Healthy Inclusion

Migrants' perspectives on participation in health promotion in Estonia

Empirical analysis II and III: Interviews with migrants from selected countries with and without access

National report

ESTONIA

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1. Introduction

Most of world migrants, about 64 million, live in Europe (UN Migration Chart, 2006). Its current migration flows are very heterogeneous and the profiles of migrants are very diverse. While some migrants may not face any special threat or radical change, others encounter many and can put people in a more vulnerable situation. Frequently similar to those of the disadvantaged groups, migrants are overexposed to several risks which have an impact on health: dangerous and low-paid jobs, poor nutrition, deprived housing, missing social insurance, lack of access to information and (health) treatment. This further may have repercussions on education, possibilities of active participation in (municipal) living, and feeling welcome and respected as determinant for wellbeing in general (Caritas Europa 2006). Consequently, the health dimension of migration is a critical issue for the EU and for the member states. The EU, as agreed by all member states, shall respect fundamental rights as guaranteed in the European Convention for the Protection of Human Rights and Fundamental Freedoms. Addressing the health of migrants is seen not only as a humanitarian cause, but moreover as a need for attainment of the best level of health and well-being (Padilla & Miguel 2007). Realising these rights and bettering the health status of all people living in the EU, the access to the health care system and all related issues that support equity has to be fostered.

“Healthy Inclusion. Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Interventions and Services” is an European project carried out within the Public Health Programme 2003-2008, co-funded by the European Commission, DG Health and Consumers, Public Health. It is taking the special impact of health promotion in mind:

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices (c. p. Ottawa Charter, WHO 1986).

The overall aim of the project is to contribute to the increase of participation of migrants in health promotion interventions. Specifically, “Healthy Inclusion” has the aim of gaining knowledge about barriers and supporting factors for migrants in using health promotion interventions by exploring the perspectives of the providers as well as the migrants. Based on this gained knowledge and with the support of external experts, recommendations for health promotion providers on how to integrate migrants in health activities will be developed. The setting chosen is a municipal one as interventions, especially provided within local communities, have an important function in reducing the barriers; they are relevant for building networks which are central for social inclusion (Portugal, R., et al. (Eds.), 2007: 21). This is also important for health status becoming a part of a social net or community and is one of the most important resources of salutogenesis (Herringer 2002).

The duration of the project is from July 2008 to July 2010. Eight EU member states are part of the consortium of “Healthy Inclusion”: Austria, Czech Republic, Denmark, Estonia, Germany, Italy, The Netherlands and Slovakia. In each country (except for Germany which is evaluating the project) the national explorations are carried out. All national results are merged and will lead to the final recommendations. As it is important to consider local needs and possibilities of individual countries when developing health promotion strategies and programmes, the recommendations will have a “general suitable part” for all countries but there will also be the need to add national recommendations specifically related to each country.

The first exploration phase took place between September 2008 and March 2009. It focused on the perspectives of the interviewed providers on barriers and their concrete experiences with migrants as participants of interventions as well as their suggestions for enhancing the participation of migrants. The report “Perspectives of the providers on participation of migrants in health promotion in Estonia” reflects the results[1].

The second and third exploration phases took place between June and October 2009. The explorations centred the perspectives of two migrant groups: one group which already has had access to health promotion interventions, and another group who did not have access yet. The present report “Migrants’ perspectives on participation in health promotion in Estonia” describes the results of background literature review as well as of these interviews.

[1] Available online: http://rahvatervis.ut.ee/handle/1/1401

First, it gives an overview on the data of national migrants in Estonia and views their actual (living) situation by focusing especially on “migration and health” issues. Secondly, selection criteria of interviewees and methods used are delivered. The third and main part concentrates on the empirical results; besides ‘hard’ facts like origin, legal status, religion, marital status, etc., ‘soft’ facts like ability to speak the language of the host country, habits or (cultural) orientation - based mainly on self-estimation of the interviewees - are described. Furthermore, interviewees’ perceptions on health, their information level and awareness about health rights and opportunities are spotlighted. Finally, the report demonstrates the interviewees’ experiences respective suggestions for fostering participation and compares at least the suggestions of the migrant users with those of the providers.

2. The Background

2.1. Migrants in Estonia

2.1.1 Brief description of the data of national migrants

Current ethnic composition of Estonia is a result of historic events of the 20th century. After gaining independence in 1918 until the outbreak of World War II, ethnic Estonians constituted 88% of the population. Following geopolitical changes – annexation by the Soviet Union in June 1940 and occupation in 1944 led to the rapid inflow of foreign born migrants.

According to Katus et al (2003) two major immigration waves can be distinguished between 1940 and the 1980's: first wave occurred in the immediate post-war decade when immigration reached its highest level in absolute numbers (40 000-60 000 immigrants per year); by the mid-1950s overall immigration decreased but intensified again in the late 1960s. By 1989 census proportion of ethnic Estonians had decreased to 61.5% of total population of 1 372 071. The beginning on the 1990s with the fall of the Soviet Union and Estonia restoring its independence showed a rapid increase in emigration which declined by the end of the 1990s (Tiit 2006). From 1989 until the census in 2000, the total population had decreased by over 193 000 people.

Estonia's total migration with respect to other countries has been constantly negative in 2000-2007. In the period 2000–2007 the total number of immigrants was 10 326. Main countries of origin were Finland (re-immigration of Estonians) and Russia (accounting for 31% and 24% of migrants). A considerable number of people also arrived from the Ukraine, Germany, Sweden, Latvia and the United Kingdom. 43% of the immigrants were Estonian citizens which indicate that they are most probably re-immigrants. A relatively high percentage of people with Russian and Ukrainian citizenship (respectively 15% and 5% of the immigrants), however, confirms that a fairly large number of immigrants come from the CIS[2] countries. Significant proportion of immigrants (11%) has Finnish citizenship.

[2] Commonwealth of Independent States (CIS) is a free association of 12 sovereign countries that were part of Soviet Union before 1991.

Finland, Russia and the Ukraine are also the main countries of origin of immigration (Migrant population in Estonia 2009).

Immigration to Estonia has increased from all the aforementioned countries in 2000–2007 whereas since 2004 the rate of immigration has increased more rapidly than earlier. While immigration has grown steadily over the years, a rapid increase in emigration can be observed immediately after Estonia's accession to the EU (*ibid*).

2.1.2 Factors affecting the situation of living

Majority of foreign born people live in urban settlements of North-East Estonia; the percentage of immigrant population is the highest in Ida-Viru County where the number of immigrants exceeds that of native population. Many immigrants are also located in Harju County. 10–14% of immigrants are located in Valga and Lääne Counties. Immigrants also tend to move to big cities such as Tallinn, Narva and Kohtla-Järve. The location of immigrants has not changed a lot during the last eight years (Migrant population in Estonia 2009).

Majority of problems for migrants are related to language skills and legal status. It has been noted that migrants speak the Estonian language more fluently if the migrant community is small in the region. For example, in Rapla County most immigrants had a good command of the Estonian language but in Ida-Viru County less than a half could speak Estonian (*ibid*).

Unfavourable socio-economic conditions that affect foreign born people often have structural nature. After 1991, many men and women lost their jobs, positions, and security as Soviet factories closed, creating substantial unemployment, particularly in the Estonian North-Eastern region and capital Tallinn. Many of the unemployed were ethnic Russians who were originally imported by the Soviet Union to provide a labour force for the Russian factories in Estonia. These ethnic Russians, who occupied a superior position in society during the Soviet occupation, abruptly found themselves without the status and privilege they formerly enjoyed as ethnic Estonians emerged into social, economic, and political

prominence with independence. Regarding the period after the restoration of independence in Estonia the unemployment rate of non-Estonians was the highest in 2000 reaching 18%. In 2004 it was still nearly 16% and only in 2007 the unemployment rate of non-Estonians dropped to 6.9%. In 2008 the unemployment increased again more among non-Estonians compared to Estonians (statistical yearbook of Estonia 2009). High unemployment rates are common in some specific industries (i.e. mining), rural and/or in mono-functional settlements/regions. In case of North-Eastern Estonia, where the majority of non-Estonian residents are located, these issues have a considerable effect on their general well-being.

Empirical data has proven that employment significantly reduces the risk of falling into poverty: six out of ten among unemployed lived with an income below the poverty threshold. The depth of poverty among Estonians and non-Estonians is basically identical. Differences emerge when comparing the at-risk-of-poverty gap with citizenship: Estonian citizens and citizens of other countries still have their at-risk-of-poverty gap at 20% but people with unspecified citizenship live in slightly deeper poverty — their median income is 24% lower than the poverty gap (ibid.).

Ethnic background is also related to income inequality — non-Estonians and non-citizens have on average lower income. Persons with citizenship of another country stand out in particular — on average they are not poorer than Estonian citizens but the rich and the poor of this group have incomes closer to each other than those of the natives (*ibid.*).

Estonian legislation does not set any direct restrictions to the employment and work finding opportunities of the migrants; the prerequisite for finding a job is a valid residence permit, language skills are often needed as well. Persons with permanent residence permits do not need to apply separately for a work permit. A right to work is directly related to the citizenship only in the public sector where Estonians and also citizens of other European Union Member States can be employed; only Estonian citizens have a right to work in some positions where official authority is exercised and public interests are protected. Citizens of third countries and persons with unspecified citizenships cannot be employed in the public sector (Migrant population in Estonia 2009).

2.2. Migrants and Health

2.2.1 Health of migrants

All available data on the health status of persons with migratory background comes from different national health surveys, majority of which make use of cross-sectional design. All available studies distinguish different population groups in terms of ethnicity, first language used or citizenship. As terms ‘migrant’ and ‘ethnicity’ (or nationality) differ significantly and are self-reported in the surveys, the results from national health surveys can not be generalized directly to migrant population and should therefore treated with caution.

Various studies have indicated that the overall health status of non-Estonian minority being lower than that of native Estonians. Ethnic differences are present in mortality; also non-Estonians have lower life expectancy at birth which Lower socio-economical status is often considered as one of the main factors related to the worse health status of the migrants. Psychological aspects of economical and social uncertainty and insecurity of immigrant status might be some of the prerequisites of higher suicide rates among ethnic minority groups.

According to the data from Estonian Health Interview Survey 2006, healthily lived life at birth of migrant population is 4 years shorter than that of Estonians from which people have an estimated 52.8 years of healthy life on average. Self-rated health of migrant population is also ca 15% lower compared to Estonians. Leinsalu (2002) found that low educational level, Russian nationality, low personal income and for men only, rural residence were the most influential factors underlying poor health. Personal income was found to be an important factor in explaining some of the educational and ethnic differences in poor self-rated health. Income had mediating effect among women, which reduced the association of ethnicity with poor self-rated health. Russian women had a lower income and also poorer self-rated health.

According to Leinsalu et al (2004), ethnic differences in life expectancy in the period of 1989–2000 increased from 0.4 years to 6.1 years among men and from 0.6 years to 3.5 years among women. In 2000, Russians had a higher mortality rate than Estonians in all age groups and for almost all analysed causes of death. The biggest differences were found for some alcohol-related causes of death, especially in 2000. Lang (2009) found that in 1988-1990 the total cancer incidence among Russian men was higher than that of Estonian men but in 1999-2000 ethnic differences in total cancer incidence decreased. Some of the differences in cancer rates between the Estonians and Russians in Estonia are likely to be attributable to the variation in exposure to specific etiologic factors that are caused by differences in lifestyle and habits such as personal hygiene, smoking and alcohol consumption.

Prevalence of unhealthy habits, excessive alcohol use and smoking is higher among migrant population: there are over 33% of people with an alcohol problem and 20% more regular smokers among migrants compared to the general population. Although alcohol problems are more prevalent among younger population, the relative ratio of older people with an alcohol problem among migrants is bigger than in general population. It is an indication of different patterns of alcohol usage and might also relate to a higher prevalence of depression among older migrants (Sakkeus and Karelson 2008). Although there are no significant ethnic differences in illicit drug usage, more than 25% of 15-35 year-olds previously had used drugs. Uusküla et al (2005) study on the prevalence of injecting drug use found that there are approximately 13,800 injecting drug users, up to 62% of who were HIV-infected. The majority of injecting drug users live in Ida-Viru and Harju Counties; approximately 90% of them are non-Estonians.

Significant ethnic differences in morbidity lie in case of native population in determinants affecting physical health (i.e. obesity) and for migrants in mental health related issues which are aggravated by alcohol problems, regular smoking, risky sexual behaviour and frequent usage of drugs among younger people. This is also an indication of lower general health awareness (Sakkeus and Karelson 2008).

2.2.2 Access to health services

Access to healthcare services and health insurance is related to a person's legal and employment status which is a prerequisite for having a health insurance. Health insurance applies for persons who are permanent residents of Estonia or for those living in Estonia as temporary residents and social tax is paid either by the employer or even privately (according to the contract between Estonian Health Insurance Fund and the person). Insured persons are, among others, persons working on the basis of an employment contract, persons receiving social allowance, persons receiving child care or unemployment benefits. Equal status to insured persons has been granted to pregnant women, persons under 19 years of age, persons receiving state pension and students who are permanent residents (Insured persons. Estonian Health Insurance Fund). Sakkeus and Karelson (2008) note that proportion of persons without health insurance among native and migrant population is comparable (3.1% and 3.6% respectively).

Every person who has a health insurance is assigned (also can be chosen by a person himself/herself) to a general practitioner. In case of illness, the general practitioner is the first contact person who provides primary medical assistance and counselling in prevention of diseases, injuries, and poisonings. Insured persons are eligible for various sickness benefits. Health insurance also covers all persons under the age of 19; all school-aged children are also provided with free school healthcare service and dental care is free of charge for the persons up to 19 years as well. This service provides vaccination and health monitoring of children, health counselling and health promotion initiatives. (Ministry of Social Affairs).

According to the constitutional law, emergency medical care will be provided to everyone despite their nationality, citizenship or presence of health insurance. Every person residing in Estonia, regardless of their legal status or citizenship, has the right for emergency medical service which is provided 24 hours a day in case of life threatening situations.

Information and medical counselling is provided by various telephone advisory-lines which have a regular telephone operator fee (i.e. general practitioner advisory-line 1220) or are

free of charge (service is financed by Estonian Health Insurance Fund). Health information can also be obtained from the internet where information and contacts of all government institutions and majority of health service providers are available. There are also several multilingual web pages (i.e. www.terviseinfo.ee) for promoting healthy lifestyle and providing essential health information.

Sakkeus and Karelson (2008) state that availability of medical care from a person of the same migration and cultural background is a very important factor regarding the health of migrants. Migrants are also represented in medical care system with quite significant relative proportion.

3. Empirical Analysis

3.1 Respondents of the interviews

This chapter provides an overview of selection criteria and sampling process of migrants and describes the process of contacting the respondents. Overview of used data analysis methods and description of the final respondent sample is provided.

3.1.1 Selection criteria and sampling of migrants

Empirical analysis II of the project Healthy Inclusion aims to:

- Provide information about perceived barriers of migrants for access to health promotion initiatives as well as about facilitating factors
- Develop specific recommendations on how health promotion interventions on the community level can be adapted to meet the needs of the migrants better.

For the research project Healthy Inclusion the following general definition of a ‘migrant’ was used:

> *Persons who have been born in another country, who have lived in the host country for at least five years and who have the intention of staying permanently, who have a legal (residential) status and who (as a group) have a disadvantaged (socio-economic or social cultural) position in the host country.*

An inclusion criterion of respondents was derived from the general definition of a migrant which implied that suitable respondents had to be:

- Persons who have been born in another country
- Persons who have lived in the country for at least five years, who have the intention of staying/integrating in the country (thus excluding temporary guest workers).
- Persons who have a legal status in the country (thus excluding 'sans-papiers' and asylum seekers but including (former) refugees.)
- Persons who (as a group) have a disadvantaged (socio-economic of social cultural) position in the host country.

To find the answers to the proposed research questions, the sample was divided into four analytical groups:

- Persons with and without access to health promotion initiatives
- Persons with different migratory backgrounds

According to the definition of WHO, health promotion is the process of enabling people to increase control over, and to improve their health. In this report, terms 'health promotion initiatives', 'health promotion interventions' and 'health promotion services' are used to refer to broad range of public health measures available to general population, which are planned, implemented and provided by different stakeholders (i.e. NGO's, public sector; non-profit organizations and limited-liability companies etc.). No specific distinction between these categories (if not stated otherwise in the text) is made in this report as it was not required by methodological guideline of the project.

Persons with access and persons with no access to health promotion interventions groups: the term ‘access’ refers to past or present participation in health promotion interventions and initiatives while ‘no access’ group indicates that no previous experience with health promotion is available.

The Estonian project’s approach on migratory background indicator differs from the one proposed in the project’s methodological guideline. Instead of ethnical division time periods are used; particularly the year 1991 as a cut-off point. The rationale behind this distinction is that ethnical composition of migrants and forces influencing migration in Estonia can be divided into two major periods: a) the Soviet occupation from 1940 – 1991 with migrant inflow from areas of the Soviet Union and b) Regaining independence from 1991 when migration patterns are described by emigration and (re)migration from western Europe. These two groups are referred to in the analysis as ‘old’ and ‘new’ migrants.

Total number of respondents to be interviewed was 20. From both migration groups, 10 persons (from which five had to have previous experience with health promotion interventions and five not) had to be interviewed. Social characteristics such as gender, age and education were taken into consideration in sampling process. Sample size was defined by methodological guidelines of Healthy Inclusion project and was same for all participating partner countries.

3.1.2 Methods used to reach migrants

Methodological guideline of the project suggested variety of methods for reaching the target group. Respondents should be contacted using social network based sampling – “snowball” method -, but also through contacting migrant organisations, taking advantage of company’s networks and personal contacts. Experience from previous empirical analysis (interviews with providers) could also provide an entry-point for contacting the target group.

In practice, snowball method and contacts from previously interviewed providers were ineffective due to different reasons: small sample of health promotion providers could not provide suitable respondents or did not respond, suggested candidates for interviews did not mach selection criteria etc.

Personal approach was preferred because sampling requirements were quite specific. Nevertheless snowball sampling was ineffective; only three respondents could recommend suitable persons for interviews. Majority of interviewed respondents were found using professional and personal contacts of interviewers, health promotion providers and also by using internet based social networks like Facebook and Orkut. All pre-selected respondents, who matched the sampling requirements (migration background, experience with health promotion etc.) based on background information given by mediators mentioned above were contacted by phone or email. When contacted person agreed with the interview, the suitable place and time for meeting was selected.

3.1.3 Description of the methods used in the Empirical Analysis

This report presents the results from the empirical analysis II which were based on 20 semi-structured qualitative interviews with the selected migrants. Respondents were interviewed between September and October 2009. Interviews were conducted by 5 interviewers in three languages: Russian, Estonian and English. Language was selected according to respondents' preferences. The duration of interviews varied between 30 to 90 minutes. All interviews were recorded and transcribed. Interviews carried out in Russian or in English were translated into Estonian for data analysis.

Qualitative content analysis which included preliminary, exploratory coding of data from interviews and later theoretical coding which followed the projects' research questions were performed using qualitative analysis software Atlas.ti version 5.0.

3.1.4 Features of the interviewed migrants

Total number of 20 interviews were conducted, 10 with persons who have experiences with health promotion and 10 with persons without such an experience. Interviewed respondents can be divided into 2 groups: persons who migrated before and after 1991(Table 1).

Table 1. Characteristics of the respondents from the older and newer migration group

		Access to HP	No access to HP
Gender	Male Female	4 6	6 4
Age	20-30 31-50 51 -	3 3 4	4 5 1
Education	Lower Middle Higher	1 2 7	0 5 5
Employ-ment status	Employed Unemployed Inactive	6 1 3	5 2 3
Self-rated economic status	Good Not good, not bad Poor	2 4 4	4 4 2
Type of migrant	Old New	5 5	5 5
Legal status	Citizen of Estonia Permanent residence Temporary residence	6 2 2	4 4 2

10 interviewed respondents who came to Estonia before its re-independence in 1991 originate from different areas of the Soviet Union, most notably from Ukraine and republics in Central Asia. They migrated in 1969-1988, most of them in the 1970s. Official policies of the 1970s supported resettling from these areas with different work and education benefits but often the decision to resettle was related to personal reasons (relatives already living here, marriage etc.)

Respondents from recent migration group arrived between 1991 and 2005 from Russia, Ukraine, Germany, Turkey, Pakistan, Sweden and Latvia. Reasons behind the decision to migrate are related to family, work and studies.

3.1.5 Self-estimation of an integration level

Interview questions also addressed the topic of integration. Respondents were asked if they feel welcomed and respected in their host country. Half of the interviewees (10) reflected that they feel themselves welcomed in Estonia – they are being respected and are satisfied with the attitudes of the general population towards them. Respondents who felt being left out (6) and reported some discrimination towards them (2) were from (old/new) migratory groups, also previous experience (or lack of it) with health promotion (description of respondents perception of health promotion concept is given in chapter 3.2.3) does not explain these attitudes. Perceived discrimination was related to the insecure legal status and negative attitudes of the general population towards migrants.

Command of an official language might be considered as a supportive factor for the access to health promotion initiatives and health services in general. In this case language skills seem not to explain the differences when accessing health promotion interventions – respondents with different language skills are evenly divided between both groups of those who have access and those who have not. But differences in command of Estonian are evident when comparing the two migrant groups regarding their age: recent migrants, being also significantly younger, speak better Estonian and have therefore fewer language problems in daily interaction.

Overall pessimistic stance regarding general satisfaction and the feeling of not being welcomed might be related to the social capital and participation in the society which applies especially for the Russian speaking group which often reported that Russian is their main language in everyday social situations. Their communication network consists mostly of Russian speakers and contacts with the main population are meagre. Estonian, if spoken, is used only in official setting i.e. work, public offices. Strong support from ethnic commu-

nity also reduces the need to learn the official language, which - in lack of possibilities for language practice - leads to lower language skills. Besides their relatively young age, recent migrants do not have strong ethnic communities which can be seen as a supportive factor for learning the language.

All interviewed migrants, except for two cases, used their mother tongue to communicate with relatives and friends from the country of origin. Contacts with relatives from the native country and maintaining traditions are seen quite important. Age had strong influence over the attitudes concerning traditions; older respondents were more persistent when keeping their cultural background. Participation in different associations was low with only two persons being active in a non-profit organisation.

3.2 Migrants and health

3.2.1 Perception of the health concept

Respondents brought up very different aspects of health. First of all, health is associated with the **quality of life** in general. For the respondents of this study, being healthy often is an prerequisite of a good, a joyful life.

> *„Life is like this. If you feel healthy, then the life is more joyful. If you feel tense somewhere, what kind of life is it? "*(M59noaccess)

Good quality life means that there are no troubles, no need to specially think or do something about one's health.

> *„I usually do not think about my health. Usually you assess how you feel. And if you feel somewhat differently/unusual, then you start thinking…That means you do not think [about health] when everything is more or less all right.“* (F43access)

For older people or people with a severe health condition being healthy means being independent, being able to go on with everyday life without someone's help. Such independence is directly related to the quality of a person's life.

> *"To be honest, now in my situation to be healthy means self-dependence. It means you can do everything yourself. This is the first principle. Also independence….This summer, 6 years after the accident, I was living like a human being. …I was able to stand up and go wherever I wanted."* (F47access)

Active participation in social life and working are seen as the main things in person's life. Health is seen as a **necessary condition for active life**/work. Health is associated with energy:

> *"To feel good…lightness, motion, happiness."* (F57access)

> *To be healthy means waking up in the morning, not being nervous. To wake up in a good mood, feeling full of life".* (F27access)

> *"Exactly. When I am able to run, exercise, live my everyday life, then I feel healthy"* (M28noaccess)

People would like to be useful: when they are in the working age, to be able to work; when a person is already retired, to be able, f. e., to help and support their children or, to play with grandchildren.

> *"To be useful. Health is a gift that you are using. To be useful for others. I have children, grandchildren and one grand-grandchild was born this summer. This is a value."* (F73access)

Health could also be defined as the **absence of illness.** A similar approach can be noted in case of psychological health: being psychologically healthy means absence of stress, tension etc.

> *"It means also that there is no illness, meaning no pain, no fever etc."*
>
> (F57access)

> *"[when I do not feel healthy] sometimes I feel such a fatigue that I do not want anything…or pain does not allow me to act, then I need to do something to get rid of this."* (F57access)

The interviews indicate also that one can look at health not as a condition but as a process: to be healthy means following healthy lifestyle. One respondent named health as being part of a Christian morality – such an interpretation also allows us to look at health as a process.

3.2.2 Perception of the status of self-health

The general assessment given to one's health was "rather good", in some cases "neither good nor bad". It is important to stress the subjectivity of the "rather good" assessment. People assess their health not based on the abstract idea of "ideal health" but on their own condition and situation. In this situation "rather good" health for a person with physical disabilities is a possibility to move around the apartment without anybody's help while for a young man it is a physical shape that allows him to run a 40-kilometre marathon.

Not feeling healthy is associated with: fatigue, being passive, being socially isolated, general apathy.

"When I am in a bad mood, I have no power to do things. I just switch on a TV set and watch it senselessly. I look at the screen but the thoughts are far away." (F27access)

When respondents do not feel good they take some steps to get better. Many of them reported having a rest or getting enough sleep as the first step to heel themselves. In general, people act according to their common sense as what to do when one is not feeling all right:

„People use common sense … They drink herb teas, all kinds of teas, use over-the counter medicines. So... . The system is still working as it used to work a long time ago." (M43noaccess)

Quite often respondents rely on themselves and seek for medical help as the last resort. This is especially true for male respondents. For example, one of the male respondents reported even making a small surgery (putting stitches) himself.

"I restrict physical activity, watch my diet carefully. Look for information what kind of causes jeopardise my health. I am trying to remove such causes by eating healthy food, getting physical action or other measures. – What about seeing a doctor? – Of course, I consult a physician but I prefer to rely on myself taking into consideration doctor's advice". (M31noaccess)

While bad health is mostly associated with insufficient energy, good health means a lot of energy. Our respondents mentioned: "feeling fresh", "feeling energetic", "feeling good", "being calm", ability to do anything without restrictions, feeling happy for whatever you do.

In general, respondents reported that in case of illness they heal themselves without seeking for external help. Strategies include getting more sleep, taking some herb medicines, praying. There are some differences in the attitude towards getting external help when not feeling healthy – some respondents look for physician's help immediately while others do it

as the last resort when it seems impossible to manage the situation alone. This regards physical health as well as psychological condition.

3.2.3 Perception of health promotion

In general, respondents regard health being a very important factor in their life. This attitude is taken for granted and interviewer's question about importance of one's health was often met with surprise.

Health promotion, however, is not as intuitively understood as being healthy. The very concept of health promotion is unfamiliar to people. During the interviews respondents asked for clarifications of the term and understood it rather as a healthy lifestyle. The first thing to mention in regard to a healthy lifestyle is doing physical exercises or sports. After additional questions other things come out as well. Following descriptions were given by respondents in relation to health promotion (healthy lifestyle):

- Sufficient physical activity/sports
- Sufficient rest
- Healthy food (bio, vegetarian)
- Personal hygiene
- Positive emotions
- No smoking
- Moderate alcohol consumption / no alcohol
- Healthy, clean environment / fresh air / being out of town
- Traffic safety (more possibilities to ride a bicycle safely)
- Health-related self-education
- Avoiding (no need for) medical services

These issues or rather behaviours are responsibilities on the level of an individual. While discussing what should be done to improve health of the population and promote healthy lifestyle, other dimensions came out. Especially issues related to health education were stressed.

> *"If you smoke and your child sees it, she/he will start smoking, too. If you drink and your child sees it, she/he will start drinking as well. How to increase health promotion…I do not think health promotion is related to this. What I mean is that at that age the information at school should be sufficient, how to live with it. I remember that in Turkey at high school we had one class like this. We did nothing else but played football outside and then came back. But it should be that instead of doing sports we should rather learn something about human body, about how these things [tobacco, alcohol] influence human body. These are the things that should be taught in the early age."* (M29noaccess)

It is important to change people's perceptions and attitudes. All social institutions should be part of health promotion: government, law enforcement, NGOs, educational institutions. Several respondents stressed that health promotion should start on the very early life stage – schools and kindergartens play central role here.

Among the health promotion initiatives that would be interesting to the respondents, opportunities to engage in sports/fitness were mentioned most often.

The other initiatives discussed were related to getting more information about health issues:

- the holistic perspective on body functioning (including diet, medicines, body functions and malfunctions)
- expert information on (new) medicines, introduction of research results
- medical expert explanation of whether and how traditional medicine (herbs etc) are working.

It was stressed that information provided should be made understandable, "lay person" language should be used in such lectures/ seminars/ information hours/ meetings. The re-

spondents are mostly interested not in health promotion or health related information in general but in more specific information related to their situation and condition. There was no expectation (no one mentioned it) that such information would be provided during respondent's visits at a doctor.

3.2.4 Information and awareness about health rights, opportunities, access to healthcare services and health promotion services

Respondents discussed health rights only in relation to health services. Rights were referred to as a free access to the health services covered by medical insurance. The situation, when the only possible alternative to get health service is to pay for it, was considered unjust. Many respondents would rather refuse seeing a doctor than to pay for the service when they have a valid health insurance.

> *"If they offer me to turn up for commercial medical services, I would not do it. Why should I pay for the services that I am entitled to get for free? But I cannot get to the free services. When you call, they say that registration for this month is fully booked. I say I don't care. Just book me for the next month or two, three or five months. Their answer is that we register in the beginning of every month only. Then I call the first day of a month and get answer that it is fully booked. I called 8 AM when the working day starts, first nobody picks up the phone and then 20 minutes later I get an answer that everything is booked. And then I get angry…and I hang up the phone. It is impossible that they do not register and everything is booked."*
> (F57access)

The information about patient's rights is mostly "common knowledge"; no specific source of this information was mentioned. Usually respondents got such information from another person with a similar condition or trouble. According to interviewed respondents, sometimes doctors are not aware about such rights (as an example, rehabilitation plan was mentioned).

The situation concerning receiving information about health services is similar to rights and opportunities. Actually, rights are seen as having access to certain health services. This

information is also passed from one person to another, in some cases doctors were also mentioned as a source of information. NGOs / associations for people with specific medical condition are also important sources of such information. A good opportunity to get full information about services and access to services is when a doctor is a close friend or a relative – the information and consultation can be provided any time and informally (e.g. phone call).

Respondents referred to having had bad experiences with health services. Among those:

- Doctor shows little interest in the patient.
- Too long waiting lists to see a doctor
- Doctors are not always aware about different health services that are provided for the patients (e.g. rehabilitation for persons with sclerosis multiplex) and therefore cannot prescribe/recommend it.
- Discrepancies between a health service and accessibility of this service for the patient that makes it impossible to use this service (e.g. SPA procedures for disabled people while construction of a shower/bath is such that it can only be used by a healthy person).
- Regular checks for healthy persons are a rather unusual practice (Exceptions are women's visits to gynaecologists).

The overall impression is that respondents are trying to avoid health services as long as it is possible. In our sample only persons with diagnosis (e.g. cancer, sclerosis multiplex, and infarct) are seeing doctors on a regular basis. For other persons only acute conditions or trauma will bring them to a doctor's office.

Health promotion is seen as a different matter. As it was mentioned above, health promotion is seen as a self-responsibility of a healthy lifestyle of the person. This influences also the way respondents get information about initiatives and opportunities. Respondents search the internet/ read leaflets. The positive effect of a campaign events (e.g. quit smoking, mass sports events) was mentioned as well.

3.2.5 Differences and similarities between the two interviewed migrant groups

In our study we compared migrants who came to Estonia before the independence and after the independence and within these groups' migrants with access to health promotion initiatives and those without access.

The difference between the "new migrants" and the "Soviet time migrants" is their ethnic composition. Persons who came to Estonia during the Soviet time were mostly people from other republics of the Soviet Union. The ethnic origin of these people did not matter – they all spoke Russian language – the official language of the Soviet Union. Now they form a group of migrants that is often referred to as Russian-speaking population. The problem related to inclusion of this group is mainly discussed in terms of the language. If a person can speak Estonian, they have access to information and services provided in Estonian; if not, there is a possibility for exclusion. Therefore exclusion/ inclusion was often discussed in terms of availability of information and services in Russian language also. With the group of "new" migrants the situation is different. Their ethnic background is quite different – in our sample we have a Turk, a Latvian, a Swede, a German, a Ukrainian and a Pakistani. Russian is not the language they speak. Sometimes they can be in a situation when the only alternative to Estonian is Russian language, the language these people cannot understand at all.

In general, no major differences between groups were found. While it is very difficult to find any difference between the "new" migrants and those who arrived pre-1991, some small differences could be noticed between "with access" and "no access" groups.

The group with access have overall more active and socially participatory stance compared to the group without access. The majority of migrants without access to health promoting initiatives felt that they do not need any of them. They stressed their individual responsibility for their health, for example, they prefer to look for information in the internet instead of attending any kind of seminars or courses.

3.3 Migrants and access to health promotion interventions

3.3.1 Migrants with access

3.3.1.1 Services used and health promotion initiatives attended

Respondents reported noticing or participating in health promotion initiatives that were organised as **general population campaigns**. Those are often initiatives co-ordinated on the country level. The list includes:

- "Heart week" – campaign for prevention of cardio-vascular diseases and promotion of healthy lifestyle
- quit smoking programmes, including consultation cabinets and a website
- organised periodical health checks (height, weight, blood pressure etc) at schools
- education about safe sex (how to put a condom etc) at schools
- sports events, such as Tallinn City Races.

The other group of health services are **sports clubs** and other sports related activities. Respondents have reported either going to sports club, attending some sports activities in the past or expressed their wish to do it when it is possible. To some extent rehabilitation centres could be considered also belonging to this group.

The third group involves initiatives related to **psychological** well being. The variety of forms was referred to here as well:

- individual consultations
- psychological group trainings
- peer support groups

The fourth group involves health promotion initiatives directed to specific group of people with a certain **problem/ diagnosis**. In the sample examples of such initiatives are “Drug Addicts Anonymous” and “Estonian Association for People with Sclerosis Multiplex”.
The fifth group includes participation in the initiatives that can be named **“alternative”** approach to medicine or healing. Some of them are based on old Oriental traditions (Feng Shui or Yoga were mentioned), some other are balancing on the edge of a fraud scheme (in our sample, we got an example of “Coral Club” – pyramid scheme for selling coral-water).

3.3.1.2 Access procedures and approach to interventions

The access procedures for the 5 described types of health promoting initiatives are different.
For the campaigns for the general public the main source of information is social advertising and media. This does not require any special or additional activities of a person. Therefore participation in such programmes is passive. One exception here was a quit smoking project that involved different channels – informative, a motivating website, information in mass media, and a possibility of personal consultations (so called “quit smoking cabinets”). Participation is such programmes are usually free of charge. Mass sports events require a registration fee and that can be an obstacle for participation. However, participants are motivated with attractive rewards – e.g. free cruise to Finland.

> *“One good thing that Estonian government does… that they encourage people to participate in health marathons, walks by giving them free tickets to Finland and other things like this.”* (M29noaccess)

To attend a sports club a person usually does some kind of an inquiry – what clubs are around, what is the equipment, how expensive it is, who are going to the club etc. Internet is the main source but also information from friends and other people is used. Factors related to attendance/ not attendance of sports’ clubs are high price, proximity to one’s home or work place, lack of free time or laziness.

> *"I would say that if it would be financially possible, I would prefer going to a sports club instead of just exercising at home. It is better in clubs than at home. Sport equipment is expensive and there is no space at home for it.. So it is what I miss. I would also do some extra activities after workout: go to a swimming pool or a sauna. Of course, if I had more money, I could take better care of my health."* (M37noaccess)

The information about psychological/ crisis advice can be provided by a doctor or some people can recommend a psychologist. In case of a group training reported by our respondents, the information was passed from one person to another. The fee for the services was mentioned not as an obstacle but as a motivator (in order to get something back you need to invest something).

Information about supporting peer groups is spread among people with a similar problem/ diagnosis. Drug Addicts Anonymous mentioned advertising their groups by putting information (notes/ posters) in the places where drug addicts move quite often (bus stops, market places, syringe exchange centres etc). Participation is free, so if a person has no money it would be no obstacle to participate in the initiative. For disabled persons, however, lack of accessible public transportation, access routes etc. are important obstacles.

The so called "alternative groups" recruit new members from their social circle – friends of friends etc. This is the basis for their commercial model.

> *"A friend called me. She got into this club [Coral Club -* http://www.coralclubunion.com/ *- AM] in Tallinn. They all are doctors there. It also influenced me that there are many Christians working in this organisation. They are believers and therefore honest people. They visited us here (9 persons) and conducted a seminar. Now there are approximately 15 people who know about it. I made it clear for myself that first of all body should be cleaned, then fed and healed. One should protect the body, not to cause damage to it – this is our program. Some persons got rid of a head ache; some got rid of an allergy."* (F73access)

3.3.1.3 Concrete results and outcomes of the interventions on migrant's health

All respondents reported these interventions as having positive impact on their well-being. For example, doing excercises or participating in sports makes people feel better; a drug addict managed to stay clean for 8 months and considers it as being the beginning of a new life; disabled people see the initiatives as a way to live a more "normal" life, which helps them to adjust to their condition and to improve it. Psychological consultations and trainings help persons to put priorities in their life, improve relations with close relatives etc. Therefore, it can be concluded that health promotion interventions have positive effect on health status but also on the overall quality of life.

3.4 Migrants who do not have access to health promotion interventions

3.4.1 Reasons for not using the services

Respondents who did not use health promotion initiatives explained their non –participation mainly with lack of time.

> *"Most difficult is to find time for such things"* (M29noaccess)

The code 'lack of time' was often used together with the codes 'laziness' and 'lack of interest'. Having no interest in health promotion interventions is one of the main reasons for having no experiences with it. Lack of interest was related to satisfying overall health status or no health complaints. Interviews revealed that interest in health promotion has a lot in common with perceived health needs and individual understanding of good health:

> *"I have no need for this (health promotion) and actually I haven't seen such initiatives before. I don't smoke, so I don't have the need to participate; I'm not fat, therefore I don't need the information how to lose weight; I don't have any pains either..* (F25noaccess)

Lack of interest for participation was interrelated with scepticism towards possible benefits of interventions:

> *"I don't believe that I would get something out of it, some knowledge... If I want to know something then I can take a book and read it from there".* (M21noaccess)

Also unclear objectives and usage of professional terms were claimed to be hindering factors by respondents. Information is often provided using confusing medical terminology which can be complicated to follow, especially in the case when migrants' language skills are not very high. Non- participation was also reasoned with personal traits or preferences of interventions.

> *"Let's say because my personality, I don't like big gatherings. Maybe in small groups it would be interesting but I am not ready yet. I think I am self-centred enough and I can get all the information I need myself."* (M37noaccess)

Other important key terms regarding reasons for not using health promotion initiatives were lack of information.

> *"The problem lies in advertising, language, in information that something is happening. I am not even sure if Estonians have info about these health promoting initiatives"* (M29noaccess)

> *"I don't know if I can participate in such events /.../ if I am not reading newspapers and if there's something in these papers, I won't get the information. I have no idea where should I get this kind of information"* (F43access)

Nevertheless, lack of information was not reported by all respondents. Most of them had at least general ideas where to find health information with the 'use of internet' being a key term, relevant information is also found using personal contacts. Language barrier might also be considered as important barrier of participation. Problems with language skills in everyday communication and when using health services were often reported:

> *"A drug, you buy it from a pharmacy after getting a doctor's prescription... it is impossible to read instructions… even in a pharmacy. Truth to be told, even in everyday life if you have questions about health – information is only in Estonian and in English."* (M59noaccess)

> *"...because if they do something in Estonia, they do it in Estonian only. So we can't understand anything, even if it is being advertised. I just don't know it."* (M29noaccess)

Although language problems are present, its association with ethnical discrimination is not reported:

> *"I personally think that doctors do their job well. I haven't met such who distinguishes by ethnical background... haven't seen such."* (M59noaccess)

> *"Let's say the question of nationality is not an issue, it is not important if there are people not animals."* (M37noaccess)

> *"In my opinion, everything is the same for Estonians."* (M31noaccess)

3.4.2 Suggestions to enhance their personal usage of interventions

Interviewed respondents acknowledged that personal interest and greater awareness on health are prerequisites for making first contacts with health promotion initiatives. Overall interest in health promotion varied among 'no access' group with two attitude types appearing: a) Individual attention to health (physical exercise, relaxation); b) interest towards general health promotion initiatives.

Persons with high individual interest in their health were mostly already living 'a healthy lifestyle' paying some attention to their eating and drinking habits and physical activity. Interest towards health promotion was in most cases passive and their non-participation was reasoned with various hindering factors:

> *"...nobody invites me. I have also problems with the official language. If info were in my mother tongue, then maybe I would call them and participate."* (F43noaccess)

Personal interests in health promotion seem to derive from direct health needs. Although all interviewees claimed good health being very important in life, it is more associated with persons reporting health problems while interviewees with no medical conditions were more moderate:

> *"Seldom. It won't happen that I would sit down and think about my health. Not even so: "I have to do physical exercises because it's good for my health."* (F57access)

> *"It is impossible to say no because I think about eating, sports – about all these aspects. But "yes" is not a good answer because I am not very passionate about it."* (F25noaccess)

Often reported language problems could be avoided if information would be provided in migrants' language. Ethnic differences in reaching information from various media chan-

nels are evident. Although there were no shared opinion on effective and suitable information channels, it is clear that more attention to advertising is needed:

> *"There is very little information. Many don't read something like that and get their info only from TV and radio... even the Internet is not always used ."* (M37noaccess)

> *"I don't think that TV advertising was of any use, booklets and info sheets might be better."* (F43noaccess)

Some financial obstacles were also reported in the interviews in the context of admission fees of sports clubs:

> *"When I lived in Tartu, I went to aerobics. Did it for one and a half years. Then I don't know, maybe I didn't have time or maybe there wasn't enough money.. I quit. Some time after that I visited dance classes for 3-4 months. Then I quit due to my financial situation".* (F27access)

> *"Sure good gyms cost much. But if there were more gyms in the town, maybe they would cost less. I recon lot of people think also that if the prices were lower, they could afford it."* (M37noaccess)

4. Improvement suggestions of the users

4.1 Proposals of the migrants

Interviewed respondents proposed a range of suggestions for a better accessibility of health information and improvement of environmental factors associated with healthy life-style. One recurring theme was the need of cycle tracks between bigger towns and surrounding settlements. It would improve road safety and encourage people to live a more active lifestyle. For example, one respondent compared current situation with neighbouring countries:

> *"When we compare with the Scandinavian countries, then they have many cycling tracks. With bicycle you can go anywhere. In the city and outside of it is safe and nice. And you just want to ride and ride /.../ we also need more cycling tracks."* (M37noaccess)

Another and more applicable set of suggestions focused on organisation of interventions. Proposals included the need for interventions specially targeting migrants or more flexible regarding language used:

> *"If there was an opportunity to get information in the way migrants need it, then it would be more useful."* (M43access)

> *"Not for me but regarding the speciality of the region, we would really need more leaflets and materials in Russian."* (F57a_access)

> *"And translation would be good. Interventions for Russians only...it is definitely needed. But if it had also a translation, it would be good."* (M35access)

Advertising and availability of information is considered to be very important. The message of these campaigns needs to be clear and its possible benefits easily understandable:

> *"More advertising is needed. And it needs to be published also, so I could reach this information. This advertisement should also say couple of sentences why it's good for you health."* (F27access)

The form in which these interventions are provided is also important:

> *"There should be differentiation between lectures and action programmes. Last one is more needed. Lectures have relative values."* (F57a_access)

The content of interventions was also discussed. The most important topic was healthy nutrition which, according to respondents, needed more advertising targeted to children and adolescents. Topic of interest was also traditional medicine:

> *"I also like to hear...not this eco-thing but things like if stomach hurts you should drink chamomile tea not take an Ibuprofen pill. About traditional medicine."* (F25noaccess)

> *"I'm for traditional medicine: For example, no research has been done on effects of goose fat but people are using it against cold symptoms. I would like to know if there is such research and would these results confirm the positive effect of it. Something like that I would like to know."* (F27access)

Health promotion was seen as public responsibility with different shareholders starting from the government policy makers to education system:

> *"It (HP) should be defused, meaning it has to be everywhere. And government should deal with it, enforcement agencies. Schools. Starting from the kindergarden. Overall culture needs to be educated… attitudes towards it….it is a national task."* (M59noaccess)

A lot of attention was given to education system which role as socializing agent is influential when shaping individual health behaviour. Therefore health promotion interventions

should be integrated more into educational policies and curriculum. Parental examples and parental role in internalization of health behaviour is also recognised.

4.2 The proposals of the migrants in comparison with the proposals of the providers

In the empirical analysis providers' ability to speak Russian or the multiethnic composition of the staff were estimated as supportive factors by the providers to increase potential participation of the migrant population. This was also mentioned in the interviews with the migrants. However, it came out that for the "new" migrants this will be not sufficient because of their different language and cultural background. Although the proportion of "new" migrants is still relatively small, the number and variety of migrants with different backgrounds is expected to increase. It would be wise to introduce a network of interpreters, e.g. involving cultural centres, communities, etc.

Providers also recognised the need for better availability of information in a language suitable for the target group which could be met by translating information about the interventions into Russian and other (English, Finnish) languages. Availability of information in the native language is also seen as supporting factor for participation in health promoting initiatives by the migrants themselves. Therefore, based on both the opinions of the migrants and the providers, translation of essential materials is recommended; especially important is usage of internet, where its availability in different languages and also sufficient advertising are prerequisites for reaching migrant groups.

Both, providers and migrants, acknowledged the importance of education. The important role of the school for teaching healthy lifestyles to children came out from interviews with the migrants. More attention and active partnership with educational institutions is important also from the providers' point-of-view; health promoting interventions should target issues of school stress and school violence.

Providers mentioned that to grant access of vulnerable groups to health promotion, interventions should be made available and affordable to all. Interviews with migrants confirmed this, especially related to sports and physical training groups/facilities. Bettering

overall quality of the infrastructure and its facilities, although an expensive measure, could improve the situation.

Providers also described the importance of monitoring and evaluating the programmes which on the organisational level could enhance effectiveness of interventions; this was not reported by the migrants.

5. Conclusions

Based on the analysis of 20 qualitative interviews conducted for the present study, this part provides general conclusions of the data regarding good experiences and also persistent difficulties in the experiences of the migrants with participation in health promotion initiatives.

Our study revealed, that migrants are not familiar with the health promotion concept. It was very difficult for the respondents to understand what health promotion means and what interventions can be considered as health promoting initiatives. Usually sports and diet are the first things to being mentioned, followed by non-smoking and not drinking alcohol. Misunderstandings about health promotion, limited knowledge about health in general and low social participation might be considered as main reason behind lack of interest towards the available health promotion initiatives. Although this information – starting from the general principles of health promotion and ending with concrete initiatives – is available from different channels, including internet, which also was the main information source for our respondents to look for information, more attention to advertising and popularising of health promotion and healthy lifestyles can be recommended.

Interviews indicated, that the information needs vary significantly; interviewed respondents reported, that they would like to know for example about symptoms of illness, alternative medicine, spiritual practices, sports and fitness clubs. Interviewed migrants mentioned internet as the main source for health-related information; this information is usually available also in other languages (Russian and English as a rule). Although the information may be available, the effect and acquisition of knowledge depends on how the information is presented.

There are traditional health promoting events such as heart week and quit smoking campaigns, which are week are noticed by the migrants. Interviewed migrants were aware of these events, however, their participation was passive – e.g. stopping by to look at cam-

paigns' activities on the street or noticing an advertisment. Among positive health promoting campaigns often noticed by our respondents are mass sports races and walks. Organisation of these events was often brought as an example of successful health promotion initiatives. Although these notions might indicate that overall health awareness is rising, none of the respondents had participated in such events personally.

Lack of interest and motivation to participate in health promoting initiatives was often reasoned by respondents with lack of time - interest or just laziness. We find that to overcome this situation some additional motivators like interventions free of charge, elements of play (i.e. recently implemented alcohol diary, webpage to calculate and record daily alcohol consumption), or co-operation with commercial companies (like ferry cruise tickets for the event participants) could be helpful to provide additional motivation.

Majority of services or at least information is also available in Russian language. All Russian-speaking migrants that we interviewed reported that they always have received medical services and that personnel have had good command of the Russian language. Although about 30 per cent of the Estonian population speaks Russian, this language is not the official language of Estonia. Therefore, formally there is no obligation for the personnel to speak Russian or to provide information in Russian language. With the health promotion interventions provided by the NGOs the situation may be slightly different – some personnel may not be able to speak Russian, but in such cases they always look for someone else from the staff who can manage. However, we have not crossed any case of denial of medical services due to the respondent's inability to speak Estonian language. One respondent reported that sometimes no information about medicines (leaflets included into the package) is available in Russian, which is not acceptable and might have serious health consequences. Although information leaflets are probably available on the internet, it can not be expected that elder persons will search the internet for this purpose.

There is a need for better infrastructure to support a healthy lifestyle, which can be considered as an important aspect for increasing general health awareness. In several interviews respondents mentioned the lack of infrastructure to cycle, jog or otherwise work out outside a sports club. Lack of cycling roads was mentioned as an obstacle to ride a bicycle as

much as it was wanted or to consider a bicycle as an alternative to the automobile. It was also noted that in a situation like the one present now when bicycles share road with cars, riding a bicycle instead of doing good for a person's health actually threaten one's life. Availability of public facilities for sports and exercising can be a solution for the situation when a big part of migrants said that they cannot afford going to a fitness club.

It can be concluded, that to improve migrants' access to the health promotion services, general awareness about health promotion, its aims and possible health benefits at individual level should be increased. Because individual interest may vary significantly, offered possibilities should be broad-based, but attractive. Therefore it is important to include different motivational mechanisms, provide essential information in comprehensible and understandable format in attractive media (i.e. internet). Regarding design of health promotion interventions and health policies targeting migrant population, further co-operation with different stakeholders – policy makers, regional governments, education institutions, migrant organisations etc. – is a crucial challenge for increasing migrants' participation in health promotion interventions in Estonia.

6. Summary

"Healthy Inclusion" is an international project carried out within the Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, Public Health (EAHC).

The overall aim of the project is to contribute to the increase of access of migrants in health promotion interventions. Specifically, "Healthy Inclusion" has the aim of gaining knowledge about barriers and supporting factors for migrants in using health promotion services by exploring the perspectives of providers as well as of migrants.
This report provides the perspectives of migrants on their perception of health, health status and attitudes towards health promotion, on explored barriers and supporting factors when accessing health promotion interventions.

Literature overview on migration in Estonia revealed that immigration has played a significant role in the current ethnic composition of Estonia where the year 1991, when Estonia regained its independence, marks both symbolic and structural division between different migration patterns: the OLD - Soviet occupation from 1940 – 1991 with migrant inflow from areas of the Soviet Union; and (b) New – since 1991 characterised emigration and (re)migration from western Europe.

It can also be mentioned that general socio-economic conditions of foreign born persons are less favourable and there are also distinguishable ethnic differences in objective health status and more risk taking health behaviour.

To explore and describe possible differentiation in factors influencing access to health promotion in migrants with different migratory backgrounds, 20 qualitative semi-structured interviews were carried out. Sample was stratified on the basis of previous experience with health promotion initiatives and migration backgrounds of the respondents. Current analysis includes respondents from two groups: 1) persons who migrated to Estonia before year

1991, and 2) persons who arrived after year 1991 when Estonia regained its independence. Socio-demographic factors (age, education, gender) were also taken into consideration.

Results of the analysis indicate that health is seen as a very important factor in life. It is associated first of all with quality of life in general. Health is seen as a necessary condition for an active life/work and ability to be useful to others. Negative definition of health defined as the absence of illness was also mentioned several times.

The general assessment of one's health was "rather good", in some cases "neither good nor bad". Not feeling healthy is associated with: fatigue, being passive, being socially isolated, general apathy. When respondents do not feel good they will take some steps to get better. Although in some cases, immediate medical help was sought, quite often respondents tend to rely on themselves which meant getting more sleep and using herbal medicine; medical help was used only in serious situations.

Interviews indicated that the term health promotion is not so intuitively understood and is rather unfamiliar to people. Health promotion is defined as a process described in terms of personal hygiene, healthy food and lifestyle habits, sufficient physical activity/sports, positive emotions, health education among others. Although institutional form of health promotion was recognised and health promotion was seen as a public responsibility, also the role of a person him- or herself was mentioned.

Interviewed respondents reported noticing or participating in different health promotion initiatives that were organised as: 1) general population campaigns; 2) sports clubs and physical activities; 3) psychological counselling; 4) health problem or diagnosis support groups, and 5) alternative approaches. It was stressed that information provided should be made understandable, "lay person" language should be used in such lectures/ seminars/ information hours / meetings. The respondents are mostly interested not in health promotion or health related information in general but in a more specific information related to their situation and condition indicating a need for more individual approaches. Interventions

appear to have a positive impact on their well-being, affecting not only the health status but the overall quality of life as well.

Interviewed respondents acknowledged that a personal interest and greater awareness on health are prerequisites for making first contacts with health promotion initiatives. Having no interest in health promotion interventions is one of the main reasons for having no experiences with it. Interest seemed to derive directly from personal (health) needs - majority of migrants without access to health promoting initiatives felt that they do not need them. Another important key term regarding reasons for not using health promotion services was lack of information.

In general, no big differences between the two migration (old/new) groups were found. The difference between the “new migrants” and the “old migrants lays in their ethnic composition and age.

The group with access has overall more active, more “social” position in other aspects of their life compared to the group without access. Overall interest in health promotion varied among the ‘no access’ group with two attitude types appearing: a) individual attention to health (physical exercise, relaxation); b) interest towards general health promotion initiatives.

Respondents proposed several recommendations for improving health promotion interventions and its applicability to migrants. Out of interviewed respondents’ proposals and suggestions most stressed was the need for better accessibility of health information and improvement of environmental factors associated with healthy lifestyle. Comparing results to Empirical analysis I of Healthy Inclusion project which focused on perspectives of health promotion service providers, there are some common factors. Providers and migrants both mentioned that there is a need for more information and materials in Russian language, and for partnership with different stakeholders (i.e. educational institutions). Both parties recognised the need for a more adaptive approach to enhance the overall access of migrants in health promotion initiatives.

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8. Appendixes

8.1 Interview guides

8.1.1 An interview guide for migrants with access (English version)

A. General Personal information

1. What is your country of origin?

2. Why did you leave your home country?

   - Family reunion - family reasons
   - Work/economic reasons
   - Study reasons
   - Refugee/asylum seeking
   - Other

3. When did you arrive to this country?

4. Did you live somewhere else before coming here?

[Research question 1: What perception of health does the migrant have?]

B. Personal perception of the health concept and self-assessment

5. What does it mean for you to be healthy?
   Why?

6. What do you do to stay healthy?
   - Do you think you can influence your health through specific behaviours? [read aloud the categories and mark one answer]

   - Doing exercise (taking the stairs, daily walks to the supermarket/job etc., activities during the day, sports etc.)
   - Paying attention to food consumption (diet, vegetables and healthy food..)
   - Paying attention to alcohol consumption (don't drink, drink less…)
   - Paying attention to smoking (smoke less, quit smoking..)
   - Trying to collect information about health (reading/seeking information..)
   - going to periodical medical check-ups

- None of the above
- Other. Please specify:

7. Do you consider health as an important factor of your life? Yes/No
   - **If Yes**,
     a. Do you often think about your health? How often (daily, sometimes, ever)?
   - **If No**, Why?

8. Do you feel healthy? Yes/no
   If yes, Why?
   If not, Why?

9. How do you generally estimate your health? [read aloud the categories – mark one answer]
   - 1: Very good
   - 2: Good
   - 3: Not good, not poor
   - 4: Poor
   - 5: Very Poor

   Please specify your choice:

10. In which ways does your healthy/unhealthy condition influence your daily life?

    a) If you feel healthy, what do you do? [if there's no answer read aloud the suggestions – mark answers]
    - stay up until late,
    - do physical activities with no worries,
    - lift heavy objects,
    - spend time outdoors etc.
    - drink and eat with no worries,
    - don't take medicines,
    - don't see the doctors

    b) If you don't feel healthy, what do you do? [if there's no answer read aloud the suggestion – mark answers]
    - restrict physical activity,
    - don't lift heavy objects,
    - don't stay up until late
    - try to rest more
    - try to eat and drink carefully
    - see your doctor,
    - use medications,
    - call for experts of your community or call for persons you trust to ask for advice

[Research question 2. How do migrants have access to hp interventions?]
[Research question 3. Which specific interventions do they use: their perceptions of initiatives and outcomes on their health?]

C. Participation in health promotion activities, use and perception of specific activities

11. Which health promotion activities do you attend/ have attended?

12. Could you describe it? E.g.
    - Which kinds of actions were provided? [see activity checklist and tick]
    - What was their content? [see content's checklist and tick]
    - How long did it last?
    - Was it for free or with a payment?

[Checklist for interventions' activities: tick mentioned activities]

- seminars, courses or periodical meetings
- campaigns or informative interventions,
- consulting,
- mass screening
- other - specify

[Checklist for interventions' contents: ticks mentioned methods]

- Sports/exercise
- Nutrition
- drinking
- smoking
- accident prevention etc.
- job safety.
- woman's health
- newborns' and children's health
- psychological health
- other - specify

13. How did you know about it? How did you get informed about that intervention/service? [give examples by reading aloud and mark answers]
    - mouth to mouth info,
    - general doctor info,
    - friends,
    - informative publications…
    - sons and children
    - other

14. Why did you choose exactly this health promoting initiative/service?

[if there is no answer on why they choose especially that intervention, suggest reading this elements below and tick answers]

Suggestion for the interviewee:

- friends and people from their country of origin participating
- distance to home (closeness),
- daily opening hours compatible with his/her engagements,
- no fee/charge service
- translated information materials,
- presence of cultural and linguistic mediation in welcoming and follow-up services,
- Multi-ethnical staff
- others

15. When you use health promoting initiatives/services, do you have any problems or difficulties in the access to the initiative or to the use of the initiative? How did you experience this?
[**ONLY IF** interviewee is not able to tell which problems he/she faced, mention one of this factors that could have been hindering factors to the access]

Suggestion for the interviewee:

- lack of hospitality and kindness
- no speaking of your language,
- communication and information strategies (translated materials, guides, leaflets etc, recruiting strategies, contact with communities of migrants)
- kind of intervention setting and access procedures (i.e. free or partly free or full payment service, daily opening time, weekly schedule, documents, distance from home, intercultural training for staff, for migrants),
- incapability to understand because of different cultural backgrounds (ex.: different perception of diseases and idea of well-being and health,
- cure systems that refer only to the hosting country's medical system (it doesn't include use of traditional medicine like an ayurvedic medicine, Chinese etc – i.e. lack of integration between occidental medicine and other medicines)

16. How would you solve these problems?

17. What was the concrete outcome/result of it in your daily life, if any?
    - Do you feel more informed about your health?
    - Do you feel more self-assured?
    - Did your change you habits, activities..?

18. Are you aware of other/similar initiatives/services?

If yes: Why didn't you choose those?

19. Would you like to participate in something else?

D. Information about rights and facilities

20. Did you know what your opportunities/rights were for using the health care system, facilities, and services of your host country? (i.e. how to have access to hp interventions, ho to use outpatient's departments, what services are allowed to use and which not etc…)

21. Did you have instructions about this?
IF yes,

- Have you been informed orally (informally) about your rights and opportunities by health professionals, police, health workers, teachers, nursery staff or others, mouth to mouth information from friends, people from your country etc.

- Or have you been informed by leaflets, posters, direct mail, TV, radio etc..

[Research question 4. What are migrants' suggestions to enhance their participation in hp interventions?]

E. The feedback and proposals of the migrants

22. What would encourage you to use health promoting activities more often?
[**ONLY IF** an interviewee is not able to give any suggestion read aloud suggestion below and mark answers]

Suggestion for the interviewee:

- more hospitality and kindness,
- translated materials, guides, leaflets etc,
- language and cultural mediator within the service,
- particular or custom daily opening time and weekly schedule,
- free service,
- closer proximity to your residence area,
- Intercultural trained staff,
- use of cure systems that refer also to traditional medicine like ayurvedic medicine, Chinese etc – i.e. integration between occidental medicine and other medicines)

23. Do you think there should be more/other health promotion activities? **yes/no**

If yes: What kind and why?
[IF AN INTERVIEWEE cannot give answers, read aloud examples and mark answers]
- more frequent interventions on health education, information on good lifestyle, prevention, on more frequent risks

- interventions suggested by the users of the services and with community participation
- interventions to be provided not only in usual health settings (health centres, community centres, hospitals etc..)

If no: Why?

24. Which topics and contents would you include in these initiatives?

25. In which way do you think these initiatives should be supplied?
[read aloud examples and mark answers]
- peer groups,
- meetings with experts coming from the countries of origin,
- meetings on traditional medicines
- other, specify

26. What would be especially interesting and useful for you?

_____

_____

FURTHER PERSONAL INFORMATION ABOUT THE MIGRANT

F. Detailed personal information

[Ask questions aloud and tick one option or fill with information required]

Legal status: **Which is your legal status?** □ citizen □ refugee immigrant: □ Temporary resident □ permanent resident	**Sex:** □ Female □ Male
Age:	**Religion:** **What is you religion?**
Marital status: □ married □ single □ children	
Education/Schooling: **What is you education level?** (achieved in home country or in host country) □ none □ elementary level □ junior high level □ senior high level □ university □ PhD □ other	**Present occupation** Please specify**:** □ employed □ unemployed □ housewife □ retired □ in maternity leave □ incapacity for work □ studying □ other Please specify:_____ **Economic status:** **How easy or difficult is for you to live here with your income?** □ Difficult □ Neutral □ Easy

G. Level of Integration

1. How do you feel in this country? Do you feel generally welcomed/respected at home here? [read aloud the categories – mark one answer]
   - you feel welcomed and respected
   - not welcomed, not respected
   - you feel left out

[ability to speak the language of the host country and the actual use of this language]

2. How do you feel speaking your host country's language?
   - Expert/fluent speaker
   - Average speaker
   - Basic speaker
3. Was it difficult to learn it? Yes/No
4. Do you still use your home country's language? Yes/no

   - **If Yes**,
     - Do you use it with your relatives?
     - Do you use it with people coming from your home country but now living in your host country?
     - Do you use it with others? Please specify

   - **If no**, Why?

[identification with their 'own' group]

5. Do you still keep in contact with the persons from your country of origin who live in this country? Yes/No
   - **If yes**, why? What do you do with them?

   - **If not,** why not?
     a. Would you like to do it? Yes/no
     b. Why/why not?

6. Do you participate in some groups like associations, church, cultural/community centres, sports e.g.)?

   If yes:
   a. Which activities or groups do you follow?
   b. Are these activities directed at its own group/culture?

   If no: Why?

7. Do you have contact with the host country's community people? Yes/No?
   - **If yes,**
     a. Which kind of contact you have?
     b. How often?

- **If Not,**
  a. Why?
  b. Would you like to have this contact with them?

[cultural orientation]

8. Do you find it important to adhere to your cultural traditions? Yes or No?
   a) If yes, why?
   Can you give us some example of what you do?

   b) If not, why not?

8.1.2 An interview guide for migrants without access (English version)

A. General Personal information

1. What is your country of origin?

2. Why did you leave your home country?

   - Family reunion - family reasons
   - Work reasons
   - Study reasons
   - Refugee/asylum seeking
   - Other

3. When did you arrive to this country?

4. Did you live in another country than your home country before coming here? If yes, where and for how long?

[Research question 1: What perception of health does the migrant have?]

B. Personal perception of the health concept and self-assessment

5. What does it mean to be healthy for you?
   Why?

6. Do you do anything to stay healthy?

- **If yes**, what?
- **If no**, why not?

7. Do you think you can influence your health through specific behaviours? [ask open question first – then read aloud the categories and mark answers]
   - doing exercise (taking the stairs, daily walks to the supermarket/job etc., activities during the day, sports etc.)
   - paying attention to food consumption (diet, vegetables and healthy food..)
   - paying attention to alcohol consumption (don't drink, drink less…)
   - paying attention to smoking (smoke less, quit smoking..)
   - trying to collect information about health (reading/seeking information..)
   - going to periodical medical check-ups
   - none of the above
   - other. Please specify:

8. Do you consider health as an important factor of your life? Yes/No
   - **If yes,** do you often think about your health? How often (daily, sometimes, ever)?
   - **If no,** Why not?

9. Do you feel healthy? Yes/no
   If yes, why?
   If not, why?

10. How do you generally estimate your health? [read aloud the categories – mark one answer]
   - 1: Very good
   - 2: Good
   - 3: Not good, not poor
   - 4: Poor
   - 5: Very Poor

   Please specify your choice:

11. In which ways does your healthy/unhealthy condition influence your daily life? [ask openly]
   [ask questions a) and b) from all the respondents]
   a) If you feel healthy, what do you do? [if there's no answer read aloud suggestions – mark answers]
      - stay up until late,
      - do physical activities with no worries,
      - lift heavy objects,
      - spend time outdoors etc.
      - drink and eat with no worries,
      - don't take medicines,

- don't see the doctors
- see family and friends
- feel energetic

b) Is there anything you would like to do when you feel healthy but can't, because of economy, work, distance etc.?

c) If you don't feel healthy, what do you do? [if there's no answer read aloud suggestions – mark answers]

- restrict physical activity,
- don't lift heavy objects,
- don't stay up until late
- try to rest the more
- try to eat and drink carefully
- see your doctor,
- use medications,
- call for experts of your community or call for persons you trust to ask for advice,
- don't see family and friends,
- feel unable to cope with the daily life

d) Is there anything you would like to do when you don't feel healthy but can't, because of an illness, economy, work, distance etc.?

e) Who do you turn to when you don't feel healthy – if any?

[Research question 2: How are barriers towards using health promoting initiatives conceived with regards to communication, feeling welcomed, culture, accessibility etc.?]

C. Use and perception of the health promoting initiatives

12. Have you previously visited a health promoting initiative in your host country? [Interviewer gives examples of hp initiatives from host country]

If yes:

- Which? (describe it/them)

- How would you describe their perception of you? [read aloud each category]
  - Did you feel welcomed?
  - Did you feel that the staff understood you?
  - Did you understand the personnel?

- Did you feel better/healthier when using it/them?

- Why are you not using the initiative(s) anymore?

- Did you have any problems or difficulties when the accessing to the initiative? If so, which ones?

- Have these places been discredited by friends, family or acquaintances?
  If so:
  - Did they have contact with the health institutions themselves?
  - Did they have any negative accounts and did this affect you? (I.e. the means to becoming healthy, the staff, the hospitality, lack of understanding, payments, distance to their home etc.)

If no:

- Why not?

- Do you know any health promotion initiatives? [Interviewer gives examples of hp interventions from the host country.] **If no**, go to question 13.

- **If yes**, please specify.

- Would you be interested in participating in any of these initiatives? Why / why not? **If yes**, why haven't you yet?

- Did you find any conducive elements in the access?
  For example
  - cultural-linguistic mediation,
  - follow-up,
  - information services in the native language,
  - contact with associations, with migrants' community.
  - Etc.

- Have you read any negative accounts of these places? If so, please specify:

D. Information about rights and facilities

13. Do you know your possibilities and rights for using these health promotion initiatives? [ask openly and then ask the deepening questions]
  - Do you know where to go if you, for instance, want to learn about healthy food, to do exercise or quit smoking?
  - Do you know if you have to pay for it?
  - Do you know how often you can participate in courses, classes etc.?
  - Do you know if you are allowed to participate?

If yes to question 13:

14. How did you get to know about this?

- Have you been informed orally (informally) about your rights and possibilities by health professionals, police, health workers, teachers, nursery staff or others, mouth to mouth information from friends, people from your country etc.? **If yes**: Were you informed in your mother tongue or in the language of your host country?

- Or have you been informed through leaflets, posters, direct mail, TV, radio etc.? **If yes:** Has the information been accessible in the language of your host country and other languages such as your mother tongue?

- In other ways?

[Research question 3: What would it take for the migrant to start using health promoting initiatives?]

E. The feedback and information of the migrants

15. What would encourage you to start using health promoting initiatives?
[ONLY IF the migrant is not able to give suggestions, please suggest the factors below]

Suggestion for the interviewee:

- If there were employees with the same cultural background as you?
- If all the communication took place in your native language?
- If there were other opening hours?
- If it was free of charge?

16. Do you think there should be more/other health promotion activities? **yes/no**
If yes: What kind and why?
[IF AN INTERVIEWEE cannot give answers, read aloud examples and mark answers]
- more frequent interventions on health education, information on good lifestyle, prevention, on more frequent risks
- interventions suggested by the users of services and with community participation
- interventions to be provided not only in usual health settings (health centres, community centres, hospitals etc.)

If no: Why?

17. Which topics and contents would you include in these initiatives?

18. In which way do you think these initiatives should be supplied?
[read aloud examples and mark answers]
- peer groups,
- meetings with experts coming from the countries of origin,

- meetings on traditional medicines
- other, specify

19. What would be especially interesting and useful for you?

F. Detailed personal information

[Ask questions aloud and tick one option or fill with information required]

Legal status: **What is your legal status?** □ citizenship □ Refugee □ immigrant: □ Temporary resident □ permanent resident	**Sex:** □ Female □ Male
Age:	**Religion:** **What is you religion?**
Marital status: □ married □ single □ children	
Education/Schooling: **What is you education level?** (achieved in home country or in host country) □ none □ elementary level □ junior high level □ senior high level □ university □ PhD □ other	**Present occupation:** □ employment. Please specify: □ unemployed □ housewife □ on maternity leave □ retired □ incapacity for work □ studying. Please specify: □ other:_____ **Economic status:** **How easy or difficult is for you to live here with your income?** □ Difficult □ Neutral □ Easy

G. Integration

1. How do you feel in this country? Do you feel generally welcomed/respected at home here? [read aloud the categories – mark one answer]
   - you feel welcomed and respected
   - not welcomed, not respected
   - you feel left out

[ability to speak the language of the host country and the actual use of this language]

2. How do you feel speaking your host country's language?
   - Expert/fluent speaker
   - Average speaker
   - Basic speaker

3. Was it difficult to learn it? Yes/No

4. Do you still use your home country's language? Yes/no

   - **If Yes**,
     - Do you use it with your relatives?
     - Do you use it with people coming from your home country but now living in your host country?
     - Do you use it with others? Please specify

   - **If no**, why not?

[identification with their 'own' group]

5. Do you still keep in contact with persons from your country of origin who live in this country? Yes/No
   - **If yes,** why? What do you do together?
   - **If not,** why not?
     a. Would you like to do it? Yes/no
     b. Why/why not?

6. Do you participate in some groups like associations, church, cultural/community centres, sports e.g.?

   If yes:
   a. Which group?
   b. Which activities do you follow?
   c. Are these activities directed to its own group/culture?

   If no: Why not?

7. Do you have contact with host country's community people? Yes/No?
   - **If yes,**
     a. Which kind of contact do you have?
     b. How often?
   - **If Not,**
     a. Why not?
     b. Would you like to have contact with them?

[cultural orientation]

8. Do you find it important to adhere to your cultural traditions? Yes or No?

   a) If yes, why?
   Can you give us some examples of what you do?

   b) If not, Why not?

8.2 Description of respondents

Appendix table 1. Characteristics of interviewed migrants who arrived before 1991

Experience with HP	Reference	Religion	Age	Years of permanence/	Legal Status	Cause for migration	Education/ schooling	Occupation	Financial situation
Users									
Woman 1	W57access	Catholic	57	Since 1970	citizen	study	university	employed	easy
Woman 2	W57a_access	Orthodox	57	Since 1979	Citizen	Work	University	retired	medium
Woman 3	W43access	Orthodox	43	-	Citizen	-	University	Employed	medium
Woman 4	W73access	Protestant	73	Since 1988	Permanent resident	Family	Senior high	retired	difficult
Man 1	M35access	-	35	-	citizen	-	University	employed	medium
Non-users									
Women 1	W43noaccess	Non-religious	43	Since 1969	Citizen	Family	University	Non-active	medium
Women 2	W47noaccess	Orthodox	47	Since 1978	Citizen	Work	Senior high	Incapacity	difficult
Woman 3	W28noaccess	Nonreligious	28	-	Citizen	-	Senior high	employed	medium
Man 1	M59noaccess	Orthodox	59	Since 1972	Russian citizen	Work	University	Retired	medium
Man 2	M37noaccess	Non-religious	37	-	Citizen	-	Senior high	Employed	difficult

Appendix table 1. Characteristics of interviewed migrants who arrived after 1991

Experience with HP	Reference	Religion	Age	Years of permanence	Legal Status	Cause for migration	Education/ schooling	Occupation	Financial situation
Users									
Women 1	W27access	Protestant	27	Since 1998	Permanent resident	Study	University	employed	easy
Man 1	M52access	Protestant	52	Since 1996	Permanent resident	Family	University	employed	medium
Man 2	M23access	Non-religious	23	Since 1991	Citizen	Family	Senior high	Employed	difficult
Man 3	M24access	Non-religious	24	Since 1991	Permanent resident	Family	elementary	Incapacity	difficult
Man 4	M43access	Non-religious	43	Since 1996	Temporary resident	Family	University	Unemployed	Difficult
Non-users									
Women 1	W25noaccess	Protestant	25	Since 2004	Temporary resident	Study	Senior high	Non-active	easy
Man 1	M21noaccess	Non-religious	21	Since 1994	Citizen	Family	Senior high	other	easy
Man 2	M40noaccess	Protestant	40	Since 2002	Permanent resident	Personal	University	Employed	easy
Man 3	M31noaccess	Non-religious	31	Since 2001	Permanent resident	Family	University	Unemployed	medium
Man 4	M29noaccess	Muslim	29	Since 2005	Temporary resident	Family	Senior high	Employed	easy