

Substantial Universalism? The Swedish case

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Abstract

Migrants show on average poorer health conditions than native Swedes, both in mental and physical health. In particular mothers have a higher degree of various forms of reproductive ill health than Swedish-born women. Existing studies show that in the Swedish health system members of ethnic minorities enjoy equal rights and receive equity of treatment. Yet, little is known about the extent to which the needs of ethnic minorities are actually met, the barriers in access, and the specific situation of women. Drawing from existing data and from policyseminars with experts and stakeholders from the civil sector and the public sector, we find that these health inequalities have more structural and cultural than institutional roots. Sweden is surely one country where ethnic minority women's rights and access to health care is extensive and has been pursued following a multicultural and bottom-up approach. Yet, the reason why ethnic minority women express more unmet needs and report less continuity in care than Swedish-born women seem to primarily lie in persisting forms of "cultural mismatch". As the good practices selected enlighten, support to health care access and to healthy lifestyles can be improved through better contacts with families and communities and better training both to health care workers and to migrants, to promote health information and to understand and smooth their mistrusts.

I migranti mostrano condizioni di salute mediamente peggiori dei nati in Svezia, sia nel campo della salute mentale che fisica. In particolare, rispetto alle donne svedesi, le donne straniere hanno più frequentemente varie forme di disturbi riproduttivi. Gli studi esistenti mostrano che nel sistema sanitario svedese le minoranze etniche godono di pari diritti e ricevono equità di trattamento. Eppure, poco si sa in che misura le loro esigenze siano effettivamente accolte, quali siano le barriere di accesso, e quale sia la situazione specifica delle donne. Attingendo dai dati esistenti e dai seminari condotti con gli esperti e le parti interessate del terzo settore e del pubblico, troviamo che queste disuguaglianze di salute hanno radici più strutturali e culturali che istituzionali. La Svezia è sicuramente un paese in cui i diritti delle donne appartenenti a minoranze etniche e l'accesso alle cure sono estesi e sono stati perseguiti seguendo un approccio multiculturale e *bottom-up*. La ragione per cui le donne appartenenti a minoranze etniche esprimono bisogni più insoddisfatti e riportano meno continuità nelle cure rispetto alle donne nate in Svezia sembrano prevalentemente risiedere in forme persistenti di "mismatch culturale". Come le buone pratiche selezionate mettono in luce, stili di vita più sani e un più efficace accesso ai servizi possono essere promossi attraverso un contatto migliore con le famiglie e le comunità e una più adeguata formazione sia per gli operatori sanitari che per i migranti, per promuovere l'informazione sanitaria e per comprendere e levigare le loro diffidenze.

Sweden today is a multi-ethnic society, having a higher proportion of foreign-born inhabitants than Great Britain or the USA. In 2007, 17% of all women of reproductive age in Sweden were foreign born¹. After the culmination of the labour immigration of the 1950s and 1960s, new waves of refugees from conflict zones in non-European countries began to arrive. As do all people, migrants carry with them 'footprints' of the socio-economic and cultural environments of their countries of origin. Moreover, they typically occupy worse positions in the host countries, having lower educational levels, lower incomes and living conditions than native born. They also exhibit worse health conditions: members of ethnic minorities are

¹ Data from Statistics Sweden, 2010, http://www.scb.se/statistik/publikationer/BE0101_2007A001_BR_04_BE0108TAB.pdf

particularly at risk of long-term illness, poor mental health and affected well-being (Sundquist and Johansson, 1997; Sundquist, 1995).

The different life styles and the different physical and social environments they were born in and they live in the host countries, together with the stress of the migration process, surely are connected to different health risks. But to what extent and how does policy matter? Swedish health policy has an ambition of offering equal access to medical care for all Swedish residents, regardless of social class or ethnicity. A number of projects to stimulate the development of adequate methods in primary and psychiatric care to meet the needs of ethnic minorities have been funded by the Swedish Government², but little is known about the extent to which the needs of ethnic minorities are actually met in Swedish health services and the specific situation of women. Drawing from existing data and from policyseminars with experts and stakeholders from the civil sector and the public sector, in this study we want to describe the health profile of ethnic minority women and their use of health services in relation to need in the maternal reproductive sphere. The aim is to add some insights on the following issues: is there equity in access to health services for ethnic minority women in Sweden? And what are the outcomes? What is the institutional setting in which women move and the good practices addressed to them?

1- The ethnic minorities context

In Sweden, from the end of the 1940s to the middle of the 1970s, there was extensive labour force migration. In particular people moved from Finland (around 400 000), but also migration from Yugoslavia, Italy, Turkey, Greece and Austria was common. From the beginning of the 1980s, migration has mostly concerned refugees and relatives of refugees and former labour force migrants: during the period 1980-2010, of the 1.2 million people who migrated (with permanent residence), 43 % were refugees or relatives of refugees. Refugees come mainly from the former Yugoslavia (26%), Iraq (19%), Iran (12%) and Somalia (7%), and are concentrated in the big cities and big regional centers. In Örebro County, 12-13 % of the population are migrants, both of the female and male population. In Örebro municipality the share is 15%. The percentage of migrants varies between age groups. In the age group 25-44 years, it is up to 20 %. At these ages, the majority of migrants are refugees or relatives of refugees. In the older age groups, i.e. 55 years and older, the proportion of migrants is around 10 %³.

In Sweden, as well as in England, the steady nature of migratory flows since the post-war period makes the foreign population a well-established component of society, evenly distributed over all demographic groups. Yet, the labour market positions and general socio-economic conditions differ between migrant groups and native born. Table 1 shows that a higher share of migrants, compared to those born in Sweden, are at the end of the income distribution, have difficulties in meeting current expenses, and do not have cash margins of 2000 euro. Moreover, the unemployment rate is twice as high among those born abroad than those born in Sweden. However, there are variations between groups of migrants. Migrants from the Nordic countries have almost the same socio-economic conditions as native born, but migrants from South and Central America, former Yugoslavia, the Middle East and Africa

² Information from The National Board of Health and Social Welfare. Information. Rehabiliteringsprojekt (Information. Rehabilitation projects). Stockholm: The National Board of Health and Social Welfare, 1995.

³ 9 Data from: http://www.migrationsverket.se/info/start_en.html

have far worse conditions. Also, there are almost no differences between native born (Swedish parents) and second generation migrants.

Table 1: Socioeconomic conditions migrants vs. native born in Sweden (1993-2000)

	Disposable income below social assistance norms	Difficulty in meeting current expenses	No cash margin of 2000 euro	Earnings (native born=index 100)	Proportion of employed 18-64 yr (native born=index 100)	Unemployed
<i>Native born</i>	7 %	16 %	13 %	100	100	4 %
<i>2nd generation migrants</i>	8 %	20 %	18 %	99	97	5 %
<i>All migrants</i>	15 %	29 %	37 %	88	74	8 %
Nordic countries	8 %	21 %	22 %	99	92	7 %
Central Europe	11 %	18 %	20 %	91	93	6 %
Turkey	33 %	39 %	39 %	74	56	10 %
South and Central America	14 %	41 %	59 %	77	73	10 %
East Europe	15 %	27 %	35 %	85	73	8 %
Former Yugoslavia	25 %	35 %	56 %	77	44	10 %
The Middle East	24 %	45 %	61 %	67	44	13 %
Africa	25 %	41 %	69 %	60	56	9 %

Source: Statistics Sweden⁴

Migrants also show on average poorer health conditions than native Swedes, both in mental and physical health. This is most evident in mental health. They are more exposed to psychiatric care, onset of schizophrenia and other psychoses, mood disorders, alcohol dependence, suicide attempts and suicide⁵. Anxiety, fatigue and insomnia are several times more common among migrants than among the native born population, but on a low rate of occurrence. In particular it is refugee migrants that are at high risk of mental health disorder and social exclusion (Ekblad *et al*, 2009). These risks seem quite independent of socio-economic factors, especially for migrant women (Westman *et al*, 2006). They also seem unrelated to exposure to violence before migration, while related to what has happened since arriving in Sweden (Sundquist *et al*, 2000).

There is a considerable amount of research into why migrants have poorer health than natives. Is poorer health explained by migration in itself or by lower socio-economic status for migrants? What is the role of policies? A study by Wiking *et al* (2004) shows that women from Iran have a five times higher risk of poor self-rated health than native Swedish women. Yet, the difference is not fully explained by socio-economic factors. Knowledge of Swedish and discrimination are also important factors for poor self-rated health. In another study on

⁴ The complete reference is: Statistiska centralbyrån, Arbetslivsinstitutet, 2002, Levnadsförhållanden, Rapport nr 96, Integration till svensk välfärd? Om invandrares välfärd på 90-talet, utgivare Statistiska centralbyrån (Statistics Sweden and the National Institute for Working Life, 2002, Living condition, Report number 96, Integration to Swedish welfare? Regarding immigrants' welfare in the nineties, Statistics Sweden).

⁵ The National Board of Health and Services, *Hälsa-och sjukvårdsrapport 2001 (Health Care Report 2009)* 2009, The National Board of Health and Services: Stockholm.

acute myocardial infarction, Hedlund *et al* (2007) show an increased risk for women from Iraq, even when socio-economic factors were considered. An increased risk remains after more than 20 years in Sweden.

Thus, the migration story and the lower socio-economic status of migrants are surely connected to worse health conditions, but it is only part of the story. Different cultural backgrounds and gaps with the cultures of the receiving country and of the health services also play a role. Migrant women have a higher degree of various forms of reproductive ill health than Swedish-born women of similar age. Infant mortality rates are also significantly higher among migrant women from Africa and from parts of the Middle East than among Swedish-born women (Essen *et al*, 2002b). Harmful practices such as female genital mutilation, early marriage, coercion, sexual abuse and violence of various kinds contribute to ill health. Yet, also cultural differences may contribute to migrant women refraining from seeking prenatal care or to seeking treatment late. In which way do Swedish policies tackle such barriers to the use of health services? Section two describes the regulatory framework of the Swedish universal health system, enlightening strengths and weaknesses. Section three examines data on the health needs of, and the use of services by, ethnic minority women in relation to sexual and reproductive health. Section four presents some good practices that have been selected.

2- A universal health care system: the regulatory framework

Health and medical care is a core part of the welfare system. Swedish health and medical care is based on the principles that care should be provided on equal terms and according to need and that it should be under democratic control and financed on the basis of solidarity. Access has to be universal for all residents, regardless of class or ethnicity. On the 1st of July 2013, Sweden also introduced a new law that guarantees illegal immigrants full access to health care as asylum seekers. It means for adults the right to health care that cannot be delayed (for health reasons), and full access to health care for children (up to 18 years old).

Health and medical care is to be characterised by high quality and good accessibility in which the patient comes first. Indeed, the Swedish Health and Medical Services Act states as follows: *“Health and medical services are aimed at assuring the entire population of good health and of care on equal terms. Care shall be provided with due respect for the equal worth of all people and the dignity of the individual. Priority shall be given to those who are in the greatest need of health and medical care”*. Responsibility is divided between the state, county councils and municipalities. The Health and Medical Services Act sets out the respective responsibilities of county councils and municipalities for health and medical care. The Act is designed to give county councils and municipalities considerable freedom with regard to the organisation of their health services. The state is responsible for the overall health and medical care policy not only on paper but de facto, in order to guarantee the universal principle that inform it. Thus, as the stakeholders participating in the seminars have declared, decentralisation or privatisation is not an issue in Sweden as it is in many other European countries. Further, in times of cyclical downturn in Sweden it is common to expand the public expenditure more than to cut it, with the aim to compensate for the weak labour market. The health care sector has indeed increased its share of GDP during the last decade; from the end of the nineties to 2009, it increased from 8,5 % to 9,5 % (Statistics Sweden).

Since equal access and treatment of all residents are emphasised, there are no specific rules concerning ethnic groups or minorities in Swedish Health Care. That is, health care addressed to ethnic minority women is provided with the same organisation as health care for everybody

else. Most obvious resources targeted to ethnic minorities are interpreter services whose availability depends on budgets but most of all on interpreters speaking the actual language. These are scarce in rural sparsely populated areas, concentrated in forest and mountain areas in northern Sweden. According to the Swedish Health Care Act, equal health care shall be offered to the whole population. However, long distances to primary health care centres and hospitals reduce healthcare utilisation. In general, people in rural areas use health care less than people in urban areas. In particular, as many stakeholders have underlined, in rural areas accessibility to an interpreter may be a problem.

3- Needs and outcomes of ethnic minority women in sexual and reproductive health: some numbers

The proportion of migrants/foreign-born women giving birth in Sweden has steadily increased, moving from 5% in 1978 to 21% in 2008. The Swedish maternity health care system is free of charge and distributed equally to all women. Child Health Services (CHS) in Sweden are offered, free of charge, to all Swedish parents with children under the age of 6 years. The regular service schedule includes home visits, health examinations and vaccinations at Child Health Centers (CHC) by public health nurses and general practitioners (GP). The contact between the family and the CHS is programmed to be established by way of a home visit. In several studies, home visits have been shown to offer effective opportunities of identifying families in need of extra support and of making early disclosures of children at risk. All parents are also to be offered participation in a parental group, where parents of children of similar ages gather to discuss issues of mutual interest. Parental groups generally are guided by a nurse at the local CHC. In addition to the regular programme, the child health nurse is expected to be available for counseling and guidance related to children and parenthood. The CHC nurse has a particular responsibility to detect children at risk and to pay extra attention to disadvantaged families.

Does this generous availability of health support apply also to ethnic minority mothers? In a recent study, Wallby and Hjern (2011) have observed the uptake of child health care among low-income and migrant families in the county of Uppsala, to investigate whether these families received extra attention as proposed in the Swedish Child Health Services (CHS) state-of-the-art consensus document from the year 2000. Data were collected for 25,024 infants born 1998-2006 from the database of statistics of the Child Health Care Unit in Uppsala and socio-demographic indicators from Swedish national registers. Disposable income was divided into quartiles. Country of birth of the mother was categorised into four regions with two subgroups each, mothers with or without a Swedish-born partner. Wallby and Hjern find small differences between Swedish vs. migrant and high vs. low-income families. Overall 99.9% of all children involved in the study had contact with the CHS at least once during the child's first 2 years. The mean number of visits at the nurse's office was 14.8. Of the total population, 97% had received the mini visit level of six or more visits at the nurse's office. Of all children, 92% had received the three health examinations by the CHC physician stipulated in the CHS programme, and 83% had received at least one home visit. Of the total population, 98% had received a full series of vaccinations against diphtheria, tetanus, whooping cough, hemophilus influenza type B and poliomyelitis, and 93% had received vaccination against measles, mumps and rubella. No influence of disposable income or country of birth region on outcome variables, except for participation in parental group, was observed (Wallby and Hjern, 2011).

Yet, they also found that non Swedish mothers tend to participate less in parental groups held by the Child Health Services. Of first time mothers, 48% participated at least once among mothers born in Sweden with a Swedish partner compared to 47% among mothers born in other countries with a Swedish partner, 12% without a Swedish partner. Regression analyses confirmed that, controlling for socio-demographic confounders, mothers born in non-European countries had decreased participation rates compared with Swedish-born mothers with a Swedish partner. Also income and age play a role. Low-income mothers showed lower participation rates in parental groups compared with high-income mothers; so do children of young mothers, aged 13–21 years, compared to children of older mothers. (Wallby and Hjern, 2011).

Results of other studies document that foreign-born women have increased risks of suboptimal care, delayed care seeking behaviours, stillbirths and maternal death at childbirth. A study by Ekéus *et al.* (2011) finds that the risk of stillbirth was increased in births to women from Africa (including Somalia) and Middle East compared with native Swedish women. The relatively large proportion of stillbirths is unexplained but a relation between poor socio-economic status and stillbirth emerges. Moreover, the access to health assistance plays a role. It seems probable that the possibility for migrant mothers to draw attention from health care professionals for pregnancy complications improves with, on the one hand, a stronger intercultural training for professionals, on the other hand, a better acquisition of language skills and growing experience of Swedish maternal health care for migrants.

Other studies show that foreign born women face a higher risk of dying during reproductive age in Sweden, with the largest discrepancy in mortality rates seen for infectious diseases and diseases related to pregnancy, a cause of death pattern similar to the one in their countries of birth (Esscher *et al.*, 2013). The high HIV/AIDS mortality in women born in low-income countries may not be surprising, as a majority migrated from countries with a high HIV prevalence and died during the first half of the study period, that is, before the introduction of highly effective antiviral therapy in the mid-1990s. Inadequacies in offering HIV testing may have increased the risk of dying from AIDS for such migrants in Sweden. Yet, Sweden is not alone. A higher risk for maternal death among women born in low-income countries has also been observed in other European countries. An increased risk of death in women of reproductive age was also seen in women born in high-income countries, but for different reasons: suicides, accidents, alcohol and drug abuse and circulatory diseases (Esscher *et al.*, 2013). For ethnic minority women reasons are different and are not independent from difficulties with the process of integration. Besides well-known obstetric risk factors and conditions of the migration process⁶, several studies have shown that substandard care, including that caused by communication problems, are more common among migrants than native-born European women (van Roosmalen *et al.*, 2002; Essen *et al.*, 2002a).

4- Equal rights and treatments but barriers in access: examples of good practice

In a study of 1,890 Swedish residents aged 27-60 years born in Chile, Poland, Turkey and Iran and 2,452 age-matched Swedish-born residents, Hjern *et al.* (2001) found that people of ethnic minority backgrounds received equity of treatment according to self-assessment needs. All four minority study groups reported more ill-health than the Swedish-born study group.

⁶ Refugees are more likely to have experienced violence, food shortages, lack of public health services, discrimination and psychological stress than people who have been able to plan their migration (Adanu and Johnson, 2009).

Yet, after adjusting for health status, the use of consultation (with a physician, nurses as well as physiotherapists) did not differ. Moreover, approximately 57% of the minority study groups expressed high or very high confidence in Swedish health services. However, there were hints that the situation may not be quite as satisfactory as it first appears. The minority study groups expressed also considerably more unmet needs than the Swedish-born study group and there was a tendency for minority members to report less continuity in care than Swedish-born residents.

As the studies in the previous sections suggest, unmet needs and discontinuity in care are connected to information gaps, and linguistic and cultural “communication” problems. The Swedish health system emphasises equal treatment and access and gives universal rights to all residents, regardless of socioeconomic status or ethnicity. Yet, ethnic minority people might encounter cultural barriers, especially women in the reproductive and sexual sphere, which can “threaten” such universal aspiration. The awareness of such possible barriers seems quite widespread between policy makers and stakeholders, who have developed several programmes to tackle them. Following four criteria⁷ and with the help of our contacts with relevant stakeholders, among these programmes we have identified three “good practices”: a Health project in Örebro Mosque, aimed to find a more efficient way to provide health information and support healthy lifestyles, and to ensure that care actually will be sought if necessary; a study on the effectiveness of International Health Advisors for newly arrived refugees from Iraq; “Development of Healthy district”, a health project in a socio-economic disadvantaged district (Varberga within the municipality of Örebro) to reinforce, through “Dialogforums”, citizens participation and power in matters of their own health and quality of life. All these projects are promoted and implemented within the Health Care System, although not delivered inside traditional healthcare facilities and in cooperation with NGOs or universities. Moreover, these projects are not specifically targeted at women, but women are the main potential beneficiaries.

The Health project in Örebro Mosque, started in November 2011 and is still running with the idea of transforming it into a permanent activity. The project is provided for members of the mosque that is for migrants (including second generation migrants) of Muslim faith from different countries and ethnic groups, such as those from Iran, Iraq and Somalia. For ethnic, cultural and linguistic reasons, and because of inadequate adaptation to the views of women and men in different cultures, public health care interventions have lower effectiveness in this population. One problem underlined by stakeholders is that it is difficult to organise meetings between women and health care staff in such a way that is acceptable for Muslim women. Many of the members of the mosque are poorly integrated into society and have a distrust of authorities, including health care. Unhealthy lifestyles are more common in this group than in the general population (for women mainly poor eating habits, physical inactivity resulting in overweight /obesity; for men, the addition of smoking). Also morbidity and premature death from heart disease, diabetes and cancer are more common among migrants than Swedish-born. The Örebro Mosque project, realised through a partnership between Örebro Mosque and the Örebro County Council⁸, aims to find a more efficient way to provide health information and support healthy lifestyles. It plans to act through two steps. As a first step, health information will be provided in the mosque. It will be done through oral briefings to groups in which religious leaders, members with medical training and personnel from the Örebro

⁷ The four criteria are: relevance; clear and adequate information; sustainability; reproducibility and transferability

⁸ Örebro Mosque is an NGO, ruled and mainly financed by their members. They are responsible for the project in relation to their members. Örebro County Council is the local health care authority and responsible for the health care in the region. They are responsible for health care efforts (preventive) in the project in relation to the participants.

County Council provide information. This will be supplemented by written information in the most common languages. As a second step, lifestyle counselling in smaller groups will be arranged. These groups will be divided according to language group and gender. An important part of this counselling will be to encourage better eating habits and increased physical activity among women, and to create physical activity and exercise opportunities that are attractive and acceptable to the women. Since the project works in the arena of health promotion and contact with a part of the population that the health care system has difficulties to meet, then if the project succeeds, the potential of reducing health inequalities is large⁹.

The project on the Impact of Multicultural Health Advisors (IMHAD) is being conducted outside Örebro County Council and is a partnership consisting of Region Skåne, Lund University, Malmö University and Uppsala University. However, Örebro County Council also has participated¹⁰. Health advisors are not anything new. However, this project is innovative in that it has made a scientific evaluation carrying out a longitudinal quantitative study complemented by a qualitative study (consisting of Focus group discussions on the preliminary themes and individual in-depth interviews). The project is also innovative in the target population: the newly arrived Iraqis in municipalities. In recent years, Iraqis have been the largest refugee group in Sweden. Newly arrived Iraqis have worse physical and mental health than native Swedes, poorer lifestyles and worse living conditions. Since the objective of the study is to evaluate the effectiveness of the presence and work of IHA, both refugees using or not using IHA have been interviewed¹¹. Moreover, they have been interviewed in two moments, during December 2007 to February 2008 (first wave) and in May to June of 2010 (second wave).

Katarina Löthberg, (responsible for the project), underlines, that the project has achieved its overall objective: it has investigated the effects of health advisors' work, informed both parts (the refugees and the health advisors), and disseminated results at many levels. Indeed, the project has delivered an image of the target group's health and of the IHA work through conferences of and contact with the authorities and other organisations in the various study counties and they have produced a number of sub-reports and scientific articles. These have been disseminated through the reference group in which the Swedish National Institute of

⁹ Since the project is still running, a systematic final evaluation has not been conducted yet. Moreover, as underlined by stakeholders interviewed, there have been attempts to do a baseline measurement, but the members of the mosque are cautious in giving information to authorities, and they think researches are too "western" and connected to the government. This is an interesting result in itself.

¹⁰ The project is indeed a collaboration between 4 universities, 3 regions and 4 municipalities. The project also collaborates with a number of relevant organisations and businesses across the country and a potential synergies with existing activities and projects concerning health communicators, such as project "Partnership Skåne" Sörmlandsleden Line and Center for Health and integration, CHI, in Växjö. Research results are disseminated through the partnership, by working together with the country's county boards, through regional and national conferences as well as through reports and scientific papers in order to help equalise the unequal public health and to promote health, well-being and quality of life in our multicultural society. For more information see: <http://www.mah.se/english/research/Our-research/Centers/Malmo-Institute-for-Studies-of-Migration-Diversity-and-Welfare/Research-at-MIM/Projects/IMHAD---Impact-of-Multicultural-Health-Advisors/>

¹¹ International Health Advisors was a project developed within the framework of the governmental Metropolitan City Initiative and the European Community Initiative Equal. The project has dealt with two of the most central issues in the Swedish integration policy: to enable the enjoyment of the same rights and opportunities as the general population – in this case through providing newly arrived refugees and asylum seekers with information – and to raise awareness and disseminate knowledge about the need for different sensitivity – in this case in health care practice. The International Health Advisors' work focuses on three themes: access to health care, disease prevention and health promotion. This happens through education in cooperation with introduction programmes offered to all newly arrived refugees. The main contents are: information about the health care system and its utilisation, self-care for alignments and health promoting lifestyle. The information and advice are as far as possible given in the mother tongue of the migrants. Written information in Swedish is handed out and the Swedish language teachers are using this to train the participants to use the knowledge in their contacts with the health care. The International Health Advisors also work in primary care. The advice sessions mainly concern child care. Group activities are conducted for people with diabetes or people in need of physical activity.

Public Health and The National Board of Health and Welfare are also represented. They have also been disseminated through the European research collaboration COST, within the field of migration and health: “Health and social care for migrants and ethnic minorities in Europe”, funded by the Seventh Framework Programme¹².

Yet, the results of the evaluation have not been encouraging. The longitudinal research conducted has shown that changes in health over a two-year period are small and in most cases not significant. It might be that the time span is too short, that positive effects emerge after two years. But a role is surely played by criticalness in the work of International Health Advisors. The empirical data shows that many respondents did not know the health advisors they were going to meet. Moreover, the groups that health advisors face were often not properly organised for the purpose. The lowest common denominator for participation was simply to speak the same language. Otherwise, they tended to be extremely heterogeneous – for gender, age, educational background, family status, number of years in Sweden etc. This affected the ability to convey *ad-hoc* information, adapt to the various specific needs and profiles, which in turn affects the refugees’ perception of the utility of these supports. According to the stakeholders participating in the seminars, other possible obstacles to success lie in the frequency and modality of meetings. In order to achieve a reduction of migrants’ health risks, it seems important that group meetings will be repeated several times. It is also important to stimulate two-way forms of communication, with a higher active participation of beneficiaries, and to increase the number of health advisors, whose number was very small compared to the number and complexity of the target groups.

The third good practice selected, “Development of Healthy district”, focuses on a socio-economic disadvantaged district in the municipality of Örebro, with the aim at increasing their integration through better self-awareness of their health conditions and risks and of their rights, and with better participation in the decision processes. Örebro is the main city of Örebro county, where half of the population in the region lives (in 2010 135 000 out of 280 000). In the neighbourhood of Varberga lives around 3 200 persons, and among them 63,5% have foreign origins and 44,5 % are born abroad (compared with the municipality of Örebro where 20,4% have foreign origins and 14,8% are born abroad). Migrants come from different countries and ethnic groups (such as those from Iran, Iraq, Lebanon, Syria and Somalia) and suffer from relatively bad socio-economic conditions. In particular, women in Varberga are subject to unemployment, low incomes and they live in the most resource-poor neighbourhoods, all socio-economic factors that have been demonstrated to have negative impacts on health. The aim of the project is to develop a strategy for citizens’ dialogue in a multicultural context to reinforce citizens’ participation and power in matters of their own health and quality of life¹³.

The project has a three year duration, from autumn 2010 until spring 2013 and it is the follow up of an earlier project, a three-year project ‘Brickebacken - a healthy neighborhood’ that began in the fall of 2005. Evaluation of this project (carried out in 2009 by the Department of Community Medicine and Public Health, Örebro County Council) has been positive since it has observed an increased range of activities and the strengthening of local cooperation – both factors that increase the chances for residents to improve their health. Negative aspects put forward were the difficulty of engaging the residents, especially in the various immigrant groups, and ambiguity in how the project should best be managed and

¹² IMHAd - a research project co-financed by The European Refugee Fund. In September 2007 The European Refugee fund decided to grant a research project to find out if International Health Advisors can make a difference.

¹³ The project is a partnership between Örebro municipality, Örebro County Council, Örebro County Sports organisation and Örebro County Educational association.

controlled. In addition to a final evaluation of the project, during the period 2005 – 2009 mapping/surveys have been conducted in six districts in Örebro in order to highlight the way in which societies and local actors work with public health and integration issues and how they wish to develop work. Örebro County Council and Örebro have jointly agreed to develop cooperation on public health and integration. The main instrument designed has been “The Dialogforum” which have worked as the political coordination group for the development of Varberga as a model for a Healthy district. There has been two leading idea in the design of the project: to design it flexibly enough to be used in other parts of Örebro and to actively involve citizens and their associations. “The Dialogforum” is indeed formed by political representation from Public Health Board and the municipality, with the addition of members of the boards from Örebro County Sports organisation and Örebro County Educational association. Following a model in five steps (information, dialogue, consultation, participation and decision making), The dialogue has been extended to citizens, through visits to families in one part of Varberga and through arrangements of focus groups and of decision-making meetings. As the experts interviewed have underlined, if the project succeeds, it has the potential to reduce health inequalities and support integration. The evaluation in the pilot study conducted in 2013 concluded that the project has been successful. There is however a strong need for political presence and participation and the value of a well organised civic dialogue, which requires long-term planning. It has also emerged that there is an increasing need to focus on education and employment (Nilsson, 2013). These results are in line with results of similar projects (Eriksson *et al*, 2010). From all these experiences a model showing the way for further work in Örebro municipality to promote inclusion and health in different neighbourhoods was presented in September, 2013¹⁴.

5- Conclusions

Migrants show on average poorer health conditions than native Swedes, both in mental and physical health. In particular mothers have a higher degree of various forms of reproductive ill health than Swedish-born women of similar age, such as stillbirths and maternal death at childbirth. Infant mortality rates are also significantly higher among ethnic minority women from Africa and from parts of the Middle East than among Swedish-born women. Our research suggests that these health inequalities have more structural and cultural than institutional roots. That is, they seem little connected to access to care, more to different lifestyles and physical or social environments, different stress linked to the migration process with the “acculturation request” and the loss of own familiar settings and networks. Indeed data shows that migrants receive equal access and equal treatment according to need. In the reproductive sphere, home visits, health examinations and vaccinations at Child Health Centers (CHC) by public health nurses and general practitioners (GP) do not differ between foreign and Swedish-born mothers. Yet, non Swedish mothers tend to participate less in parental groups held by the Child Health Services and to exhibit more risks of suboptimal care and of delayed care seeking behaviours.

¹⁴ Dialogforum för Örebro kommun (2013). *Modell och arbetssätt: Samverkan för social hållbarhet och minskade skillnader i hälsa i Örebro kommun, med fokus på delaktighet, inflytande och integration, samt med stöd av medborgardialog (Model and practices: Collaboration for social sustainability and reducing inequalities in health in Örebro Municipality, with a focus on participation, influence and integration, and with the support of civil dialogue)*. Örebro kommun, Örebro läns landsting, Örebro läns Idrottsförbund, Örebro läns bildningsförbund

The health services not only legally but also in practice provides care regardless of class, gender and ethnicity. Yet, what marks the difference is the frequency and timing of the use of these universal welfare supports: ethnic minorities express more unmet needs and report less continuity in care than Swedish-born residents. Literature on health and migration and in particular on health as an important aspect of integration point out the crucial role played by “intercultural competence” in health care workers and services and “health literacy” of migrants. High access and high quality of care also requires a “matching” process, a dialogue in which both parties need to appreciate each other’s underlying assumptions, concepts, expectations, and biographies. These apply also to women, where the development of “culturally competent” care implies a specific sensitivity to the issue of gender. The main reason for ethnic minority women for not seeking antenatal care or for seeking treatment late lie indeed in a linguistic and cultural “mismatch”. In the health care system mediation through an interpreter is available and also international health advisors. Yet, even in a universal welfare state, these services are not equally distributed in the territories, being scarcer in rural areas. Moreover, different cultures of motherhood, of the role of formal professional figures in the process of childbearing and childrearing and different ways of “doing gender” might deter migrant women from fully using this Swedish welfare support. Migrant families suffer also from information gaps on the range of services available in the territory where they live.

The Health project in Örebro Mosque, aimed to find a more efficient way to provide health information and support healthy lifestyles, and the longitudinal survey conducted on the effectiveness of International Health Advisors for newly arrived refugees from Iraq, have highlighted the importance of developing “culturally appropriate” care. In particular they point to the necessity to increase contact with migrant families and their communities and to organize constant meetings and activities in their environments and to do this in a two-way process, based on the idea and practice of mutual learning and of empowerment. That is, promoting the health and health literacy of migrants and ethnic minorities imply the development of migrant and minority-friendly routines for service provision, and creating migrant and minority-friendly settings. In line with the recommendations of the MFH (“Migrant Friendly Hospitals”) initiative¹⁵ and of the research results of the IMISCOE network (Network of excellence on Immigration, Integration and Social Cohesion in Europe)¹⁶, this means assuming a patient-citizen centered perspective and an equity perspective. It also means moving away from an assimilation paradigm towards an integration paradigm, within the larger concept of citizenship. The degree to which migrants rights are taken seriously will depend on the prevailing ideology concerning citizenship and diversity, including ethnicity and gender. An explicit policy of multiculturalism will stimulate the adaptation of services to the needs of migrants, through not only the usual “top-down” approach, but also a “bottom-up” approach with the direct involvement of users; a “monocultural” or assimilationist policy, by contrast, will discourage this.

Sweden is surely one of the European countries where migrants’ rights and access to health care are most extensive and have mostly been pursued following a multicultural and bottom-up approach. That is, structural integration (defined as equality of access, allocation of resources and participation) is high. Yet, more cultural integration has to be pursued. Even in Sweden actual access and reduction of worse starting health conditions still suffer from “cultural mismatch”. This needs to be smoothed if equality and better health want to be achieved, especially considering that fertility is higher among migrants than Swedish born.

¹⁵ See <http://mfh-eu.net/public/home.htm>

¹⁶ See <http://www.imiscoe.org/>

The interviews with stakeholders and in particular the seminars with policy makers made at the end of the BHBI project have also underlined the necessity to improve data collections. So far, there is a lack of knowledge about the living conditions, health and lifestyles of different migrant groups, and about the health care received in comparison with other sections of the community. Regular questionnaire investigations are carried out locally and nationally in Sweden but the response rate is only approximately 60%. There is reason to believe that such no-responses are not random, that groups that are not well integrated in society are more likely to not respond. Moreover, in Sweden the health care system does not record data concerning ethnicity or from which country individuals have migrated. It is not therefore possible to trace the health care provided to different groups of migrants. Yet, it seems important to develop appropriate indicators of minority status not only for improving knowledge on the migrants' state of health and their actual access and use of public health services but also, on the basis of this better knowledge, for decisions in allocating resources, especially in areas with a high proportion of migrants, such as in the sexual and reproductive area.

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