to tackle ethnic inequalities in health: Belgium 1 Scotland 4*, Lorant and Bhopal applied Margaret Whitehead’s framework (‘the logic of health inequalities interventions’, Whitehead 2007) when performing a comparative analysis of the two countries. The framework consists of the four following components: 1) recognition of the problem and its causes, 2) policies to tackle inequalities, 3) interventions and their underlying theories and 4) outcomes. The researchers met with several key stakeholders to discuss policy issues. Official policy documents from the two countries found on official websites were reviewed. A search was also done in two European databases on migration and health, i.e. Mighealthnet and Eugate project. Finally, ethnic inequalities in health were compared through comparison of census data and research literature. The authors emphasise challenges in measurement of ethnicity and the concept of policy as study limitations (Lorant and Bhopal 2010).

Vázquez and her co-authors, in their article on health policies for migrants in England, Italy and Spain (2010), completed what they call a “descriptive comparative study of policies for immigrants” with the use of content analysis, limiting their study to “those health policies that are enshrined in national and regional plans” (Vázques et al. 2010, p.2). According to the authors, no particular framework for analysing the content of migrant health policies has been
developed to date. The authors suggest that such an analysis should allow the detection of important migrant health policy elements that would improve access to services and the health of migrant population (ibid.).

In their study, they carried out comprehensive searches for scientific and grey literature on migrant health policy, but with poor results. Official policy documents were found on the governmental websites of the three countries and “manual health policy analysis was done by classifying, describing, and systematically interpreting the contents of these policies” (Vázquez et al. p 3). The documents were analysed along the following three dimensions: policy objectives, strategies and evaluations. Strategies were again analysed according to three fields of action: addressing specific health issues, access to health services and improvement of quality of care. There were four different researchers participating in the analysis of the data in order to assure scientific quality (ibid.).

### 3.2.3 Content Analysis

Content analysis has been defined as a “systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding” or broader defined as “any technique for making inferences by objectively and systematically identifying specified characteristics of messages” (Stemler 2001, p.1). The method can only be applied to permanent data due to the requirement of replication (ibid.)

Content analysis are methods and techniques of collecting and organising data in a standardised way allowing for analysis of inferences of characteristics and meaning in written and other recorded material (GAO 1996). The technique makes it possible and manageable for researchers to go through large volumes of data in a systematic way and it can help researchers to uncover and describe the focus and attention of individuals, groups, institutions or society. Assumptions that are made can then be validated by other research methods (Stemler 2001). Content analysis can be seen more as a technique of measurement than a technique of description.

Content analysis was already used in the 18th century and by the end of the 19th century techniques of quantitative ‘newspaper-analysis’ were developed in the US. The electronic age and the introduction of statistical computer techniques, paired with the increasing availability of written information online, have opened up a range of possibilities for and interest in content
analysis. Content analysis is applied in many different disciplines across social sciences and humanities and above all in mass media research. (Bergstrøm and Boréus 2005).

**Use of content analysis**

The concept of content analysis is, above all, being used for studies which aim to quantify or measure certain words, concepts, themes, expressions, metaphors, arguments etc. within a text or a set of texts. This is sometimes called ‘quantitative text-analysis’. Content analysis also has a broader application and includes ‘any analysis that aims in a systematic manner to describe content of text’. A distinction between qualitative and quantitative content analysis is often made. Qualitative content analysis is sometimes regarded as a method where nothing is measured or counted. However, most often something is being quantified and additional forms of interpretations are necessary (Bergstrøm and Boréus 2005, p.44).

Normally, it is the content aspect of a text that is being investigated; what does the text say? How different texts “speak” to their audience, as well as the interpersonal aspect, can also be analysed by this method. Content analysis is suitable for examining trends and patterns in large materials. It can be used to organising text in broad categories and then look closer into each of them. More complicated classification can be made, like registering certain types of metaphors or comparison of texts in real time or across a time span. The method has its roots in an empirical science tradition and the topic of investigation is what is manifested in the text, what is expressed explicitly (ibid.).

As a research method, content analysis has become widely used in health studies and is regarded as a flexible technique for the analysis of text data. Its approaches to the analysis can be ‘impressionistic, intuitive, interpretative or more systematic and strictly textual’. The theoretical and principal interest of the researcher and the topic under investigation will influence the type of analysis chosen (Hsieh and Shannon 2005).

Qualitative content analysis is one of several ways to analyse text data and has its focus on the content or contextual meaning of the text. It is more than just counting words; qualitative content analysis seeks to study the language in order to classify large volumes of text into meaningful groups. The aim is “to provide knowledge and understanding of the phenomenon under study” (Hsieh and Shannon 2005, p. 1278).
As pointed out above, content analysis is more than simple word counts. But it is the dependence on coding and categorisation of the data that makes the method especially rich and meaningful. A category is understood as “a group of words with similar meaning or connotations” and these “categories must be mutually exclusive and exhaustive” (Stemler 2001, p.3)

There are two different ways of coding data; emergent or a priori coding. With emergent coding, categories are established after a process where two persons independently go through the material and suggest some preliminary categories which then are compared and checked with regard to reliability. In a priori coding, the categories are decided prior to the analysis based on some theory or knowledge. Revisions are made if necessary and the categories are strengthened with regard to mutual exclusivity and exhaustiveness (ibid.).

There are different ways of classifying coding units. Often, two different types are used in content analysis, i.e. recording units and sampling units. The recording units are the specific words, metaphors, themes, arguments etc. that are being measured or identified in the material. The sampling units are made up of each unit of text that is being analysed separately and this is where the coding units occur. It can be a whole document, speech or article, a paragraph or a sentence. When having decided upon the recording and sampling units a coding scheme is developed, this gives the details of what and how to record when going through the text. After analysing the whole material, parts of it should undergo a ‘double coding’ to control both the intra-subjectivity and inter-subjectivity of the analysis. This is an important measure in order to secure the replication of the instrument of analysis, and a basis for the ideal of scientific intra-subjectivity and scientific cumulativity (Bergstrøm and Boréus 2005).

### 3.3 Study design

A content analysis of main health policy documents have been carried out in five stages:

1. Documents to be included in the analysis were selected based on inclusion criteria.
2. Each document has been examined by using seven different search words as recording units to identify pages and paragraphs in the documents describing or referring to migrant health issues.
3. Introduction, summary, and the paragraphs and sections describing or referring to migrant health issues in each document were copied into separate word documents to facilitate analysis and coding of the identified texts into sampling units.
4. For all documents, the identified texts were categorised according to seven sampling units and the results were summarised into tables to provide an overview of the results and to prepare for analysis.

5. The results were analysed.

![Study design diagram](image)

**Figure 1: Study design**

### 3.3.1 Materials – selection of documents

**Inclusion criteria**
- The study is limited to national health policy documents issued by either the Ministry of Health and Care Services, in cooperation with other ministries or by the Norwegian Directorate of Health, which is an executive agency and competent authority subordinate to the Norwegian Ministry of Health and Care Services.
• The national health policy documents are enshrined to White papers and strategies and action plans concerning public health challenges as outlined in the Public health report 2010 issued by the National institute of public health (Folkehelseapot 2010)

Ten Reports to the Storting (Parliament) from the last decade (1999-2011) issued by the Ministry of Health and Care Services were included in the study. Eight Reports to the Storting from the same time period were excluded as they were not relevant to the research question.

18 national strategies or action plans from the last decade (1998-2011) were selected as data and 26 strategies or action plans from the same time period were excluded as they were not relevant to the research question.

Reports to the Storting (Parliament) / white papers

Reports to the Storting are drawn up when the Government wishes to present matters to the Storting that do not require a decision. White papers tend to be in the form of a report to the Storting on work carried out in a particular field and an outline of proposed future policy in that area. A Report to the Storting has sometimes been preceded by an Official Norwegian Report (NOU) where the matter in question has been explored and investigated by an appointed committee or working group. These documents, and the subsequent discussion of them in the Storting, often form the basis of a draft resolution or bill at a later stage or for proposed actions and measures in national strategies and action plans (The Norwegian Government 2012).

National strategies and action plans

National strategies and action plans form part of a management model where the overall policy frames have been decided by the Ministry of Health and Care Services based on political decisions. The strategies and action plans are tools in implementing the decided policy. In principle, action plans are more concrete than strategies and often, but not always, come with earmarked funding, while strategies are meant to be carried out within existing frames of financing. An action plan is often limited in time and could be seen as a political instrument for specific actions in a certain field. On the other hand, strategies tend to have a more long term perspective, focusing more on the underlying mechanisms and causes, and are more theoretically based (Econ Pöyry 2009).
The following ten Reports to the Parliament (white papers) from 1999-2011 and 18 National Strategies or Action Plans (1998-2011) were included as data (see table 3).

<table>
<thead>
<tr>
<th>Title</th>
<th>Theme</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. meld. nr. 26 (1999-2000) Om verdier for den norske helsetenensta</td>
<td>On the values for the Norwegian health care services</td>
<td>1999</td>
</tr>
<tr>
<td>St. meld. nr. 28 (1999-2000) Innhold og kvalitet i omsorgstennestene Omsorg 2000</td>
<td>Content and quality in the care services</td>
<td>2000</td>
</tr>
<tr>
<td>St. meld. nr. 16 (2002-2003) Reisefor å utvikle Nore</td>
<td>A broad policy for public health</td>
<td>2003</td>
</tr>
<tr>
<td>St. meld. nr. 25 (2005-2006) Gebyere, muligheter og meninger</td>
<td>The future challenges of the care services</td>
<td>2006</td>
</tr>
<tr>
<td>St. meld. nr. 20 (2006-2007) Nasjonal strategi for å utdanne sosiale helsedepoll</td>
<td>National strategy to reduce social inequalities in health</td>
<td>2007</td>
</tr>
<tr>
<td>St. meld. nr. 47 (2008-2009) Sanhandlingstraffinem</td>
<td>The Coordination Reform</td>
<td>2009</td>
</tr>
</tbody>
</table>

Table 3: Overview of documents included in the study

3.3.2 Data review and analysis

An analysis has been done by systematically classifying, describing and interpreting the contents of the policy documents.

All selected documents are available on the official websites of the Ministry of Health and Care Services and the Norwegian Directorate of Health. All documents can be downloaded in a PDF version or as a word document.

Seven different search words were used to identify pages and paragraphs in the documents describing or referring to migrant health issues. The following words were chosen as search words migrant [innvandrer], multicultural [flerkultur], ethnic/ethnicity [etniske/etnisitet], mi-
nority [minoritet], refugee [flyktning], asylum seeker [asylsøker], migration/migrant [migrasjon/migrant]. These words were chosen based on the researcher’s knowledge of the migrant health field and her view that they would be sufficient for the purpose of identifying text mentioning immigrants. In the cases where there were no results from the search, an additional search was done by the use of words like language [språk], culture [kultur] and foreign [fremmed] to ensure that anything of relevance was not missed.

A table for the result of each search word, stating the page numbers of the identified text have been developed and forms part of the word document that has been created for each report, action plan or strategy (see table 4). In these word documents the introduction and summary of each selected document, together with the identified sections or paragraph related to immigrants were copied in order to get a better overview and to facilitate further analysis and coding into sampling units. In the identified sections or paragraphs that were copied in the word documents each result of the word search was marked by highlighting the words in yellow.

<table>
<thead>
<tr>
<th>Search of pages mentioning immigrants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innvandrer</td>
</tr>
</tbody>
</table>

Table 4: Search words

The findings of the searches for each selected document were reviewed and the introduction and summary of all documents were studied in order to get an overview of the main objective and content in relation to the specific findings.

Sampling units partly adopted from the work of Vázquez et al. (2010) had been developed a priori, however during the material review other sampling units emerged as more adequate and relevant. Consequently, the planned sampling units had to be abandoned. The following categories were used as sampling units for coding of the material:

For reports to the Storting (White papers): General policy objectives, Values / aim, Section on immigrants, Description, Challenges, Suggestions, Measures.
For action plans and strategies: *Overall aim, Section on immigrants, Description, Challenges, Suggestions / proposed actions, Specific measures, Responsible Ministry (or other institution)*.

All the findings in the selected documents were coded according to the sampling units and the results were summarised into two tables (one for the Reports to the Storting and another for the action plans and strategies) to provide an overview of the results and to facilitate presentation and discussion of the results (see appendices I and II).
4 Results

4.1 Reports to the Storting / White papers

4.1.1 Overview

The ten reports included as data are concerned with different topics such as public health, social inequalities, national health plans, health reform, values, pregnancy, birth and maternity care and dental health. These ten reports were chosen with the intent to give an overview of how the Government and the Ministry of health and care services have addressed migrant health issues in development and formulation of national health policies the last decade.

Below follows a brief introduction to each report:

_St.meld.nr.26 (1999-2000) Om verdiar for den norske helsetenesta_
_On the values for the Norwegian health care services_
This report outlines and discusses central values when it comes to planning, development and operation of the future health and care services in a time of several different reforms. The Government wanted to underline the ultimate goal; a health system based on solidarity and as a part of a comprehensive welfare system with equity, equality and respect for human dignity as fundamental values.

_St.meld.nr.28 (1999-2000) Innhald og kvalitiet i omsorgstenestene Omsorg 2000_
_Content and quality in the care services_
This report discusses the values, quality and content of the care services. Adaption of services in order to meet the unique individual needs of the patient, coordinated and integrated services and diversity in service provision are central elements that should characterise the organisation of care services,

_St.meld.nr.16 (2002-2003) Resept for et sunnere Norge_
_A broad policy for public health_
The report has its focus on public health in Norway and the factors that affect health and those which promote health. New trends in the development of the society create new health chal-
The main objective of the report is to see the big picture when it comes to health policies and to contribute to the public health work. The goal is to form a policy that contributes to more life years in good health for the whole population and to reduce health inequalities between gender and different social and ethnic groups.

**St.meld.nr.25 (2005-2006) Mestring, muligheter og mening**

*The future challenges of the care services*

The future challenges of the care services and its users are the main focus of the report. The Government wants to give an overview of the main challenges and to put down short-term and long-term strategies. New user groups require other competencies and ways of delivering services and the ageing population demands a substantial increase in activity and capacity of services. Concrete measures and strategies are formulated in a separate document Care Plan 2015.

**St.meld.nr.20 (2006-2007) Nasjonal strategi for å utjevne sosiale helseforskjeller**

*National strategy to reduce social inequalities in health*

The report formulates a broad and long term strategy to reduce social inequalities in health and outlines the principles for a comprehensive policy the next ten years through budgets, steering of subordinate bodies and institutions, legislations, regulations, guidelines and inter-departmental coordination and organisation.

**St.meld.nr.35 (2006-2007) Tilgjengelighet, kompetanse og sosial utjevning**

*Dental health and dental health services*

In this report the Government presents a formulation of a comprehensive policy on dental health services based on an analysis and assessment of the current situation and future challenges. The suggested policy is aimed at achieving equitable services, reducing inequalities and targeting health promotion activities.

**Nasjonal helseplan (2007-2010)**

*National Health Plan (2007-2010)*

In this report the Government presents the current status for the health services and suggests political approaches for improvement. Prevention and user involvement are emphasised and the report has focus on future challenges as the ageing of the population, shifting disease pat-
terns and advances in medical technology and treatment. The plan aims at reducing inequalities, promoting health and preventing illness.

*St.medl.nr.12 (2008-2009) En gledelig begivehent*

*On pregnancy, birth and maternity care*

This report presents a proposal for future organisation and structure of pregnancy, birth and maternity care. Through better organisation and utilisation of resources the goal is to achieve a more coherent and consistent care through pregnancy, birth and maternity and to contribute in reducing social inequalities in health. Vulnerable groups including women with immigrant background are to be prioritised.

*St.meld.nr.47 (2008-2009) Samhandlingsreformen*

*The Coordination Reform*

In this document the Government presents a new health reform. It is the present and the future challenges of health and care which are emphasised and the main challenges relate both to the patient perspective and the economic perspective and sustainability of services. Better coordination and early intervention, prevention and health promotion are the key elements of the forthcoming development of the health services.


*National Health and Care Services Plan (2011-2015)*

This report outlines the political course for health and care services and public health for the coming four years. The Governments starting point is that promoting health, preventing illness and providing necessary health care to the entire population is a public responsibility.

### 4.1.2 Findings

All reports describe or refer to migrant health issues and all of the reports have a specific section or paragraph related to immigrants. The table below (table 5) gives an overview of the number of pages where the different search words appear in each document and the total number of pages where one or more of the search words appear in each document. As one can see from the table it is the report on public health and the report on social inequalities that have the highest number of pages where one or more of the search words are found. However
because of the different nature, topics, structures and size of the reports it does not give any significant information comparing the numbers between the different reports.

### Table 5: Overview of identified pages in documents.

<table>
<thead>
<tr>
<th>Report to the Storting (white papers)</th>
<th>Theme</th>
<th>Total pages</th>
<th>Innvandrer</th>
<th>Multiculture</th>
<th>Etnisk / ethnicity</th>
<th>Minority</th>
<th>Flyktning</th>
<th>Asylsøker</th>
<th>Migrasjon/migrant</th>
</tr>
</thead>
<tbody>
<tr>
<td>St.meld.nr. 26 (1999-2000)</td>
<td>On the values for the Norwegian health care services</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St.meld.nr. 28 (1999-2000)</td>
<td>Content and quality in the care services</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>St.meld.nr. 15 (2002-2003)</td>
<td>A broad policy for public health</td>
<td>35</td>
<td>28</td>
<td>6</td>
<td>13</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St.meld.nr. 25 (2005-2006)</td>
<td>The future challenges of the care services</td>
<td>12</td>
<td>6</td>
<td>1</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>St.meld.nr. 20 (2006-2007)</td>
<td>National strategy to reduce social inequalities in health</td>
<td>30</td>
<td>21</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>St.meld.nr. 35 (2006-2007)</td>
<td>On dental health</td>
<td>16</td>
<td>4</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>St.meld.nr. 12 (2008-2009)</td>
<td>On pregnancy, birth and maternity care</td>
<td>11</td>
<td>8</td>
<td>1</td>
<td>11</td>
<td>12</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>St.meld.nr. 47 (2008-2009)</td>
<td>The Coordination Reform</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Meld St. Id (2010-2011)</td>
<td>National health and care services plan (2011-2015)</td>
<td>17</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

An overview of the detailed findings can be found in a table in appendix I. However the main findings are summarised below.

### Values and aims

The overall goal for the Norwegian health care services is equity; that provision of services should be equitable regardless of gender, residence (geographic location), ethnic and social background or financial ability.

*Helsetenesta har i tida etter den andre verdskrigens utbrytning blitt bygd ut slik at det norske velferdssystemet skal gje likeverdige tenestetilbod over hele landet, uavhengig av kjønn, bustad, etnisk og sosial bakgrunn og økonomisk evne.*

St.meld.nr.26 (1999-2000) Om verdiar for den norske helsetenesta

This aim is repeated in all following reports in the data material in this study, in some reports more accentuated than in others. Equity is together with notions as equality, solidarity, respect, dignity and integrity highlighted as central elements in provision of health care services. It is underlined that the health services should be of good quality and accessible to all and that health care service delivery is a public responsibility. User participation and individual adaption of services to the unique needs of each patient are other objectives that are emphasised. In the public health report (St.meld.nr.16) and onwards reduction of social inequalities in health is stated as one of the main goal of Norwegian health policy. An example is the
box below from the report on dental health stating that reduction of social inequality in dental health is the overall goal.

Det overordnede målet er utjevning av sosial ulikhet i tannhelse. Det vil si å hjelpe dem som trenger det mest.

St.meld.nr.35 (2006-2007) Tilgjengelighet, kompetanse og sosial utjevning

Sections on immigrants

All ten reports had specific sections or paragraphs related to immigrants. Ranging from a ¼ of a page to 1 ½ page, most of them around ½ of a page. The headings that are used are focusing on the multicultural perspective, society or nation, immigrants, competency challenges – language and culture, or more specific elderly immigrants, dental health among children and adolescents with immigrant background and pregnancy care to women with immigrant background. Most of the descriptions, challenges, suggestions and measures that I will elaborate on below are found in these specific sections, while some also appear other places in the reports that have been investigated.

Description

Most of the text identified by the search words is of descriptive and general nature, describing in brief the immigrant population (with a focus on ‘non-western immigrants’) and the demographic development, living conditions, several health challenges as lifestyle diseases and risk factors, mental health problems, reproductive health, infectious diseases and dental health. The increased disease burden and health inequalities between immigrant groups and compared with ethnic Norwegian are also referred to. Different cultural perceptions of health and illness, poor Norwegian skills and lack of knowledge and understanding of the health system are emphasised. Some of the reports point out the fact that both primary health and care services and hospitals have a diverse workforce with employees with background from many different countries. There are in one report facts on organisation of interpreter services; organisation and legislation and in another on asylum seekers rights to dental care.
Challenges

Health personnel’s lack of knowledge on other cultures (‘multicultural understanding’) and different cultural perceptions of culture and illness among patients with immigrant background can together with language and communication problems increase the risk of misunderstanding and conflict. This could lead to reduces quality and effect of health care. It can be difficult to reach out and provide equitable services to elderly immigrants which can result in underuse of services. Health literacy and knowledge about the health services can be poor and patients’ expectations can sometimes be too high and sometimes too low.

Living conditions and the burden of health challenges among immigrant groups lead to inequalities in health. There are research gaps when it comes to ethnic minorities and health. There is a lack of data on health care use and outcome and little knowledge on adult immigrants’ dental health. Women with immigrant background have a different risk profile during pregnancy and need a closer follow-up. Few immigrant women attend child birth preparation courses and there is lack of time at health clinics to attend these women. Accessibility to interpreter services can be challenging.

There are some overlap between the two categories description and challenges and it has in some cases been a bit difficult to distinguish between the two sampling units. What should be coded as description and what should be coded as challenges is not always straightforward. These two categories are not totally mutual exclusive. In cases of doubt it is the wording of the sentences that has determined if the researcher experiences that an issue is communicated more as a fact or accentuated as a challenge.

Suggestions and proposed actions

When reading the identified text from the different reports a sampling unit which the researcher has chosen to call ‘suggestions and proposed actions’ emerged as a necessary and relevant category for coding the material. Most answers to the challenges that are described come in a form of normative and very general descriptions and suggestions of what should be done or how health services ought to be, while some others are proposing more concrete actions. Two example of this are shown in the boxes below. The first one is an example of a normative ‘suggestion’ stating that increased safety and well-being for patients with minority background is necessary for achieving equality and that this often will imply individual adap-
tion of services. It also says that the responsibility for being responsive to cultural differences lies with the health personnel and the health services.

The other example has the form of a proposal of a concrete action stating that increased resources for informing women with gestational diabetes will be a very important preventive measure against development of diabetes and development of secondary complications as cardiovascular and renal diseases. But it is still categorised as a suggestion or proposed action and not a measure because it is not stated as an explicit will to action or measure and it does not say anything further on who will be responsible and how it should be implemented.

Individual adaption of health services, improved information and communication, targeting of public health and health promotion activities and low threshold and outreach services are mentioned in several reports as important actions to meet the health challenges in immigrant groups. There is a need for highlighting the specific health problems in the immigrant population and increase awareness among service providers.

Better health surveillance and better data and investigation of socioeconomic factors and health among immigrants in Norway are necessary and measures to strengthen research, research programmes and strategic prioritisation, should be implemented. Health information needs should be assessed to enhance health literacy and common features of health care needs should be identified in order to improve communication and participation and make services more available. Better interpreter services and adapted multilingual information resources are needed,
Increased ‘multicultural’ understanding, better knowledge of languages and cultures and knowledge on migration and health among health personnel are topics that are repeated in several of the reports. Training and guidance of health workers on these issues are important in order to secure that language and cultural barriers do not affect quality of care. Some reports underline language skills and cultural competency among health personnel with immigrant background and that this should be emphasised as a resource and qualification.

There is a need for comprehensive approaches on several levels, documented knowledge, anchored leadership and systematic work over time to meet the challenges.

**Measures**

Only explicitly stated measures have been defined into this category. Examples are statements under the heading “Tiltak” (measures), statements as “The Government wants to” or proposed actions related to available earmarked funding or specified actors, time and actions. But even though defined in this way several of the measures are of a rather diffuse nature and which actions that should follow are difficult to see. In the box below is an example from the National Health Plan (2007-2010) stating that ‘the Ministry will during the period of this plan have an increasing attention aimed at measures that will contribute to ensure equitable services and to attend to the user perspective of ethnic minorities’.

Departementet vil i planperioden ha en økende oppmerksomhet rettet mot tiltak som skal bidra til å sikre likeverdige helsetjenester og ivaretakelse av brukerperspektivet overfor etniske minoriteter.

Nasjonal helseplan (2007-2010)

All reports expect from the report on values for the Norwegian health care services contain some kind of measures. However there is a lack of concordance between the situation analysis and description of the challenges in the reports and the proposed measures. Both the public health report and the report on social inequalities in health are quite detailed in describing health status and disease burden and suggest several actions, but most of them are not reflected in the explicitly stated measures.
4.1.3 Summary of findings

• All selected report explicitly state equity as an overall value for the Norwegian health care services

• Several reports underline reduction of social inequalities as a main goal and that vulnerable groups should be prioritised

• All ten report had specific sections or paragraphs on immigrants

• Most of the identified text is descriptive, describing the immigrant population, living conditions, health status, cultural perceptions and language and communication barriers

• Several of the same challenges are identified in many of the reports
  o Health personnel’s lack of knowledge and skills of ‘multicultural’ understanding
  o Different cultural perceptions of health and illness among immigrants
  o Language and communication barriers
  o Hard to reach and underuse of services
  o Health literacy and knowledge about health services
  o Interpreter services and accessibility
  o Quality and effect of healthcare
  o Disease burden and inequalities in health
  o Research gaps in migrant health
  o Lack of data on health care use and outcome

• Suggestion and proposed actions are formulated in a general and normative manner
  o Individual adaption of services
  o Improved information and communication
  o Targeting of public health and health promotion activities
  o Low threshold and outreach services
  o Highlighting the specific health problems in the immigrant population
  o Increase awareness among service providers
  o Better health surveillance and better data
  o Investigation of socioeconomic factors and health among immigrants
  o Research programmes and strategic prioritisation
- Assessment of health information and health care needs and enhancement of health literacy
- Better interpreter services and adapted multilingual information resources
- Increase knowledge among health personnel
- Health personnel with immigrant background as a resource
- Comprehensive approaches on several levels
- Systematic work over time
- Leadership anchored

- Lack of concordance between situation analysis and stated measures

4.2 Action plans and strategies

4.2.1 Findings

18 action plans and national strategies in the public health domain issued by the Ministry of health and care services or the Norwegian Directorate of Health were included in the analysis. The results from using the search words showed that five of the plans did not mention immigrants; there were no results for the search words. Another five plans barely mention immigrants while eight of the plans have, if not a comprehensive, at least a broader approach to immigrants and their specific challenges. An overview of the different plans and which plan fell into one of the three categories can be found in table 6 below.

The action plans and strategies are of different nature both when it comes to kind of public health issue and scope of the issue, and type and size of document. One example is the action plan on mental health which is a plan aimed at improving mental health services for all people with mental health problems in Norway compared to the action plan on chronic kidney disease (CKD) which is limited to a specific condition which concerns a much smaller group of patients. The mental health plan is specific on measures while in the plan on CKD there is no concrete measures concerning immigrants, only normative formulations on what ought to be done.
### Table 6: Action plans and national strategies.

An overview of the detailed findings of the 13 documents describing or referring to immigrants can be found in table in appendix II. However the main findings are summarised below.

#### Overall aim

Despite the different nature and scope of the action plans and strategies there is a common overall aim which is to prevent illness, promote health and improve quality of health services.

#### Section on immigrants

Eight of the 13 documents had specific sections or paragraphs on immigrants. Especially the plans on mental health, nutrition, physical activity and prevention of unwanted pregnancy and abortion and the strategy on HIV give a quite good overview of the immigrant population’s challenges related to the specific topic.

<table>
<thead>
<tr>
<th>National strategies and action plans</th>
<th>'Broader approach'</th>
<th>&quot;Barely mentioned&quot;</th>
<th>&quot;Not mentioned&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handlingsplan for fysisk aktivitet 2005-2009</td>
<td>Action plan on physical activity</td>
<td>National strategy on smoking prevention</td>
<td>2006</td>
</tr>
<tr>
<td>Handlingsplan for bedre kosthold bedre kosthold i befolkningen (2007-2011)</td>
<td>Action plan on nutrition</td>
<td>Dementia plan</td>
<td>2007</td>
</tr>
<tr>
<td>Opprøpringsplanen for rusfeltet</td>
<td>Action plan on alcohol and drugs</td>
<td>National strategy on habilitation and rehabilitation</td>
<td>2008</td>
</tr>
<tr>
<td>Nasjonal strategi for barn og ungens miljø og helse 2007-2016</td>
<td>National strategy on children and adolescents’ environment and health</td>
<td>National strategy on prevention of accidents</td>
<td>2009</td>
</tr>
<tr>
<td>Forebygging av uønsket svangerskap og abort 2010-2015 – strategier for bedre seksuell helse</td>
<td>Action plan on prevention of unwanted pregnancy and abortion</td>
<td>2010</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for diabetesområdet 2006-2010</td>
<td>National strategy on diabetes</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>Demensplan 2007</td>
<td>Dementia plan</td>
<td>2007</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for habilitation og rehabilitering</td>
<td>National strategy on habilitation and rehabilitation</td>
<td>2008</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for forebygging av ulykker som medfører personskade 2009-2014</td>
<td>National strategy on prevention of accidents</td>
<td>2009</td>
<td></td>
</tr>
<tr>
<td>Nasjonal beredskapsplan for pandemisk influensa</td>
<td>Preparedness plan on pandemic flu</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for KOLs-området 2006-2011</td>
<td>National strategy on COPD</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for kreftområdet 2006-2009</td>
<td>National strategy on cancer</td>
<td>2006</td>
<td></td>
</tr>
<tr>
<td>Nasjonal Strategiplan for arbeid og psykisk helse</td>
<td>National strategy on work and mental health</td>
<td>2007</td>
<td></td>
</tr>
<tr>
<td>Nasjonal strategi for forebygging og behandling av astma- og allergisymdrommer 2008-2012</td>
<td>National strategy on asthma and allergy</td>
<td>2008</td>
<td></td>
</tr>
</tbody>
</table>
Description

The eight reports that have a ‘broader approach’ to immigrants and their specific challenges have some description of health status; prevalence, rates or shares related to the specific topic, and of living conditions. Whereas the strategy on diabetes barely mentions the specific challenges of certain immigrant groups and do not refer to any numbers concerning prevalence.

Challenges

Immigrants’ mental health challenges are clearly described in a comprehensive manner. In the other plans and strategies with a ‘broader approach’ some of the challenges of immigrants related to the topic in question are described and also several more general and common issues like greater risk and vulnerability, communication and language, cultural differences and misunderstandings, hard to reach and accessibility to services, knowledge and health literacy and need for adaption are pronounced.

Suggestions and proposed actions

Some of the suggestion and proposed actions in the different plan and strategies are of a general nature like adaption and targeting of strategies, adaption of information and communication, outreach and low threshold services, dialogue with immigrant organisations and need for mapping and research to improve knowledge.

The suggestions in the action plan on chronic kidney disease (CKD) are formulated more as description of what is needed and not followed up by any proposed actions or concrete measures specific to patients with immigrant background despite the higher prevalence and the challenges that are described. Also the suggestions and proposed actions concerning prevention of unwanted pregnancy and abortion are very vaguely formulated and which is also reflected when it comes to the stated concrete measures.

Other suggestions and proposed actions are more concrete and specific to the particular topic in question. This applies for example to some of the proposed actions of the HIV strategy and the action plan on alcohol and drugs.
Specific measures

Nine out of the 13 plans or strategies which are referring to immigrants have some stated specific measures directed particularly at immigrants. Six of these are action plans and three are strategies. However there is a great variation in the “specificity” of the formulated measures, which institution is responsible and how they answer to the challenges that have been described and to the suggestions and proposed actions.

One example is the concrete measures related to immigrants in the strategy on prevention of unwanted pregnancy and abortions are rather vague. Therefore it is difficult to ascertain the actions that should follow. In the box below is an example of stated measure (tiltak) which translated would be ‘to stimulate voluntary organisations and other central actors in work concerning sexual health in the communications arenas of the target groups – particularly actors in the arenas of sexual vulnerable minority groups’.

The ‘relevant partners’ for the above measure are also not very precisely described. Ethnic minority groups are, in this action plan highlighted as one of the main target groups.

Despite the known challenges of a high prevalence of diabetes in many immigrant groups the strategy on diabetes specifies just one measure related directly to the immigrant population which is screening pregnant South-East Indian or North African women for diabetes.

On the other hand in the action plan on nutrition there is accordance between the specific measures and most of the challenges, suggestions and proposed actions. The stated measures are clear and straightforward.

Responsible ministry (or other)

Eight of the 13 plans or strategies have stated which ministry or other institutions are responsible for the different measures identified.
4.2.2 Summary of findings

- Five of the 18 selected plans or strategies do not mention immigrants as a group
- Five plans or strategies ‘barely’ mention immigrants
- Eight of the plans or strategies have a broader approach to immigrants and their specific challenges
- Eight of the 13 plans or strategies which do mention immigrants have a specific section or paragraph on immigrants
- Description of health status; prevalence, rates or shares and of challenges can be found in the eight reports that have a “broader approach”
- The strategy on diabetes barely mentions the challenges of certain immigrant groups
- Six action plans and three strategies have some stated measures referring particularly to immigrants
- There is great variance in formulation of suggestions and proposed actions and specific measures. Ranging from description of needs and vaguely and general formulated measures to proposed actions and measures which are clear and straightforward
- There is to a great extent a lack of concordance between stated concrete measures and the described challenges and the formulated suggestions and proposed actions
5 Discussion

The documents which have been analysed communicate equity as the overall value of the Norwegian health care system, reduction of social inequalities as a main goal and that vulnerable groups should be prioritised.

The ten white papers have sections on immigrants as a specific group describing the immigrant population, health inequalities and challenges of health care provision. Suggestions and proposed actions are comprehensive, but formulated in a general and normative manner. There are few explicitly stated measures and they are not in concordance with the situation analysis.

Action plans and strategies are tools for implementing decided policy. Five of the documents did not mention immigrants as a group while five ‘barely’ mentioned immigrants among these documents on important health challenges as diabetes, prevention of accidents and use of tobacco. Eight action plans or strategies on essential areas like mental health, nutrition, physical activity, drugs and alcohol use, HIV and sexual health had a ‘broader’ approach to immigrants and their specific challenges. However the documents vary a lot when it comes to specification of measures, most of them vaguely and generally formulated making it difficult to see which concrete actions should follow.

There is no doubt that a lot of the public health challenges of immigrants are known and recognised, but whether actions are being taken is more uncertain. The results show that there is a huge gap between the described challenges, proposed actions and the explicitly stated measures.

5.1 Methodology

5.1.1 Study limitations

The main limitations of the study are as follows:

- Weak theoretical foundation for content analysis as a research method
- Few studies found where content analysis of health policy documents have been used as a method
• The large amount of documents has impeded an in depth investigation of each document
• Due to the scope of the study several documents that could be relevant have been omitted
• Inter-rater reliability has not been checked
• A language challenge analysing Norwegian documents and writing the thesis in English
• The study design and the amount of material put limits to what is being analysed
• Governmental health policy documents as the only source of data provide a limited approach to policy analysis
• The scope of this thesis inhibit assessment of validity of the analysis through triangulation with other qualitative methods

The applied method will now be discussed in more detail.

5.1.2 Content analysis

Because of its systematic nature, content analysis requires sufficient human resources and can be very time consuming. Content analysis is by nature reductive, too often consisting only of word counts (GAO 1996). The important thing is not always the number of times something is said, but how it is said or not said. The unspoken or unwritten can in some instances also be as important and interesting for understanding a phenomenon. The researcher’s choices when coding the data might be disputable and can highly influence the findings and conclusions. The coding units tend to direct the researcher’s attention in a way that makes it difficult to be open to the material and ‘let the text speak’ and not only the unspoken or unwritten, but also manifest content is in danger of getting invisible (Bergstrøm and Boréus 2005).

There is a lack of theoretical foundation for this research method and conclusions of relationships and impacts are too freely assumed, often disregarding the context in which the text has been produced (ibid.).
5.1.3 Reliability and validity

Some claim that content analysis puts reliability before validity, but an assessment of validity can only be done in each study of how the inferences made address and answer the research question. This is the overarching problem of content analysis research; do the conclusions that are made follow from the data? (Bergstrøm and Boréus 2005).

According to Weber (1990) in order “to make valid inferences from the text, it is important that the classification procedure be reliable in the sense of being consistent: Different people should code the same text in the same way” (Stemler 2001, p.5). The reliability of content analysis refers to the manner in which coders are able to consistently recode data over a period of time. There are two terms, which relate to reliability; stability and reproducibility. Stability or intra-rater reliability refers to cases where the same coder will get the same results repeating the process of coding. Reproducibility or inter-rater reliability means that different people will code the material in the same way. One way to measure reliability is to calculate the percentage of consistency between coders (Stemler 2001).

In content analysis, one is often seeking simple ways of evaluating large amounts of materials with high reliability. This implies easy and uncomplicated coding categories which makes it difficult to draw sound inferences and conclusions. The choice of words or concepts as categories must carefully be evaluated with regard to their ambiguity and different use and meaning, especially when comparing material over a time span. To assess the validity of content analysis, triangulation with other qualitative methods should be applied (Stemler 2001).

5.1.4 Methodological challenges

Introduction

The objective of this study is to analyse if the evidence-based knowledge on the public health challenges of immigrants in Norway has translated into concrete actions in the national health policies, strategies and plans. The method chosen to do so has been reviewing governmental health policy documents by the means of a content analysis.

According to Bergstrøm and Boréus (2005) there is lacking a theoretical foundation for content analysis as a research method. This has also been the experience of the author. It has been
difficult to find theoretical guidance on the use of content analysis for reviewing policy documents. In addition it has not been easy to find specific studies where this method has been applied in reviewing policy documents and in particular health policy documents. The few studies or articles of relevance that was found are unfortunately not very explicit on how the analyses of policy documents have been carried out (Dahl 2002, Fosse 2011, Lorant and Bhopal 2010). Vázquez et al. (2010) has been an exception and has provided some direction for developing the design of this study.

Political documents as government white papers and action plans meet the criteria of authenticity and credibility as they express the formulated government policies. However used as the only source of data they provide a limited approach to policy analysis, and often stating policy intentions, more than policy actions (Fosse 2011). Yet the scope of this thesis restricts a broader approach to the study objective. As a starting point for analysing migrant health policy in Norway and if the evidence on the health challenges has translated into policy, governmental health policy document is an appropriate place to begin.

**Selection of documents**

Only policy documents issued by either the Ministry of Health and Care Services, in cooperation with other ministries or by the Norwegian Directorate of Health were selected. The policy documents are enshrined to White papers and strategies and action plans concerning public health challenges.

The main intent has been to give an overview of national health policy documents of relevance to public health and how these documents relate to the challenges of immigrants. Therefore quite a number of documents were chosen to map the content in these white papers, action plans and strategies in order to be able to say something on a general level and not specific to one particular public health challenge.

Documents issued by other ministries on policies with regard to migrants, integration and inclusion, but not related directly to public health issues have not been included. Some of these documents have sections and paragraphs on health issues and could maybe have given additional information on policymaking in the area under investigation.

The amount of documents included in the study has impeded a more in depth investigation of each document. Having selected fewer and only the most central documents might have given
other information. On the other hand documents like the national health budget, task documents, letters of allocation, circulars, evaluations of plans and strategies and supervisions would probably provide valuable information on how policies are being implemented and carried out in service delivery, but is beyond the scope of this thesis.

Even though the selected documents are confined to three types; white papers, action plans and strategies, they are many in numbers, concerned with diverse topics and written and structured in different ways. This has given some challenges in managing, comparing and summarising findings.

**Review of documents and preparation for analysis**

Search words were used as recording units to identify pages and paragraphs in the documents describing or referring to migrant health issues. The seven search words used are comprehensive enough for the purpose of identifying text which explicitly refers to immigrants and migrant health issues. All selected documents are available electronically, and each search was repeated once in order to validate the results and the reliability of the review of the documents.

The introduction and summary of each selected document, together with the identified sections or paragraph were studied for further analysis of the text. Sampling units were developed and the identified materials were coded into the different units. There were some challenges in developing the sampling units. The author had first decided to use a modified version of the sampling units used by Vázquez et al. (2010), but studying the identified text other categories emerged as more relevant. The author spent time on coding the material and since some of the sampling units were not mutually exclusive some doubt arose on how to categorise parts of the material. The results of the coding has been gone through during analysis, but has not been repeated in a systematic ‘blinded’ manner to test intra-rater reliability. However in the opinion of the author this has not influenced the results in any significant way.

Because of the scope of a master thesis neither in developing the sampling units nor in coding the material it has been possible to check inter-rater reliability.
Analysis

The study design and the amount of material put limits to what is being analysed. The use of the specific search words might lead to other relevant parts in the documents being missed. General policy measures and specific measures aimed at ‘vulnerable groups’ or ‘reduction of inequalities’ probably would come to the benefit of many immigrants too. On the other hand immigrants have some specific challenges unlike other patient groups and it is therefore in this study important to look particularly on how these challenges are addressed.

The large amounts of material and the scale of this study do not open up for more profound analysis of meaning and context. The manifest text and use of wording and concepts, the unspoken and unwritten and in which context the documents have been produced would probably add explanatory value to this study.

Language

For the author language has been a challenge. English is not her mother tongue and the data material is all in Norwegian. When referring to different parts of the documents it has been a deliberate choice to translate almost directly word by word. This has been done to try to communicate the text as it is; often very vague, imprecise and inconsistent formulations. The different concepts that are used like multicultural understanding and ethnic minorities or immigrants have also been translated as is, in order not to manipulate the text. Therefore the use of concepts is not consistent and in such direct translations of formulations nuances can be lost.

Positionality

According to Walt et al., in the article ‘Doing health policy analysis’, it is important to the development and quality of health policy analysis that researchers reflect on and are explicit about their own positionality and how this impacts on the research agenda and knowledge generation. How the researcher is ‘situated’ in the field of investigation will influence the research agenda (Walt et al. 2008).

The author of this thesis must be said to be a ‘participant observer’ and an ‘insider’. She has for the last five years been actively engaged in the migrant health field, both through work and through representing a non-governmental institution. This NGO has been active in send-
ing letters and consultation notes and the author has been a representative in regular meetings with the Ministry of Health and Care Services the last four years.

Her choice of topic and her motivation for writing this thesis is, above all to influence policymaking and too see more action and less inaction in development of migrant health policies in Norway.

5.2 Results

The main picture from the analysis can be described in the following points:

- The existence of a higher burden and prevalence of several diseases and conditions in the immigrant population is known and acknowledged as a challenge.
- The need for highlighting the specific health problems of immigrants, for more knowledge and research, better data on health status and health care needs, use and outcome is pronounced.
- Improve quality of health care through adaption and targeting of health services and health promotion activities and increased knowledge and understanding among health personnel is stated as important in provision of equitable health services.
- However there is no evidence of a comprehensive approach to research and knowledge development, improvement of quality of health care and reduction of inequalities in health.
- There is a missing link between the situation analysis and explicitly stated measures and how to improve the health of immigrants.

5.2.1 Diffusion of evidence

The remaining question to be answered is if and how the evidence on immigrants’ public health challenges has translated into national health policies?

Margaret Whitehead’s framework (1998) of the action spectrum on inequalities of health will be applied in trying to answer this question.

Whitehead developed this framework in relationship to analysis of policy development in Europe on social inequalities in health. Her evaluation of if and how research evidence and
general awareness of the issue had ‘diffused’ into policies was based on some indicators reflecting official commitment to action. The indicators used by Whitehead are “establishment of national research programs or commissions of inquiry; official modification of national information systems to facilitate measurement and monitoring of the issue; the publication of government reports; and parliamentary statements or bills that establish the topic as a priority and signal a commitment to policy development” (Whitehead 1998, p.470).

Whiteheads’ action spectrum framework is based on the ‘stages heuristic’ model of the public policy process and can add value and insight in analysing and understanding policy development (Exworthy 2008). The framework identifies seven stages towards action (Figure 2).

Figure 2: Action spectrum on inequalities in health (Whitehead, 1998).

**Measurement**

Already in a report to the Parliament in 1975 there was a focus on the need for systematic collection of data concerning immigrants’ health (Austveg 2005). Several of the documents included in this study underline the need for surveillance and data.

Available statistics on health in the immigrant population in Norway is scarce compared to statistics on employment, income and education. Ethnicity or country of origin is not regis-
tered in patient records. The Central Population Register contains relevant demographic information, like own and parental place of birth which identifies the immigrant population. Norway has several health registries of high quality where linkage to the Central Population Register could provide valuable information on immigrants’ health. However such linkage is for privacy reasons cumbersome requiring permissions and resources and has not been prioritised (Spilker et al. 2009).

Several epidemiological studies and other research in the field of immigrants’ health have been carried out in the last decades and the majority of them revealing a higher burden of important public health problems. Abebe found in his systematic review of research related to public health challenges of immigrant in Norway 224 references, mainly published peer-reviewed articles. They were grouped into five main categories; 32 articles on lifestyle- and diet-related disorders, 41 on mental health, 54 on infectious diseases, 21 on reproductive health and 74 on other public health problems. No published articles on cancer were found and there were only a few studies investigating use of and access to health care (Abebe 2010).

As part of the Coordination Reform the new Public Health Act entered into force on 1st of January 2012. The act has provisions on the state’s, the counties’ and the municipalities’ responsibility for monitoring public health and health determinants. The National Public Health Institute has a special responsibility for providing the counties and municipalities with relevant data based on statistics from the central health registries. It is not described what should be the content of such monitoring, but The Ministry of Health and Care Services may prescribe, by regulations, the requirements for the overview of public health (Lovdata 2012).

The National Council on Quality and Prioritisation in the Health and Care Services made the decision in their meeting in June 2011 that it is necessary that data on public health and health determinants include immigrant groups and that such data must be aggregated on regular basis in order to follow development over time. Data should be available from the 1st of January 2012 (Nasjonalt råd for kvalitet og prioritering i helse- og omsorgstjenesten 2012).

There exists no system today which automatically monitors public health and health determinants among immigrants; however action has been taken by the National Council on Quality and Prioritisation in the Health and Care Services to alter this and by facilitating linkage of census data to the already existing health registries a significant improvement of knowledge and information on immigrants’ public health can take place.
Recognition and awareness raising

Recognition of the seriousness of public health challenges among immigrants in Norway can be tracked in documents included in the study. Other reports from institutions like the Norwegian Directorate of Health, the Public Health Institute and the Norwegian Medical Association have contributed in raising awareness of the issue (Norwegian Medical Association 2008, Norwegian Directorate of Health 2009, National Public Health Institute 2008 and 2010).

The Norwegian Directorate of Health launched their report ‘Migration and health, Challenges and trends’ in 2009 with the aim of presenting a picture and providing ‘valuable input on the formulation on a health policy’. Throughout the different sections of the report several general recommendations are given, very much in line with the suggestions and proposed actions found in the white papers included in the study.

Concern, denial or indifference?

It is not easy to ascertain whether there is a real concern or if policy making in this field is more characterised if not denial, by indifference. A comprehensive answer to this cannot be given on the basis of the findings in this study and will require other qualitative approaches like studies on other types of documents and elite interviews with key persons within the policy making environment.

However as the described challenges in the analysed documents can be seen as an expression of concern, at the same time the lack of concordance between the descriptions and the stated measures could be interpreted as a kind of indifference. If there is a concern, where is the will to take action? Or do policymakers suffer from some kind of mental block, due to the complexity of the challenges?

Mental block or will to action?

Having analysed the outlined policy pronounced through national health policy documents like white papers and action plans and strategies with regard to immigrants’ public health challenges, in several areas there seem to be a mental block. It appears that in many of the plans and strategies proposed actions and even stated measures are articulated more as ‘ought to do’s’, calls for more research, knowledge and competence building than concrete decisions on what to do.
Even where there apparently is a declared will to take action, like in the action plan on sexual health and the HIV strategy, there seems to be confusion on the way ahead and which concrete actions should be taken. This is particularly interesting and should be of concern as an evaluation of the former national plans in these areas came to the conclusions that immigrant groups should be better prioritised. It is pointed out that grants to prevention activities among immigrants have been low and diminishing. The evaluation recommends increased health promotion activities towards vulnerable immigrant groups and gives concrete advice on organisation and clarification of actors that should be involved (Econ Pöyry 2009). However it is difficult to see how these recommendations have translated into actions in the new action plan on sexual health and the new HIV strategy.

Nevertheless there is also evidence of will to take solid action. One of the concrete measures of the action plan on mental health was allocation of funds for the establishment of competence unit on immigrant’s health and in 2003 NAKMI (Norwegian Centre for Minority Health Research) was set up.

**From isolated initiatives towards more structured developments?**

The last five years there have been several isolated initiatives both within the services, in research and in decision making bodies.

The regional health enterprise of the South-East region assessed through a two year project (2008-2010) the foundation for provision of equitable health services. Akershus University Hospital and Oslo University Hospital have systemised work in this field through dedicated units and personnel. NAKMI organises NONEMI which is a network of 13 ‘migrant friendly’ hospitals. A larger two year project (2010-2012) involving the municipality of Oslo, Akershus University Hospital, Oslo University Hospital, Vestre Viken HF and Lovisenberg Hospital has also been launched.

Comprehensive research initiatives like the SOMAH project, the STORK project and a three year program on dementia and elderly immigrants have been initiated. The Norwegian Directorate of Health have taken a more comprehensive approach by setting up a dedicated department for immigrant health within the institution and prepared an internal strategy for equitable health services which applies to all departments of the directorate.
From being a field characterised by many dedicated and enthusiastic persons driving progress and improvement through smaller studies and project based initiatives there are several signs of more structured developments and a more systematic will to action. However governmental policy formulation towards a comprehensive, systematic and coordinated approach is still lacking. Yet there is one exception and that is the case of female genital mutilation. In this area the health authorities have formulated and implemented a comprehensive and coordinated approach through several action plans (Mighealthnet). The experiences of the efforts in this area could maybe serve as an example for development of broader migrant health policies.

5.2.2 Conditions for a comprehensive coordinated policy

The field of migrant health is complex consisting of many diverse issues in different immigrant groups and involving many different parts of the health care system. The documents in this study and how the challenges are described in many ways show this. However there are several public health challenges among immigrants in Norway that are of great concern and require attention and action.

This study has revealed several weaknesses when it comes to formulation of migrant health policies; challenges have been identified, but proposals for action and concrete measures are general, normative and blurred. This is probably a general characteristic of policy documents and not only specific to the migrant health field, maybe only more pronounced. The consulting company Econ Pöyry do in their evaluation of two national plans on sexual health, criticise these plans for not being concrete on the measures and responsibilities and that several of the measures are formulated as goals. They recommend that such plans should be designed in a way that make them more accessible for those working with the specific issue and that strategies and measures are operationalized and made measurable (Econ Pöyry 2009).

Countries use national health policies, strategies and plans to give direction and coherence to improvement of people’s health and health care provision. However such documents vary a lot from values and vision, policy direction, strategy and strategic planning to detailed operational planning. There is a lack of consistency and consensus on the use of terms such as policy, strategies, plans and programmes and often there is a ‘downstream’ disconnect between the principal national health policy, as formulated in a white paper, and disease-specific or programme-specific strategies and plans (WHO 2010).
The World Health Organization (WHO) outlines in a consultation document elements of good practice for development of comprehensive national health policies, strategies and plans:

- **Sound process**

Policies, strategies and plans will be more robust and the likelihood of effective implementation if all relevant stakeholders are included in the development process. Consensus on the situation analysis and broad consultation on formulation of goals, priority setting and design of the policies, strategies and plans are important elements. Systems for feedback on implementation and corrective measures should be set up.

- **Realism**

Implementation of national health policies, strategies and plans is more likely to happen if they are made by those who will implement them, correspond with capacities, resources and constraints and policy directions are politically and legally anchored to ensure sustainability.

- **A comprehensive, balanced and coherent content**

National health policies, strategies and must articulate vision, values, goals and targets, a sound situation analysis including assessment of health system capacity, resources and performance, a complete strategy for implementation and the leadership and governance arrangements necessary.

- **Linking with medium-term and sub-national plans and linkage with programs**

For national health policy, strategies and plans to be effective they must be linked with regional and local plans and disease-specific programs (ibid.).

In the report from ‘Health of migrants – the way forward’ from the global consultation in Madrid in 2010 among several recommendations the following within policy and legal frameworks are priorities that should be addressed and key actions that should follow:

- **Develop and implement national health policies that incorporate a public health approach to the health of migrants and promote equal access to health services for migrants, regardless their status.**

- **Monitor the implementation of relevant national policies, regulations and legislation responding to the health needs of migrants**
- Develop frameworks and indicators to monitor the success of policy implementation
- Promote and monitor the sufficient availability of resources for adequate policy development (WHO 2010).

Despite sufficient evidence for action on the health challenges, Norway still has a way to go in order to facilitate systematic measurement and monitoring of immigrant’s health. There is recognition and awareness of the challenges, but a real concern has not been reflected in comprehensive policies. There is today a greater will to take action and more structured developments are taking place.

The results from this study clearly demonstrate a need for a more comprehensive and systematic policy approach to the public health challenges of immigrants. The proposed actions must be given a much more concrete content through formulations of specific and operational measures and systems for feedback on implementation and corrective measures should be set up.

5.2.3 Norway in a European perspective

This study show that migrant health issues are included in most health policy documents in Norway. Norway compared to many other European countries has a solid body of evidence on many of the health challenges of immigrants, and many of the problems of accessibility, availability and quality of health care services are acknowledged. Despite recognition and awareness of the challenges related to migrant health, sufficient action has not been taken and evidence on implementation of policies is almost absent.

In Europe there are substantial differences in the approaches taken, both in scope and issues and groups targeted. Norway should look to European countries like England, Scotland, Spain and the Netherlands who have taken a broader approach to the development of migrant health policies. Even though European countries have different immigration and integration history and differs with regard to political and welfare systems, the challenge of migrant health are very much the same and lessons could be learnt from successes and failures in other countries. Still each country will have to adapt migrant health policies within the existing frames of their health care system.
It can seem from the review of the documents in this study that Norway has tried to ‘mainstream’ migrant health policies into existing national policies, strategies and plans, and it would be particularly interesting to look closer at those countries who have developed specific migrant health strategies and plans and their experiences.

Scotland has worked systematically for the last ten years and has developed both an ‘Ethnicity and Health Policy’ where the following five key issues were formulated:

- Energizing the organisation and leadership
- Demographics, understanding the population under consideration
- Access and service delivery, modifying existing services to diverse needs
- Human resources, equality in employment
- Community development, strengthening communities

In addition has also an ‘Ethnicity and health research strategy’ been developed, setting priorities for research in the field of migrant health (Bhopal 2012).

Spain is another interesting country where several of the regions have developed specific migrant health policies (Nuñez et al. 2009).
6 Conclusions

Norwegian health policy included in the analysis emphasise equity as the overall value of the Norwegian health care system, reduction of social inequalities as a main goal and that vulnerable groups should be prioritised.

Despite a solid body of evidence on immigrants’ health status and the recognition of these challenges in national health policies for the last fifteen years, the attempts to meet and incorporate the health needs of immigrants into the Norwegian health care services are still fragmented and uncoordinated.

This study has shown that there is a huge gap between the situation analysis and proposed actions and explicitly formulated measures. Proposals for action and concrete measures are general, normative and blurred and there is a missing link between how the public health challenges are described and concrete actions to improve the health of immigrants.

Despite sufficient evidence for action on the health challenges, Norway still has a way to go in order to facilitate systematic measurement and monitoring of immigrant’s health. There is recognition and awareness of the challenges, but a real concern has not been translated in comprehensive policies. There is today a greater will to take action and more structured developments are taking place.

The results from this study clearly demonstrate a need to move from awareness and concern to concrete action within more comprehensive and systematic policy approaches to the public health challenges of immigrants. The proposed actions must be given a much more concrete content through formulations of specific and operational measures, and systems for feedback on implementation and corrective measures should be set up.

Norway should look to European countries like England, Scotland, Spain and the Netherlands who have taken a broader approach to the development of migrant health policies, and especially to look closer at those countries that have developed specific migrant health strategies and plans and their experiences of implementation.

Governmental health policy documents as the only source of data provide a limited approach to policy analysis, but as a starting point for analyzing migrant health policies in Norway it is
an appropriate place to begin. Analysis of migrant health policies is a new area for research fi and there is further need for developing the design and methodology.

It is important to evaluate policies that are instrumental in steering Norway’s’ health care sys-
tem and services. There is a need for research, internal audits and external evaluations on the implementation of national health policies, strategies and plans.
7 References:


COUNCIL OF EUROPE (2011) Recommendation CM/Rec (2011)13 of the Committee of Ministers to member states on mobility, migration and access to health care [WWW] Council of Europe. Available from: [https://wcd.coe.int/ViewDoc.jsp?id=1872157](https://wcd.coe.int/ViewDoc.jsp?id=1872157) [accessed 12/05/12]


HSIEH, H-F. and SHANNON, S.E. (2005) Three Approaches to Qualitative Content Analysis *Qualitative Health Research* 15 (9) Sage Publications


KOMMUNAL- OG ARBEIDSDEPARTEMENTET (1997) *St.meld.nr. 17 (1996-97) Om innvandring og det flerkulturelle Norge*


g Accessed [14/05/12]


NATIONAL PUBLIC HEALTH INSTITUTE (2008) KUMAR, B. et al. (eds.) The Oslo Immigrant Health Profile. Oslo: Rapport 2008:7


8 Appendices

Appendix I: Report to the Storting – Overview of findings

Appendix II: Action plans and strategies – Overview of findings
# Reports to the Storting (white papers) - Overview of findings

<table>
<thead>
<tr>
<th>Document</th>
<th>Year</th>
<th>General policy objectives</th>
<th>Values / aim immigrants</th>
<th>Section on immigrants</th>
<th>Description</th>
<th>Challenges</th>
<th>Suggestions / proposed actions</th>
<th>Measures</th>
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<tbody>
<tr>
<td><strong>On the values for the Norwegian health care services</strong> <em>St.meld.nr. 26 (1999-2000)</em> Om verdier for den norske helsetenesta**</td>
<td>1999</td>
<td>Outlines the central values for the future health care services</td>
<td>Solidarity, equality, equitable and accessible, human dignity</td>
<td>A section on the 'multicultural perspective' (p.88)</td>
<td>Different cultural perception of health and illness. Lack of knowledge and understanding of the health system.</td>
<td>Risk of misunderstanding and conflict. Reduced quality and effect of health care. Lack of knowledge in the health services on other cultures</td>
<td>Increase safety and well-being for patients with minority background. Individual adaption of services.</td>
<td>No concrete measures</td>
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<tr>
<td><strong>Content and quality in the care services Care 2000</strong> <em>St. meld.nr. 28 (1999-2000)</em> Innhald og kvalitet i omsorgstene Omsorg 2000**</td>
<td>2000</td>
<td>Discusses the values, quality and content of the care services. Organisation of services, individual adaption, diversity in service provision</td>
<td>Equality, equity, solidarity, respect, dignity, integrity</td>
<td>A section on the 'multicultural society' (p.48)</td>
<td>Demographic facts. Worse living conditions and health among elderly immigrants. Lack of information on rights and services for elderly immigrants. Elderly immigrants are isolated and have poor Norwegian skills</td>
<td>Difficult to reach out and provide good and equitable services to elderly immigrants. Underuse of services.</td>
<td>Out-reach services. Awareness of the problems among service providers.</td>
<td>Recruitment of health care personnel with immigrant background.</td>
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<tr>
<td><strong>Prescription for a healthier Norway (A broad policy for public health)</strong> <em>St.meld.nr 16 (2002-2003)</em>**</td>
<td>2003</td>
<td>Public health in Norway. Formulation of comprehensive policies that contribute to more life years in good health</td>
<td>Reduce inequalities (also ethnic), individual responsibility for own health, society and its</td>
<td>A section on ‘a multicultural Norway’ and a special focus on ‘non-western’ immigrants (p.20). Immigrants also</td>
<td>Facts on demographic development and living conditions. Description of several health issues and the differences</td>
<td>Burden of health challenges, and living condition, less physical activity vitamin D deficiency,</td>
<td>Need for highlighting the specific health problems of the immigrant population. Adaption / targeting of public</td>
<td>Measures concerning women’s health (p.126): Knowledge on treatment, health</td>
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<td>Resept for et sunnere Norge</td>
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<td>for the population and reduced health inequalities</td>
<td>democratic institutions’ role for information and knowledge</td>
<td>mentioned in several other parts on different public health challenges. Special part on immigrant women’s health (p.123-124)</td>
<td>between immigrant groups; lifestyle diseases and risk factors, infectious diseases, mental health, self-assessed health, reproductive health</td>
<td>health activities / services. Health surveillance and need for more data. More resources / assessment of health information needs.</td>
<td>services provision, violence, side effects of drugs in elderly women with a special focus on immigrant women. Evidence-based knowledge and measures in the area of health and living conditions and use of health and social services among immigrant girls and women.</td>
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<td>Training / education in order to formalise / qualify unskilled care workers with immigrant background and others.</td>
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<td>On dental health St.meld nr. 35 (2006-2007) Tilgjengelighet, kompetanse og sosial utjevning</td>
<td>2007</td>
<td>Formulation of a comprehensive policy on dental health and dental health services.</td>
<td>Equality. Equitable services. Quality. Better accessibility for those in most need. Reduce inequalities. Strengthen the public responsibility and role in health and care.</td>
<td>Section on ‘dental health among children and adolescents with immigrant background’ (p.29).</td>
<td>Dental health among children with immigrant background worse compared to ethnic Norwegian children. Refugees and asylum seekers in reception centres have right to dental care.</td>
<td>‘Multicultural understanding’ and language skills are prerequisites for equitable services. A challenge to improve dental services to the children with immigrant background. Little knowledge on adult immigrants’ dental health.</td>
<td>The public system must ensure low threshold and outreach services, training in language and culture combined with development of interpreter services. This will require a broad cooperation and must be initiated by the administrative entity which is responsible for dental health services.</td>
<td>The Government will initiate various measures in this area; prepare adapted information material towards immigrant parents and their children and mapping of dental health in the immigrant population before deciding upon additional measures.</td>
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<td>Document</td>
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<td>National health plan (2007-2010)</td>
<td>2007</td>
<td>To present status of the health care services and to suggest political approaches for improvement and how to meet future challenges.</td>
<td>Equity and reduction of inequalities. Six mainstay: Cohesion and interaction. Democracy and legitimacy. Proximity and security. Stronger patient role. Professionalism and quality. Work and health.</td>
<td>A section on ‘Special competency challenges – language and culture’ (p. 290).</td>
<td>Short facts on the immigrant population. Primary health and care services and hospitals have a diverse workforce with many employees with background from many different countries. The multilingual and multicultural gain more and more importance when it comes to equitable services and the user perspective both as patients and employees.</td>
<td>Increasing immigrant population. Need for language and cultural knowledge. Research gaps concerning ethnic minorities.</td>
<td>To understand each other it is necessary with knowledge of languages, cultural and multicultural understanding. Implement measures to strengthen research; research programmes / strategic prioritisations (Norwegian Research Council). Better inclusion of ethnic minorities as users and employees in development of the health services.</td>
<td>‘The Ministry will during the period of this plan have an increasing attention aimed at measures that will contribute to ensure equitable services and to attend to the user perspective of ethnic minorities’. Implemented and planned measures in the area of services for traumatised refugees and asylum seekers.</td>
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<td><em>The Coordination Reform St.meld.nr. 47 (2008-2009) Samhandlingsreformen</em></td>
<td>2009</td>
<td>Secure a future health service that answers to the challenges in a patient perspective and economic perspective. Better coordination of services, more focus on early intervention, prevention and health promotion.</td>
<td>Equitable services.</td>
<td>A section on ‘Specific challenges concerning the immigrant population’ (p.121-122).</td>
<td>Facts on the immigrant population in Norway. Patient rights act with regard to ethnicity. Health inequalities between immigrant groups and compared with the majority population.</td>
<td>Different understandings of health and illness. Different disease patterns and prevalence. Communication and language.</td>
<td>Identify common features in health care needs, how to make services more accessible and how to improve communication and participation. Need for documented knowledge, systematic work over time, comprehensive approaches on several levels, leadership anchoring.</td>
<td>A spectre of measures is necessary, but a complete review is not done in this report. The Ministry focus on two areas in the future work with the reform; dialogue with stakeholders as a central element in the implementati on of the reform and defining patient pathways in order to get a good understandin g of needs to be able to identify and implement necessary measures on the system level.</td>
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<tr>
<td>National health and care services plan (2011-2015)</td>
<td>2011</td>
<td>Outline the political direction the next four years for health and care services and public health. It is a public responsibility to promote health and prevent illness.</td>
<td>Equitable services. Safety, quality, accessibility and efficiency. Reduce social inequalities</td>
<td>One section on immigrants under ‘Challenges’ (p.27) and another section on immigrants under ‘Equitable health and care services’ (p. 91)</td>
<td>Brief facts on the immigrant population and health inequalities. Many health care personnel with immigrant background.</td>
<td>Mental health in the immigrant population. Different disease patterns. Language and cultural understanding. Health literacy.</td>
<td>Need for more knowledge and more concrete measures to ensure equitable access to health services. Adapted and multilingual information resources on health and health care services. Need for competence related to migration among health personnel. Adapted leisure and sports activities for better inclusion of minority groups. Increase competence in multicultural understanding in the services. Language and cultural competence among health personnel with immigrant background should be emphasised as a resource.</td>
<td>The regional health enterprises are asked to implement measures that secure equitable access to emergency call services for minorities (non-native speakers). Increased attention towards the multicultural workforce as a resource when it comes to language and cultural competence.</td>
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### Action plans and strategies – Overview of findings

#### ‘Broader approach’

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| **Action plan on mental health**  
Opptrappingsplan for psykisk helse (1999-2006)  
(Report to the Storting no.25 (1996-97)) | 1998 | A financially binding scale up plan with concrete measures to strengthen mental health care services. | A section on ‘Immigrants, refugees and asylum seekers with mental disorders (section 4.8.1)’ | This action plan contains only concrete measures, but it is based on Report to the Storting no.25 (1996-97) which has a comprehensive section on 'Immigrants, refugees and asylum seekers’ (section 5.1) | Described in the white paper:  
Higher prevalence of mental health problems.  
Contributing factors: lack of language skills, weak cultural and social integration, loneliness, little education, poor economy, unemployment, racism, discrimination and family conflicts.  
Traumatised refugees and post-traumatic stress.  
Refugee children, adolescents and unaccompanied minors.  
Challenges for the health and social services; cultural differences, understanding and manifestations of mental illness, communication and language problems.  
Use of interpreter in treatment of mental health problems. | Described in the white paper:  
Continue to finance Psycho-social centre for refugees and its regional teams.  
Systematise work in the field of cross-cultural psychiatry in order to make competency available in larger part of the mental health services.  
Enable specific hospital departments / psychiatric units to be responsible.  
Establish a competence unit for somatic and mental health and care among persons with immigrant background.  
Map mental health status in newly arrived refugees. | 1. 1, 5 million NOK to establishment of a psycho-social team for refugees in the Southern region of Norway.  
2. 3 million NOK to the establishment of a competence unit for somatic and mental health and care among persons with immigrant background.  
3. 1, 5 million NOK for strengthening the existing psycho social teams and the psycho social centre during the period of the action plan. | MHCS |
<p>| Document                  | Year | Overall aim                                                                 | Section on immigrants                                                                 | Description                                                                                                                                                                                                 || Challenges                                                                                                                                                                                                 | Suggestions / proposed actions                                                                                                                                                                                                 | Specific measures                                                                                                                                                                                                 | Responsible Ministry (or other) |
|---------------------------|------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| Action plan on physical activity | 2004 | Reduce factors that lead to physical inactivity and increase and strengthen factors that promote physical activity. | A section on ‘Persons with immigrant background’ (p.14) and a section on ‘Inactive with immigrant background’ (p.33) | The immigrant population. Physical activity / inactivity in different groups. Health status. Living conditions. Examples; MoRo project. | Less physical active. Other traditions / culture for physical activity, leisure time. Difficult to reach with information. | Low threshold activities for vulnerable groups. More knowledge on different immigrant groups views on physical activity. Dialogue with immigrant organisations and others working directly with immigrants | 1. Grants to develop activities and social integration in sports clubs aimed at children and adolescent with immigrant background among other groups. 2. Stimulate and make attractive outdoor activities for disabled and immigrants. 3. Development and adaption of low threshold activities aimed at inactive groups. 4. Stimulate and make attractive physical activities for vulnerable groups. | 1. MCMA 2. ME 3. MHCS 4. MHCS |
| Action plan on nutrition  | 2007 | Better public health trough a healthy diet. Improve nutrition in the population as a whole, with a special focus on children, adolescents and elderly. Reduce social inequalities in diet. | Immigrants, especially ‘non-western immigrants’ one of the specific target groups of the action plan (p.16) ‘Nutrition and health challenges among immigrant groups’ (p.106). | Belonging to two cultures impact on nutrition and lifestyle. Higher prevalence of nutrition-related problems like obesity, diabetes type 2, gestational diabetes, vitamin D and iron deficiency. Poor dental health among children with immigrant background. | A challenge to reach out to those groups which lack knowledge on diet and nutrition and which do not actively seek information. Limited knowledge of breast feeding, dietary habits, nutritional status and growth in immigrant children. Language and culture a challenge to effective communication on health and nutrition. | Acknowledge the diversity of society when developing and implementing both population-based and individual-based measures. Public communication and information should be adapted to different groups. Emphasise efforts towards women and children with non-western minority background. Introduce food, cooking and diet as part of introduction | 1. Develop and implement a comprehensive plan for information and communication in the area of nutrition, considering the need for adaption of information to minority groups. 2. Specify the official dietary guidelines and make them available to the entire population, regardless of ethnic background. 3. Offer updated information material on breast feeding, infant and young child nutrition. Material adapted to different immigrant groups and in the mother tongue of the largest non-western | 1. MHCS, MAF, MOFC, MCFA, MER 2. MHCS 3. MHCS 4. MHCS 5. MHCS 6. MHCS 7. MHCS, MAF, MOFC |</p>
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<td>Action plan on alcohol and drugs Opptrappingsplanen for rusfeltet</td>
<td>2007</td>
<td>This scale up plan shows the prioritised areas in this field with emphasis on prevention and a public health approach. Local adaption of services and measures based on social inequalities, gender and ethnicity.</td>
<td>No specific sections on immigrants, but immigrants are mentioned in other sections.</td>
<td>A small number of marginalised youth with immigrant background are involved in sale of drugs, especially cannabis. The causes are complicated and compound.</td>
<td>Disturbing use of khat among certain groups leads to weak social inclusion. Certain groups of children and adolescents with immigrant background seem to have a particular risk of developing problems with substance abuse.</td>
<td>Need for measures across several areas as employment, education and cooperation between public authorities and relevant immigrant organisations to meet the challenge of khat consumption. More knowledge and assessment of measures.</td>
<td>1. Strengthen the knowledge base and implement measures directed at youth with immigrant background involved in selling drugs and measures directed at consumption of khat. 2. Adapted information material on treatment possibilities and rights directed at groups with ethnic minority background will be developed.</td>
<td>1. The Norwegian Directorate of Health 2. The Norwegian Directorate of Health</td>
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| **National HIV strategy**  
*Aksept og mestring – nasjonal hivstrategi (2009-2014)* | 2009 | To reduce transmission of HIV and to secure all HIV infected good quality treatment and follow up regardless of background. The strategy continues and reinforces efforts of earlier action and strategy plans. | A section on ‘Certain immigrant groups’ in the part on ‘Reducing transmission of HIV – particularly among vulnerable groups’ (p.23-24). Immigrants are mentioned in almost all other parts throughout the document. | Prevalence of HIV in certain social groups. Estimate of immigrants with HIV infection living in Norway and origin. Increase of HIV positive immigrants coming to Norway. Gender distribution of HIV infected immigrants, approx.50 % women. Immigrant women a particular vulnerable group. Greater risk of stigma, discrimination, exclusion and isolation among HIV positive immigrants. Greater risk for transmission of HIV in certain immigrant groups due to higher prevalence and lack of knowledge. Barriers to accessing healthcare; language, knowledge about the health care system, unclear residence | concerning children and adolescents. Adapted information; use of translated information and use of interpreter should be regarded concerning persons with immigrant background. Vulnerable groups with comprehensive needs should be regarded in preparation and development of guidelines. | 1. Counteract social exclusion of HIV positive within minority groups. 2. Strengthen dissemination of knowledge and coping strategies among particular vulnerable groups. 3. Support targeted interventions aimed at vulnerable groups: women and men who have sex with men. 4. Implement knowledge based | 1. MCES, MHCS 2. MHCS, MCES 3-5. MHCS 6. MHCS, MCES 7-11. MHCS 12. MHCS, MJPS |
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<td>status, misunderstanding between patient and health personnel. Lack of knowledge about sexual minorities within the immigrant population in Norway, Lack of routines for offering HIV test and information / guidance to refugees, asylum seekers and other immigrants.</td>
<td>and effective interventions to increase the use of condom and femidom. 5. Work towards equitable public services. 6. Encourage religious communities and voluntary organisations to engage in HIV prevention among the immigrant population. 7. Disseminate knowledge on the importance of early testing in vulnerable groups. 8. Implement rapid test for vulnerable groups in cooperation between health services and voluntary organisations. 9. Improve the health services concerning tracing source of infection and guidance after diagnosed HIV infection. 10. Secure good access to testing</td>
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<td>Action plan on prevention of unwanted pregnancy and abortion</td>
<td>2010</td>
<td>Reduction of numbers of abortions. Good reproductive and sexual health. Strengthen adolescents and young adults’ ability to take care of own sexual health. The action plan is a continuation of four former action plans (1992-2009).</td>
<td>Ethnic minority groups are mentioned as one of the main target groups (preface p.3 and p.14-15). Particularly young unaccompanied refugees and asylum seekers and young girls in danger of forced marriage or female genital mutilation. The plan prioritises Ethnic minority groups more vulnerable concerning their sexual health. Less action competence in sexual situations and less possibilities to claim autonomy. Abortion rate are significant higher among ethnic minority women above 25 years compared to More vulnerable, less action competence and autonomy to secure sexual rights. Abortion rates. Difficult to reach out to ethnic minority groups with mainstream measures. Accessibility to health services, health information and contraceptives. Use of contraceptives. Today’s services are not sufficiently adapted to meet the</td>
<td>and guidance for vulnerable groups. 11. Strengthen routines for TB and HIV testing among immigrants who come as family reunification. 12. Secure sufficient follow up of HIV infected persons without legal residence. The above points have been coded as suggestions / proposed actions because they are formulated as “possible strategic actions” and not specific measures. *Ensure that dialogue and educational measures have a clear gender and minority perspective. Measures and strategies must be adapted to ethnic minority groups and other vulnerable groups. *Ensure a clear gender and minority perspective in the</td>
<td>1. Stimulate voluntary organisations and other central actors in work concerning sexual health in the communication arenas of the target groups, particularly actors in the arenas of sexual vulnerable minority groups. 2. Continue strengthening health care services for sexual vulnerable minorities, particularly through improving competency in the services to meet the needs of this group and help them take Relevant partners: 1.IMDi, relevant organisations, professionals, reception centres for unaccompanied minors. 2. Relevant professional communities and organisations. 3. Relevant professional communities and user</td>
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**Document** | **Year** | **Overall aim** | **Section on immigrants** | **Description** | **Challenges** | **Suggestions / proposed actions** | **Specific measures** | **Responsible Ministry (or other)**
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Main target groups are adolescents and young adults, ethnic minority groups and vulnerable groups. |  | measures aimed at ethnic minority groups. The minority perspective is to some extent integrated throughout the document. | ethnic Norwegian women, particularly among women with refugee background. Double minorities a particular vulnerable group. | needs of particular vulnerable groups. | health services so they can reach out to those in most need – boys, vulnerable groups, ethnic minority groups and sexual minorities. *All strategies must be adapted to disabled, LGBT children and adolescents, ethnic minority groups and sexual vulnerable groups. | care of own health. 3. Implement new knowledge based measures to increase the use of condom among vulnerable ethnic minorities and other sexual vulnerable groups. | organisations

**Action plan on chronic kidney disease (CKD)**
Handlingsplan for forebygging og behandling av kronisk nyresykdom (2011-2015)

| 2011 | Reduced prevalence, morbidity and mortality of chronic kidney disease | Section on 'Ethnicity and chronic kidney disease (p.60.61). | In the Eastern part of Norway is the share of 'non-western' dialysis patients higher than in the rest of Norway. At Oslo University Hospital Ullevål 20-30% of the dialysis patients are of 'non-western' background. The impression is that incidence and prevalence of CKD is higher in certain immigrant groups compared to ethnic Norwegian. Diabetes type 2 | The prevalence of CKD among persons of other ethnic background, especially persons with African or South-East Asian background. The great number of patients with foreign background in the dialysis units represents a challenge due to language and cultural differences. Some patients are illiterate. There is an underrepresentation of immigrants at patient education activities. Compliance to treatment regimens can be a challenge. | Population based strategies must be designed in a way that also is adapted to the needs of minority groups. There is a need for mapping the prevalence of CKD in the immigrant population. In order to ensure equitable services. All patients with CKD shall have an equitable access to high quality and individual adapted treatment regardless of background. There is a need for research on the |
and nephropathy are more prevalent and seen in younger patients than among ethnic Norwegians.

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<td>National Strategy on Diabetes</td>
<td>2006</td>
<td>Prevention of new cases of type 2 Diabetes and reduce development of complications. Reduce social inequalities in health. Equitable health services. Systematic follow up of high risk groups. Reduce numbers of undiagnosed type 2 diabetes.</td>
<td>A paragraph on ‘Special (særskilte) groups’ (p.5)</td>
<td>Type 2 diabetes more prevalent among persons with ethnic background in Asia and Africa. Gestational diabetes twice as frequently among immigrants from North Africa and South Asia compared to ethnic Norwegian women.</td>
<td>relationship between CKD and geographic, socioeconomic, cultural and ethnic factors.</td>
<td>Adaption of strategies and measures to the different patient groups. Respect for the different conditions. ‘An important part of the diabetes strategy is to get in dialogue with special patient groups, for example groups in certain immigrant communities, in order to, through specific measures, ensure that prevention and treatment are appropriately adapted’</td>
<td>I. Guidelines for pregnancy care; screen women with ethnic background from the Sub-Indian continent or North Africa for diabetes.</td>
<td>The Norwegian Directorate of Health and the National Council for birth care responsible for implementation of the guidelines.</td>
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<tr>
<td>National strategy on smoking prevention</td>
<td>2006</td>
<td>Promote health in the whole of the population and gain more life years through</td>
<td>Section on a ‘Multicultural perspective’ (p.30)</td>
<td>Facts on the immigrant population and socioeconomic status of ‘non-western’</td>
<td>Not possible to develop measures directed at all with ethnic minority background. Language can be a</td>
<td>Ensure that information on tobacco use and smoking cessation is available in relevant languages.</td>
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<td>tobakksforebyggende arbeidet i Norge (2006-2010)</td>
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<td>reduction of tobacco consumption.</td>
<td>immigrants.</td>
<td>Difference in smoking habits in different immigrant groups and between men and women.</td>
<td>barrier for contact with the health services, telephone services, smoking cessation courses.</td>
<td>It is desirable to get knowledge on social and cultural factors contributing to some groups smoking more than others.</td>
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<td>National strategy on children and adolescents’ environment and health</td>
<td>2007</td>
<td>Focus on the most important environmental and health challenges with regard to children and adolescents in Norway and contribute to best possible environment and health for children and adolescents in the age 0-20 years.</td>
<td>No specific section, but stated in the preface that all public authorities have responsibilities for service provision to all groups in the population, and thereby have the same responsibilities in own area for children and adolescents with immigrant background as for the rest of the population.</td>
<td>Lack of data on health among children and adolescents with immigrant background.</td>
<td></td>
<td>1. Grorudalsatsingen (a long term project in Oslo). 2. Survey on living conditions among children of immigrants (16-24 years) by Statistics Norway. 3. Action plan on integration and inclusion of the immigrant population include several measures directed at childhood and adolescent environment</td>
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<td>Nasjonal strategi for barn og unges miljø og helse 2007-2016</td>
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<td>Dementia plan 2015 (Demensplan 2015)</td>
<td>2007</td>
<td>Targeted measures to improve dementia care in three main areas; day programmes, adapted living facilities and increased knowledge and skills</td>
<td>One section (paragraph) on ‘persons with minority language background who develop dementia’ (p. 16).</td>
<td>Investigate central themes as information needs, treatment, diagnosing and need for services</td>
<td>1. A Nordic research and development project on persons with minority language background who develop dementia will be implemented. A Nordic cooperation requires participation and financing from the other Nordic countries, especially Sweden and Denmark</td>
<td>1. The Norwegian Directorate of Health</td>
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<td>Dementia plan 2015 revised Demensplan 2015 revidert</td>
<td>2011</td>
<td>As above</td>
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<td>1. Project on persons with immigrant background who develop dementia to be continued. 2. Information and educational material adapted to persons with minority ethnic background shall be developed.</td>
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<td>1. The Norwegian Directorate of Health 2. The Norwegian Directorate of Health</td>
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<tr>
<td>National strategy on habilitation and rehabilitation Nasjonal strategi for habilitering og rehabilitering</td>
<td>2008</td>
<td>To increase resources and focus on rehabilitation as an important part of health care</td>
<td>Norway as a multicultural society.</td>
<td>Minority groups’ perspective and service needs not sufficiently reflected in the health and care services.</td>
<td>Necessary to establish contact with organisations that promote perspective of minority groups</td>
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<td>1. The Ministry will establish contact with organisations with perspectives and interests of minority groups, including immigrant organisations.</td>
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<td>National strategy on prevention of accidents Nasjonal strategi for forebygging av ulykker som medfører personskade 2009–2014</td>
<td>2009</td>
<td>To achieve a better overview and cooperation on prevention of accidents in different areas in society.</td>
<td>Persons with minority background might have different damage patterns than ethnic Norwegians; types of injuries / damages and prevalence</td>
<td>Develop knowledge on risks for and extent of damage / injuries in persons with minority background</td>
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Ministries responsible for the measures in the Action plan:
- Ministry of Labour and Social Affairs, MLSA
- Ministry of Children and Family Affairs, MCFA
- Ministry of Health and Care Services, MHCS
- Ministry of Local Government and Regional Development, MLGRD
- Ministry of Culture and Church Affairs, MCCA
- Ministry of the Environment, ME
- Ministry of Transport and Communications, MTC
- Ministry of Education and Research, MER
- Ministry of Fisheries and Coastal Affairs, MOFC
- Ministry of Agriculture and Food, MAF
- Ministry of Children, Equality and Social Inclusion, MCES
- Ministry of Justice and Public Security, MJPS

Other Institutions
- Directorate of Integration and Diversity, IMDi