Service provision

INVESTIGATION FOLLOWING THE TRAGIC DROWNING IN TROMSØ

5 Service provision

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Innholdsfortegnelse

Use of interpreters

Sarah had the same rights, including the right to healthcare, as the general population in Norway (33). As far as we have been able to map her story, there was no-one who knew that Sarah had any particular need for support. The investigation seeks to describe aspects associated with the services in the local authority that have an impact on how new arrivals may feel and how those who need support can access such support.

Upon arrival in Norway, refugees are generally healthier than the general population, both in their home country and in the new country. In other words, new arrivals display a significant “healthy-migrant effect,” which, among other things, is expressed through a lower risk of death and fewer diagnoses (7). However, health deteriorates significantly within a few years. After a few years in Norway, what we could refer to as an “exhausted-migrant effect” occurs (34). This means that the stress of adjusting to a new society leads to an overall deterioration in health (35).

NHIB's assessmemt:

- There is a risk that the current system does not take into account the knowledge that refugees will experience more health problems over time and fails to take into account that refugees experience stress related to the migration.

It is known that various factors, known as stressors, have an impact on health. We know, for example, that discrimination leads to an increased risk of poorer health. The way in which society deals with refugees has an impact on the way in which their health develops. Over time, negative attention aimed at refugees can generally be perceived as a burden. Additionally, negative personal experiences, linked to e.g. feeling like an outsider, may also be stressors.

In combination, stressors may constitute a major burden. According to Bhopal, (4) socioeconomic status has a significant impact on refugee health. Bhopal believes that this is something that has received inadequate attention, but recognises that it is a political issue that has not been adequately discussed.

It can be difficult for refugees to find the correct health service. They do not know where to look or who to ask.

Kvinne med barnevogn. Illustrasjon.

The guide to health services for refugees, asylum seekers and reunited families (“Veileder for helsetjenester for flyktninger, asylsøkere og familiegjenforente”) describes the rights of refugees and is intended to be an adequate and practical overview document of what refugees can expect from the health services and other services (36). The guide includes a separate chapter on the early identification of needs, but does not have any particular focus on the fact that refugees may experience psychosocial difficulties and other health problems after they have lived here for some time. Routine health screening may identify needs that they find it difficult to speak about.

Service provision as experienced by new arrivals

NHIB has looked at how the services could identify refugees that are experiencing particular difficulties during the establishment phase. Since it is the local authorities that receive refugees, we have used the responsibilities of the local authorities’ health and social care services as a starting point.

The Municipality of Tromsø has a dedicated refugee health service. The service is aimed at recently settled residents who are participating in the introduction programme.

The service follows up on the refugees until they have been assigned a personal identification number and a general practitioner. The follow-up period varies depending on any health problems and illnesses on the part of the individual. The refugee health service conducts a health appointment and refers all new arrivals for tuberculosis screening. Refugees are also referred to other services within the primary or specialist health service.

The refugee health service has a role to play during the transition period until the ordinary services take over.

According to the National Strategy on Migrant Health (2013-2017), (37) the service provision for people with a migrant background must be part of the overall health and social care services. It must be designed based on local conditions and must be accessible to users. At the same time, political guidelines and the national guide for health services for asylum seekers, refugees and reunited families “Helsetjenester til asylsøkere, flyktninger og familiegjenforente” (36) state that the ordinary services must safeguard those who require assistance with mental health issues and psychosocial problems.

All the time during which refugees may experience symptoms that the services do not possess the expertise or capacity to identify poses a risk of the group not receiving equal health services compared to the general population.

Healthcare professionals and other support bodies encounter people from different cultures, in which suffering and symptoms may be expressed and interpreted differently. Most immigrants access the health services to a lesser extent than the general population. The factthat healthcare professionals do not always see the complete picture but look only at individual symptoms is a problem (38).

Inadequate mutual cultural understanding and language barriers make the meeting between the service provider and the newly arrived refugee that may require assistance more difficult. As an example, we can reference Eline Skirnisdottir Vik’s research (38). She has taken a closer look at how migration-related conditions have an impact on stillbirths. Vik shows that there is an increased risk of complications and deaths among minority women. Documentation shows that there was inadequate communication between the woman giving birth and healthcare professionals in 47 percent of stillbirths. Furthermore, Vik is also conscious of the fact that midwives experience difficulties when it comes to recording a proper medical history when meeting women who do not speak Norwegian and who are not familiar with the health service. This makes it difficult to make good decisions.

It can be challenging for the ordinary services to have adequate expertise relating to migrant health. We found that various sources of expertise were not always used by the ordinary services.

How might refugees experience the health and social care services?

Services, authorities and users often use different terms to refer to the same services and several services have overlapping functions. This can be difficult for refugees to understand. In Norway, the public sector performs care tasks that are often performed by families elsewhere. When a woman arrives in Norway, her husband is unlikely to be able to replace the female community and extended family.

Where women seek help and whether they manage to communicate their need for support may be somewhat random.

The midwife we interviewed as part of our investigation explained that some female refugees were afraid of the child welfare services. This is also a recurring theme from the interviews we conducted as part of our investigation. Women may feel uncomfortable contacting the various agencies to get help. They may be afraid that the child welfare services will become involved if they show weakness and that they may lose their children.

NHIB's assessment:

- There is a risk that refugees do not seek help because they do not have trust in and an understanding of the services.

Mental health among immigrants

Sarah has subsequently been described as a quiet woman and some of the informants reflected upon whether this should have been an indicator of her not being in a good place. Dalgard and Sveaass (39) note that simply a lack of knowledge about the country you have moved to may lead to a sense of powerlessness that could become a precursor to mental health issues. Even though we do not know enough about Sarah's mental health, it is necessary to take a closer look at mental health and how service provision is adapted for refugees.

There is little systematised knowledge about the state of health among newly arrived refugees in Norway. According to Bhopal, (4) there are few studies that use objective targets or observations to describe lifestyle and health among immigrants. Self-reported data is often used, which makes it difficult to compare results between the various groups.

According to the Norwegian Centre for Violence and Traumatic Stress Studies (NKVTS), a study is currently being conducted to develop knowledge about the health, quality of life and integration process of refugees and asylum seekers. The immigrant group is disparate, which can be seen from surveys on living conditions. According to one living conditions survey among immigrants, (40) fewer immigrants generally consider their own health to be good or very good compared to the general population. The proportion experiencing mental health issues is greater among immigrants and this finding is most evident among immigrant women.

Mental health and symptoms of mental illness are perceived differently in different cultures. Walås (41) describes that, in some immigrant communities, mental health issues are linked to insanity and have been labelled as taboo. Mental health can also be an unknown concept in certain cultures. There is limited knowledge of mental illness among non-western immigrants. Often, they are not used to talking about emotions. This makes it challenging for the service to meet the different needs.

NHIB's assessment:

- There is a risk of women not speaking about experiences that they find it difficult to manage on their own, one reason for which could be the fear of being labelled as crazy.
- There is a risk that refugee women may not be aware that mental health services exist.

The social conditions faced by newly arrived refugees may complicate their lives. This could relate to living on the poverty line, traumatic experiences, retraumatisation, negative experiences with public agencies, lack of understanding of the welfare state, unemployment and a feeling of inadequacy in Norwegian language lessons. Stresses linked to trauma experiences may become stronger only after some time has passed (27).

Illustration photo; Shutterstock.

The guidelines that state that refugees should use regular health and social care services, what is referred to as rapid normalisation, may also pose a risk. This is because the ordinary services do not always have adequate expertise in migrant health or because the service is not organised in line with what we know to be appropriate for this group.

NHIB's assessment:

- There is a risk that the ordinary services do not have adequate knowledge of how refugees are doing after a period of time in Norway.

Opaas (27) recommends that general practitioners, health visitors or counsellors at school be available for scheduled meetings over a period of time. Sometimes, refugees that are experiencing mental health difficulties must be referred elsewhere. This requires service providers to identify needs and provide flexible and accessible support. Teachers and others at the adult learning services in Tromsø asked themselves whether there was anything they should have noticed. One of them said: “but we also do not have the medical expertise.”

Furthermore: “How should those of us at school provide preventive help if there is no one available to help us with this? A health visitor assigned to the adult learning service would be a fantastic resource.”

There was no health visitor available to the adult learning service. One employee at the Municipality of Tromsø reflected on the fact that the adult learning service should employ a counsellor. Among other things, she has said that: “The adult learning service doesn’t really fall under that legislation. The rights relating to the psychosocial environment in schools and daycare facilities also do not apply to adult learning. This is covered by national legislation and I would imagine that aspects of adult learning could be incorporated into legislation.”

NHIB's assessment:

- There is a risk of refugees who need help not being identified
- There is a risk that refugees do not receive the necessary follow-up when health and social care professionals are not available through the introduction programme.

Illustration photo: Proper social conditions and adequate public services combat poor mental health.

“At the school, we could have had a women’s group, a discussion group with a health visitor in the same way that they do at lower secondary school.”

- Municipality of Tromsø employee

Refugee health team

Sarah was in contact with the refugee health team when she fell pregnant. Her follow-up care was fairly rapidly moved to the GP and the regular health centre.

The Norwegian Directorate of Health’s guide on health services for asylum seekers, refugees and reunited families “Helsetjenester til asylsøkere, flyktninger og familiegjenforente” (36) states that the local authorities have positive experiences of interdisciplinary refugee health teams. The guide recommends that all local authorities that are preparing to welcome refugees or asylum seekers establish interdisciplinary refugee health teams, which may also include the specialist health services. Such teams make it easier to gain an overview of the field. The Norwegian Directorate of Health also states that intermunicipal collaboration may be appropriate when establishing refugee health teams. According to the Norwegian Directorate of Health, it is important to ensure that the teams are an integral part of the overall health and social care services in the local authority, so that the expertise that is gained is not overly dependent on any individuals.

How many refugees arrive in Norway depends on the influx of refugees, conflicts in the countries concerned and, not least, political guidelines in Norway in terms of how many refugees we will accept. Economic allocations to the local authorities that welcome refugees are made in line with political guidelines and the economic allocations are currently linked to the number of refugees

received by the local authorities. The resources available to the refugee health teams therefore vary over time and the teams are dependent on the priorities of the relevant local authority. This is also the case in the Municipality of Tromsø. The local authority had planned to strengthen refugee health but since fewer refugees had been arriving in Norway, these efforts were reduced.

The interviews show that there is a need for a migrant health team/refugee health team. This is also a necessary resource that several parties would like to refer to and collaborate with. It is a challenge that such resources are scaled up and down in line with the number of new refugees. The service provision is therefore unstable and it becomes difficult to develop and retain expertise. Many providers, such as GPs, also find it challenging to develop relationships when resources vary over time.

NHIB's assessment:

- There is a risk that the expertise in and interaction with the refugee health team will become inadequate when scaling and organisation vary over time.

Our informants highlight political support in the local authority as an important aspect in ensuring that migrant health is placed on the agenda, as well as in following up on this work over time.

One of the informants argued that the refugee health service should include everything the family needs, including midwives, health visitors, doctors and social workers, to ensure that refugee families know who to deal with. The overall service may seem a bit random and follow-up may not be continuous.

The Norwegian Association of Local and Regional Authorities has devised ten steps for successful integration. These are practical tips that indicate the importance of a proper flow of information and a positive collaboration between relevant partners (42). They reference examples where the services are co-located and where this has had a positive impact.

Some informants explain that some families still get in touch with the refugee health service for a long time after becoming users of regular services.

Too rapid a transfer from the refugee health service to the regular health service may be perceived as unsafe if the family has developed trust in the refugee health service.

NHIB's assessment

- There is a risk that families will not receive equal health services if they have to use the regular health services, which have inadequate knowledge of refugee health at too early a stage.

There is a need for a more gradual transition to the regular services that is better adapted to the needs of the individual.

Illustration photo: The regular health service does not always have adequate expertise in refugee health.

GP services

The GP was also not aware of how difficult Sarah found her situation. She has subsequently reflected on how concerned Sarah seemed about her daughter's nappy rash. In hindsight, we might ask ourselves whether there was something Sarah wanted to convey but that she was unable to express or whether there was something that was not detected. This is a challenge when offering equal services.

The overall objective of equal services also applies to GP services. There is little research-based knowledge of the GP service for refugees, but some studies have been conducted. In connection with the trial of initial health examinations of refugees with the GP, a study was conducted on the experiences gained (43).

The study indicated that the transition to such a scheme led to the health services for refugees not being adequately adapted to their needs. GPs found that they did not have enough time, few professionals to collaborate with and that they needed better cultural and migrant health expertise.

Another Norwegian (44) study showed that there was little reflection among doctors about the fact that they have a specific culture themselves and how this influences what they consider normal.

Medical studies have not previously paid any special attention to the special needs experienced by refugees. The fact that general practitioners are free to independently choose whether to strengthen their expertise in relation to refugee health is a challenge.

Refugee health and cultural expertise have been put on the agenda more in recent years, which has also resulted in courses at some campuses. In 2019, Esperanza Diaz and Bernadette Kumar published the book: "Migrant Health: A Primary Care Perspective" (45). This is the first book about migrant health intended for general practitioners.

In an article in the Journal of the Norwegian Medical Association (46), Johanna Laue and Torsten Risør write that those working with refugee health have called for the strengthening of the health service for refugees, as well as more research in the field. They state that we need more knowledge of the existing challenges and underlying mechanisms in order to improve health services. Certain GPs have more knowledge of and a greater commitment to refugees and some local authorities even have a dedicated refugee doctor role.

NHIB's assessment:

- There is a risk that GPs do not have adequate expertise in refugee health and that this can be challenging for both refugees and GPs.

For example, different cultures express pain differently. Religion and culture determine how we express anxiety and pain, as well as our understanding of illness (47).

A refugee doctor was employed in a part-time position in Tromsø. As well as admitting refugees, the doctor was also available as a resource for other general practitioners. The refugee doctor told us that she did not feel that she utilised as such a resource. We have not investigated the cause of this any further, but it would be reasonable to assume factors that GPs otherwise indicate, such as the barriers to interaction (48, 49) also apply in this field. GPs are under pressure and GPs find that they do not have enough capacity (50, 51).

NHIB's assessment:

- There is a risk that GPs do not use the opportunities to consult the refugee doctor and others who possess specialist expertise in migrant health.

Being able to explain your emotions requires you to be good at expressing yourself. In her doctoral work, Emine Kale (52, 53) showed that patients who do not speak Norwegian struggle to express their concerns to doctors. Doctors may have a tendency to ignore emotional signs from a patient who does not speak the Norwegian language well. According to Kale, doctors should take the time to determine whether the patient is concerned about anything. It is also appropriate to acknowledge language concerns and to discuss any uncertainties that arise through communication. This requires time during consultations.

NHIB's assessment:

- There is a risk that GPs do not have adequate time and frameworks to determine whether refugees have any concerns they need help in managing.

When meeting refugees, there are a number of barriers to good communication. These may be linked to language, body language, culture, trust, social understanding and the fact that the GPs working day is pressurised.

Midwifery services

Many women come into contact with the health service only when they fall pregnant. Sarah met a midwife soon after arriving in Norway. The midwife was employed by the regular midwifery service in the local authority and had some collaboration with the refugee service/refugee health service. The midwife offered regular prenatal care but believed that more and better adapted services were required for refugee women. She had knowledge of cultural challenges, rights and the ability to speak about difficult things.

Sarah sometimes turned up to see the midwife simply to talk, including after giving birth and without an appointment. The midwife perceived Sarah to feel safe with her but that Sarah was exhausted for a period of time. She felt that something was wrong but was unable to establish what it was. It was difficult to understand what Sarah was trying to say. There were language issues.

The midwife explained that many female refugees experience a sense of yearning and a lack of belonging and that being pregnant and having young children are often harder for them. There are stark contrasts between the postnatal period in Norway and in a country such as South Sudan.

Kvinne med hijab med spebarn hvilende mot skulderen. Omsorg. Mor og barn. Familie. Illustrasjon i farger.

Furthermore, the midwife explained that she sometimes finds that other immigrant women also seek her out without an appointment and that they want to talk about matters other than just women's health. They may, for example, bring up their housing situation.

It can be difficult for a midwife to follow up on matters like these because the services are organised under different agencies. There are no interpreters available when women turn up to see the midwife unannounced. The investigation found that when the midwife, health visitor and other services are flexible and able to see the whole picture, they are also able to meet many of the needs.

Flexibility appears to be a good and necessary characteristic of the services. This is also confirmed by other service providers working with integration.

NHIB's assessment:

- A midwife or another service provider with a flexible understanding of their role and function may constitute crucial support for women who have just arrived in the country.

Midwives may find that women speak with them in confidence. They may, for example, talk about a longing for their home country or that they miss their sisters and mother. The midwifery service can therefore gain a better insight into the situation of these women than is the case for the other services.

Health centre services

Refugee families with young children have early contact with the health service through the health centre. All three of Sarah and Adam's girls followed the health centre programme and one of the children was offered additional support.

Mann leier et barn i hver hånd. Familie. Far med barn. Illustrasjon i farger.

The parents explained that they were concerned about showing that their children were not following normal development. They were afraid that the child welfare services would be notified. In this way, the health visitor may, by some, be perceived as a threat.

NHIB's assessment:

- There is a risk that women will not ask the health visitor for advice and support in fear of showing that they are struggling to cope and because they are afraid of the child welfare services.

As part of the investigation, several people noted that a refugee health nurse is a necessary resource to collaborate with. This resource has now been reduced in Tromsø. When dealing with the regular health services, language issues and cultural differences may be reasons why not everyone benefits from the service.

There may be a need for a more gradual transition to the regular services. For example, the health centre may need to collaborate with the local authority's refugee health team. This requires the refugee health team to have adequate capacity.

Child welfare services

The child welfare services had no contact with Sarah and Adam. No reports of concern had been submitted in relation to the family. Nevertheless, Sarah did, on several occasions, express fear of the child welfare services and it was important to her to show that she was able to look after the children. For example, there was one occasion when she was late collecting the children from the daycare facility and she was afraid that the child welfare services would find out.

Distrust in and fear of the child welfare services among parents with a refugee background have been thoroughly documented over time. Stories spread and many people have heard stories even before they arrive in the country. One study from 2018 confirmed that one element of the stories that is constantly repeated is that "the child welfare services simply take children away" (54). For many refugees, the idea that the state should play such a key role in a family is foreign. This leads to scepticism, reservations and caution. The study found that refugees called for the child welfare services to provide more information about the opportunities for support, as the general perception is that they will simply take children away.

The Norwegian child welfare services have recently been addressed in a discrimination report from the Council of Europe. The report highlights a lack of trust in the child welfare services among minority groups. It also transpires that this affects relationships with daycare facilities, schools and the health services, all of which have a duty to notify the child welfare services in the event of concerns. The Council of Europe has asked the Norwegian child welfare services to get better at supporting minority families (55).

NHIB's assessment:

- There is a risk that refugees' fear of the child welfare services in Norway means that they will withhold information that is needed to be able to help them.

Use of interpreters

An interpreter was not used for many of the meetings Sarah had with the services. The healthcare professionals we spoke with said that the use of interpreters can be complicated.

Equal health and social care services and equal access to services require adequate language skills or the use of an interpreter (27). The right to the necessary use of interpreters is enshrined in international agreements such as the UN Racial Discrimination Convention from 1965, ratified by Norway in 1970 (56) and incorporated in the Norwegian Public Administration Act (57), the Norwegian Patient and User Rights Act (58), the Norwegian Specialist Health Service Act (59), the Norwegian Healthcare Professionals Act (60) and the Norwegian GP Regulations (Section 28) (61).

On 7 June 2021, the Norwegian Parliament passed a new act relating to public agencies' responsibility for the use of interpreters (the Norwegian Interpreters Act). The purpose of the act is to ensure legal protection and adequate support and services for people who are otherwise unable to communicate sufficiently with public agencies. The act will also ensure that interpreters maintain sound professional standards (62).

Interpreting requires excellent knowledge of both languages. The Norwegian Official Report on legal protection and equal "interpretation in the public sector" (63) refers to the fact that healthcare professionals may find that managers do not like spending money on interpreters, even though they will not say so directly. Healthcare professionals may also overestimate the patient and their spouse's language skills and therefore refrain from requesting an interpreter.

There are several reasons why GPs do not use interpreters. It may be that the doctor is uncomfortable or inexperienced with the use of an interpreter in consultations, the availability of interpreters, time pressure, finances and knowledge of rights and rates (64, 65).

The Norwegian GP Regulations (61) suggest that there should not be any financial obstacles to the use of interpreting services. Such costs should be covered by the local authority (65) and the use of interpreters should not create any financial burden on the part of GPs. GPs may, for example, apply one rate for the use of interpreters and another rate for any time exceeding 20 minutes (66).

This facilitates GPs being able to spend more time with patients who require the use of an interpreter when the GP is concerned that they may not be able to understand one another. A survey conducted by the Norwegian Medical Association (66) found that doctors who have a lot of contact with those who require interpreters and that have positive experiences of this are more likely to use interpreters.

NHIB's assessment:

- There is a risk that healthcare personnel do not use interpreters even when there is a need for one.

When refugees are asked whether they need an interpreter, they may decline the offer because they do not know that it would not cost anything.

In some cases, Adam accompanied Sarah to meetings with the health services. It is rarely recommended or sufficient to use family members as interpreters (67) and the use of children as interpreters (68) is prohibited in Norway.

Misunderstandings may arise when someone with insufficient language experience translates a nuanced message. There could also be a risk that the woman will not receive the entire message or all of the options if their spouse interprets.

NHIB's assessment:

- There is a risk that the patient will not receive adequate information if a spouse acts as an interpreter.

When a qualified interpreter is used, confidentiality and anonymity are not a problem in principle. The use of qualified interpreters in the health service would also reassure patients and ensure good understanding (63). Even in small, transparent communities, it can still be difficult to establish trust when meeting patients/users from a minority background who are reluctant to use an interpreter from the same minority background.

Through our work in this investigation, we have learned that it is an advantage if the interpreter has a good understanding of health-related terms and phenomena, so that there are no misunderstandings.

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