HEALTH PROBLEMS AMONG PEOPLE WITHOUT LEGAL RESIDENCE IN NORWAY

Who are the patients at the Health Center for Undocumented Migrants, and what are their health problems?

Masterstudent: Ida Marie Bregård

Supervisor: Prof. Dr. Med. Bjørgulf Claussen

Thesis submitted as a part of the Master of Philosophy Degree in International Community Health

University of Oslo,
The Faculty of Medicine
Institute of Health and Society, Department of Community Medicine

2016

HEALTH PROBLEMS AMONG PEOPLE WITHOUT LEGAL RESIDENCE IN NORWAY

Who are the patients at the Health Center for Undocumented Migrants,
and what are their health problems?

Summary

Background: Persons without legal residency have limited rights and access to health services. This can create health problems or worsen conditions they have. The Health Center for Undocumented Migrants in opened in 2009, and provides health care to people without legal residence.

Aim of the study: Present an overview of the patients at the Health Center for Undocumented Migrants and their health problems.

Method: This study is a retrospective register study based on the Health Center for Undocumented Migrants' first 593 patients. The limitations of the data material from the Health Center allowed me to include som of my own experiences and reflections from volunteering as a nurse at the Health Center over the last 6 years.

Findings: The patients were 0-80 years old, of which 2/3 were men. About 4/5 of the patients were persons without legal residence. The majority of patients was from Asia and Africa. The patients had various health problems related to all organ systems by the classification in the ICPC-2 diagnostic list. The majority of the diagnoses were symptom diagnoses, but some diagnoses could indicate more severe underlying diseases. The most common diagnoses were digestive problems, sexual- and reproductive health problems and mental health problems.

Discussion: The demographic characteristics of the patients at the Health Center diverted from similar European studies, but the prevalence of the various diagnoses corresponded with findings from other European studies within the same field. The ICPC-2 diagnoses gave an impression of the burden of disease, but did not reveal the complex health problems some of the patients live with.

Conclusion: Persons without legal residence have various health problems, which can lead to a deterioration of their health. This study contributes to knowledge so that health professionals and decision makers better can formulate procedures are commensurate with both patients' needs, and with Norway's human rights obligations towards everyone residing in the country.

Acknowledgements

First and foremost, an immense thank you to my supervisor Prof. Dr. Med. Bjørgulv Claussen! Your support and supervision has been beyond what could have been expected, and your positive attitude has been crucial to finishing this thesis. You have truly been a life saver.

A great thank you also goes to everyone who has been a part of this master project: Dr. Med. Bernadette Kumar, director at Norwegian Center for Minority Health Research. NAKMI. You welcomed me into team NAKMI in 2011, and your contributions to my professional development will always be remembered and appreciated.

Also thank you to Prof. Akhtar Hussein, Prof. Gunnar Bjune and Marte K. Kjøllesdal at the University of Oslo, Ursula Georgine Småland Goth, Oslo and Akershus University College, for fruitful discussions and contributions during the initial phases of the project.

This thesis would not have been possible without help and support from the Health Center for Undocumented Migrants in Oslo, run by the City Church Mission and Oslo Red Cross. You have both been of enormous help in providing the data material for the project. A special thanks to Frode Eick at the Health Center - your positive attitude and support is greatly appreciated. I would also like to thank the volunteers at the Health Center, and ecpesially Dr. Nils L. Johnsen for interesting and valuable discussions over the years!

To my former colleagues at NAKMI: Thank you so much for five inspiring years as a research assistant and head of teaching. I have learnt a lot from all of you, and will think back at my years at NAKMI fondly. A special thanks to Mette Sagbakken for your contributions to this project. My former boss at the Health Office for Asylum Seekers: Marianne Bendixen, you once told me that health care to vulnerable migrant groups is a discipline of nursing, and I could not agree more. You are my hero!

To all of my family and friends: Your support has been crucial to the completion of my thesis. Your firm belief in me has encouraged me to follow my dreams.

Håvard, none of this would ever have been possible without you and your enormous patience and support. I will never be able to express the extent of my gratitude. Oslo, May 2016

Preface

Writing this thesis has been both exciting - and challenging. The field of migration and health has interested me ever since I started my Bachelor of Nursing Degree more than 10 years ago. It has therefore been very interesting to have the opportunity to immerse myself further in health problems among persons without legal residence while working on this thesis.

My first encounter with this patient group was as a nurse in various health services for asylum seekers. These services were within the primary health care system, where I had the opportunity to learn from skilled colleagues with long experience and broad expertise. However, in working with patients without legal residence, I also met health professionals without expertise in the field. This group of patients have limited right and access to health care, and the attitudes and prejudices of some health professionals have contributed towards the patients not receiving the limited health care they have needed and been entitled to.

During the work on my thesis, I have had the opportunity to use data material from The Health Center for Undocumented Migrants in Oslo, run by the City Church Mission and The Red Cross. This Health Center provides health care free of charge for persons without legal residence who are not entitled help within the ordinary health service. When initiating this center, one of the aims was to see and provide medical help for persons without legal residence, as well as to advocate for better right and access to health care for this group of patients.

For me personally, choosing this topic for my thesis is not driven by a political conviction seeing as it is not a political statement to provide health care for persons without legal residence in Norway. On the contrary, this present study is an attempt to contribute to more knowledge about a vulnerable group of whom we have little prior knowledge.

I have had the pleasure of being a volunteer nurse at the Health Center since 2009 and until now, and I have thus established a close relation with the Church City Mission in Oslo and the Red Cross that operates this health center. There are certain limitations to the data material from the Health Center. This has led me to draw on my own experiences and reflections from my work with persons without legal residence, both at the Health Center, and from other parts

of the health service. I believe that this can shed light on the data material and help in the analyzing process.

The effort of the Health Center, their employees and volunteers is why 3,500 people without legal residence have received medical care over the past six years. The efforts of the Health Center has led to several awards. The volunteers at the Health Center received the Amnesty Price in 2011 and Annette Thommessen Memorial Prize in 2013.

The work on my thesis has been carried out in stages over the past five years, which has been both an advantage and a disadvantage. One advantage is that further research has been carried out, increasing the knowledge about persons without legal residence, their health problems and living conditions both in Norway and other European countries. During this period, the legislation related to health care for this group of patients has also changed, as the «Priority regulations for health and social services for persons without legal residence in Norway» (Priority regulation) came into effect in 2012. The increased focus on migration and persons without legal residency in in media and research have contributed to persons without legal residence is well known among the general public. The findings from this study can therefore meet a keenly felt need for increased knowledge among health professionals.

The disadvantages, however, are also present. It has been several years since I completed the theoretical part of my master's degree, and the project protocol was developed several years ago. It has at times also been almost one year between each time I have worked with analysis of the data, and this may have influenced the final product.

I have a strong desire that health professionals who encounter people without legal residence, as well as decision-makers in the health and justice sector can benefit from my findings in this thesis. I further hope that this new knowledge generated helps to ensure that people without legal residence receive health care based on their medical needs rather than their legal status.

Table of content

List of abbreviations

CEAS	Common European Asylum System	Det felles-europeiske asylsystem
CIOMS	Council for International Organizations of Medical Sciences	De nasjonale forsknings-etiske komiteer
CXR	Chest X-ray	Røntgen thorax
DnLF	Norwegian medical association	Den norske legeforening
EMA	Unaccompanied minor asylum seekers	Enslige mindreårige asylsøkere
EPJ	Electronic patient journal	Elektronisk pasientjournal
EU	European Union	Den europeiske union
GP	General practitioner	Fastlege
ICMH	International Centre for Migration and Health	
ICD	International Classification of Diseases	Den internasjonale klassifi-kasjonen av sykdommer
ICPC	International Classification of Primary Care	Den internasjonale klassifikasjonen for primærhelsetjenesten
ICRC	International Red Cross	Røde Kors
MdM	Médecins du Monde	Leger i verden
MSF	Médecins Sans Frontières	Leger uten grenser
NIS	National Insurance Scheeme	Folketrygden
NGO	Non-governmental organization	Ikke-statlig organisasjon
NSF	Norwegian Nurses Union	Norges sykepleierforbund
OSH	Occupational Safety and Health	Helse, miljø og sikkerhet
OUS	Oslo University Hospital	Oslo universitetssykehus
PU	The National Police Immigration Service	Politiets utlendingsenhet
SSB	Statistics Norway	Statistisk sentralbyrå

TB	Tuberculosis	Tuberkulose
UDI	Norwegian Directorate of immigration	Utlendingsdirektoratet
UN	United Nations	De forente nasjoner (FN)
UNE	Immigration Appeals Board	Utlendingsnemnda
UNFPA	United Nations Population Fund	FNs befolkningsfond
WMA	World Medical Association	Den internasjonale legeforeningen

List of tables and figures

Tables

Figures

1 Introduction

This thesis is a part of the masters' degree in International Community Health at the University of Oslo. The aim of this thesis is to describe the patients at the Health Center for Undocumented Migrants and their health needs. This Health Center provide health care free of charge to persons without legal residence in Norway, a group which is not included in the National Insurance Scheme and thus are not entitled to ordinary health care in Norway.

The study is based on data material from the Health Center and the patients who sought help there from the opening in 2009 and its first 18 months of operation. The patients receive diagnoses according to the ICPC-2 classification, and these diagnoses along with the patients´ demographic characteristics form the base of the data material.

In addition to the somewhat sparse data material from the Health Center, experiences from one of the most experienced volunteer physician at the Health Center are included. This has been done in order to clarify the data material related to the diagnoses given the patients.

Since the Health Centers opening in 2009 and until today, I have been a volunteer nurse at the Health Center. I have therefore chosen to include some of my own experiences and reflections from the Health Center where I believe these will shed some light on the results.

1.1 Migration

Migration has taken place at all times, and in 2016 3,3 % of the world's population are migrants (1). Migration involves migration into or out of an area; emigration and immigration. Over the last 50 years there has been a significant increase in migration to Norway, and in 2016 16,3 % of the Norwegian population are immigrants or children born in Norway to immigrant parents (2,3).

The United Nations Population Fund, UNPFA, defines permanent migration as a "stay longer than one year in a country» (1), while some countries may have other definitions. Semi-permanent migration is of short duration, for example in connection with seasonal work and student exchange programs. Circular migration refers to migration between countries or between one or more countries and the migrants' home country (4,5). This group often consists of labor migrants (6).

There are several reasons for migration and many emigrants seek a better future. This may include the opportunity for work, study or protection from war or persecution (5). Which country you immigrate to may partly depend on the ability to get work, to study or be granted protection (7).

EU and the European Economic Area countries cooperate closely on migration policy, including asylum policy. Among the objectives of the collaboration is to facilitate labor migration, strengthening of the asylum system and to combat irregular migration (8). Norway is one of 27 member states of the Schengen area and thus bound by the Schengen Treaty. This is a treaty whose purpose is to remove border posts between member states, and establish an outer border (9). This permits everyone to travel freely within the Schengen area. Different compensatory measures have been enforced to counteract irregular migration into and between member states (10). EU-citizens have the right to stay in Norway for a certain period of time, depending on where they are from and why they come to Norway. During their stay in Norway, they are entitled health care in case of need (11).

1.2 Asylum seekers

According to the Universal Declaration of Human Rights, Article 14, all people have the right to seek asylum in the country of their choosing (12,13). The right entitles the applicant to a consideration of the application after the current criteria, but does not grant protection (asylum).

A small number of immigrants in Norway have come as asylum seekers (14). Whether or not a person is granted asylum depends on their background and reason for applying. The asylum seekers are mainly from areas of war and conflict. A recent example of this is the steep increase in asylum seekers to Europe and Norway from Syria in summer and fall 2015 (15).

In order to seek asylum in Norway, the applicant has to be in Norway. The applicant must first register with the Police Immigration Service (PU). The PU registers identity where the applicant claims to come from and on what ground they seek asylum. The Norwegian Directorate of Immigration (UDI) processes asylum applications (13,16). This includes an approximately 5-hour interview with the asylum seeker, and includes questions as to why the

person is applying for asylum, about their true identity and other subjects that may be relevant when assessing the application. If the asylum seeker has severe medical problems this will also be a subject during the interview, since certain medical problems may grant residence permit on humanitarian grounds.

There is an interpreter present during registration and interviews with both PU and UDI, and all asylum seekers are assigned a lawyer for two hours free of charge during the asylum process (16).

The processing of an asylum applications can last for several months to several years. This depends partly on the number of asylum seekers to Norway at that time, and the resources allocated to the Immigration Authorities (16). During the processing of the asylum application, the asylum seekers have the right to stay in the country and are offered voluntary housing at an asylum center (17,18).

If the asylum application is rejected, there is the opportunity to appeal the refusal. The first appeal goes to the UDI, and if the refusal is upheld, there is an opportunity to appeal to the Immigration Appeals Board (UNE) (16). If there is no appeal or if the rejection is upheld, the applicant becomes an «asylum seeker with a final rejection of the asylum application». After this final rejection, the asylum seeker is thus given a deadline for leaving the country. This deadline is often 2-3 weeks, and if one exceeds this deadline one becomes «a person without legal residence» (19). After the final rejection, the applicant is permitted to send commutation petitions to UNE. These petitions ask for reconsideration, either with or without new information from the applicant that is relevant to the application.

Asylum seekers who are granted protection (asylum) either by UDI or UNE, get residence permit in Norway, and can be resettled in a municipality (20). Pending the settlement, the asylum seekers often continue to live in the asylum reception centers. Resettlement of extra vulnerable groups e.g. persons with severe illnesses may prove challenging (21).

Most asylum seekers who come to Norway are single men, and the majority of asylum seekers are between 21-40 years (15). Some single women and families with and without children also arrive. Unaccompanied minor asylum seekers, children without guardians, also apply for asylum (22).

The nationalities of the asylum seekers who come to Norway reflects largely areas of war and war-like conditions (27). Furthermore, the asylum seekers come from countries and regions where people are subjected to persecution based on political, ethnic, religious or social affiliations or groups. A social group may include sexual orientation (23, 117 Art. 1 A).

During the last five years, the main groups of asylum seekers to Norway are from Afghanistan, Eritrea, Stateless and Syria. However, there has been a significant increase in the number of asylum seekers from Syria in 2015 compared to previous years (24,25,26,27,28).

There are several types of asylum reception centers. This includes some centers which have certain areas assigned for asylum seekers with special needs but who are not in need of specialist care or continuous medical attention. There are five such centers («tilrettelagt avdeling») with room for a total of 100 asylum seekers (17).

Asylum seekers who choose to stay at the asylum reception centers receive a monthly benefit from UDI of NOK 2,920 per adult in 2015 (18). The asylum seeker will receive this amount until a final rejection of their asylum application. After final rejection the asylum seeker receive a monthly benefit from UDI of NOK 1980 (18) for the duration of their stay at the asylum reception center. The amount received is meant to cover the general expenses the asylum seeker has, including food, sanitary products and medical expenses.

1.2.1 Health care services for asylum seekers

Asylum seekers are covered by the National Insurance Scheme (NIS) (29), and have access to most parts of health services during all phases of the asylum process (30).

All municipalities with reception centers are obliged to provide health services for asylum seekers. Some municipalities choose to have a nurse or community health nurse (helsesøster) who acts as intermediary between the asylum seeker, the asylum reception center and the rest of health care services (30). All asylum seekers are entitled to a general practitioner (GP). Some municipalities have hired doctors with special responsibility for asylum seekers, but most municipalities allocate the asylum seekers to the different GPs in the municipality (30).

Within 14 days of arrival to Norway, asylum seekers are screened for tuberculosis (TB). This is normally done at an arrival transit center. In addition to this screening, treatment for acute and severe conditions, including pre-natal care, is provided (30). Chronic conditions and other health problems that can wait are often not treated in the arrival transit center, because of the short stay. During the stay in ordinary reception centers, the Directorate of Health recommends that all asylum seekers should be offered a medical examination (30). This examination should include a short physical and mental screening. However, this is not a compulsory examination, neither for the municipality not for the asylum seeker. It therefore varies what kind of healthcare each asylum seeker has received during his time as an asylum seeker.

Asylum seekers are entitled to a «Health certificate for use in immigration cases» («Helseerklæring til bruk i utlendingssaker») (31,32,33). This is a health certificate that includes health information which may be of importance in the assessment of the asylum application. The UDI and UNE have strict criteria on which health conditions that may be of importance. Some severe disorders such as ongoing psychosis and severe or terminal cancer are examples of medical conditions that may grant the asylum seeker the right to stay in Norway on humanitarian grounds, if the asylum seeker is not in need of protection (asylum) in the first place. Writing the Health Certificate for use in immigration cases is extensive and time consuming work, and subject to certain criteria in terms of design. There is no reimbursement for GPs writing health certificates for use in immigration cases (33), and this might be a barrier for the asylum seeker in receiving such a certificate from the GP.

1.3 Irregular migration

An irregular immigrant is a person who is not permitted to stay in the country he or she is in (34). The Norwegian Authorities mainly use «personer uten lovlig opphold i riket» (Persons without legal residence in the country) at the term for this group of people, even though there are no official definitions of the different groups of persons without legal residence. However, in the consultation for the Priority regulation, the Authorities name different categories of which a person without legal residence may belong:

1. Persons whose application for asylum or other forms of residence has been rejected, who has exceeded the deadline for leaving the country, and whose forced removal from the country has not been expedited.

2. Persons whose application for asylum or other forms of residence has been rejected, and who has evaded deportation.

3. Persons who have arrived in Norway legally (including foreigners who do not need visa, foreigners with a valid visa, and foreigners with residence permit) who have exceeded their legal stay.

4. Persons who have entered the Schengen Area illegally and who don´t apply for asylum or other forms for residence (4,5,34).

Several terms and definitions are used to define this group. In Norway these terms include:
- «papirløse migranter» (paperless migrants)
- «papirløse flyktninger» (paperless refugees)
- «illegale innvandrere» (illegal immigrants)
- «irregulære innvandrere» (irregular immigrants)
- «udokumenterte innvandrere» (undocumented immigrants)
- «returnektere» (people who cannot be subject to forced return, and who do not contribute to voluntary return to their home country.)

Several terms and definitions are used in the English language. In addition to the terms mentioned above both “clandestine” and “illegal” workers may be used to describe people who live in the country without legal residence and who work illicitly (4,5).

It is difficult to know how many people who live in Europe without legal residence. Estimates from 2009 indicate that there were between 1.9 and 3.8 million people without legal residence in the 27 EU Member States In several countries persons without legal residence are persons who come to work illicitly (35, 6).

1.3.1 Persons without legal residence in Norway

Statistics Norway estimated that there were 18.000 persons without legal residence in Norway in 2006, of whom 2/3 were asylum seekers with final rejections, persons whose visa had expired ad persons who were not registered with the authorities (36).

Some asylum seekers choose to remain in an asylum reception center after final rejection on their application, while others may see it as unwise to have an address that is known to the authorities. This is because PU can forcibly return some of these asylum seekers (37,38 , p. 63). This applies to people from countries where Norway has a return agreement, which means that they can forcibly return people without legal residence to their country of origin. If the PU suspects that a person who awaits forced return will evade this, the person can be detained in Norway`s only Immigration Detention Center, Trandum utlendingsinternat (39). Residents at Trandum utlendingsinternat may only have a short stay at the Immigration Detention Center, but the Immigration act (40) gives the possibility to detain people for up to 18 months, cf. § 106 f in the Immigration Act. People who have never registered with the authorities and who have no other residence permit, persons who pend their return to a third country according to the Dublin Convention and people who come to Norway to seek asylum, but have not clarified identity can also be detained at Trandum utlendingsinternat (39).

1.4 Right- and access to health care for people without legal residence

Persons without legal residence have restricted rights and access to health care in Norway. They are not members of the NIS (30) in contrast to persons residing lawfully in the country including immigrants and asylum seekers (30,41).

Norway has incorporated the United Nations´ (UN) Human Rights into its constitution (42). The World Health Organization (WHO) Constitution enshrines "…the highest attainable standard of health as a fundamental right of every human being». WHO especially focuses on vulnerable groups´ access to health care. They further state «The right to health includes access to timely, acceptable, and affordable health care of appropriate quality» (43).

The United Nations´ Convention of the Rights of the Child, Article 24 states that

> ”the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.” (44)

1.4.1 The Priority regulations for health and social services for persons without legal residence

Despite the Human Rights and its conventions being incorporated into the Norwegian legislation, there was a great uncertainty among health professionals and administrative staff in the health and social services. This uncertainty was related to which medical treatment they should offer persons without legal residence in Norway, and to what extent one could claim payment for help that was rendered. This uncertainty was among the factors that necessitated a clarification of the right and access to health care for persons who were not members of the NIS. The result was «The Priority regulations for health and social services for persons without legal residence in Norway» (45).

Professional ethics for different groups of health professionals state that one shall treat the patient based on his or her needs (46,47,48). This was also an issue when the Priority regulation (45) was sent out for consultations among different departments, directorates and organizations. This was done before the regulation came into effect in 2012.

In that connection, various labor organizations had objections and comments to the Priority regulation. Among these organizations were The Norwegian Medical Association (NMA/DnLF) who had discussed the Priority regulation in its National Board (Sentralstyre). DnLF points out that the rights and access to health care, as they are described in the Priority regulation do not include the rights- and access all patients should be granted according to the medical ethical point of view: “According to the human rights conventions and ethical rules, doctors (and other health professionals) are, in principle obliged to offer the same scope of health services to anyone who seek medical attention” (49).

DnLF argues further that not providing health care to people without legal residence violates basic medical ethics, including the fact that everyone should have equal treatment, regardless of social status, position and ethnicity, and that patients must be given the necessary treatment

to prevent worsening of the condition. DnLF points out that in order to discover mentally ill patients who are a danger to themselves or others, cf. letter f) in the proposed Priority regulation, patients must initially have access to healthcare. DnLF also addresses the question of payment for the services rendered, and that this may lead to confusion among health professionals. Another of DnLFs points are that one must distinguish between the rights- and access to health care and immigration policy (49).

Several of the points made by DnLF recurs in other consultations from different health professional associations, such as The Norwegian Nurses Union (NSF) (50), but also from the Norwegian Board of Health (51). The latter states, inter alia in its submission that

> "supervisory authorities have not always had a tradition of applying human rights in its supervisory work. However, we see that this could become more relevant in the future, and perhaps particularly in relation to persons who are residing illegally in the country".

The Norwegian Directorate of Health (Helsedirektoratet) also submitted a consultation in relations to the Priority regulation. They note that people without legal residence often have long stays in the country and that the need for health care could increase with their stay. The Directorate of Health further argues that “all persons residing in the country should explicitly be entitled to health care based on individual assessment and regardless of residence status” (52). They mention in particular preventive and curative health services in primary and specialist health services.

A recurrent theme in the consultations to the Priority regulation is that even people without legal residence should be entitled to rights and access to health care in accordance with their medical needs. Moreover, it is argued by several agencies who consulted, that it would be difficult to identify the individual patient's residence status. Differentiation of health care based on a patient's legal status will also be in direct conflict with the Ethical Guidelines for different health professions. These comments were to little or no extent taken into account or implemented in the Priority regulation.

«Priority regulations for health and social services for persons without legal residence in Norway» (Priority regulation) came into effect on January 1st 2012 (45).

The Priority regulation states that
"People without legal residence in Norway are entitled to medical care that can not wait" and further that this is understood as

> "health care that is absolutely necessary and can not wait without danger of imminent death, permanently impairment, serious injury or severe pain. If the person is mentally unstable and constitutes an obvious and serious risk to their own or another's life or health, the person is entitled mental health care regardless of legal status (45)."

Persons without legal residence are entitled to pre-natal care and termination of pregnancy according to the Priority regulation. Children have almost full rights and access to healthcare. This includes health care from the municipal health services and specialist health services (30,44,53).

In certain situations, some people without legal residence have extended rights and access to health care according to the Priority regulation. This includes health care during imprisonment and detention at Trandum detention center (54, § 5).

There are still uncertainties related to the rights and access to health care for persons without legal residence. One uncertainty is related to the persons without legal residence not being members of the NIS, and therefore do not have the right to subsidized health care. This means that they can be fully charged for the expenses for the delivery and the hospital stay. Several women have also been asked to pre-pay for surgical or medically induced abortions (55).

The reason for why some women have been asked to pay for the health services they are entitled to is not clarified in the regulation who are responsible for covering the charges. This uncertainty regarding payment has led to a written question in Parliament to Minister of Health Anne-Grethe Strøm Eriksen in 2011, just before the Priority regulation came into effect. Later the same question was asked Minister of Health Bent Høie in 2015 (56,57). On both occasions the respective Health Ministers stated that the health service or institution that provide health care is responsible for covering the charges, if the patient has no opportunity to cover it themselves. The reason why the question was asked again in 2015, was that there was confusion related to the responsibility for payment, in spite of Strøm Eriksens answer in 2011. It is now clarified that it is the institution providing the treatment which is responsible for covering the charges in cases where the person without legal residence has received treatment.

Restrictive rights- and access to health care for persons without legal residence is also found in most other European countries. In a review of 27 EU countries, it appears that persons without legal residence has access to health care in five countries, limited access in 13 countries and lack of access in nine countries (58).

Different parts of both primary- and specialist health care services have rejected people without legal residence who have been in need of medical attention based on their legal status, both before and after the Priority regulation came into effect. This has been patients who meet criteria for acute, essential health care according to the Priority regulation. There has been sent several complaints to the Board of Health and to the County Governor (59,60) regarding these refusals. The Health Center for Undocumented Migrants submitted a complaint to the Oslo and Akershus Board of Health in 2011 (55). It concerned a woman in 9th gestational week who was referred for an induced abortion. The Health center referred her to Oslo University Hospital, who rejected the patient, because "she did not have valid asylum seeker card and could not pay." The Oslo and Akershus Board of Health stated that the hospitals treatment, or lack thereof, was a violation of the Specialist Health Care Act § 2.2 (55,61). Both the Health Center and DnLF have filed several complaints regarding rejection of both mental and physical health care to the County Governor, and by the end of 2014 there were three ongoing complaints under consideration (62).

1.5 The Health Center for Undocumented Migrants

The Health Center for Undocumented Migrants (Health Center) (Helsesenteret for papirløse migranter) (63,64) is run by the Church City Mission (Stiftelsen Kirkens Bymisjon Oslo) and Oslo Red Cross, both nonprofit organizations (NGO). Both organizations had plans to help people without legal residence, and decided on a joint action and opened the Health Center in October 2009 in Oslo, three years before the Priority Regulation came into effect and there was still uncertain to which extent persons without legal residence should receive health care.

1.5.1 Purpose of the Health Centre

The purpose of the Health Center is to provide health services to persons without legal residence. Furthermore, the Health Center wants to offer information to the public and politicians, including knowledge and experiences about the life situation of people without

legal residence, especially in relation to health problems. The Health Center wants to make the relevant authorities accountable and make them assure that people without legal residence may also have full entitlements, rights and access to health care within the universal health care system (62), thus making itself redundant.

1.5.2 Procedures and routines at the Health Center

The Health Center has hired a general manager and a head nurse, and has at times had other employees in different positions (62). In addition to the employees, the staff is volunteer health workers. These are both nurses, physicians, psychologists, psychiatrists and physiotherapists. In addition, there are pharmacists, midwives and laboratory technicians on duty. There are approximately one employee and ten volunteers present at each shift, and the Health Center is open to patients twice a week for 4-5 hours.

The first time a patient seeks help at the Health Center, he becomes registered by a nurse in the reception. This reception is a closed off room, which has several common features and procedures in common with the first point of contact in a municipal emergency ward or at health centers for asylum seekers (62). The reception is staffed with nurses. The nurse records the patients' name, age, sex, residence status, length of stay in Norway, as well as the patients' country of origin (65). During this initial phase the patients are given an ID-number in the Health Centers Electronic Patient Journal (EPJ) system SOMA. The nurse also registers a patient anamnesis and gives the patients an appointment with a health professional. This appointment is normally within the same day, and can be with a physician, psychologist, midwife, physiotherapist or other, according to the patients needs. If patients come to the Health Center several times, the nurse will record the patient anamnesis, but the demographic information such as sex, age, country of origin and length of stay will not be registered again.

Patients receiving consultations by physicians or psychologists at the Health Center primarily receives diagnoses by the International Classification of Primary Health Care, ICPC-2 classification (66), even though a few patients also have received ICD-10 diagnoses (67). The patients receive one diagnose per consultation, thus the number of diagnoses equals the number of consultations.

1.5.3 The Health Center's experiences

The Health Center publishes annual reports each year in addition to several project reports. During 2015, the Health Center treated 908 patients from 63 different countries and performed a total of 3,193 consultations (68). The Annual Report 2015 also presents a comparison of patients who received treatment in 2015 and patients who received treatment from the Health Center's opening in 2009. Overall, patients from 110 different countries have received treatment at the Health (68).

Most patients are from Afghanistan, Somalia, Mongolia, Romania and Ethiopia. In the Annual Report 2015, it is further stated that 15,260 consultations have been carried out in the period 2009-2015, of which 86% (n = 13,097) are related to various somatic problems including sexual- and reproductive health and the remaining 15% (n = 2163) are related to mental health. The five most common health problems, according to the ICPC-2, are the same in 2015 as in Health Center's total operating period.

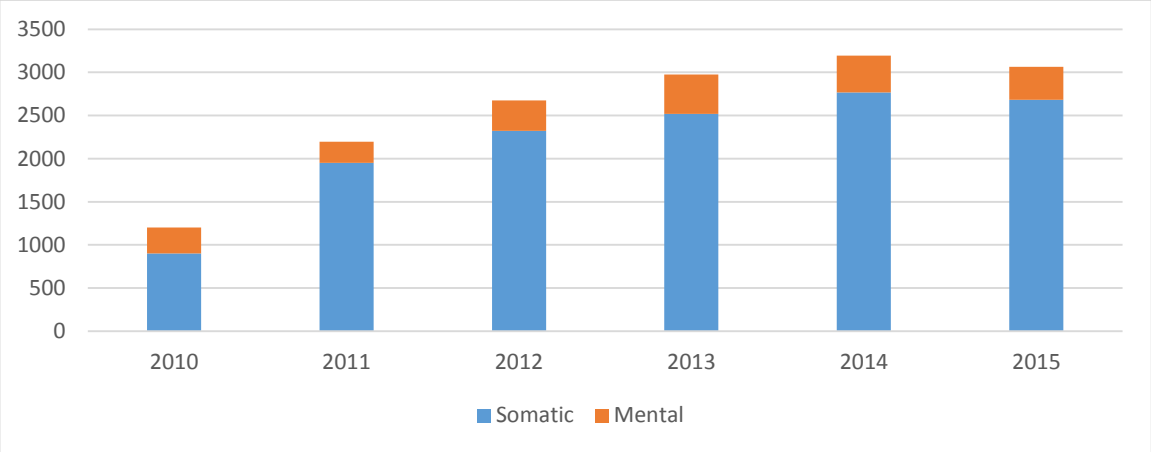


Figure 1 Number of consultations at the Health Center from 2010-2015

The Health Center's annual reports from 2014 and 2015 also states that "Poor mental health is more commonly seen in patients who have been refused asylum in contrast to those who are not registered in Norway"(62,68). The annual report further states that the patients seek help for common medical problems, otherwise seen at a regular GP´s office or a Health office for asylum seekers within the Municipality health services.

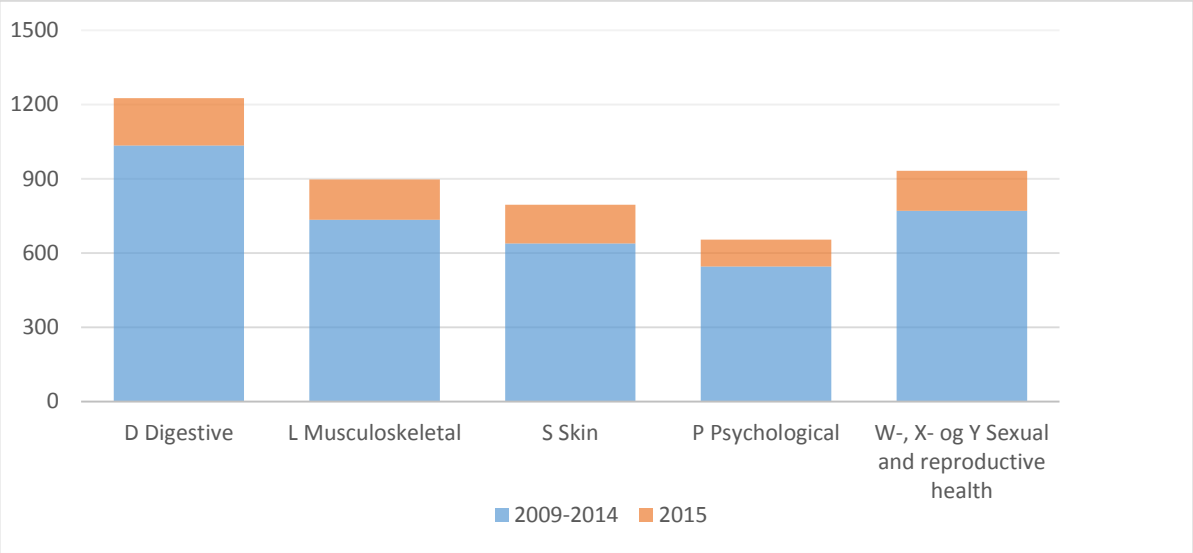


Figure 2 Number of diagnoses related to the five most common diagnostic chapters in 2009-2015 according to the ICPC-2 classification as presented in the Health Center´s annual report for 2015 (68)

The Health center has initiated various projects related to mental health, sexual- and reproductive health and other programs related to health and social problems. These are both individual and group programs, but also concrete measures such as HIV and chlamydia-testing (69, p. 11).

Since October 2015, the Health Center has collaborated with several NGOs in other European countries who provide health care for persons without legal residence. As a part of this collaboration, the Health Center has a broader data collection than previously. The Annual report from 2015, contains information about housing conditions among the patients.

Table 1 Overview of housing conditions among patients at the Health Center from Oct-Dec 2015 as presented in the Annual Report (68, p. 8)

Respons rate 80,4 %	**Number**	**%**
Rough sleeper (street, emergency accommodation under 15 days)	10	12%
Living in an org./charity /hotel (more than 15 days)	8	9,6 %
Camp	0	0 %
Squat (husokkupant)	0	0 %
Living at friends or family	57	68,7 %
Working place	0	0 %
Personal flat or house	8	9,6 %
Total	83	100 %

The Health Center collaborates with Diakonhjemmet hospital in Oslo, which has agreed to analyze several tests taken at the Health Center, such as blood tests. Diakonhjemmet hospital also accept some of the referrals from the Health Center to the specialist health services whenever needed. Of the 528 referrals from 2009-2015, 72 % have been carried out. This collaboration, both with Diakonhjemmet hospital as well as other health services that accept these patients, permit some of the patients to receive health care according to their medical needs in spite of their limited right and access to health care.

In several European countries there has been health centers for people without legal residence over several years. These centers have been driven by various NGOs as a result of the lack of access to healthcare provided from the respective authorities (58).

1.6 Health problems among people without legal residence

Despite an increasing focus on persons without legal residence in the EU and Norway in recent years, the literature search found only a few scientific papers about health problems among persons without legal residence in the EU and Norway.

1.6.1 Literature review

Literature searches were conducted in March 2011 and September 2015. OVID (71), NorArt (72) and SveMed+ (73) databases were used in the start.

OVID is a search engine that includes variety of databases, such as MEDLINE, PreMEDLINE, Cochrane Database, CINAHL and EMBASE. Ovid's interface allows one to run the same search across mulitple databases. An OVID search was conducted in orter to get a broad overview of the existing research literature related to health problems among persons without legal residence.

Table 2 Ovid search strategy, search terms and number of articles in the literature search from May 2016

	OVID Search strategy	**Number of articles**
1	Transients and Migrants	9065
2	Refugees	7357
3	"Emigration and Immigration"/ or "Emigrants and Immigrants"/	30603
4	Ethnic groups	52321
5	Minority Groups/ or Minority Health/	11902
6	1 or 2 or 3 or 4 or 5	100015
7	(paperl* or undoc* or illeg* or irreg* or clandes*).ti.	5658
8	((europ* or norw* or denm* or dan* or swed* or germ* or swi* or franc* or french* or spain or spanish* or malt* or belgi* or nether* or dutch* or british* or britain or finland* or finnish* or irish* or ireland or greec*) not usa).tw.	1046923
9	6 and 7 and 8	106
10	Years 2005-2016	70

Inclusion criteria were articles in English or Scandinavian languages, no older than 10 years, published in peer reviewed journals and related to health problems among persons without legal residence in Europe.

This search strategy found 70 articles, where of 18 were included in this study. The incluced articles were mainly related to prevalence, health problems and treatment, whereas articles related to ethics, barriers to health care and other subjects specific for the different European countries were excluded. Of the 70 articles, 10 were also excluded as they were not related to persons without legal residence or their health problems.

Articles from outside of Europe were excluded from the literature search. This is due to differences is health systems and access to health care for persons without legal residence. There are also differences in the populations who live without legal residence in Australia, Asia and America and the reasons for why they chose to migrate.

NorArt is a database which includes articles from Norwegian and Nordic journals. The OVID-search did not include non-scientific articles. In order to include interviews or other articles which included the volunteers´ perspectives a literature search in NorArt was conducted. The search strategy was : (papirlø? Or paperles? Or undocumented? Or irregu? Or ulovl? Or udokum? Or illeg? Or clandestine?) and (migrant? Or immigra? Or asyl? Or indvan? Or innvan? Of flykt? Or refug? Or minorit?)

There were 21 hits in Norart from 2005-2015. Most of these are non-scientific articles and interviews with volunteers at the Health Center and other clinicians who meet and treat persons without legal residence in other parts of the health servises. These articles were mainly published in journals related to the volunteers specific health profession. Four articles were included, as they were directly related to health problems among persons without legal residence in clinical settings. Three of these articles shed light on the volunteers´ and other clinicians perspectives from the Health Center. One additional article was included from the NorArt search. This was an article about Norwegian GPs´ experiences with undocumented migrants.

A search in SveMed+ was also conducted. Search words were: Undocumented* OR papperslös* OR papirløs*. There were several non-scientific articles related to ethical aspects in providing health care to persons without legal residence. Of the 25 articles published from 2005-2015 related to persons without legal residency, 17 were from Denmark and Sweden and 7 were from Norway. All of the latter were also found in NorArt.

Search words as paperless, papperslös and papirløs leads to an inclusion of articles related to paperless systems, such as e-journals or paperless patients journals. In NorArt and SveMed+ it was not possible to exclude these in the search strategy, where as this was possible in OVID. These were all excluded.

The Health Center for Undocumented Migrants was contacted in order to get an overview of the master thesis and other studies that has been conducted at the Health Center and which included informants recruited at the Health Center. Six masters thesis were written, and four of these included informants from the Health Center. These were qualitative studies which describe the self-perceived life situation and to a certain extent the health condition of the patients at the Health Center. One master thesis analysed the City Church Mission´s role in

the public debate relating to persons without legal residence in Norway. This thesis was also included. One scientific article was published in 2015, related to female patients at the Health Center. This article did not emerge from the literature searches. Two scientific articles from research at the Health Center are accepted for scientific publication but are not yet published. The same is the case for a recently submitted masters thesis.

Due to the low number of scientific articles, grey literature was also included. Spending almost five years writing this thesis, also permitted me to meet several of the national and European researchers within this field. They have suggested different reports and helped me find reports that were not available online or in other databases. I have also had the possibility to participate in conferences where researchers and clinicians' findings or experiences have been presented. Some of these presentations are also includes in the grey literature This permitted the use of several overviews from international NGOs like Doctors of the World (MdM) (74), Doctors without borders (MSF) (75) and the Red Cross (ICRC) (76). They have run health centers for people without legal residence in several EU countries for some years and have published several reports on health problems among this group of patients based on their experience and statistics from these various centers. In spite of differences, there are some similarities between people without legal residence in different countries. This may also apply to the present sample. Several of the reports and studies are based the ICPC-2 diagnostic classification, which permits a comparison between the findings of those studies and the findings in this study.

a) Scientific articles

Eighteen articles were included in the study. The first article was a scoping review of the primary research from EU from 1990-2012 (77). The results were summarized in physical, mental and social health issues, as well as access and barriers to care. Mental health issues as well as obstetric needs and injuries were common reasons for seeking health care

Four of the articles include the broad specter of symptoms and diseases among persons without legal residence. The article "Undocumented migrants have diverse Health Problems" (78) was published in 2014. This is a register study from an NGO clinic in Denmark including 830 patients Health problems were diagnosed according to the ICPC-2 classification, and the health problems among patients corresponded largely with the health problems seen in ordinary general practices, and were primarily related to the digestive problems,

musculoskeletal disorders and sexual- and reproductive health. A cross-sectional study from Sweden examined causes of death among 860 persons without legal residence over 13 years. Almost half the population died due to external causes, including suicide (n=92) (79). One third died due to diseases of the circulatory system. The rest died of various conditions.

A Dutch study examined the self reported health among 100 females without legal residence. Two thirds rated their health as «poor», and 91 % reported having current health problems. On average the women had 11,1 complaints. Most health problems were related to mental or sexual health (80). Another Dutch study examined the health seeking behavior of detained persons without legal residence in the Netherlands. Of 122 respondents, 46 % had sought medical help prior to detention, mainly due to injuries and dental problems (81).

Seven of the articles focus on sexual and reproductive health. Unwanted pregnancies and sexual violations is frequent. In a Dutch study, including 223 informants, almost all had experienced sexual assaults while in the EU (82). A Swiss study shows that women without legal residence have more unwanted pregnancies, higher abortion rates than the general population. Knowledge of emergency prevention is scarce (83, 84). A study from the Netherlands included 100 women without legal residence. They experienced not being able to exercise control over their own sexual health, and also experienced lack of knowledge about health services and contraception. They experienced barrieres in seeking health care related to poor economy, sexual/physical violence and fear of deportation. This study found high abortion rates (80). Of 313 women who came to a Swiss hospital for induced abortion, 5,8 % were found to have chlamydia (85). Another study found a prevalence of 13 % chlamydia Of 161 women without legal residence, 75 % had unplanned pregnancies and 61 % were unaware of emergency contraception. Only 63 % of patients had a prenatal visit during the 1st trimester (86). Several women find that their current situation and dependence on migration law affects sexual ill health (87). In the study from the Health Center, eight female patients and eight volunteer health workers were interviewed. The patients were found to have difficult living conditions; difficulties related to occupational safety and health (OSH) and had a fear of being reported to the authorities. The pregnant women were unaware of their rights to pregnancy related care within the public health services (88).

Three of the studies focus on mental health in the Netherlands, and indicate a high prevalence of mental health issues among persons without legal residence. An explorative study among

15 persons without legal residence showed that these patients considered mental health problems to be directly related to their living conditions. There were barrieres to accessing health care, such as taboos, lack of knowledge related to health care and distrust in the GPs (89). An other study from the Netherlands explored the views and experiences of GPs treating mental health problems in persons without legal residence. Low consultation rates, physical presentation of mental health problems, high number of other problems, lack of trust, cultural and linguistically barriers made it difficult for GPs to record mental health problems among this group of patients (90,91).

Three articles focus on communicable diseases, of which two are related to tuberculosis (TB). Of 5383 persons entering Malta without legal residence, 85 % were screened for TB by Chest X-ray (CXR), and 3,5 % had CXR suggestive of TB. Of these, 12,5 % (n=20) had active TB. An additional 13 patients were found to have TB during the next 12 months (92). An explorative study from Switzerland examined 125 persons without legal residence for TB. Of these, 25 % were found to have latent TB and two patients had active TB. There was low compliance to the treatment for latent TB (93).

A longitudinal study from northern Italy screened 3728 persons mainly without legal residence for hepatitis B. Of these, 224 persons were found to have be Hepatitis B surface Anti gene-positive (94). This was not related to sexual activity, but independently associated with the prevalence in the patients' country of origin.

b) Grey literature

A study from the ICRC` center Sjukvårdsforminlingen for papperslösa in Stockholm from 2008 (95) is based on 83 patients who all were examined by two specialists in general medicine at Sjukvårdsformedlingen. The physicians concluded that 83% of patients could be treated in primary care, and 18% of patients could be passed directly to pre-natal care. Patients with long residence in Sweden tended to be sicker, and authors of the study concluded that half of the health problems should have been diagnosed and treated at an earlier stage.

Medecins sans frontières (MSF) examined the diagnoses that were given to patients at a health center for people without legal residence in Sweden (96). Approximately 75% of the patients were asylum seekers with a final rejection on their asylum applications. MSF found a

high prevalence of mental disorders and suicidal ideation. Approximately 64% of the patients who were examined by a physician (n = 102) reported an increase in their mental health problems after receiving the final rejection on their asylum application, thus going from legal to illegal immigrant in Sweden. Of the 102 patients, 23 completed the Hopkins Symptom Checklist (HSCL-25). This is a symptom inventory which measures symptoms of anxiety and depression (97,98). Despite a limited number of informants, findings showed that 48% of patients struggled with anxiety, 56% with depression, 38% with "a great deal or very much of suicidal ideation", according to the divisions in HSCL- 25.

Two larger reports from Europe were included. Medicins du Monde (MdM) launched the report "Access to health care for undocumented migrants in these 11 European Countries" in 2009 (99). This is a major review of access to health care for undocumented migrants in 11 European countries. The informants were 50% women and men. Respectively 34% and 23% reported having "poor" or "very poor" health. Nearly 33% had at least one chronic health problem, and 65% of patients had conditions in need of medical treatment. The main health problems were related to musculoskeletal disorders (19%), psychiatric symptoms and diseases (16%), gastrointestinal (including teeth / gums) (16%), respiratory (11%) and sexual- and reproductive health, including men (10%).

International Centre for Migration and Health (ICMH) published the report "The process of Social Insertion of Migrants, Refugees and Asylum Seekers in the Context of Access to and Use of Health and Social Services"(100) in 2004. This report presented access to health care and social conditions among illegal clandestine workers in Geneva. ICMH found that a quarter of their informants without legal residence experienced that their health was poorer now than in their home country, and that the majority of respondents stated that they suffered from depression.

Reports from Rosengrenska, an NGO in Sweden (101) reported poor health, including previously undergone rape, torture and assault. The patients describe a difficult life, with hard working and living conditions.

In the report «Without papers, not without teeth» (Papperslös but inte tandlös) (102) dentists examined the dental health of 54 people without legal residence who sought medical attention at Rosengrenska. Of the patients, 60% reported to have generally poor health, 68% reported

having poor dental health and 85% of patients reported having had toothache previous month. Over 94% (n = 51) of patients had caries.

c) Literature from Norway

Some research on people without legal residence in Norway has been carried out, however most of the research has been focused on the psychosocial factors related to existence as a person without legal residence. Kristiansen conducted a Quest back survey in 2007 as a part of her masters thesis. GPs in Oslo, Drammen and Lier municipalities participated (103). The survey was about the GPs´ experiences with people without legal residence. The results from the survey was that the main problems among patients without legal residence were related to somatic complaints, psychological disorders and various infections. Some of these findings were presented in more detail in a non-scientific article in Utposten in 2009 and at a conference in 2011 (104,105).

When looking into the grey literature from Norway, both reports from research institutions and Annual Reports from the public sector emerge. In the report, "I always worry - undocumented migrant and their relationship to health care services in Oslo" from 2010 (106), Hjelde used the same methodology as ICMH did in their survey from Geneva in 2004. Hjelde had 15 informants without legal residence, and all but one reported having "poor" or "very poor" health" (106, p. 35) They also stated that their health was worse than before their departure from their home country. Informants reported digestive problems, including dental pain, musculoskeletal disorders and problems related to sexual- and reproductive health.

In 2011, Øien and Sønsterudbråten at FAFO published the report "No way in - no way out: study of living conditions of irregular migrants in Norway» (38). This report included a chapter on "housing and health". "Health was a theme that came up in one way or another in the majority of the interviews" Informants mentioned various health problems. This included toothache, pregnancy, mental disorders and abdominal pain (p. 67).

Fafo also published a report in 2008, where authors Brunovskis and Bjerkan looked into methods for conducting research on persons without legal residence in Norway (107).

The Supervisory Board of Trandum Detention Center Annual Reports include little information about health, and the reasons for use of safety/security cells (sikkerhetscelle) are

presented. The annual report for 2014 (108) reveals 390 decisions of placement in a safety/security cell, of which 12 % were due to "Self-harm and threats of such" and 6% of the decisions were due to «health».

The Health Center also have annual reports. These include general information of who the patients at the Health Center for the last 12 months are, and a brief overview of their main health problems. The Annual reports also include information about the different projects the Health Center has conducted over the last year. The main findings from the Health Center´s annual report 2014 were presented in chapter 1.5.3.

d) Master thesis from the Health Center for undocumented migrants

Three of the four masters thesis with informants who are or have been patients at the Health Center were included. In «How do undocumented migrants describe and understand their everyday life in Norwegian society?» from 2012, five informants are interviewed. They experienced fear of deportation and lack of support (109). They talked about their current life situation and health problems. In «Parenthood in Nowhereland» (Foreldreskap i Ingenstedsland) from 2014, parents without legal residence living with their children in Norway described some of their daily challenges. This included diverse health problems, lack of sleep and poverty. They are also afraid that their children may understand that they are different from the other children and parents (110).

The thesis «How do undocumented immigrants experience and understand their situation in Norwegian society» from 2015, four persons without legal residence are interviewed. They describe a difficult life situation including poverty and hunger. Lack of family and friends create an additional burden (111). The fourth masters thesis with informants from the Health Center had an other scope than to describe the life situation for the informants, and did not supply information that seemed relevant to our study.

A fifth masters thesis seemed relevant. The master thesis «The Critical Diaconal voice in the Society» (Den kritiske diakonale stemmen i samfunnet) (112) from 2013, analyses the City Church Mission´s role in the public debate relating to persons without legal residence in Norway. The perspectives of key informants in the City Church mission is included and compared to quotes of political and other debates in the society.

e) Experiences and reflections from volunteers at the Health Center

Several volunteers at the Health Center have been interviewed about their experiences at the Center. One of the medical laboratory technologists say that the most common blod tests they preform are C-reactive protein to check for infections, INR to see the prothrombin time and hemoglobin level. They also have the possibility to send test for analysis at Diakonhjemmet hospital in Oslo (113).

One of the physiotherapists was interviewed about the complex health problems among the patients at the Health Center he would see during his shifts. He mentions inactive stays at asylum reception centers, patients who worry about their families, and patients who have traumatic experiences related to physical abuse. He states that several of the problems are psychosomatic. Few of the patients at the Health Center have acute conditions (114).

Different nurses volunteering have also been interviewed. They experience that patients should have received help at an earlier stage, and that there are several barriers for persons without legal residence in the public health system (115).

f) Experiences and reports from activities organized at the Health Center

The Health Center and the volonteers arrange groups with different focuses for some groups of patients. In addition to the previously mentioned HIV-project, the Center has had groups for women, men, parents in different languages. The focus has been on mental or somatic health, parenting or stabilizing. Some researchers have followed some of these groups, but the results have not yet been published. There are some reports which summarizes the experiences of the volonteers, and the main focus is on the barriers or challenges directly related to the groups/interventions. These reports are thus not included in this study.

1.7 Aim of the study

The aim of the study was to describe who the patients at the Health Center for Undocumented Migrants are and what health problems they have.

This was answered by

- Identifying those who seek and receive treatment at the health center for undocumented migrants
- Make an overview of the diagnoses which are given at the Health Center
- Investigate any differences between different groups of patients at the Health Center
- Actively compare my own reflections and experiences as volunteer nurse, and see if the nurse´s perspective contributes to shed light on which health problems the patients at the Health Center present when seeking help at the center.

2 Methodology

2.1 The study design

The study design was aimed to provide an overview of health problems among the patients at the Health Center for Undocumented Migrants in Oslo. The sample consisted of all patients who sought help during the Health Centers first 18 operating months. The descriptive analysis was based on several sets of data from the Health Center, and permitted an overview of who the patients were and which diagnoses they received. The diagnoses were given according to the ICPC-2 classification.

In addition to the descriptive analysis, my own experiences and reflections as a volunteer nurse at the Health Center were included. This will help explain the results by shedding light on the patients´ pathways through the Health Center from their first visit and registration to they return for follow ups. This information didn´t emerge from the data material from the Health Center, but was relevant in order to understand who the patients at the Health Center were and what health problems they had.

2.2 Study group

This study was a retrospective register study, and all patients who sought treatment at the Health Center from October 27th 2009 until April 27th 2011 constituted the study group (n=593). This was the first and foremost selection criteria.

2.2.1 Inclusion and exclusion criteria

The majority of these patients had an examination by a psychologist or physician and thus received a diagnosis (n=547). Some of the patients only saw a nurse or physiotherapist and have not been given a diagnose (n=46).

The majority of patients have received ICPC-2 diagnoses, but 30 patients have also received diagnoses according to the ICD-10 classification. It was not possible to exclude these from the other patients, and they were therefore included in the study.

Some patients at the Health Center were registered with various forms of legal residence in Norway. It was however not possible to exclude these patients from the study, as it was not possible to connect the datasets and see who these patients were. All patients, regardless of their residence status were therefore included in the study.

Four of the 547 patients were registered without country of origin, and one person was registered without age. The patients without country of origin and age were still included in the study.

One patient was registered without age, sex and country of origin. This person could be a misregistration, and was therefore excluded from the study. The sample then included 593 persons.

2.3 Data Collection

The data were from the Health Center´s EPJ SOMA Solutions and obtained via the data program Crystal Reports. This was done by staff at the Health Center. It is voluntary for the patient to provide the correct information, but the Health Center asks the patients to use the same information each time they seek help at the Health Center. This will help avoiding having several EPJs for each patient with the possible consequences that may result. Collected data is not validated by the nurses who registers patients. The data material from the Health Center consisted of three different sets of data. None of these could be linked.

2.3.1 Dataset 1: Demography

The first data set was an overview of the patients´ age, sex and country of origin, and was based on the information registered by the nurse in the reception. This dataset included all patients registered at the health center in the data collection periode (n = 593).

In the reception the patients were asked about their «country of origin». The nurse registered the country the patient claimed to come from. The nurse asked about residence status during the initial registration. The patient may not know his or her own status, and one patient could belong to several of the categories that the nurse could choose from in the EPJ. In this dataset it was not possible to connect length of stay in Norway and residency status with other

variables. It was not clear whether it was length of stay at the initial contact with the Health Center or length of stay at the time of data retrieval.

2.3.2 Dataset 2: Diagnoses

The second dataset consisted of four different periodic reports. A periodic report is an overview of the diagnoses given to the patients in the data collection periodic. The periodic reports showed diagnoses distributed by sex, country of origin and age respectively. Dataset 2 included all 547 patients who have had at least one consultation.

2.3.3 Dataset 3: Prescriptions

The third dataset consisted of an overview of prescriptions. This overview was not complete, as some patients have received medicines at the Health Center and thus have not been given a prescription. This overview was not included in the study as it was incomplete and does not have direct relevance to who patients were or which ICPC-2 diagnoses they have recieved.

2.3.4 Classification of Diagnoses

This study focused on the most frequent diagnoses from the Health Center. Diagnoses were mainly based on the ICPC-2 classification. Certain diagnoses were emphasized in this thesis, as they were frequent or as they contributed to a greater understanding of health problems among people without legal residence.

a) The International Classification of Primary Care (ICPC)

The ICPC-2 classification is used when diagnosing a patient in primary care (66). The ICPC-2 is an international system that was created in 1987 by the World Organization of National Colleges, Academies and Academic Associations of General Practitioners / Family Physicians (116). The ICPC classification primarily consist of one letter and two or three digits. The letter indicates an organ system. The digits 00-29 indicate symptom diagnoses, while 70-99 indicates disease diagnoses. Codes 30-69 are therapy, treatment and processing codes. All of these sub categories are common to all organ systems in the ICPC-2 classification (66). Most diagnoses which has got a letter are set by physicians, but also psychologists give P-diagnoses.

Table 3 ICPC-2 Index of organ systems (66)

A	General and unspecified
B	Blood, blood forming organs and immune mechanism
D	Digestive
F	Eye
H	Ear
K	Cardiovascular
L	Musculoskeletal
N	Neurological
P	Psychological
R	Respiratory
S	Skin
T	Endocrine, metabolic and nutritional
U	Urological
W	Pregnancy, childbearing, family planning
X	Female genital
Y	Male genital
Z	Social problems

b) International Classification of Diseases (ICD)

The ICD-10 is a clinical cataloging system which is used by specialist health services in Norway. It is a diagnostic tool for epidemiological and clinical purposes and is used when reporting to the National Patient Register (67). Physician specialists who volunteer at the Health Center, have to some extent used the ICD-10 classification. The ICD-10 diagnoses were not included in the thesis as they only amounted to 3 % of the total number of diagnoses (n=38), but it was not possible to exclude the 30 patients who have received these diagnoses.

2.4 Data analysis

2.4.1 Country of origin

Patients from 62 different countries from four different continents have sought help at the Health Center. Different countries were divided into several groups in the analyzing process.

a) Asia

Patients from a total of 17 Asian countries have sought help at the Health Center. These were divided into four groups, respectively Middle East, Afghanistan, Mongolia and "Other, Asia". Patients from Afghanistan and Mongolia were presented separately, as patients from these countries constitute considerable groups.

b) Africa

The patients from Africa came from 26 different countries, and were divided into three groups, Horn of Africa, Africa South of Sahara and North Africa.

c) Europe

Patients from Europe came from 12 different countries, and were divided into three groups: respectively Russia, Romania "Other, Europe." Russia and Romania were presented separately to show any contrasts within patients from Europe. The other 10 countries were grouped together.

d) Other

A total of eight patients came from North-, Latin- and South America. Four patients were registered without country of origin, but with sex and age. These patiens were included in this study, but were categorized in Other.

2.4.2 Age

The nurse registered date of birth upon the initial registration of the patients. Dataset 1 included the patients exact age. This age was generated from the patients´ year of birth.

In dataset 2 with the diagnoses there was also a list of age, generated using the date of birth. In this dataset, the patients' age were grouped into categories, from age 0-10 years, 11-20 years, 21-30 years, 31-40 years, 41-50 years, 51-60 years, 61-70 years and 71-80 years. These age groups had to be used when analyzing diagnoses.

2.4.3 Sex

The patients were registered as either man or woman.

2.4.4 Residence status

Many patients were uncertain about their own residence status. This hampered the initial registration of the patients, as it could be difficult to categorize the different patients' status.

One and the same patient could belong to several of the 13 categories defining residence statuses. For example, a patient having "Application rejected" (final rejection on the asylum application), and at the same time "unreturnable" (no opportunity for the authorities to return the patient to his or her country of origin)and / or "expelled from country" (patient is expelled from the country, or has exceeded the departure deadline after a final rejection on the asylum application or another application for residence) while the patient consider themselves "refugee", even if he or she has not been granted refugee status under the UN Refugee Convention (117).

Accordingly, it could be difficult for both patient and nurse in reception to categorize some patients. Information about residence and residence status was self-reported and not validated by other information. The analysis was based on the categories that were registered on the individual patient, even though these were not validated with different types of documentation.

Information about the patients' residence status and length of stay emerged from data set 1. Residence status was divided in to 13 different categories. In our study these categories were grouped in three: "illegal residence", "legal residence" and "unknown residence status.»

a) Illegal residence/persons without legal residence

Five of the 13 categories of residence status indicated that the patients were without legal residence. These categories were: "false / expired visa," "not registered" (by the authorities), "application denied," "unreturnable" and «expelled".

b) Legal residence

Five of the categories of residence status indicated that the patient had legal residence in the country. Persons belonging to these categories had legal residence in Norway:
“labor migrant,” “asylum seeker”, “family reunification”, “refugee” and “Schengen / EU citizen”.

c) Unknown residence status

Three categories indicated that the patients had unknown residence status. These were "not set", "lost" and "uncertain / do not know." It may be that the patients did not know their residence status or that the Health Center for various reasons has not registered their residence status.

2.4.5 Length of stay

The length of stay registered at the Health Center were the patients´ total length of stay in Norway. This included the time the patients may have had legal residence in Norway, for example, before final rejection to an asylum application. In the data from the Health Center, length of stay was grouped in to five different categories: 0-3 months, 4-12 months, 1-3 years, 3-7 years and over 7 years. This study used the same categories.

2.4.6 Diagnoses

The number of diagnoses equaled the number of consultations (62). A patient may have received more than one diagnose related to one and the same organ chapter. It did not emerge from the data material for how many patients this was relevant.

2.4.7 Reflections and experiences

I have been volunteering once or twice a month at the Health Center since its opening and until today´s date (118). Before starting at the Health Center, I had some years experience

from working with asylum seekers in the municipal health services. This was at an asylum reception center which was staffed with health professionals both night and day, and included «home based services» (hjemmesykepleie) and a nurse driven drop-in health clinic. The habitants were mainly asylum seekers with severe diagnoses related to diverse somatic and mental health problems, complicated pregnancies and communicable diseases. This included asylum seekers in all stages of their asylum procedure, including patients with final rejections. I have also had a shorter engagement at a health office for asylum seekers with final rejections on their applications. This was also organized as a nurse driven drop-in health clinic located at the asylum reception center.

My main task at the Health Center is the initial registration of patients, as well as recording a short patient anamnesis before referring the patients to a physician, psychologist or physiotherapist at the Health Center. I have followed the Health Centers guidelines for registration, and thus registered the patients in the same way as the other nurses.

My experiences from the Health Center and from other work with the patient group has given me useful backdrop for the study. This applies specially for prior knowledge about the Norwegian Immigration system and the asylum process. In addition, it has been a great advantage to know the procedures and practices at the Health Center. My unique experiences from working within this field is also relevant in analyzing my finding in this study because the data material has some limitations (p. 30-33).

My previous experiences from the municipal health services and from the Health Center influence how I meet the patients and which questions I ask when registrering a patient anamnesis. Any attempt to exclude my experiences and reflections during the discussion in this study would be difficult, especially considering that my own experiences from the municipal health services are the direct reasons for choosing this topic for my thesis.

When including my own experiences and reflections, this will be clearly marked with indents, and are merely considered an addition to the data material from the Health Center in order to create a broader understanding of the health problems of persons without legal residence.

2. 5 Ethical assessment about research on persons without legal residence

In 2005 United Nations Educational, Scientific and Cultural Organization approved the Universal declaration for Bioethics and Human Rights (119). This declaration also included research on vulnerable groups, and aimed to ensure that also particularly vulnerable groups were included in the development of medical, scientific and technological knowledge (p. 7 art. 4). The Universal Declaration on Bioethics and Human Rights contained no specific definition of vulnerable groups. The Belmont report "Ethical Principles and Guidelines for the Protection of Human Subjects of Research" (120) listed different definitions, such as ethnic minorities, the economically disadvantaged, critically ill and people living in institutions (Chapter C. 3). The Council for International Organizations of Medical Sciences´ (CIOMS) International Ethical Guidelines for Biomedical Research Involving Human Subjects, mentioned political disadvantaged individuals, ethnic minorities, refugees and asylum seekers as potentially vulnerable groups (121, guideline 13, p. 39).

Persons without legal residence is a very heterogeneous group, both in age and country of origin. The aim of the study was to make an overview of the health problems of the group as a whole. Despite their heterogeneity, the patients had their lack of legal residence in common. The lack of legal residence left them in a situation with very limited rights- and access to healthcare. CIOMS´ International Ethical Guidelines for Biomedical Research Involving Human Subjects section 8., stated that "for purpose of epidemiological study, investigators may define groups that are composed of statistically, geographically or otherwise associated individuals who do not interact socially". (121, p. 6) To define people without legal residence as one group may be expedient for research on persons without legal residence.

CIOMS noted that study design should help to generate new knowledge that will benefit the groups who have been the focus of the study. (119, p. 4). Results from the study may help to improve the quality of the health services people without legal residence will receive in the public or private sector. All medical research studies should be justified. However, according to the Helsinki Declaration, ethical considerations may be especially relevant when it comes to research on vulnerable groups. Such research sets additional requirements for the study design and ethical considerations (122, 17, p. 3).

The sample group consisted of 593 subjects. Some of them belonged to small groups that might be recognizable. Some results might contribute to stigmatization of some groups. This stigmatization may be due to certain diagnoses or groups health seeking behavior. In spite of this, it may still be important to present relevant results if that could lead to an improvement in the health services or preventive measures for these groups. Not presenting relevant findings could prevent an improvement of the relevant health services thus discriminating certain groups and prevent them from benefit from the research.

This consideration related to research on persons without legal residence was raised by Achkor and Macklin in 2009 (70). They debated whether or not to publish results of a study that claimed that persons without legal residence had more active TB than other patients. They concluded that in spite of possible further stigmatization of persons without legal residence, the importance of the results both for the persons without legal residence as well as for the public health in general "warrants wide dissemination of the results".

Knowledge about different groups of persons without legal residence and their health problems may help health professionals and policy makers target the groups´ s needs. In order to achieve this, findings related to certain diagnoses or specific groups of patients are included in this thesis.

2.5.1 Ethical approval of the present study

Before starting the study, the master student and current supervisor applied to the Regional Ethics Committee South East (Regional etisk komité, REK). REK is responsible for management of the Health Research Act (123,124). The application was submitted in March 2011 and the application was considered in May 2011. The committee stated that "the project emerges essentially as a social science research project, and therefore fall outside the scope of the Health Research Act 125, cf. Health Research Act § 2. The project can be conducted without the approval of REK." (126,127)

The study was reported to Norwegian Social Science Data Services (Norsk samfunnsvitenskaplig datatjeneste, NSD) in May 2015, and their decision was made in September 2015. NSD argued that "After reviewing the information provided in the

application and other documentation, we find that the project does not involve notification or license requirement pursuant to the Personal Data Act 128 §§ 31 and 33.» (129)
The master student was offered supervision and office space at the Norwegian Centre for Minority Health Research (Nasjonal kompetanseenhet for minoritetshelse, NAKMI) from 2011-2015. This is a part of the Oslo University Hospital (OUS), and the study was reported to the Data Protection Officer at OUS. When all data is anonymized the Data Protection Officer had no objections to the project.

3 Results

A total of 593 patients have been registered by the Health Center since its opening in 2009. All patients were registered by a nurse in the reception giving demographic data, and the majority of the patients, 92 % (n=547) who have sought the Health Center has had at least one consultation with a doctor or a psychologist. The rest of the patients (n=46) has only received advice from a nurse in the reception or from a physiotherapist.

The patients who did not receive a consultation accounted for 8,7 % (n=27) of the patients from Asia, 7,8 % (n=14) of the patients from Africa, 8,9 % of the patients from Europe (Figure 2), ie. about the same frequency across continents.

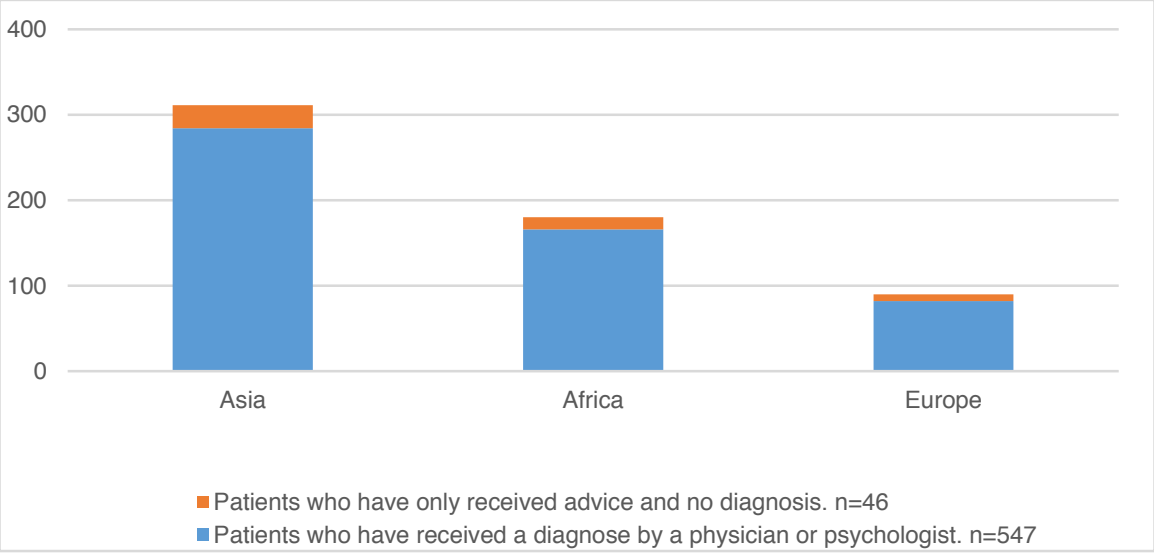


Figure 3 Number of patients who have sought help at the Health Center by continent of origin (n=593)

In this study the terms «examination» and «consultations» were limited to those patients who have received a diagnosis according to the ICPC-2 or ICD-10 classifications. Patients who have only received advice or help from a nurse or physiotherapist were not given a diagnosis, and were therefore not included in the periodic reports thus not included in the main analysis. There was no clear reason in the data as for why these patients have not received treatment. For some acute conditions, the patient in the data may, however, have been referred directly to the Oslo public emergency room (Oslo kommunale legevakt) and hence not been diagnosed at the Health Center.

3.1 Residence status

During the patients' initial registration at the Health Center, the nurse who registered could choose between 13 different residency statuses created by the Health Center in the EPJ. It did not emerge from the data sets which patients belong to the different residency status-categories. The 13 statuses were categorized in illegal residency, legal residency, and unknown residency status.

3.1.1 Persons without legal residence

The vast majority of the patients, 83 % (n=490), were persons without legal residence and were the Health Center´s target group. Of the patients without legal residence, patients with «final rejection on their asylum applications» constituted the largest group (n=316), followed by the patients who were «not registered with the authorities» (n=135). The remaining groups were «fake / expired visa» (n=19), «expelled from the country» (n=16) and «unreturnable» (n=4).

3.1.2 Persons with legal residence

Almost 5% of the patients (n=29) were registered with legal residence, the majority of whom were asylum seekers (n=20). The rest were registered as «family reunificastion» (n=3) «migrant workers» (n=3), «refugees» (n=1), and «Schengen / EU citizen» (n=2). These patients had rights- and access to the public health system in Norway, but have sought help at the Health Center. It has not been possible to exclude these patients from the study, due to the nature of the data material.

3.1.3. Persons with unknown residence status

The remaining 12 % (n= 74) of the patiens were registered with unknown residence status. This category consisted of those people who either do not know or have not stated their residency status, or where the nurses registering the patients at the Health Center for various reasons have not registered their residence status (Figure 3). The categories were either «not set» (n=55), «lost» (n=1) and «uncertain / do not know» (n=18).

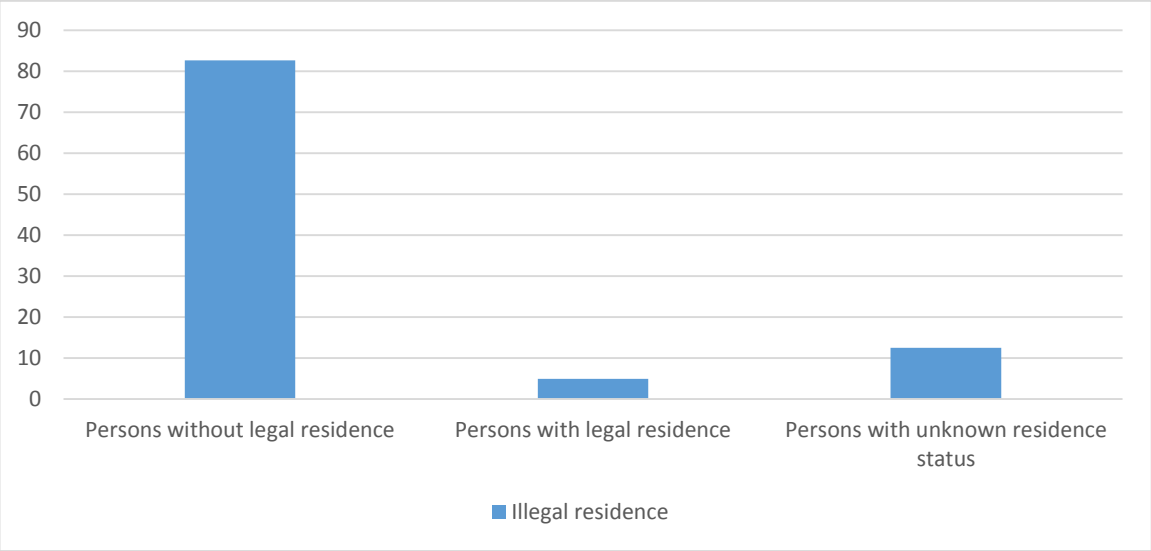


Figure 4 Residency status among the patients at the Health center in percentage (n=593)

3.2 Length of stay

The length of stay was based on all patients who have sought help at the Health Centre. The average stay in Norway was 1,5 years (570 days), but patients with both 0 months and more than 7 years stay have sought help at the Health Center. Approximately 75% (n=435) of the patients have been in Norway for less than three years (Figure 4).

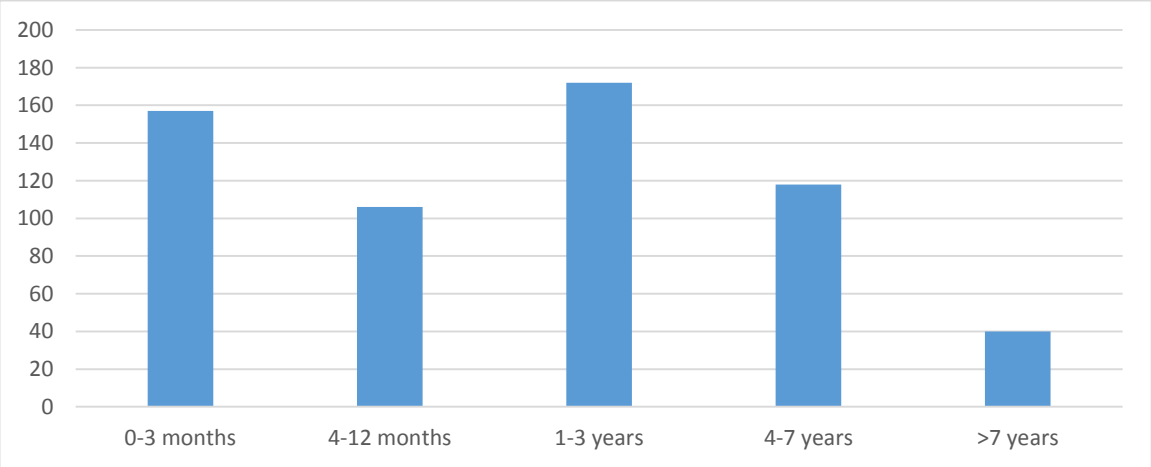


Figure 5 Length of stay in Norway among the patients at the Health Center in numbers (n=593)

It did not emerge from the data the residence status, country of origin, sex or age of these patients.

3.3 Country of origin

Patients from 62 different countries in four continents have sought help at the Health Center in our period. The majority of patients, 52 % comes from Asia, 30 % came from Africa and another 15 % came from Europe. The rest of the patients, 2 %, came from North-, Latin- and South America or were not registered with country of origin in the present thesis (Figures 5 and 6).

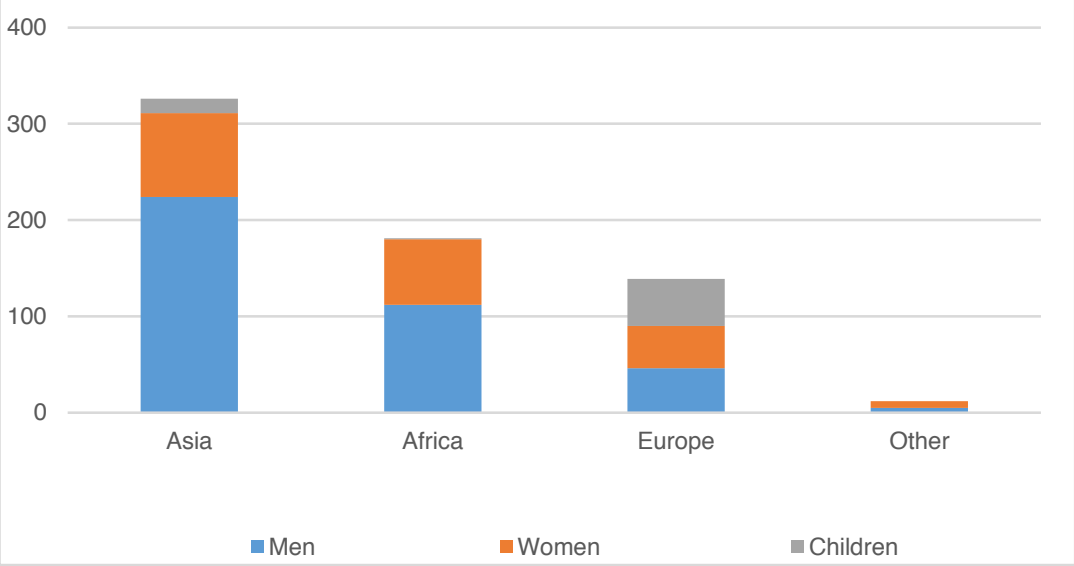


Figure 6 Number of patients at the Health center by continent of origin and sex for adults and children (n=593)

3.3.1 Asia

There were a total of 311 patients from Asia who sought help at the Health Center, 224 men and 87 women. There were a total of 15 children under 18 years old from Asia.

Patients from Asia were divided into Afghanistan, Mongolia, the Middle East and "Other Asia». Two of the patient groups from Asia stand out, patients from Afghanistan (n = 85) and Mongolia (n = 84). These were the two largest groups of patients from Asia in our sample.

a) Afghanistan

A total of 85 patients from Afghanistan sought help at the Health Center. Of these 85, 79 have received treatment. There were only Afghan men and no women among the patients. The average age was 27 years old, and the age range was from 18-55 years.

b) Mongolia

There was a total of 84 patients from Mongolia who sought help at the Health Center and 76 have received treatment. The majority of patients (n = 64) were women and 20 were men. Average age for both men and women was 35 years.

c) The Middle East

There were 112 patients from the Middle East and 101 have received treatment. Most patients from the Middle East were from Iran (n = 47) and Iraq (n = 39), out of which 44 and 36 respectively have received treatment. Other Middle Eastern countries are Syria, Lebanon, Kurdistan and a category called "stateless". Near 84% (n = 94) of patients from the Middle East were men. Men from Iraq (n = 34) were slightly younger (27.7 years) than men from Iran (n = 41) (33.4 years).The women were on average 32 years old. There were 15 patients from Kurdistan, the majority were men. The average age was 26.6 years.

d) Other, Asia

The remaining 30 patients from Asia came from Bhutan, Vietnam, Papua New Guinea, Sri Lanka, Nepal, Pakistan, Uzbekistan and Tajikistan. Of these 30, 28 received a diagnosis. There were 20 men and 10 women., and their average age were 35,8 and 29 years respectively.

3.3.2 Africa

A total of 180 patients from Africa have sought help at the Health Center. There were 112 men 68 women, of whom one child. The patients have been grouped in three categories. The largest groups were patient from Ethiopia (n=44) and Somalia (n=43).

a) Horn of Africa

Patients from Somalia, Ethiopia, Eritrea and Djibouti were included in this category consisting of 98 people, of whom 94 have received treatment. There were 50% women (n=49) and 50% men (n=49). The women from Eritrea (n = 5) were on average older (40.6 years) than women from Ethiopia (n = 27) (36.7 years). The women from Somalia (n = 17) were somewhat younger (30.5 years). On average, the men were slightly older than the women,

with the exception of men from Eritrea (n = 5) who were younger than the women (35.8 years).

b) Sub-Saharan Africa

There were a total of 66 patients from sub-Saharan Africa and 60 of them have received treatment. There were 19 women and 47 men in this group of patients. The patients came from 17 different countries with the largest patient groups being from Nigeria (n = 24) and Burundi (n = 10). The remaining patients came from Cameroon, Chad, Congo, The Gambia, Ghana, Guinea, Kenya, Liberia, Sudan, Mauritania, Togo, Zimbabwe, Rwanda, Senegal and Sierra Leone. The male patients were on average slightly older (31 years) than women (30 years), with the exception of men from Sudan (n = 8) with an average age of 37.5 years.

b) North Africa

Patients from North Africa constituted the smallest group of patients from Africa. The group consisted of 16 men, of whom 12 have received treatment. The patients came from Egypt, Algeria, Libya, Morocco and Tunisia. The patients average age were 27,7 years.

3.3.3 Europe

A total of 90 people from 12 European countries have sought help at the Health Center in our period. Of these 90 patients, 82 have received treatment.

a) Romania

There were 34 patients from Romania, 15 women and 19 men. All patients have received treatment. The average age were 38 years for women and 33 years for men.

b) Russia

There were 28 patients from Russia, 26 have received treatment. There were 17 women and 11 men, and the average age for men and women were 38,5 and 33 years respectively.

c) Other, Europe

There were 28 patients from other European countries, of whom 22 have received treatment. These patients came from Albania, Belarus, Bulgaria, Lithuania, Moldova, Poland, Serbia and

Montenegro, Portugal, Austria and Ukraine. There were 14 men and 14 women among the patients from Europe. Average age for men and women were 35 and 35 years respectively.

3.3.4 Other patients

There were eight patients from North, Latin and South America. In addition to a total of four patients were registered without country of origin. All of the latter were above 18 years old.

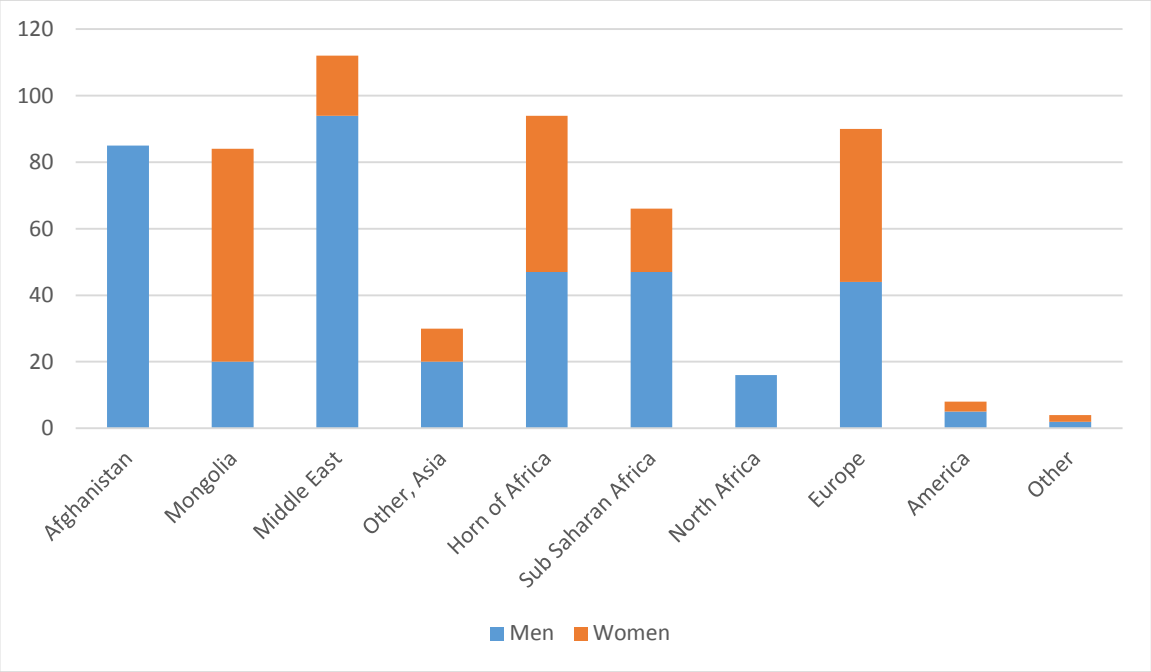


Figure 7 Number of patients at the Health Center by country or area of origin and sex (n=593)

3.4 Age and sex

The majority of the patients at the Health Center were men (n=385) of whom 357 have received a diagnosis. Of the 208 women at the Health Center, 190 have received treatment. Of the patients who received treatment, men and women constitute 65.3% and 34.7 % respectively. The patients´ age range from 0 to 80 years, and among the patients who have received treatment, more than 42 % of the patients (n=229) were between 21 - 30 years old, and 34 % of the patients (n=187) were 31 - 40 years old (Figure 7).

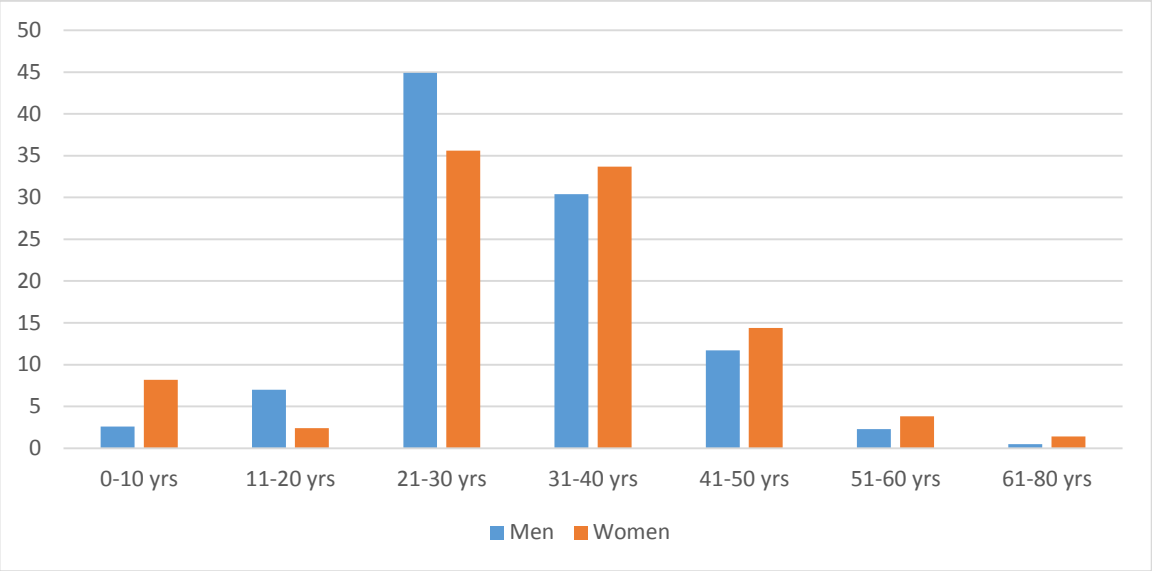
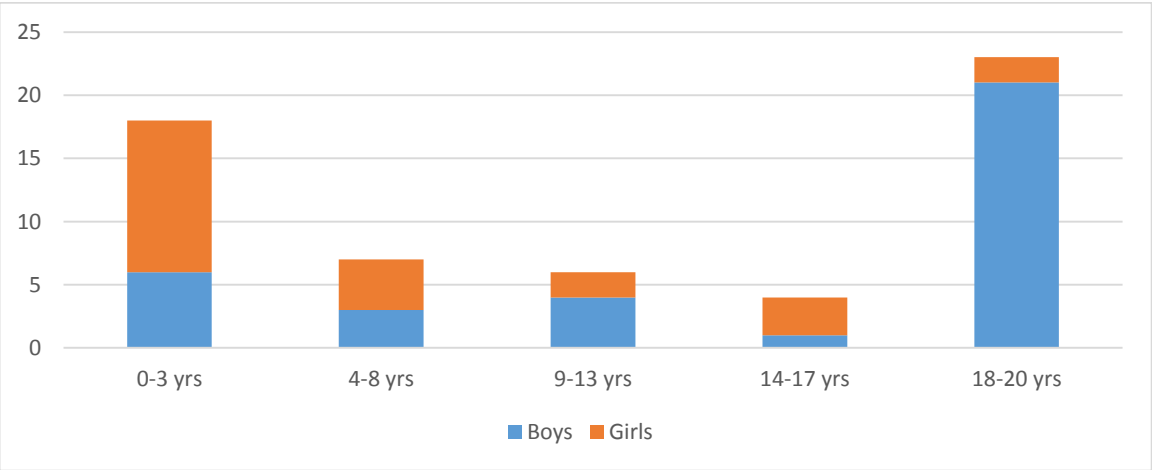


Figure 8 Distribution of age in percentage for each sex at the Health Center (n=592)*

*One patient is registered without age

The women were slightly older than men. This might be due to the high number of women from Mongolia (n=64), with an average age of 35 years.

Almost 9 % (n=53) of the patients were below 20 years old (Figure 8). There were more girls than boys between 0-10 years, but significantly more boys among the patients between 11 and 20. The majority of these patients were aged 18-20. There were 35 children below 18 years among the patients at the Health Center.



Figur 9 Distribution of age and sex among the children and adolecents at the Health Centre (n=53)

3.5 Health problems among patients at the Health Center for undocumented migrants

3.5.1 Diagnoses

There were 547 patients who had a total of 1139 consultations at the Health Center with either a physician or psychologist, thus received at total of 1139 ICPC-2 diagnoses. The patients have received 284 different diagnoses, out of which 173 diagnoses have been given more than once. Of the 1139 ICPC-2 diagnoses, 63,7 % (n=730) were symptom diagnoses and 36,3 % (n= 409) were disease diagnoses.

Patients have received diagnoses related to all 17 chapters according to ICPC-2 classification (Figures 9 and 10).

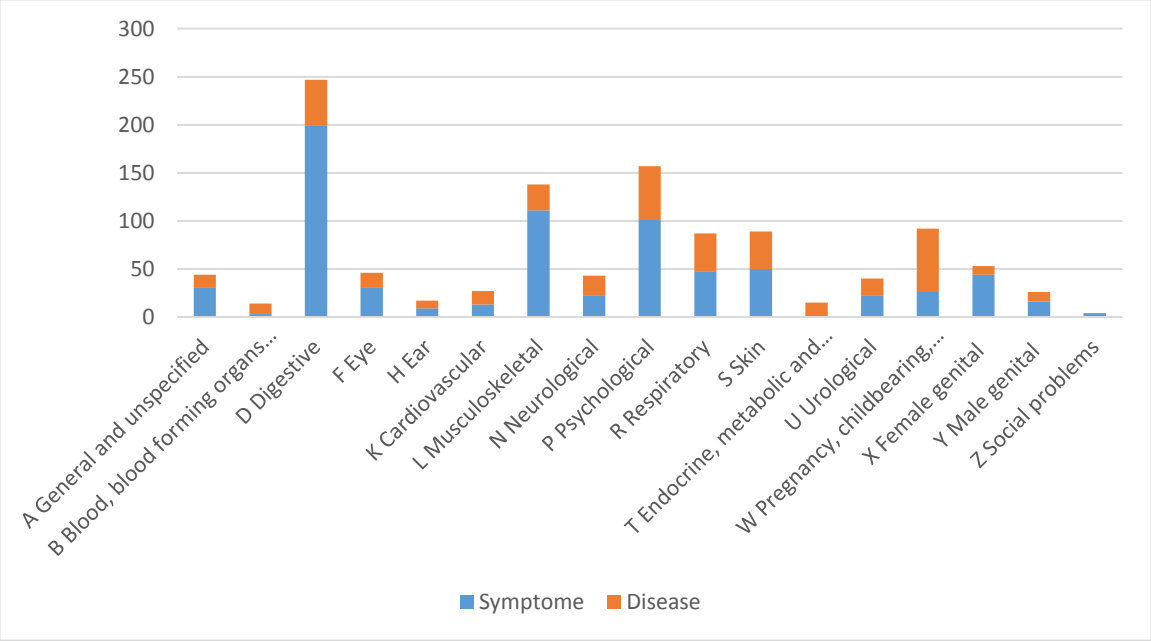


Figure 10 Number of ICPC-2 diagnoses grouped in organ chapters by symptoms and diseases among the patients at the Health Center (n=1139)

The most common diagnoses were related to digestive problems (D Digestive) (n = 247), mental health (P Psychological) (n = 157), sexual- and reproductive health (W Pregnancy, childbearing and family planning, X female genital and Y male genital) (n = 171) and

musculoskeletal problems (L Musculoskeletal) (n = 138). Patients have received four diagnoses related to social problems and living conditions (Z Social problems), which makes this the least frequently used chapter.

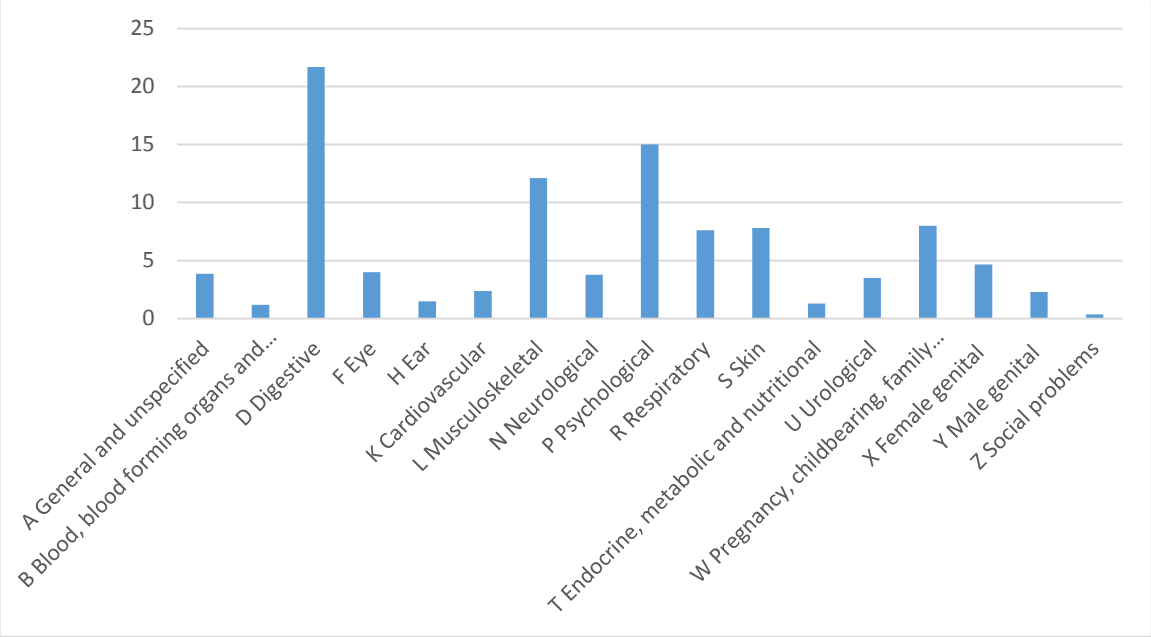


Figure 11 Distribution of ICPC-2 diagnoses grouped in organ chapters among the patients at the Health center in percentage (n=1139)

3.5.2 Diagnoses among different groups of patients

Each patient has on average had two consultations thus received two diagnoses. There were however several differences between different groups of patients, both in relation to the prevalence of the different diagnoses, but also the number of diagnoses each patient has received.

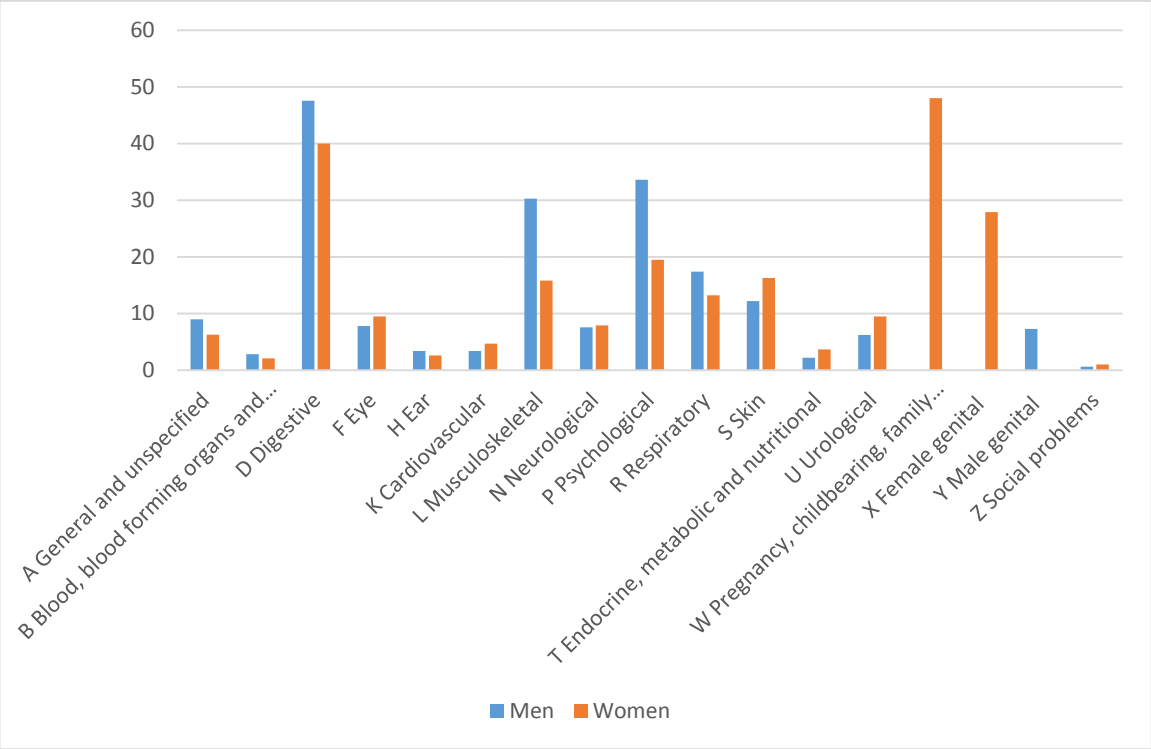


Figure 12 Prevalence of diagnoses among men and women at the Health Center in percentage. Percentage for men (n=357) and women (n=190) separately (n=1139)

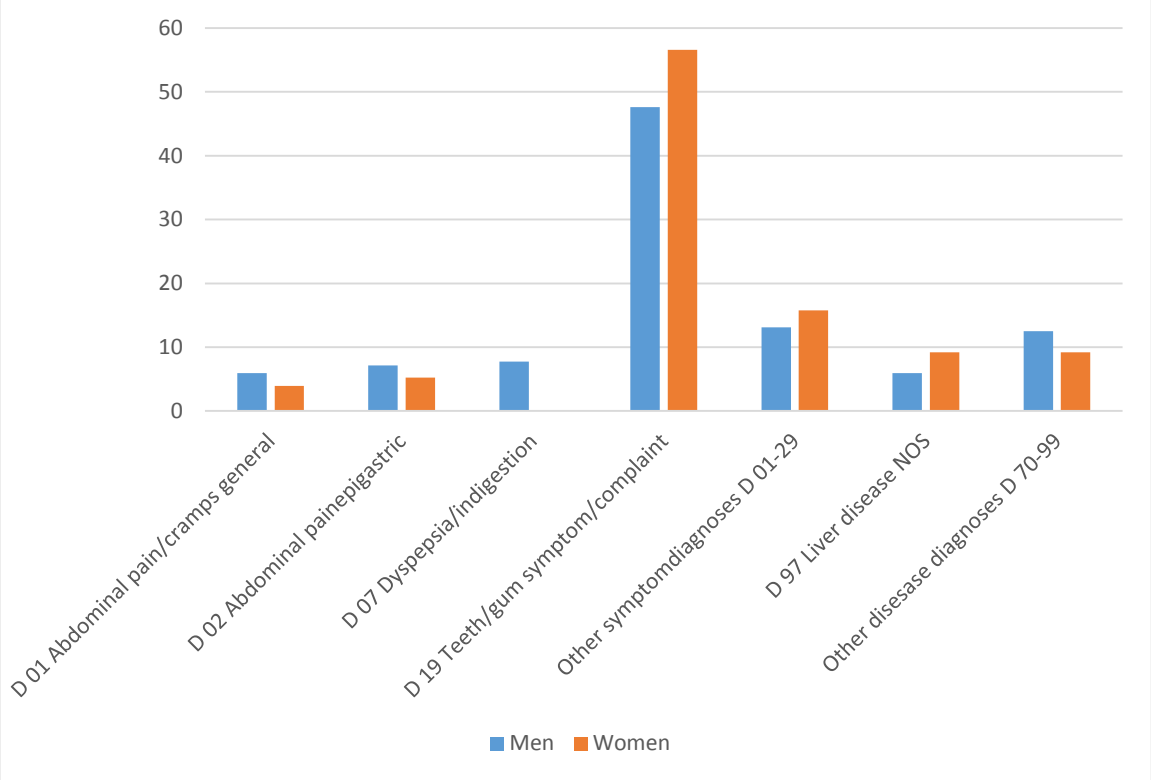
The 190 women constituted 35% of patients, but have received 38.5% of the diagnoses. This makes up 2,3 diagnoses per patient. The 357 male patients received 1,95 diagnose per patient. Both women and men had health problems related to all 17 chapters in the ICPC-2 classification, with the exceptions of gender-specific diagnoses (Figure 11).

There were differences in how many diagnoses patients from different countries received. The two largest patient groups were patients from Afghanistan, who accounted for 14, 4% (n =79) of patients, and Mongolia constituted 13.9%, (n =76). They also received respectively 16.3% (n =186) and 13.7% (n =156) of the diagnoses.

The patients from Romania (n = 34), 15 women and 19 men, including children, have had 47 consultations thus received 47 diagnoes. This gives an average of 1.4 diagnoses each. This stands in contrast to patients from Russia (n = 26),17 women and 10 men, who had 72 consultations and received on average 2.8 diagnoses each.

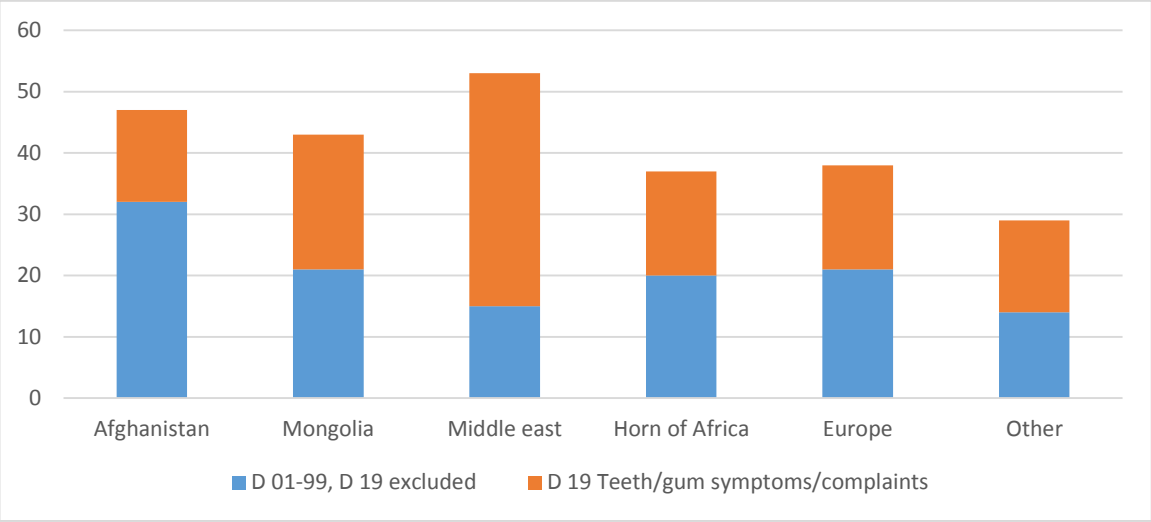
3.6 Digestive problems (D Digestive)

Both men, women and children have received treatment for digestive problems, and symptoms and diseases related to digestion has been diagnosed a total of 247 times. This represented 21,7 % (n=247) of the total number of diagnoses given patients at the Health Center, and made D diagnoses the most frequent group. Of the 247 diagnoses, 80% (n = 199) were symptom diagnoses (D 01-29) and 20% (n=48) were disease diagnoses (D 70-99). Nearly 50 % (n=123) of the D diagnoses were D 19 Teeth / Gum symptom / complaint (Figure 12).



Figur 13 Distribution of digestive symptoms and diseases in men and women at the Health center. Percentage for men (n=357) and women (n=190) separately.

Patients of all ages have received diagnoses related to the digestive system. Overall 47.6% of male and 40% of the female patients received such diagnoses. Respectively 22.4% of men and 22.6% of women have received diagnosis D-19 Teeth / Gum symptom / complaint.



Figur 14 Number of digestive problems among patients from different countries/areas (n=247)

There was a variation in the prevalence of digestive problems among patients from different countries. Among the 44 patients from Iran who received treatment, 65 % (n=31) were diagnosed with digestive problems. Among patients from Afghanistan, 61% (n = 47) were diagnosed with digestive problems, and 57% (n = 43) of the Mongolian patients. Among patients from Europe, the patients from Romania had the highest prevalence of digestive problems, with 50 % (n=17) having received either a symptom or disease diagnosis.

Table 4 Number of digestive problems among patients from different countries/areas

	Afghanistan	Iran	Mongolia	Romania	Total
Patients with a digestive diagnosis	47	31	43	17	138
Patients without a digestive diagnosis	32	13	33	17	95
Total	79	44	76	34	233

P-value= <0.001

Among the Afghan patients, 32% of the D diagnoses were related to teeth and gum, whereas 72 % of the digestive diagnoses among patients from the Middle east were teeth/gum. All the patients from Iraq who were diagnosed with digestive problems (n=11 out of 36) were diagnosed with D 19 Teeth / Gum symptom / complaint.

3.7 Vision and hearing (F Eye- and H Ear diagnoses)

Several patients at the Health Center were diagnosed with problems related to vision (F-diagnoses, n = 46) and hearing (H-diagnoses, n = 17). This amounted to just under 6% of the total number of diagnoses. The majority of the diagnoses were symptom diagnoses (F- and H 01-29) (n=40), and 23 were disease diagnoses (F- and H 70-99).

Around 40 % (n=18) of the diagnoses related to eye/vision, were F 29 Eye symptom / complaint. Three people were diagnosed with F 92 Cataract. There were eight diagnoses related to hearing/ear symptoms, H 01-29, and nine disease diagnoses, H 70-99. The most common diagnosisis was H 01 Ear pain / earache. Six children were diagnosed with problems relating to vision and / or hearing. Three children had diagnoses related to hearing and three to vision. Four of the children were between 0 and 10 years old.

3.8 Muculoskeletal diseases (L Musculoskeletal)

There were a total of 138 L-diagnoses, of which 80% (n=111) were symptom diagnoses (L 01-29). The most common symptom diagnoses were L 01 Neck symptom / complaint, L 02 Back symptom / complaint and L 03 Low back symptom / complaint. These L-diagnoses were given a total of 51 times, and mainly to patients aged 21-50 years. The remaining 60 L 01-29 diagnoses were related to all parts of the musceloscletal system.

There were a total of 27 disease diagnoses (L 70-99) related to the musculoskeletal system. The most common disease diagnoses were Back syndrome without and without radiating paint (L 84 and L 86), which occurred 11 times, while L 87 Bursitis / tendinitis / synovitis occurred six times. A total of five diagnoses were related to fractures or sprains L 73 tibia/fibula and L 74 hand/foot bone and L 77 Sprain/strain of ankle.

3.9 Mental disorders (P Psychological)

Approximately 29% of patients (n = 157) were diagnosed with a mental illness by a P-diagnosis, and P-diagnoses were given to patients from 26 countries in all four continents (Figure 15). Symptom diagnoses, P 01-29, constituted 64.3% (n =101) of the P-diagnoses, and disease diagnoses, P 70-99 constituted 35.7% (n =56) (Figure 14).

More than 42 % of the over all diagnoses (n=1139) were given to patients aged 21-30 years. However, this group has further received 60.5% of the P-diagnoses (n = 95). Two children/adolescents have received P-diagnoses. Both of these were between 11-20 years old.

An overall of 17 different P-diagnoses were given. The most common symptom diagnose is P 03 Feeling depressed (n = 39), which represented 25% of the total number of P-diagnoses (n=157). The most common disease diagnosis, P 82 Post-traumatic stress disorder (PTSD) constituted 13,4% of the total number P diagnoses (n=21).

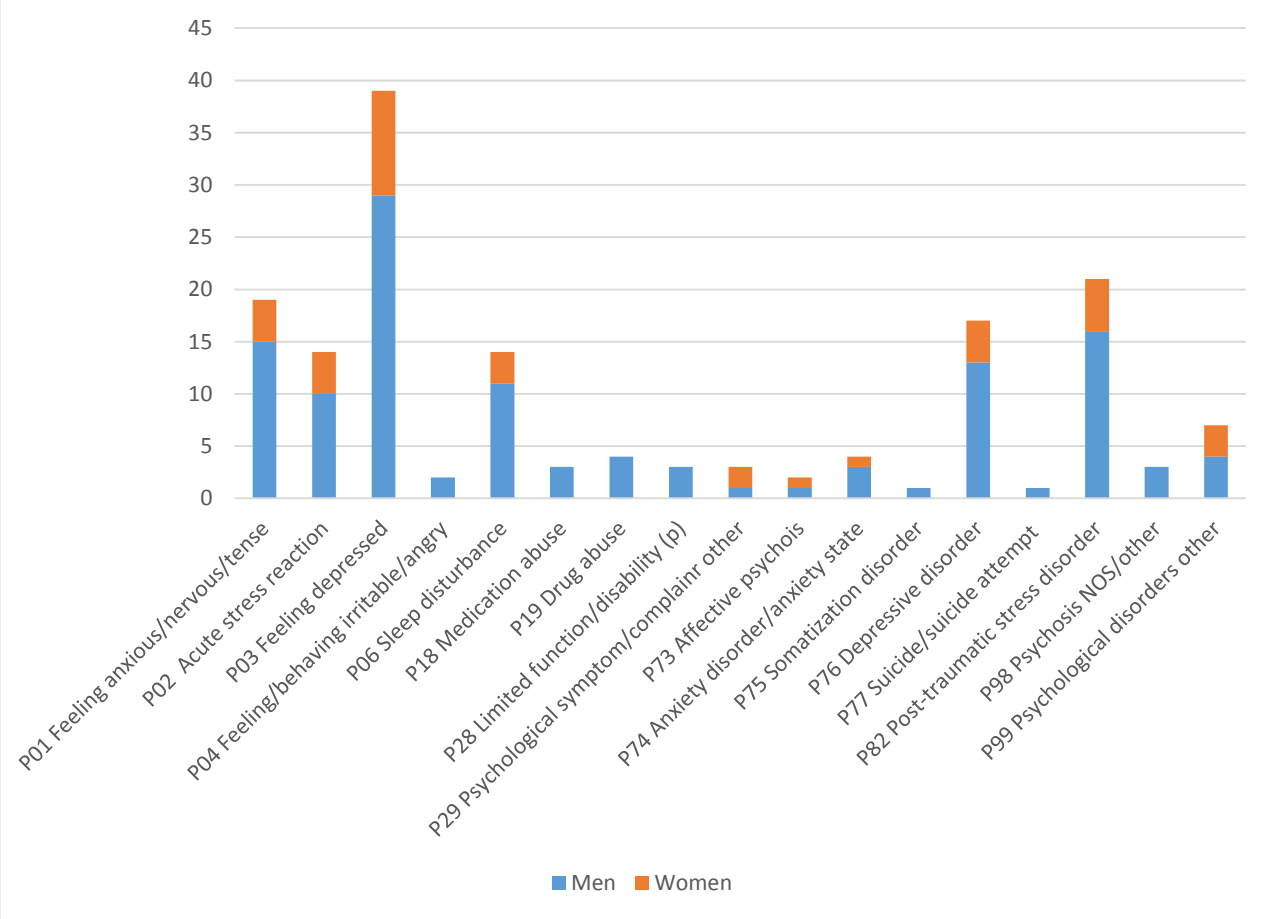


Figure 15 Number of mental disorders by sex at the Health Center (n=157)

Patients with mental disorders had very different countries of origin (Figure 15). There was a significant difference in the prevalence of mental diagnoses among patients from different countries of origin and with different residence statuses. People who were assumed to be rejected asylum seekers, had higher rates of mental illness regardless of their country of origin.

Rejected asylum seekers included people from countries and regions such as Afghanistan, the Middle East, the Horn of Africa, sub-Saharan Africa and North Africa. Approximately 50% (n = 40) of patients from Afghanistan were diagnosed with mental diagnoses. Among patients from the Horn of Africa, 36, 2% (n = 34) of patients were diagnosed with mental diagnoses. Among patients from Europe, patients from Russia constituted the largest group of patients with mental health problems 39 % (n = 11 of 28).

In some of the groups that have come to Norway as clandestine workers, few if any were diagnosed with mental disorders This applied mainly to people from Mongolia (n = 76) and Romania (n = 34), none of whom were diagnosed with mental disorders.

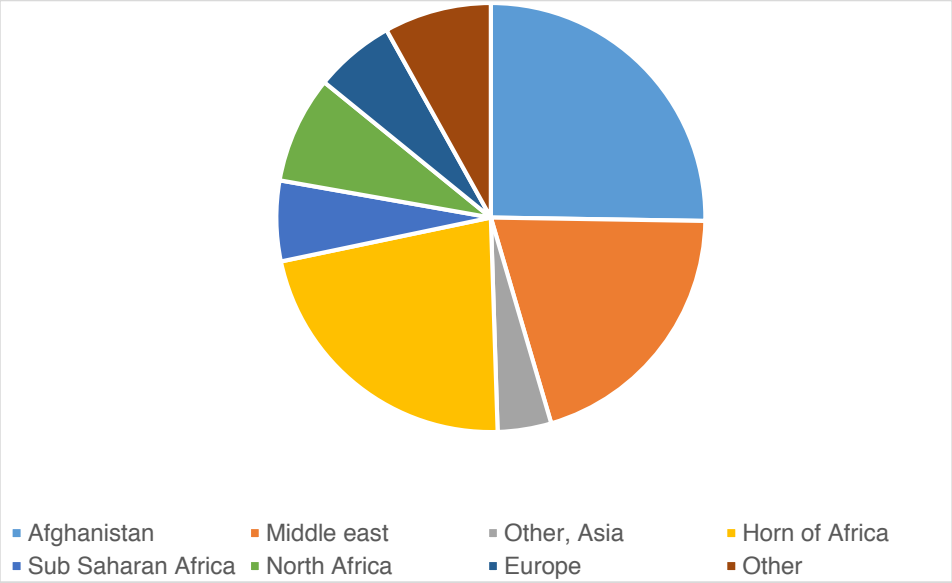


Figure 16 Mental health problems according to country of origin among the patients at the Health center

A significantly larger proportion of males (34 %) than females (n = 37) were diagnosed with mental disorders (Table 4).

Table 5 Patients with and without diagnosis related to mental health problems by sex

	Women	Men	Total
Patients with a psychological diagnosis	37	120	157
Patients without a psychological diagnosis	153	237	390
	190	357	547

P-value= <0.001

There were no female patients from Afghanistan in the sample, and men from Afghanistan had a high prevalence of mental disorders. This may explain why the prevalence of mental illness were higher among male patients, given that Afghan patients made up less than 15 % of the patients but received 25 % of the P-diagnoses. Despite the different countries of origin, the prevalence of the diagnoses was relatively similar among the men and women who were diagnosed with mental disorders (Figure 16).

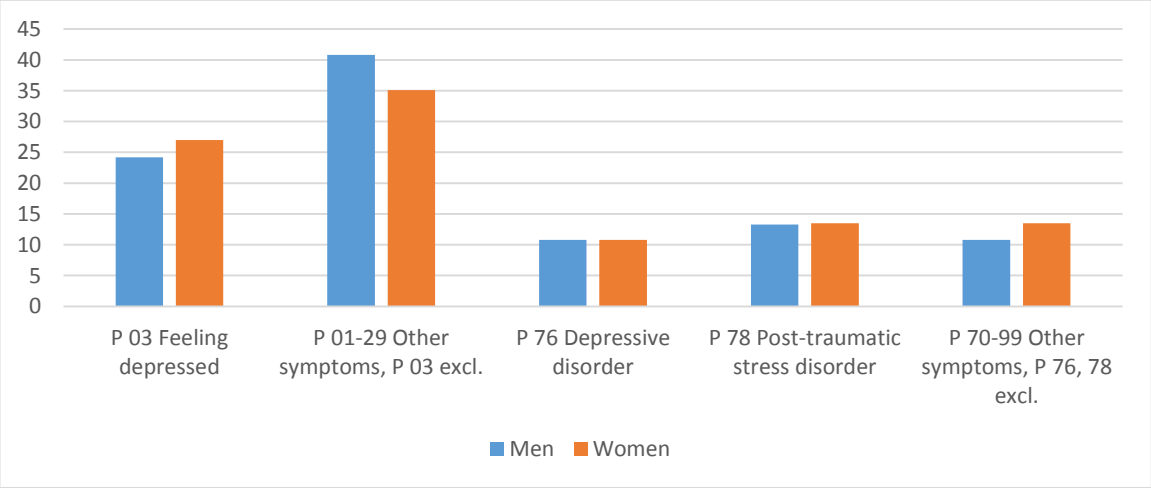


Figure 17 Psychological diagnoses in separate percentages for men (n=120) and women (n=37) at the Health Center.

3.10 Sexual- and reproductive health (W-, X- and Y-diagnoses)

Sexual and reproductive health included diagnoses related to W Pregnancy, childbearing and family planning, X Female genital and Y Male genital.

A total number of 171 W, X and Y diagnoses were given. This represented approximately 15% of the total number of diagnoses given at the Health Center in our period. Of these 171 diagnoses, 145 were W- and X-diagnoses. These diagnoses constituted 33.1% of all diagnoses given to women.

3.10.1 Pregnancy, childbearing and family planning (W-diagnoses)

Of the 171 diagnoses related to sexual- and reproductive health, 92 were related to W Pregnancy, childbearing and family planning (Figure 17). Among these, 75% (n = 69) directly related to pregnancy.

Among the women who have received W-diagnoses, 40% (n = 37) came from Mongolia, followed by 16% (n = 15) from Europe and 13% (n = 12) from the Horn of Africa and 13 % from Sub-Saharan Africa (n=12). The remaining women came from all continents. Women from 11-50 years were diagnosed with W-diagnoses. It is not possible to tell the exact age of the youngest patients who has received an W-diagnosis, other than that she was between 11-20 years old.

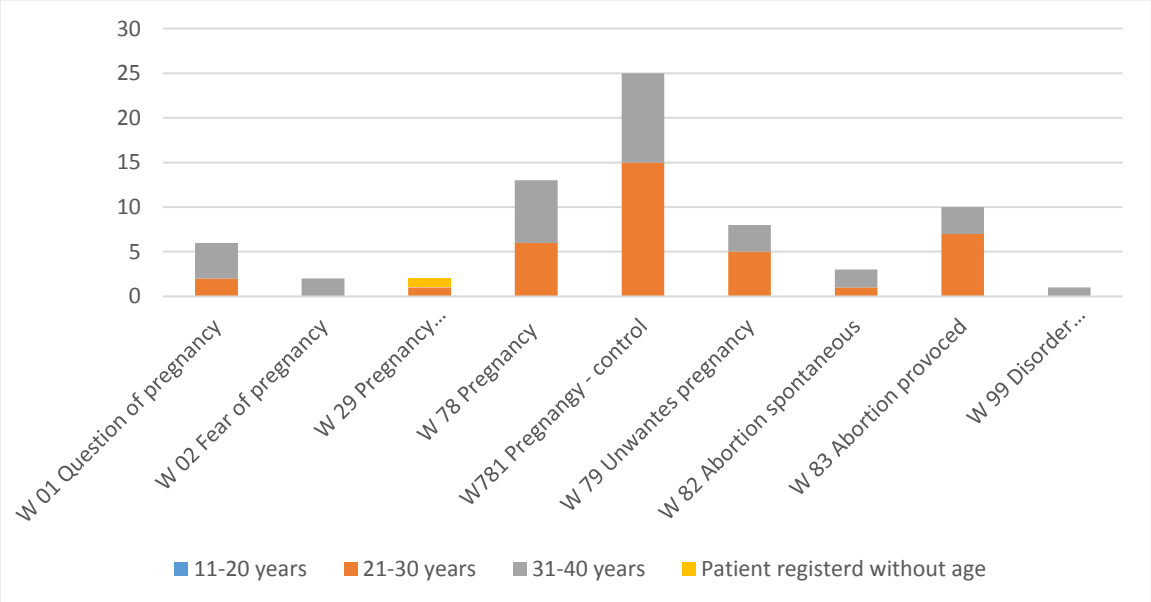


Figure 18 Prevalence of diagnoses related to W Pregnancy, childbearing and family planning by age (n=93)

Some patients have received diagnoses related to contraception (Figure 18). The most frequent diagnose is W 12 Contraception intrauterine. Condoms are available throughout the Health Center, and whether a patient have received condoms from a nurse or helped him or herself was not evident from the data, as this was not recorded with ICPC-2 diagnoses.

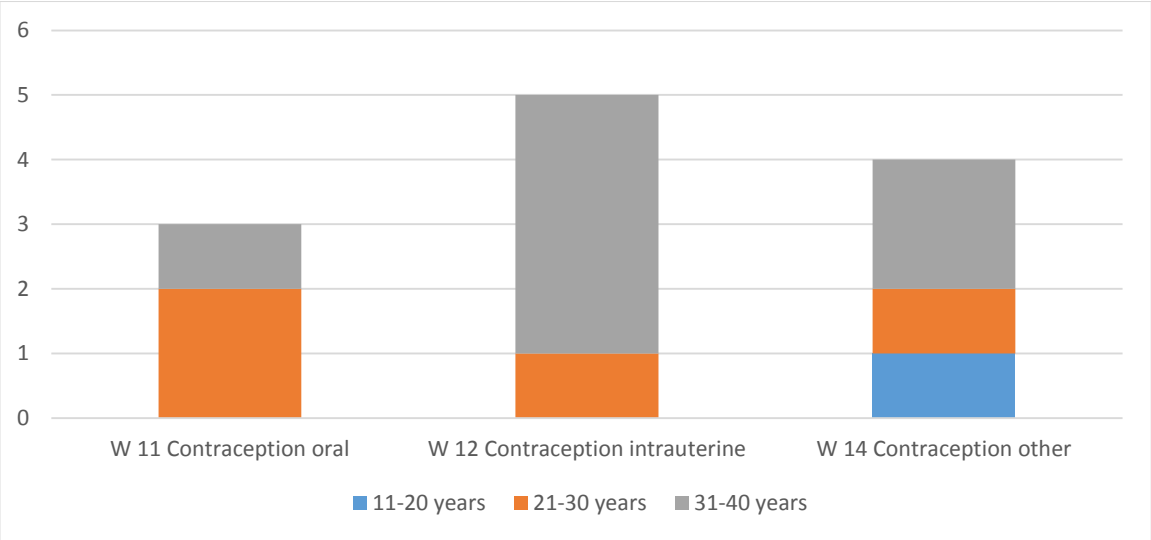


Figure 19 Number of diagnoses related to contraception at the Health center (n=12)

More than 31% (n=59) of the total number of women who have received the diagnoses related to sexual and reproductive health at the Health Center were from Mongolia. These women have received 57 diagnoses related to Pregnancy, child bearing, and family planning and Female genital. Of these diagnoses were 65% (n = 37) related to pregnancy, childbirth and family planning.

It was not evident from the data if it were the same women who received diagnoses related to pregnancy, unwanted pregnancy or induced abortion. Nine women from Mongolia were diagnosed with W- 79 unwanted pregnancies and eight women from Mongolia referred to induced abortion. The eight women from Mongolia constitute 75% of patients referred to induced abortion.

Women from Mongolia also constituted 60% of the women who received contraception, mainly an intrauterine device. The remaining women who received contraceptives came from the Horn of Africa, sub-Saharan Africa, the Middle East and Europe.

3.10.2 X- female genitals (including breasts)

Of the 171 diagnoses related to sexual and reproductive health, 53 were related to X-female genitals including breasts (Figure 19). Symptom diagnoses (X 01-29) constituted the majority (n = 44) of the diagnoses. Only a minority of the diagnoses (n = 9) were related to diseases (X70-99). The symptom diagnoses were mainly related to menstruation (X 02-, 03-, 05-, 06-, 07-, 08, n=13). Five women were diagnosed with X 19, Breast lump/mass female. The disease diagnoses (X 70-99) were mainly related to various infectious conditions.

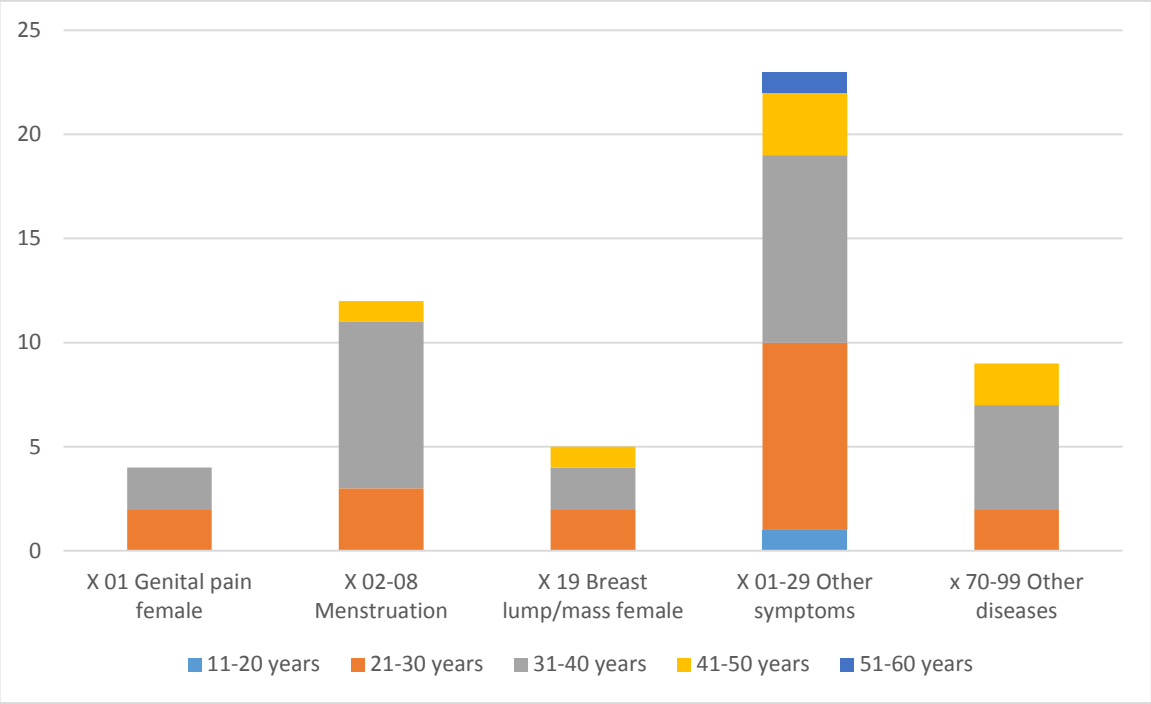


Figure 20 Number of X Female genital diagnoses by age (n=53)

3.10.3 Y- male genitals

Of the 171 diagnoses related to sexual- and reproductive health, 26 diagnoses were related to Y-male genitals. This constituted 2.3% of the total number of diagnoses at the Health Center and 3,6 % of the diagnoses given to men. Of the 25 diagnoses, 15 were symptom diagnoses (Y 01-29) and 10 disease diagnoses (Y 70-99). Only men aged from 21-50 years have received Y-diagnoses (Figure 20).

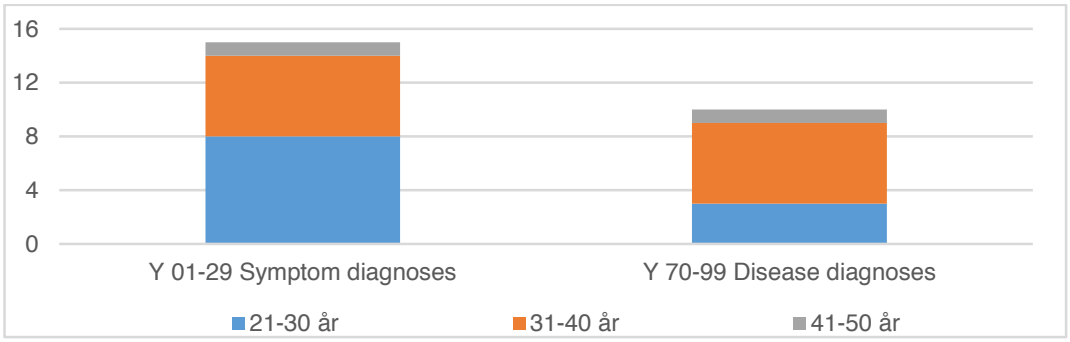


Figure 21 Number of diagnoses related to male genitals, distribution by age (n=26)

3.10.4 Sexually Transmitted Diseases

A small number of patients were diagnosed with sexually transmitted diseases (n=15). These diseases included chlamydia, gonorrhea, syphilis and B 90 HIV-infection/AIDS. These patients were aged 21-40 years, and were both males and females.

3.11 Respiratory problems (R Respiratory)

There were 87 diagnoses related to the respiratory tract. This amounted to 7.6 % of the total number of diagnoses given at the Health Center. Of these 87 diagnoses, 54% (n = 47) were symptom diagnoses (R01-29) and 46% (n = 40) were disease diagnoses (R 70-99). The diagnoses were given patients from all continents and in all age groups. The most common diagnosis was R 74 Upper respiratory infection acute (n = 13). Of these 13 diagnoses five were given to children aged 0-10 years.

Two patients were diagnosed with R 24, Haemoptysis and one patient was diagnosed with A 70 Tuberculosis. This was an ICPC-2 diagnosis related to A - General and unspecified, and it was not evident from the data whether this was pulmonary tuberculosis.

3.12 Skin problems (S Skin)

Diagnoses related to skin problems (S-diagnoses) were given 89 times. This accounts for 7.8% of the total number of diagnoses. Of these 89 diagnoses, 56% (n = 50) were symptom diagnoses (S 01-29) and 44% (n = 39) were disease diagnoses (S 70-99). Eight of the diagnoses were given to children aged 0-20 years. People from all countries had skin problems, related to both symptoms and / or diseases.

3.13 Health problems among children

There were 53 patients in the age groups 0-10 and 11-20 years old, and they received 73 diagnoses. It was not possible to distinguish between patients from 11-17 years and 18-20 years in dataset 2. All patients aged 18 to 20 were therefore included in the category «children» (p. 32-34). It was not possible to differ between boys and girls in the data material.

Of the 73 diagnoses, 41 were symptom diagnoses and 32 were disease diagnoses (Figure 21). Children under 0-10 years have received 60% (n = 40) of the 73 diagnoses. The most common health problems in children were problems related to digestion (n = 19) and respiration (n = 10).

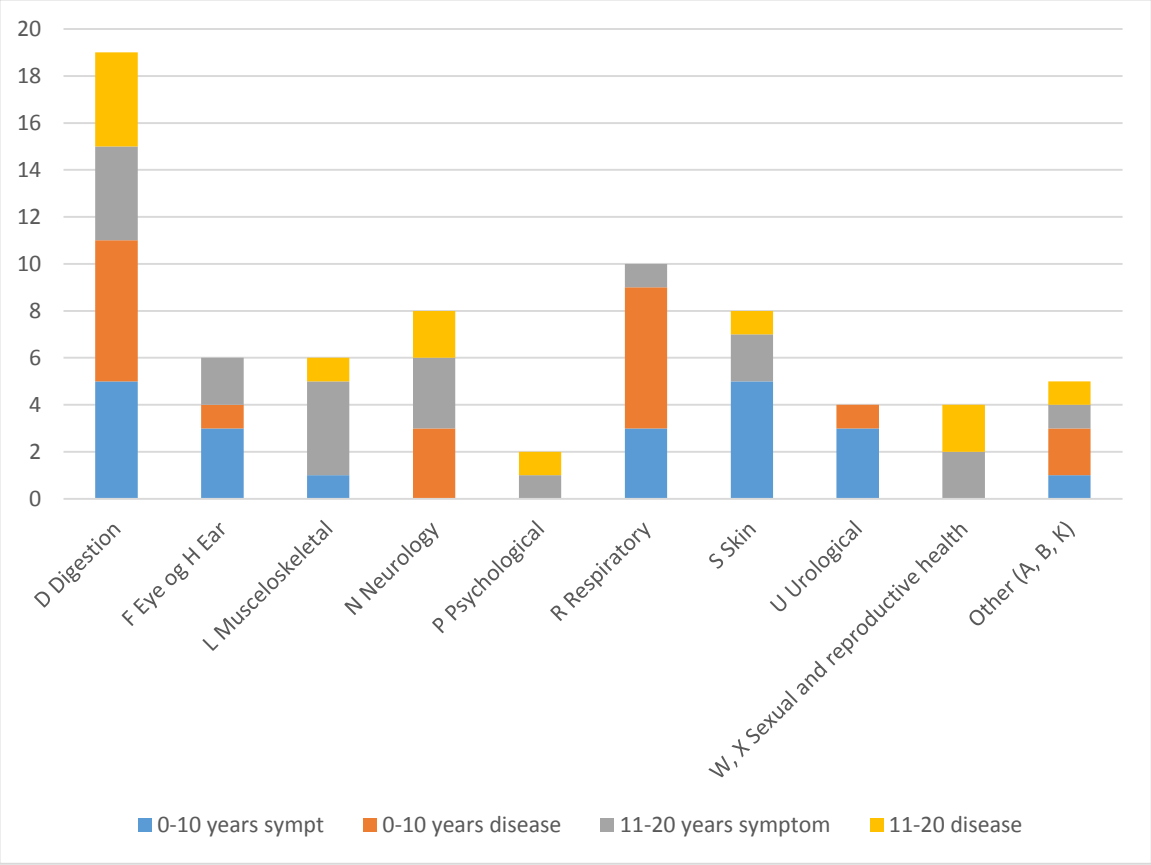
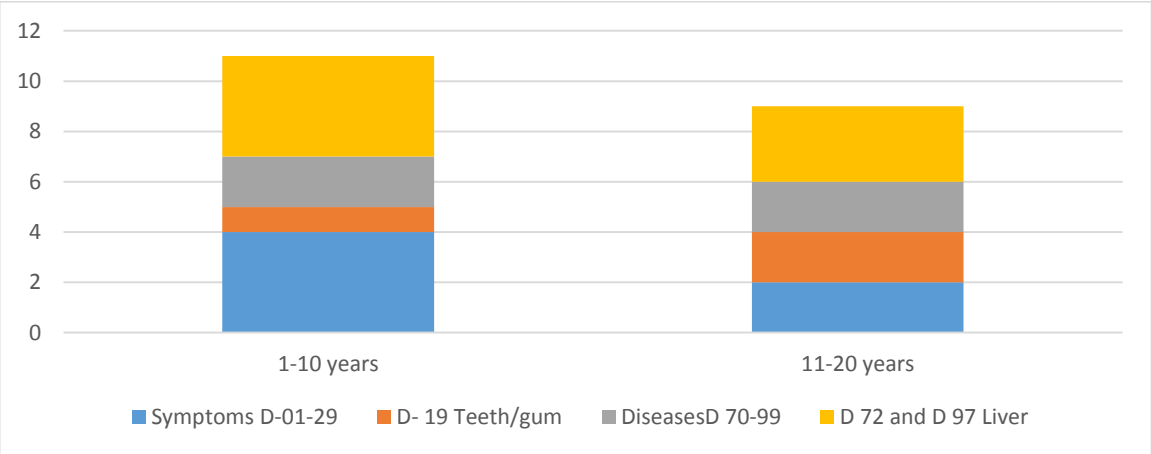


Figure 22 Number of diagnoses according to the ICPC-2 organ chapters among children by age at the Health center (n=73)

Several of the children have received diagnoses related to infections. This included both H 71 Acute otitis media/myringitis, R 74, Upper respiratory infection acute, U 71, Cystitis/urinary infection other and D 72 Viral hepatitis. Six of the children were also diagnosed with D 97 Liver disease NOS.



Figur 23 Number of digestive problems among children at the Health center by diagnose and age (n=20)

A total of 20 children from 0-20 years were diagnosed with digestive problems (Figure 22). D 97 Liver disease NOS (Not otherwise Specified) was the most common (n=6).

4 Discussion

The Health Center for Undocumented Migrants met 593 patients during the data collecting period which was the Health Centers first 18 operating months. Over 90 % of these patients received treatment from a doctor or psychologist, and the patients received 1139 diagnoses related to all 17 organ chapters according to the ICPC-2 classification. The most common health problems are related to the digestive, sexual- and reproductive health and mental health.

The Annual Reports from the Health Center include information about their patients and their health problems. The present study is based on the same data material, but goes much further in dept than the Annual Reports. It is thus a detailed supplement to the Annual Reports as well as a comparison with relevant literature from Norway and other European countries.

The diagnoses alone might not be sufficient to give an impression of the health problems among the patients at the Health Center. Some of my own experiences and reflections are also present in this discussion in order to contribute to the data material from the Health Center. My experiences and reflections are clearly marked with indents.

4.1 Demographic characteristics among patients at the Health Center

The patients at the Health Center are a heterogeneous group when it comes to country of origin, residence status, time of residence and age. The majority of patients are largely within the Health Center's target group, as 83% are without legal residence. The majority of the patients at the Health Center are asylum seekers with final rejection. This is similar to the 11 year old estimate from Statistics Norway of who constitute the persons without legal residence in Norway (36). There is uncertainty to these data from the Health Center, as they are self-reported and not validated (p. 30).

At the time of registration, the patients are asked about their legal status here in Norway. In order to get the correct information, both the nurse and the patient need extensive knowledge about the Norwegian immigration system. The patient may perceive himself as a refugee, but formally be an asylum seeker with final rejection. If he is registered as a refugee, he will not fall into the Health Center´s target group.

It is apparent from the data that 17 % of the patients at the Health Center are registered with legal residence, but have received help in spite of this. If the patient says that he has legal residence, i.e. being an asylum seeker or labor migrant, he is given information about where and when he can seek help in the public health service. It is not evident from the data sets who have received a diagnose in spite of legal residence in Norway.

Health centers for persons without legal residence in other Scandinavian and European countries treat patients from all continents (99,78,96). There are demographic differences, such as the composition between the sexes as well as at the patients' country of origin. Women from Latin America and Asia represent a significant proportion of patients at the health centers in several EU countries. These are women who mainly come to work, but who do not have work permits («clandestine workers»). Women from the Philippines make up a large group of women from Asia in these studies, but unlike the Health Center, few are from Mongolia (100,78). Male patients at the same health centers are more heterogeneous and reflect patients at the Health Center in Oslo to a certain extent.

It is not possible to say whether the patient groups who attend health centers in other countries also exist in Norway. If so, one might think that there are women from South America in Norway who do not seek help at the the Health Center, or that there are women from Mongolia in Gothenburg that do not seek help at the Rosengrenska center (101). This is not possible to tell, either from our data or from other sources in Norway.

The data material does not indicate whether patients at the Health Center are representative for the persons without legal residence in Norway. Persons who don’t feel that they are in need of medical attention probably don´t seek help at the Health Center, and that they just go to the Oslo public emergency room (legevakten) if they fall acutely ill.

It is not possible to connect the patients´ country of origin with residence status. The Annual reports from UDI (24,25,26,27,28) show that people from Afghanistan, the Middle East, Horn of Africa, sub-Saharan Africa and North Africa have sought asylum from 2004-2009, the five years prior to the data collection period. Several of these asylum seekers received a final rejection of their asylum applications. One can assume that many of the patients from these

countries at the Health Center are asylum seekers with final rejections, and that they may also be some of the patients who are registered as asylum seekers in spite of their rejections.

The second largest group without legal residence at the health center is "not registered" (by the authorities). Statistics from the immigration authorities show that very few people of Mongolia are registered with the authorities in recent years (24,25,26,27,28). It can therefore be that the majority of patients from Mongolia is included in this category, indicating that they may be «clandestine workers».

EU-citizens are entitled health care during their legal stay in Norway (11). In spite of their right to health care, there is a limited access especially if the patient is not able to pay the fee for the health care. The City Church Mission and Red Cross have defined these groups as «vulnerable EU-citizens», thus they receive health care at the Health Center (68). These patients are registreres in one of two categories, «Schengen/EU-residents» who are here legally or «Not registrered» (with the authorities). The majority of patients from Romania are registered as the latter.

Men constitute nearly 66 % of the patients in the data material from the Health Center. There could be several reasons why there are more male than female patients here. A possible explanation could be that there are more male than female asylum seekers in Norway (15), and over half of the patients at the Health Center claims to be former asylum seekers. Another explanation might be that women who are rejected asylum seekers and have been pregnant in Norway may have more knowledge about the health system in Norway, and may seek help at the same health offices when they need medical attention even after final rejections. It is also possible that more women than men choose to stay at the asylum reception center after final rejections, and that this grants them some access to the health office for asylum seekers at the reception center. This may be even more relevant for rejected asylum seekers with children, and might explain why there are few children at the Health Center who come from, or whose parents come from Afghanistan, the Middle East, Horn of Africa, sub-Saharan Africa and North Africa.

Moreover, there may be various barriers that prevent women without legal residence in Norway to seek the Health Center, such as fear of sexual exploitation from the health professionals (82). Barriers may also be present for both men and women. Other studies

indicate these barriers to be fear of being reported to the authorities (106,88), that patients are not aware that the health services are free, that they cannot afford to travel to the Health Center, or take time off from work (106, 88).

4.2 Health problems among people without legal residence

Patients at the Health Center have diverse health problems associated with all 17 organ chapters according to the ICPC-2 classification (p. 32). On average each patient has had two consultations with a physician or a psychologist thus received two diagnoses. Nearly 64 % of the diagnoses are symptoms diagnoses, and 36 % are disease diagnoses.

4.2.1 Common symptoms and diseases

Diagnoses related to digestion, mental disorders, sexual- and reproductive health and musculoskeletal disorders were common among the patients. That mirrors the findings in most studies on health problems among people without legal residence (78,99,96). Several of these studies and reports point out that their findings reflect health problems among patients in regular general practice (78). This is also emphasized in the annual report from the Health Center for undocumented migrants in 2014 (62). Furthermore, the annual report shows that the percentage occurrence of different symptoms and diseases of the Health Center from 2009-2014 is approximately equal to the prevalence in the present study.

> In my experience from recording the patient anamnesis, the vast majority of the patients start by saying: «I have multiple problems». He or she then starts to mention the problems, often five or six different things. My impression is that the problem the patient mentions often depend on his or her country of origin, residential status and current life situation. Former asylum seekers who live outside asylum reception centers may have diverse health problems, such as stomach pain, tooth aches and «to much thinking». In addition, some patients bring up health problems they have had from before they left their home country.

The same was also found in a study from the Netherlands, where the informants had 11,1 health complaints (80) as well as in both Hjelde (106) and Øiens (38) reports, where they interviewed persons without legal residence in Norway. A Swedish study found that the majority of patients at an NGO-clinic should have been treated at an earlier point (95), and

that the health condition seemed to worsen with time. This is also confirmed in an interview with volunteer nurses at the Health Center (115)

> In general, the patients describe having the health problems for a long time before they come to the Health Center. It is rare that patients bring up problems related to undergone torture while being registered by the nurse, event though small hits or indications that this may be the case emerges from time to time. Other patients who are «clandestine workers», may describe their living conditions as «ok». They live with friends or family, and have a somewhat stable income. Their health problems seem to be more related to musculoskeletal, skin- and respiratory problems and sexual and reproductive health.

The master studies from the Health Center, as well as reports about persons without legal residency in Norway, show the same tendencies (109,110,111). Their informants are mainly asylum seekers with final rejections on their applications, and mention several health problems when telling about their life situation. Common problems are related to digestion, tooth ache, mental health problems and general concerns related to their current situation.

> When recording the patient anamnesis, I ask the patient several questions in order to get a broad picture. These questions may be: for how long have you had this problem, how and when did it start, have you been to se a doctor for this before and have you received any treatment. For patients who are former asylum seekers who present with symptoms that may indicate TB, I also ask them about their Mantoux results while pointing to the left underarm where the Mantoux is given. This is because all asylum seekers who came to Norway before and during the data collection period underwent CXR and Mantoux-test during the first days of their stay in Norway.

Few of the patients at the Health Center are diagnosed with TB. The main reason may be that all asylum seekers are screened upon arrival to Norway, and receive treatment for active or latent TB. This stands in contrast to the settings for the studies related to TB among persons without legal residence in Malta (92) and Switzerland (93). Some of the patients at the Health Center are diagnosed with diagnoses that may indicate hepatitis B and/or C. The Italian study (94), found that the prevalence of hepatitis among the patients mirrors the prevalence of

hepatitis in the patients´ countries of origin and are not related to sexual behavior. This may also be the case for the persons without legal residence in Norway.

> While asking the patients different questions, I get a lot information that I find relevant. If the patient says he has a stomach pain, he may tell me that he only can afford to eat once a day, or that he has a high alcohol consumption. If a patient has an unplanned pregnancy, this may be due to rape or that she was uncareful with protection while having intercourse with her husband. Musculoskeletal problems may be due to football injuries or undergone torture. This background information is often registered in the EPJ, but does not emerge from the ICPC-2 datas.
>
> In my experience, patients come back both for follow ups, but also with new health problems. The questions I ask when they come back may be the same as for their first visit. Questions may also relate to the treatment the doctor has prescribed, in order to know whether or not the patient followed through with the treatment and to know if the treatment helped the patient. Patients may present with different somatic health problems. I find it difficult to tell whether this might be a somatization of mental health problems. This is because many of the patients have various conditions, for instance related to housing, OSE or poverty, that might contribute to poor health and somatic complaints, without it being related to mental health problems.

The physician or other health professionals read the nurses notes in the EPJ before seeing the patients. The order in which the patients´ symptoms are presented might influence the physicians focus and also which of the health problems who is given a diagnosis. When the physician gives the patient a diagnosis, information about the other health problems or the background for the diagnose will not emerge from the ICPC-2. Due to these limitations in the ICPC-2 classification, valuable information about the patients´ health does not emerge from the data material.

Information related to the different tests and referrals made at the Health Center does not emerge from the data material. The Annual Report from the Health Center in 2014 (62) and an interview with a volunteer laboratory technologist (113), show that X-rays, blood and urine-tests are common. There are also some referrals to the specialist health service.

4.2.2 Digestive problems

Almost half of the patients at the health center, have diagnoses related to digestion. Half of these diagnoses are related to the teeth and gums. Several patients have liver problems, including children.

Several studies from Norway and Europe reveal that people without legal residence reported poor nutritional status, small or varying access to food and limited opportunity to ensure personal hygien. This can affect the ability to maintain good dental health and otherwise maintain an overall good health, especially following a final rejection of the application

Digestive diagnoses constitute around 20-25 % of the overall diagnoses among the patients in several studies and report from similar health centers, including the high prevalence of tooth aches (78,81,99,96,102). Persons without legal residence are not entitled to dental health services, unless it concerns a severe condition and the patient is in an acute need of treatment. Symptoms and complaints related to teeth / gums occurs partly in groups who presumably were rejected asylum seekers. As asylum seekers, patients had virtually full rights and access to both dental services and other health services in the public health system (30). In some periods of the asylum process, these health services are free for the patient and is funded by UDI. It is not possible to say if the symptoms and discomforts has come or worsened after the individual patient went from being an asylum seeker to be an asylum seeker with a final rejection and thus a person without legal stay- and with limited right to health care.

Jansson et al. (102) examined dental health of persons without legal residence in Sweden who reported having pain in their teeth, and almost all of the patients were found to have caries. This may indicate that the majority of patients in our study who were diagnosed with symptoms of teeth and/or gums had caries, and may needed treatment for this condition.

4.2.3 Mental health problems

About 29 % of the patients at the Health Center are diagnosed with mental disorders, but there are major differences between the prevalence of patients from different countries and continents. Half of the patients from Afghanistan are diagnosed with mental disorders, in contrast to none of the patients from Mongolia or Romania. Studies and reports from other

European countries show that mental health problems are common in several groups of persons without legal residence, especially among rejected asylum seekers (89,90,100). This was also the case in Kristiansen (103) and Aarseths studies (104,105), examining the diagnoses Norwegian GPs have given patients without legal residence. Aarseth found that patients primarily had mental health disease diagnoses rather than symptom diagnoses.

Studies of people without legal residence of self evaluated health shows that people without legal residence experience having various mental problems, both symptoms and diseases. The majority of diagnoses of mental disorder at the Health Center are symptom diagnosis, and the most common is feeling of depression, which constitutes 25% of the diagnoses related to mental health. There is no clear answer as to why symptom diagnoses are more frequent than disease diagnoses among the patients at the Health Center.

There is a difference between the prevalence of mental disorders in different European and Scandinavian studies and reports, and among different patient groups at the Health Center for Undocumented Migrants in Oslo. This might be due to the difference in countries of origin among the patients. Nearly 60 % (n=345) of the patients at the Health Center are, or have been asylum seekers. This are the groups with the highest prevalence of mental health problems at the Health Center. Only a small portion of the patients in the Danish study are former asylum seekers, and this might explain the low prevalence of only 4 % of mental health problems in their findings (78).

> When taking up the patient anamnesis, my experience is that the patient tells me what he wants in the order he wants to. If he or she has mental health problems this is normally not the first health problem he or she tells me, rather the fourth or fifth. It might be that the patient is «assessing» me, or that it takes time to establish enough trust for the patient to dare speaking of mental problems. I have the impression that there is a stigma related to mental health problems for some patients, and that a part of their «assessment» of me is to se how I will react to their symptoms. Some patients choose to describe their symptoms in vague terms, whereas others tell me details from their experiences and related nightmares.

Mental health among people without legal residence could worsen when one goes from residing legally to illegally in the country. It does not appear from the data if the mental health

condition changed after final rejection on the asylum applications, but several studies may indicate that such may be the case (99,106). A Dutch study found that taboos also prevented some patients from speaking freely of their mental health problems as well as fright of seeking health care (89).

Medicins sans Frontieres (96) examined the mental health of people without legal residence in Sweden. Over half of the patients experienced anxiety, and 38 % of patients struggled with moderate or strong suicidal ideation. The annual reports of the Supervisory Board at the Trandum Immigration Detention Center also described suicide attempts and threats of suicide as the cause of 12% of imprisonments at the security cell in 2014 (108). Wahlberg (79) found that suicide («intentional self harm») accounted for over 11% of causes of death among persons without legal residence in Sweden. Brunovskis and Bjerkan also found suicidal ideation to be a recurrent theme when talking with persons without legal residence (107).

Very few patients at the Health Center were diagnosed with suicidal ideation. One of the reasons might be that patients who try to commit suicide will be referred and treated in the specialist health services. High rates of suicide and self-harm in other studies, however, suggest that it may be beneficial to map self-harm and suicidal thoughts in people without legal residence. This applies especially for patients with a background as asylum seekers and persons who have stayed long in Norway after final rejection on the asylum application.

Several of the patients at the Health Center had psychological diagnoses that would indicate treatment. This may involve urgent care, where the patient can be a danger to themselves or others, but also diseases requiring drug therapy, regular appointments with a psychologist or other measures. Limited right to health care may lead to a worsening of mental disorders, as well as other symptoms and disease. Although people without legal residence are entitled to assistance if «they are a danger to themselves or others» (45), both the Health Center and others have experienced difficulties in referring patients in need of medical treatment to the public health system. As a result of this, the Health Center, in collaboration with DnLF has appealed refusals on referrals to the County Governor (62).

4.2.4 Sexual- and reproductive health

Sexual- and reproductive health is among the most common causes for contacting the Health Center, in line with findings from similar European countries (78,96,99). The diagnoses are mainly problems related to pregnancy, childbearing and family planning.

There is s high prevalence of unwanted pregnancies at the Health Center, especially among women from Mongolia. Many of these are referred to abortion, and he high number of abortion among patients from Mongolia might be seen in light of the relatively high abortion rates in Mongolia (130). High numbers of unplanned pregnancy occurs in several European studies on health problems among women without legal residency (86,84,100). The results are high number of induced abortions. These studies outline various explanations of unplanned and unwanted pregnancies. Among these are little knowledge of emergency contraception and multiple sexual partners. Women who choose to complete the pregnancy report financial concerns and lack of knowledge about health and pregnancy and lack of familiarity with economic and other support (38,86,87,110).

> During one of my first shifts at the Health Center in 2009, I registered a woman who was in Norway as a clandestine worker. She told me that her living and working conditions were ok, and that her health was good. She was however wondering if she was pregnant. I took a test, and it tested positive for pregrancy. When I told her the result, I congratulated her with the positive result. This was a valuable experience for me, because the patient just looked at me and asked for an induced abortion as soon as possible.

The data from the Health Center and other studies in Norway does not contain information on whether the Mongolian women at the Health Center are single, and the extent to which their pregnancies are unplanned. However, it emerges from data that nine of their pregnancies were unplanned, and that eight patients were referred to an induced abortion.

It may seem that there are similarities between the women from South and Latin America who attend the health centers in other countries and the Mongolian women at the Health Center in Oslo. Both groups are clandestine migrants, and few of the patients have a background in situations of war and warlike conditions (15) unlike many of the other patients who are former asylum seekers. Women who are in Norway to work, including some of the

vulnerable EU-citizens, may have a steep decrease in income if they choose to go through with their pregnancies. This might be a contributing of the reasons as for why the abortion rates are high.

> The story above is the only time I have congratulated a woman with a positive pregnancy test. My experience has taught me that a lot of the women are well aware the lack of social support system that would meet them after giving birth. Some of the women would have to leave Norway in order to get some support, but are afraid of returning to their home countries either due to war or persecution or because to shame and stigma related to being a single mother.

Although women without legal residence have the right to abortion, there are barriers to access this right. One of several cases involved a woman who was denied an abortion at Oslo University Hospital, Ullevål when she could not prepay abortion. The woman was then in week 9, and abortion had to be performed within the 12th gestational week. The refusal from Ullevål was appealed to the Board of Health in Oslo and Akershus, which found that Ullevål had commited a violation of § 2-2 of the Specialized Health Services Act (55). The patient received an induced abortion at an other hospital in the Oslo area before the 12th week.

> My previous experiences from working with asylum seekers is in most cases relevant when meeting the patients at the Health Center. Many of the asylum seekers who became pregnant were ok with that, and wanted to keep their babies. They were a part of a system they knew would provide them with the necessities to take care of themselves during their pregnancies and their children after giving birth. The clandestine worker at the Health Center knew that she was without a system or a net work that would care for her. She would risk to pay for giving birth in a hospital, and she would not receive any benefits of leave from work after giving birth.

The time of the first prenatal care is not recorded in the statistics from the Health Center, but the other studies suggests that many women do not come for a check-up until the second or third trimester of their pregnancies. The limit for induced abortion in Norway is 12th gestational week (131). The woman therefor has to see the doctor to get a referral or contact the hospital herself before this date. Applying for an abortion after the 12th gestational week will reduce the chances considerably to get an abortion. There can be several barriers as to

why women do not seek the doctor at an earlier stage, as previously mentioned (p. 64-65). Other reasons might be differences in when one would see a doctor for prenatal care in the woman's native country, knowledge of the right and access to an abortion or knowledge of the 12th week limit for abortion.

Information on family planning and contraception for persons without legal residence can contribute to reducing the number of unplanned and unwanted pregnancies and thus the individual woman's potential vulnerability in the face of the health care system. As a measure to reduce the number of unwanted pregnancies, the Health Center offers contraception and contraceptive counseling. As with health centers in other European countries the Health Center offers intrauterine contraception (99). A further focus on contraception, particularly with a view to preventing unwanted pregnancies, must be seen as beneficial for patients in the Health Center.

> When asking patients in the reception what I can help them with, I seldom know what their answer will be. After some years of experience, some patterns seem to emerge. «I want to check full body» is one of them. This patient would typically be a healthy looking, well dressed young man. If I ask if he has any specific symptoms, the answer would often be that, no, no symptoms «just want to check full body». In these cases, I explain that in Norway, one would normally do examinations based on current symptoms and complaints. After saying this, I mention several test we can do in the reception, such as blood pressure and temperature. I also say: «or check for infections, like HIV and chlamydia». It is my impression that when the patients hear this, they are clear on that they want HIV and/or chlamydia testing. The patients are of course also referred to a physician.

Very few of the patients in the data material had sexually transmittable diseseases, STDs. In connection with the HIV project in 2011 (69), the Health Center examined 125 patients with unknown HIV status for HIV infection. Only one of the patients tested positive (69, p. 4-5). In 2014 the Health Center tested 50 people for genital chlamydia, of which only three tested positive (62, p. 11). There seems to be a difference in the prevalence of sexually transmitted infections at the Health Center versus in similar centers in other European countries. Several Swiss studies (86,85) found a higher prevalence of chlamydia among pregnant women. There are condoms available at the rest rooms and in the nurse´s reception. The patients are free to

take as many as they want. If the patients is afraid of STDs it is normal to have a general talk about protection.

This study showed that both women and men are experiencing problems related to reproductive organs and breast, and especially pain conditions are common. Pain conditions may be harmless; they may indicate sexually transmitted diseases requiring treatment or they may indicate serious disease states. Five of the women at the Health Center are diagnosed with breast lumps. This should be investigated at an early stage to rule out serious illness. It is not apparent from the data in the extent to which pap smears are taken in connection with gynecological exams, or if there has been a screening for cervical cancer. Studies from Switzerland indicates that only a few women without legal residence examine their breasts or go to cervical cancer screening (86). Offers of pap smear and information about breast self-examination may be useful measures to ensure early diagnosis and treatment of any disease. Diagnosis, however, requires access to necessary medical care.

4.2.5 Other symptoms and illnesses among patients at the health center

Several patients are diagnosed with symptoms and complaints related to vision and hearing. This corresponds to findings from other European countries (78,96,99,81,100), as well as from studies on self-reported health among persons without legal residence in Norway (106). The patients with cataract are relatively young, and this condition may worsen over time. Access to health services can at this stage be very important. Various conditions can worsen over time and this could weaken the person`s ability to get or to keep employment.

Several people without legal residency rely on various forms of work. People who need to do this will thus be put in a difficult situation if their health is, or becomes, bad. Some people work in the service industry, and can have jobs that do not meet basic safety requirements. This can partly be attributed to inadequate ventilation, limited use of protective equipment, etc. (132). The data from the Health Center do not show to what extent patients' respiratory or skin disorders may be related to this.

Musculoskeletal disorders are common among persons without legal residence in several countries (78,96,99), and can be caused by working conditions and affect the ability of patients to do work.

> In my experience, there are extremely heterogeneous explanations for problems related to the musculoskeletal system. Some patterns emerge, but there are also surprises. For some patients, lower back pain is due to working conditions, such as sitting on a sidewalk begging for money several hours every day. I have also met several young men who have sprained ankles or other minor injuries from playing football.

There might be an underdiagnosis of musculoskeletal disorders in patients at the Health Center (62). This is because nurses registering patients at the Health Center have the opportunity to refer patients directly to a physiotherapist when they consider that the patient's problem is musculoskeletal.

> From time to time a patient would come from a country where torture is frequent. When meeting patients from these countries, I pay extra attention to hints or indications of undergone torture. At one shift, I registered the patient anamnesis of a middel aged man from a Middle Eastern country. He told me about a pain in his knees. I asked for how long this problem had lasted. He could almost tell me the time and date for when the pain had started. From working with asylum seekers, I had experienced that this could indicate that traumatically experiences caused the problem(s). I tried to ask very carefully if it was something particular that had triggered the pain. He answered that it was the travel to Norway. I asked if it was something special during his travel to Norway, and after some questions back and forth, it turned out that he had been sitting hidden in a very narrow position in a small car for several days in order to pass the border control without being discovered. He had barely been able to move during this period, and he had suffered from musculoskeletal pain ever since.

The physiotherapists see various problems, more often related to an inactive lifestyle rather than acute conditions (114). They have the opportunity to refer to the doctor after seeing a patient that has ben referred from a nurse. It is not given that the doctors register the «diagnosis» given by the physiotherapist in the EPJ or that the patient has received treatment for the same problem from the doctor. This means that musculoskeletal problems may be underdiagnosed in the data material from the Health Center.

4.3 Cultural and linguistical barriers between patient and health professionals

Health professionals and patients with immigrant background may have different understanding of health, disease and treatment (106,89). This will lead to challenges in the encounter between patient and the health services. Taboos related to various diseases, especially mental disorders among certain groups of persons without legal residence may prevent these patients from mentioning concerns and complaints they may have (89). Cultural differences at how to express the mental illness may also contribute to an under-, over- or misdiagnosis (90).

> While recording the patient anamnesis, it is not necessarily important for the nurse to know all the details about the patients´ mental health symptoms. There is however one specific «diagnosis» that I have experienced many persons without legal residence telling me about over the last year. A lot of patients suffer from what they call «too much thinking». This seems to be a collective term describing symptoms and diseases related to everything from worries for the future to flashbacks and invading thoughts. In several cultures there is a stigma related to mental health problems. This can prevent patients from talking freely about their problems, as they may be afraid of being perceived as crazy. The patients may also lack the understanding or words to describe health problems. Several languages have no words to describe mental health problems, thus it might be difficult for the patient to describe the problem he or she is having with other phrases than «too much thinking».

Many of the patients at the the Health Center speak neither English nor Norwegian sufficiently well to converse with health professionals without an interpreter. The Health Center has several volunteers who interpret, but can also make use of a professional interpreter agency. In contrast with the official directions for interpreters in public sector, there are no training requirements for the Health Center's volunteer interpreters (133).

> For some of the patients it is difficult to believe in the patient-health professionals confidentiality. In my experience it can be particularly difficult for the patient to trust

> the interpreter. This may lead to the patient holding back relevant information. Some patients bring with them persons they insist using as interpreters. This is problematic on several levels. There is no guarantee that an unskilled interpreter translates correctly, and he or she may not be aware of the code of ethics for interpreters (134). It is not possible to know the true relationship between the patient and the interpreter her or she brings with them. For some patients the interpreter might be a family member or friend, or just a person who wants to help. For others the interpreter is a person who exploits them in some way. The interpreter might set as a prerequisite that her or she will come to the Health Center with the patient, so that he or she can control which information the patients give the center. As a nurse in the reception it is difficult to know when to «accept» the interpreter the patients bring, even when they insist on using them. I always offer an anonymous interpreter by phone, and tell the patients that we are obliged to use professional interpreters (135). If the patient refuse, I use the interpreter he or she brings, but make sure to specify in the anamnesis that the interpreter is someone who the patient insisted on using and not one tjat is necessarily unbiased.

Despite access to voluntary interpreters and interpretation agency, it is not possible to obtain an interpreter in all required languages. Some languages have very few - if any qualified interpreters. There is only one qualified Mongolian interpreter in Norway while there are 81 Arab interpreters (136). Some languages are spoken by few people in Norway, and it can be difficult to find an interpreter who is qualified (136). If there are communication problems or family / friends are used as an interpreter, it can also cause not all information being understood.

> My personal impression is that the relevant information emerges in most cases, even when the interpreter is a friend or family member of the patient. The patients who are rejected asylum seekers come from countries with fairly large expat groups in Norway. This can make it easier for the patient to find a person he or she trusts to bring to the Health Center. For the smaller groups, like Mongolians or Latin Americans this may not be the case. Even if there are many Mongolians at the Health Center, there are few Mongolians in Norway so there are few possibilities to contact others outside the people that might exploit you.

It is not possible to say whether different cultural and language barriers have affected the diagnoses patients received, not the information they give the nurse during the registration.

4.4 Vulnerable groups

4.4.1 Children

Children without legal residence also has health problems and the right to healthcare. However, they have no right to a GP. Almost none of the children at the Health Center are former asylum seekers, which may contribute to limited knowledge about the health services in Norway, as they have not been a part of the asylum system. This can lead to barriers related to access to health care and lead to a lack of follow up in case of chronic conditions.

The frustrations of being both a parent and living in Norway without legal residence are described in the masters thesis «Parenthood in Nowhereland» (110). The informants focus on not letting their children know that they are in Norway without legal residence, and that they postpone telling their children this for as long as possible. Pregnant women also describe challenges when planning their life as a parent without legal residence in Norway (38, p. 68).

Parents without legal residence can develop limited ability to care for their own children. This can be directly linked to the parents' health problems or concerns related to the situation and their living conditions. Children are thus in a particularly vulnerable situation, where they have limited access to healthcare and where their parents have very few possibilities for treatment if they are in need of such. Barrier for accessing health care, such as fear of being deported, lack of funds to pay for the health services may also be relevant for the parent in deciding whether or not to seek medical help (106,77).

4.4.2 Victims of sexual and physical violence

Information about sexual violence, patients having undergone sexual and other torture, prostitution/trafficking or equivalent does not emerge from the data from the Health Center. However, it is possible to assume that several patients may be victims of one or more of the above (99,101,87). This can cause problems related to health in general and sexual- and reproductive health in particular.

A person residing illegally in Norway has limited rights- and access to healthcare. Living without a legal residency permit could also mean that a person doesn´t want to contact the police if they are the victim of a criminal act. One consequence of this will be that a person who is sexually abused is hesitant to report this to the police and to seek health care. This can both affect the somatic health of the individual as well as for mental health as it is a great burden not to experience a real opportunity to report the assault. Ability to obtain biological evidence for possible prosecution ceases as well if the person don´t seek medical help with in a certain time limit.

There are some public health services that are tailored for victims of human trafficing and who work in prostitution (137). Some of these women have access to these services and may prefer them to the Health Center, even if they are in Norway without legal residence.

4.4.3 Survivors of torture

The ICPC-2 classification has no diagnoses indicating one has undergone torture or similar inflicted injuries. It is therefore not possible to see to which extent the patients have undergone this, and are torture survivors. A person having undergone torture may have symptoms from various organ systems, including the musculoskeletal, urological, sexual- and reproductive health, nervous system and linked to mental health. However, it appears from international research and various reports that patients of similar health centers in other countries have been subjected to torture. (99,101)

Undergone torture may be relevant in the treatment of any asylum case. However, not all asylum seekers have been offered a medical examination, or received a health certificate to be used in immigration cases. Torture survivors may therefore seek the Health Center both because of the health problems they have, but also to obtain a relevant “health certificate”.

4.4.4 Other vulnerable groups

There are some patients one would normally not consider vulnerable. This can be patients who come from «western countries», and who would be entitled legal residence in Norway if they applied for this.

> From time to time I meet patients whose situations are truly complicated. Some people have health problems or circumstances in life that have made them unable to maintain a normal life and that prevent them from keeping deadlines for renewal of applications for residence etcetera. Some of these patients have lived on the side of the community for a long time, both in Norway and in other countries. For some of these patients, their problems are related to physical or mental abuse, drug use or mental health problems. As well as for many of the patients at the Health Center, they are in need of medical treatment over time. The difference is that several of these patients would have access to the public health services if they register with the authorities and fill out the paper works. Some of these patients have family or friends in Norway, but are no longer in contact with them because of their current life situation, for instance extensive drug use over several years. Doing the paperwork may be too difficult for these patients at the same time that it has to be done in a period where the patient is not able to take properly care of him or her self. The patients would therefor depend on help from others in order to contact and follow up with the immigration authorities.

Several other groups of patients may also be vulnerable. This includes minority groups within the minority, such as ethnical, religious and sexual minorities. Information related to this does not emerge from the data, but it is reasonable to believe that such minorities were among the patients in our study.

4.5 Economy and living conditions among people without legal residence

Persons without legal residence receives little to no financial benefits from the state. The exception are asylum seekers with final rejection of their asylum application and who are living in asylum reception centers. These receive NOK 1980 per month (18). Some other persons without legal residence may also receive limited financial support over shorter periods. This may for example be social aid or grants from UDI due to illness (18). Because of little or no financial support, many people without legal residency depend on work to subsist (88,38, p. 65). Several of these people work illicit, often with inadequate or no employment contracts, lack of salary payments and the possibility of getting payed during a

sick leave. It may be an alternative to be away from work due to illness, both because they lose the salary and because they risk losing their job. Having to work despite illness can lead to a lack of improvement and / or worsening of disease.

> After registering a patient´s anamnesis, he asked me if the Health Center could provide any jobs for him. I said that we were not able to do that, but I provided him with some information about the organizations which provide assistance to persons without legal residence in Norway. We got to talk about his job that he had just lost. He had been working at a car wash, but it was no longer possible to work there. The reason was an increased focus from the Norwegian authorities regarding illicit work, tax evasion and persons without legal residence working in these washes. The patient told me that he would make 100-400 NOK a day, and that this was sufficient to buy food and provide him with somewhere to sleep.

However, psychiatric symptoms and diseases and other health problems lead to reduced work capacity and reduced self-care. This can further lead to difficult living conditions for the individual. Many in this group in addition have little or no social network, thus few others close to them. The ability to make optimal use of treatment may be limited as a result of this. In addition, the side effects of any drug therapy can exacerbate problems.

> I once had a patient with a common cold. He had few friends in Oslo and his economy was poor. He arrived at the Health Center right before closing time, and it would not be possible for him to see a doctor at the Health Center for another two days. I gave him some pain killers and some general advice related to the common cold, and suggested that he could drink some tea with honey and lemon.
>
> When advising him to drink tea, I knew this was something he was used to do as a part of treatment for different conditions. I however forgot that he spent his day and nights outside in Oslo, he had no place to boil the water for his cheap tea. My advice, however well intended, was not a real option in his current life situation.

Only four of the patients have received diagnoses related to social problems. There reason is that these diagnoses are seldom used when diagnosing a patient, as it does not indicate a medical problem. Other quantitative studies indicate that this group of patients have various

social problems. This can be related to inter alia poverty, lack of food and poor housing conditions. One could therefor assume that social problems are present for the majority of patients at the Health Center, even though they have not received diagnoses related to social problems (68, p. 8). This may further indicate that the patients who seek help at the Health Center have health problems, and not only problems related to their current life situation.

4.6 Poorer health due to lack of residency permit?

It does not emerge from the data material how long the individual patient has been in Norway, but nearly 75% of the patients have been in Norway for 0-3 years. Several studies indicate that the health status of persons without legal residence is worsened by emigration in general and continue to worsen over time (96,106). There are also studies that suggest that such deterioration is accelerated after rejection of an asylum application or withdrawal of a residence permit and that health also deteriorates with the length of the illegal stay.

> When a patient comes to the Health Center, I ask if they have been to se a physician before coming to us. Some of the patients tell me that they received help while they were still asylum seekers and before receiving a final rejection, but have not been to se a doctor after receiving the rejection. Some have received treatment for chronic conditions, such as hypertension or diabetes, but have not had access to a physician who could prescribe them the medication they need after they received the final rejection. Other patients have had access to a physician, but have not had the funds to pay for medicines. Some of them come to the Health Center in order to get the medicine for free.

One of the Dutch studies also focuses on how the sexual health is worsened due to the life situation (89). It is not possible to say whether this will apply to all patients at the Health Center, but it is probable that these patients will experience a deterioration of health over time, especially since of the health problems of patients in the Health Center can develop into more serious complaints with greater symptoms and suffering.

A person without legal residence may be in a vulnerable situation on many levels simultaneously. This may partly involve lack of network, financial worries, fear of return to

their home country, and fear of being reported to the authorities if they seek health care. Such concerns may in itself lead to poorer health when they persist.

A small number of patients have stayed in Norway for more than seven years. The data do not show to what extent these patients have more, or more severe, diseases than patients with shorter periods of residence in the country.

4.7 Limited rights- and access to health care

Most diagnoses at the Health Center are symptom diagnoses (01-29), and several of them can lead to or indicate serious underlying disease. Access to health care is therefore be essential, whether it takes place in primary or specialist health services. Persons without legal residence have the right to get referrals to a specialist assessed within 30 days, in line with the general population. However, this requires that the patient has an actual access to a doctor who can write such a referral.

Persons without legal residence could under certain conditions have the right to stay in Norway (30). This applies to some serious illnesses. To document such health problems, the patient depends on having access to a doctor or other health professional who can assess and document these health problems. This can then result in a medical certificate. There may be various barriers to get such a health certificate, also for people who have illnesses that may give the person the right to stay in Norway on humanitarian grounds. In order to grant such a permission, the Norwegian immigration authorities need detailed information about the disease, prognosis and need of treatment (31,33). Such a medical certificate will often include examinations by a specialist.

GPs do not receive reimbursements for writing such medical sertificates. This could lead to asylum seekers who might otherwise be granted residence in Norway on humanitarian grounds on the basis of health problems being rejected because of lack of documentation of the health problems. This may be the reason as to why some patients seek help at the Health Center. Issues relating to this does not however emerge from the data material.

Working at the intersection of the patients health needs, ethical guidelines and current legislation may be perceived as challenging for health professional. Ethical guidelines for

health professionals do not differentiate between patients with different legal status in the way as the Priority regulation does (46,47,48).

> When registrering patients, both those who come for the first time and those who have been the before, I sometimes hear stories of patients who have been rejected in the public health service. This accounts for both minor and major health problems, including patients in need of acute health care. One patient had a broken arm. He had sought help at the Oslo public emergency room (legevakten), but was rejected because he could not show a valid id-card. He came to the Health Center a couple of days later, and it was decided that he was in need of an x-ray and had to go back to the emergency room. I came with him to make sure that he would receive the help he was in need of - and entitled to: this was emergency care. The x-ray confirmed the broken arm, and the patient received the help he was in need of, however several days too late. This might have affected his recovery.

Health rights of people without legal residence are limited restricted. This stands in contrast to the right to health for both adults and children as outlined in the Human Rights (12,44), which the State Board of Health points out in its comments in connection with the Priority regulation (51). There is a great contrast between the ethical guidelines for health professionals, the Prioritiy regulations and Human Rights. This makes working with patients without legal residence challenging for health professionals, as they have to ask the patients about their legal status – and reject treatment if the patient does not have a legal residence permit.

Several Norwegian Ministers of health have in recent years confirmed that those who provide health care is responsible for covering the costs of this, if the patient cannot pay this themselves (56,57). It is thus not permitted to refuse people without legal residence the health care they are entitled to even if they cannot pay for themselves. Never the less, in recent years there have been several examples of health professionals and health authorities having denied patients' treatment, or asked for confirmation of payment before providing health care (55).

In her thesis «The Critical Diaconal voice in the Society» (112), Jonhsen analysed the public debate related to the Health Center. She found that the City Church Mission considered it self to be an advocate on behalf of persons without legal residency. As the current Seceretary

General of the organization said: «It is not a question about immigration policy. It is a question of health and care – about human dignity and human rights».

Based on Johnsens findings (112), the ethical guidelines for health professionals (46,47,48), the Human Rights (12) and the consultations from different organisations (49,50,51) and the Directorate of Health (52) to the Priority regulation (45), it seems that there is a professional concensus in that one should provide health care based on the patients need and not his or her residence status in Norway.

Limited treatment of persons without legal residence may be perceived as ethically challenging and there is often uncertainty about what right to health care the group actually has. These ethical challenges are described in studies from Norway, but also countries where people without legal residence have greater, equal to, or further restricted rights to healthcare than in Norway (58). When meeting people without legal residence, ethics, law, health and immigration authorities plays a role in access to, and choice of treatment. In every encounter with people without legal residence, it is important that health professionals have knowledge about health problems in the patient group. Both epidemiological knowledge, as this study contributes to, and knowledge of the situation and living conditions contributes to health personnel having the best possible basis for making decisions when meeting patients without legal residence.

4.8 Method for identifying health problems among people without legal residence

To my knowledge, there are few - if any, registers and overviews of the persons staying in Norway without legal residence permit and their health problems. If such registers or overviews do exist, they might be based on persons without legal residence that meets certain criteria, such as certain types of health problems or people who are detained. Lack of an overview of a larger sample of people without legal residence limits opportunities for data collection, and the only possibility to get such data material was the Health Centers data material from their EPJ system SOMA Solutions.

4.8.1 The study design and methodology

The present study is a descriptive analysis of the health problems among all the patients at the Health Center during its first 18 operating months. Such a description gives an overview of who the patients at the Health Center were in the data collecting period and what type of health problems they had.

The nature of the data material made it impossible to connect the different variables. The exception was the periodic reports wist diagnoses and age, sex and country of origin, respectively. It was not possible to connect these periodic reports with each others or with the data related to length of stay in Norway and residence status (p. 30-35).

Because of the limitations to the data material, information from other sources was collected. These were masters thesis based on informants who have been patients at the Health Center as well as the reflections and experiences of one of the volunteer physicians at the Center. Some of my own experiences and reflections based on 7 years as a volunteer nurse at the Health Center are also included in order to shed light on the data material, but are not analyzed.

4.8.2 Strengths and weaknesses of the study

Patients at the Health Center differs somewhat from the patients who attend health centers for people without legal residence in other European countries, both in terms of country of origin, sex, age and prevalence of some diagnoses (99). There is also uncertainty as to whether all groups of persons without legal residence seek help at the health centers. Although our Health Center offers health care to all persons without legal residence, it does not follow that it is available for everyone in their target group, due to various barriers. Mitigating factors may be unfamiliarity with the Health Center, that one does not dare to seek health for various reasons or that personal finances do not allow for expenses for travel (88,106).

The findings in our study are not representative for the persons without legal residence in Norway or in other areas. It only describes the patients who have sought help at the Health Center. The study therefore says nothing about the health of people who do not consider themselves sick and therefore have not visited the Health Center.

Diagnoses that are set is given according to a diagnostic system health staff at the at the Health Center is accustomed to. This makes the diagnoses itself reliable. There may be differences in how physicians, psychologists and psychiatrists uses ICPC-2 diagnosis related to P-diagnoses. In this study it is assumed that these groups employ the diagnoses in the same way.

Using diagnoses according to the ICPC-2 classification only gives limited information about the health problems among patients in general, and maybe persons without legal residence in special. The situation for the latter group, is that they have multiple problems, inter alia related to lack of health services over time (95) and to their complex life situation (88). Having extensive knowledge from working with persons without legal residence, I have been able to draw on my own experiences and reflections. This helps explaining the data material in spite of its shortcomings.

The findings in our study related to the health problems among the patients, mirrors the findings in several corresponding European studies. This is a strength of the study and might confirm that the health problems found in the data material gives an impression of the health problems the patients have - in spite of the limitations related to using the ICPC-2 classification as an indicator for health problems.

The patients have received on average two diagnoses each, but one patient might have several different diagnoses related to one and the same organ chapter. The means that one and the same patient from Afghanistan may have both a depressive feeling and a post traumatic stress disorder. The data material does not differentiate between this one patient having two different diagnoses related to the same organ chapter, og two patients from the same country having two separate diagnoses.

This is a clear weakness in the data material, and the result from the data analysis may be an impression of a large burden of diagnoses related to a specific organ chapter among different patient groups. It is however not possible to tell whether or not this is the case, or for how many patients. This means that the findings in this study is not an exact presentation of the health problems among different groups of patients. Nevertheless, the diagnoses gives an impression of the total burden of disease among the patients at the Health Center during the data collection period.

Some studies have pointed out that cultural and linguistical differences between patient and health professional can lead to the health professionals under/over or misdiagnose a patient having any mental - or other disorders. This may also be the case at the Health Center. However, it is not certain that cultural differences have greater impact there than where health professionals meet with immigrant patients with legal residence in the public health system. It is not possible to rule out that this may be the case among some patients and some clinicians.

This was one of the first analysis of the health problems among persons without legal residence in Norway. The results gave a clear impression of the burden of disease among the different groups of patients, and indicated the main health problems among the patients at the Health Center for Undocumented Migrants.

The cause of health problems and how patients experienced their health, does not emerge with this method. My own experiences and reflections are included in order to shed light on some of these aspects.

The data material does not allow for comparisons between length of stay, residence status and diagnoses, country of origin, age and sex. The study would have benefited from more information related to the patients, such as which one patient has received which diagnoses. That would allow for an analysis of whether or not a patient who have received a symptom diagnosis is more likely to receive a disease diagnose related to the same organ chapter if he or she has two or more consultations with a physician or psychologist. A comparison between length of stay and diagnoses could indicate if the patients in the study had an actual worsening of their health over time.

Despite the weaknesses of the data material, the study provides clinicians and policy makers with new and relevant information in providing and planning health care for persons without legal residence.

5 Conclusion

Knowledge of health problems among persons without legal residence in Norway is limited. The Health Center for Undocumented Migrants provide health care to people without legal residence, and has treated over 3,500 people since they opened in 2009 (62). This study contributes an overview of the patients who sought help at the Health Center during its first 18 months, and what health problems they had.

Diagnoses were given according to the ICPC-2 classification, and the most common health problems among the patients at the Health Center were digestive problems, mental health, sexual- and reproductive health and musculoskeletal disorders. This applied to both women, men and children, and mirrored findings from similar health centers in other Scandinavian as well as other European countries (78,99). Despite the fact that the health problems across Europe were similar, the demographic characteristics for the patients at the Health Center in Oslo differed from patients from health centers in other countries.

Findings from the Health Centers annual report for 2014 indicate similarities between the 593 patients in this study and the overall 3000 patients the Health Center has had since its opening (62). It is therefore reasonable to assume that many of the concrete findings from patients during the data collection periode are representative of patients in the operating period as a whole.

This study is based on the ICPC-2 diagnoses, and only one diagnose is given during each consultation with a physician or psychologist. My own experience, as well as several other studies (80,106) shows that the patients often name several health problems and not only one. Basing a study about health problems among persons without legal residence solely on diagnoses according to ICPC-2 diagnoses reduces the complexity in the patients´ life situation and health problems to one single diagnosis.

Health care for people without legal residence is complex. Legal and ethical factors, as well as the patients' life situation and living conditions contribute to this complexity (49). Proper health care in the right time at the right place may prevent the development and worsening of health problems (52). Access to health care for people without legal residency can contribute

to the maintenance of the best possible health in an otherwise challenging existence.

The Health Center is currently a part of a larger European study that investigates different aspects of the life situation and health problems among people without legal residency in Europe (68, p. 13). This study may contribute to a much needed in-dept knowledge about the health problems and life situation of the patients.

Increased knowledge about people who are in Norway without legal residence as well as their health problems is important for health- and immigration authorities in designing policies that have direct consequences for this group of people. Furthermore, increased knowledge of health problems among people without legal residence will help health professionals provide proper care to this group of patients, customized to the patients´ complex life situation.

References

1 Unfpa.org [Internet]. United Nations. International migration 2013; [cited 2015 Jul 12]. Available from: http://www.unfpa.org/migration

2 Ssb.no [Internet]. Statistics Norway; c2015. Innvandrere etter innvandringsgrunn, 1. januar 2015; 2015 Jun 18 [cited 2015 Jul 03]. Available from: https://www.ssb.no/befolkning/statistikker/innvgrunn

3 Ssb.no [Internet]. Statistics Norway; c2016. Innvandring og innvandrere – nøkkeltall; 2016 Apr 21 [cited 2016 Apr 22]. Available from: https://www.ssb.no/innvandring-og-innvandrere/nokkeltall

4 Fn.no [Internet]. United Nations Association of Norway; c2015. Migrasjon; 2013 Aug 19 [cited 2015 Jul 10]. Available from: http://www.fn.no/Tema/Befolkning/Migrasjon

5 Iom.int [Internet]. Geneva: International Organization for Migration; c2015. Key Migration Terms; 2011 [cited 2015 Jul 10]. Available from: http://www.iom.int/key-migration-terms

6 Unesco.org [Internet]. United Nations Educationl, Scientific and Cultural Organization. Migrant/migration [Cited 2016 Mar 20]. Available from: http://www.unesco.org/new/en/social-and-human-sciences/themes/international-migration/glossary/migrant/

7 Brekke JP. Samfunnsforkning.no [Internet]. Institute for Social Research: c 2015. Why Norway?; Report 2009/012); 2009 Dec. [cited 2015 Jun 22]; Available from: http://www.samfunnsforskning.no/Publikasjoner/Rapporter/2009/2009-012

8 Regjeringen.no [Internet]. Oslo: the Norwegian Government. Migrasjonspolitikk; 2013 Feb 01 [cited 2015 Jul 10]. Available from: https://www.regjeringen.no/no/tema/europapolitikk/tema/migrasjon/id692091/

9 Regjeringen.no [Internet]. Oslo: the Norwegian Government. Schengen- og justissamarbeid; 2014 Apr 14 [cited 2014 Oct 21]. Available from: http://www.regjeringen.no/nb/sub/europaportalen/norge-og-eu/schengen-justis-samarbeid.html?id=684929

10 Regjeringen.no [Internet]. Oslo: the Norwegian Government. Hva betyr Schengen-samarbeidet i praksis?; 2014 Oct 13 [cited 2015 Jul 03]. Available from: https://www.regjeringen.no/no/tema/europapolitikk/tema/schengen-i-praksis/id692069/

11 Helfo.no [Internet] Tønsberg: Helseøkonomiforvaltningen. Hva slags helsehjelp har en utenlands statsborger krav på under midlertidig opphold i Norge?; undated [cited 2016 Mar 21]. Available from: https://helfo.no/hva-slags-helsehjelp-har-en-utenlandsk-statsborger-krav-pa-under-midlertidig-opphold-i-norge

12 Fn.no [Internet]. United Nations Association of Norway; c2015. Universal Declaration of Human Rights; 1948 Dec 10 [cited 2015 Jul 10]. Available from:

http://www.fn.no/Bibliotek/Avtaler/Menneskerettigheter/FNs-verdenserklaering-om-menneskerettigheter

13 Udi.no [Internet]. The Norwegian Directorate of Immigration. Skal søke Beskyttelse (Asyl); [cited 2015 Aug 03]. Available from: http://www.udi.no/skal-soke/beskyttelse/

14 Ssb.no [Internet]. Statistics Norway; c2016. Innvandring og innvandrere – nøkkeltall; 2016 Apr 21 [cited 2016 Apr 22]. Available from: https://www.ssb.no/innvandring-og-innvandrere/nokkeltall

15 Udi.no [Internet]. The Norwegian Directorate of Immigration. Asylsøknader etter statsborgerskap, alder og kjønn; undated. [cited 2015 Nov 29]. Available from: https://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-aldersgruppe-og-kjonn/

16 Noas.no [Internet]. Oslo: Norwegian Organisation for Asylum Seekers. Information for asylum seekers in Norway; 2011 [cited 2015 Jul 29]. Available from: http://www.noas.no/wp-content/uploads/2013/08/Brosjyre-Asylprosessen-Engelsk_web.pdf

17 Udi.no [Internet]. The Norwegian Directorate of Immigration. Asylmottak (ulike typer) [cited 2015 Nov 29]. Available from: http://www.udi.no/ord-og-begreper/asylmottak-ulike-typer/

18 Udi.no [Internet]. The Norwegian Directorate of Immigration. Rundskriv RS 2008-035V1, Rutiner og satser for økonomiske ytelser til beboere i statlig mottak, regulerte satser 2015; 2012 Apr 01 [updated 2015 Jan 01; cited 2015 Oct 20]. Available from: https://www.udiregelverk.no/no/rettskilder/udi-rundskriv/rs-2008-035/rs-2008-035v1/

19 Une.no [Internet]. Oslo: The Immigration Appeals Board. Etter endelig avslag; 2007 Jun 22 [cited 2014 Jun 12]. Available from: http://www.une.no/Aktuelt/Andre-artikler/Etter-endelig-avslag/

20 Imdi.no [Internet]. Directorate of integration and diversity. Bosetting av flyktninger [cited 2015 Aug 10]. Available from: http://www.imdi.no/Bosetting/

21 Imdi.no [Internet]. Directorate of integration and diversity. Integreringstilskudd for år 1 og år 2-5; 2013 Dec 19 [updated 2014 Dec 16; cited 2015 Aug 10]. Available from: http://www.imdi.no/no/Tilskudd/Integreringstilskudd/

22 Udi.no [Internet]. The Norwegian Directorate of Immigration. Enslig mindreårig asylsøker [cited 2015 Oct 20]. Available from: http://www.udi.no/ord-og-begreper/enslig-mindrearig-asylsoker/

23 Une..no [Internet]. Oslo: Utlendingsnemnda. Retten til vern som flyktning. [2010 Jul 8; cited 2016 May 4]. Available from: http://www.une.no/no/Menneskerettigheter/Menneskerettighet2/

24 Udi.no [Internet]. The Norwegian Directorate of Immigration; c2015. Asylsøknader etter statsborgerskap og måned (2014) [cited 2015 Nov 23]; Available

from:http://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-og-maned/

25 Udi.no [Internet]. The Norwegian Directorate of Immigration; c2015. Asylsøknader etter statsborgerskap og måned (2013) [cited 2015 Nov 23]; Available from:http://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-og-maned-2013/

26 Udi.no [Internet]. The Norwegian Directorate of Immigration; c2015. Asylsøknader etter statsborgerskap og måned (2012) [cited 2015 Nov 23]; Available from:http://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-og-maned-2012/

27 Udi.no [Internet]. The Norwegian Directorate of Immigration; c2015. Asylsøknader etter statsborgerskap og måned (2015 [cited 2015 Nov 23]; Available from: http://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-og-maned-2015/

28 Udi.no [Internet]. The Norwegian Directorate of Immigration; c2015. Asylsøknader etter statsborgerskap og måned (2011) [cited 2015 Nov 23]; Available from: http://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-og-maned-2011/

29 Forskrift om trygdedekning for asylsøker m.m. 2008. Forskrift om trygdedekning for asylsøkere of deres familiemedlemmer av 2008-05-14 nr 460. Available from: https://lovdata.no/dokument/SF/forskrift/2008-05-14-460

30 Helsedirektoratet.no [Internet]. Helsedirektoratet. Veileder for helsetjenester til asylsøkere, flyktninger og familiegjenforente. IS-1022 (2015) [Cited 2015 Jun 21]. Available from: https://helsedirektoratet.no/retningslinjer/asylsokere-flyktninger-og-familiegjenforente

31 Forskrift om krav til helsepersonells attester. 2008. Forskrift om krav til helsepersonells attester, erklæringer o.l. av 2008-12-18 nr. 1486. Available from: https://lovdata.no/dokument/SF/forskrift/2008-12-18-1486

32 Une.no [Internet]. Oslo: The Immigration Appeals Board. Helseattester og oppholdstillatelse; 2005 Nov 09 [updated 2006 Aug 10; cited 2014 Jun 12]. Available from: http://www.une.no/Aktuelt/Kronikker/Helseattester-og-oppholdstillatelse-/

33 Legeforeningen.no [Internet]. Oslo: Den Norske Legeforening. Fortelling, funn, fortolkning, formidling - En praktisk veileder for legers attestarbeid i spennet mellom innsikt, innlevelse, rammer og ressurser. 2008 Apr [cited 2015 Aug 25]; Available from: http://legeforeningen.no/PageFiles/30457/En%20praktisk%20veileder%20for%20legers%20attestarbeid%20%28pdf%29.pdf

34 Regjeringen.no [Internet]. Oslo: the Norwegian Government. Høring - Endring av prioriteringsforskriften - Helsehjelp til personer som oppholder seg ulovlig i landet; 2010 Nov

25 [cited 2012 Jul 12]. Available from: https://www.regjeringen.no/no/dokumenter/horing---endring-av-prioriteringsforskri/id625912/

35 Clandestino.eliamep.gr [Internet]. The Clandestino Project; c2007-2009. Undocumented Migration: Counting the Uncountable. Data and Trends Across Europe; 2009 Nov 09 [cited 2015 Jul 03]. Available from: http://clandestino.eliamep.gr/wp-content/uploads/2010/03/clandestino-final-report_-november-20091.pdf

36 Zhang LC. ssb.no [Internet]. Statistics Norway; c2015. Developing methods for determining the number of unauthorized foreigners in Norway; Documents 2008/11; 2008 Jun 23. [cited 2015 Jul 21]; Available from: https://www.ssb.no/befolkning/artikler-og-publikasjoner/developing-methods-for-determining-the-number-of-unauthorized-foreigners-in-norway

37 Politi.no [Internet]. The Norwegian Police. Politiets utlendingsenhet: Retur. [updated 2015 Mar 24; cited 2015 Jul 20]. Available from: https://www.politi.no/politiets_utlendingsenhet/retur/

38 Øien C, Sønsterudbråten S. No way in – no way out? A study of living conditions of irregular migrants in Norway Fafo-rapport 03/2010. Available from: http://www.fafo.no/pub/rapp/20194/20194.pdf

39 Politi.no [Internet]. The Norwegian Police. Politiets utlendingsenhet: Politiets utlendingsinternat. [updated 2015 Feb 16; cited 2015 Jul 20]. Available from: https://www.politi.no/politiets_utlendingsenhet/politiets_utlendingsinternat/Tema_1824.xhtml

40 Utlendingsloven. 2008. Lov om utlendingers adgang til riket og deres opphold her av 2008-05-15 nr 35. Available from: https://lovdata.no/dokument/NL/lov/2008-05-15-35?q=Utlendingsloven

41 Molven, Olav. Healthcare, Welfare and Law. Health legislation as a mirror of the Norwegian Welfare state. 2008. Oslo: Gyldendal akademisk.

42 Lovdata.no [Internet]. Lovdata. Kunngjøring av endringer i Grunnloven (menneskerettigheter) . [updated 2014 May 14; cited 2016 Mar 2]. Available from: https://lovdata.no/artikkel/kunngjoring_av_endringer_i_grunnloven_%28menneskerettigheter%29/1430

43 Who.int [Internet]. Health and human rights: Fact sheet N°323 December 2015 [undated; cited 2016 May 2]. Available from: http://www.who.int/mediacentre/factsheets/fs323/en/http://www.who.int/mediacentre/factsheets/fs323/en/

44 Unhcr.org [Internet]. United Nation High Commisionner for Refugees. Convention of the Rights of the Child. 1989 Nov. [cited 2015 Jul 18]. Available from: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx

45 Forskrift om tjenester til personer uten fast opphold. 2011. Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket 2011-12-16-nr 1255 FOR-2011-12-16-1255. https://lovdata.no/dokument/SF/forskrift/2011-12-16-1255

46 Psykologforenigen.no [Internet]. Oslo: Norsk psykologforening: Etiske prinsipper for nordiske psykologer [undated; cited 2015 Apr 22]. Available from: http://www.psykologforeningen.no/medlem/etikk/etiske-prinsipper-for-nordiske-psykologer

47 Nsf.no [Internet]. Oslo: Norsk sykepleierforbund.Yrkesetiske retningslinjer for sykepleiere; 2014 Oct 12 [cited 2016 Mar 20]. Available from: https://www.nsf.no/vis-artikkel/2193841/17102/Yrkesetiske-retningslinjer

48 Legeforeningen.no [Internet]. Oslo: Den Norske Legeforening.Etiske regler for leger; 2015 Jun 22 [cited 2015 Jul 29]. Available from: http://legeforeningen.no/Om-Legeforeningen/Organisasjonen/Rad-og-utvalg/Organisasjonspolitiske-utvalg/etikk/etiske-regler-for-leger/

49 Regjeringen.no [Internet]. The Norwegian Government. Høringssvar – Den Norske legeforening [2010 Nov 25; cited 2015 Oct 22]. Available from: https://www.regjeringen.no/contentassets/de12c2d5ca0a490d824ee459e8bd6225/dennorskelegeforeningdok1.pdf

50 Regjeringen.no [Internet]. The Norwegian Government. Høringssvar – Det norske sykepleierforbund [2010 Nov 25; cited 2015 Oct 22]. Available from: https://www.regjeringen.no/contentassets/de12c2d5ca0a490d824ee459e8bd6225/norsksykepleierforbund.pdf

51 Regjeringen.no [Internet]. Oslo: Statens Helsetilsyn. Høringssvar –forslag til endring av prioriteringsforskriften for helsehjelp til personer som oppholder seg ulovlig i landet; 2011 Feb 25. [cited 2015 Aug 15]. Available from: https://www.regjeringen.no/contentassets/de12c2d5ca0a490d824ee459e8bd6225/statenshelsetilsyn.pdf

52 Regjeringen.no [Internet]. Oslo: Helsedirektoratet. Høringssvar –forslag til endring av prioriteringsforskriften – helsehjelp til personer som oppholder seg ulovlig i landet; 2011 Feb 25. [cited 2015 Aug 15]. Available from: https://www.regjeringen.no/contentassets/de12c2d5ca0a490d824ee459e8bd6225/helsedirektoratet.pdf

53 Barneombudet.no [Internet]. Oslo: The Norwegian Ombudsman for Children. FNs konvensjon for barns rettigheter; 1989 Nov 20. [cited 2015 Jul 23], [article 24]. Available from: http://barneombudet.no/for-voksne/barnekonvensjonen/hele-barnekonvensjonen/#24

54 Utlendingsinternatforskriften. 2009. Forskrift om Politiets utlendingsinternat av 2009-12-23 nr 1890. Available from: https://lovdata.no/dokument/SF/forskrift/2009-12-23-1890?q=Utlendingsinternatforskriften

55 Helsetilsynet i Oslo og Akershus. Avslutning av tilsynssak. 2011. Deres ref 2011/18307-9 FM-H 30.12.2011

56 Regjeringen.no [Internet]. Oslo: The Norwegian Government. Spørsmål nr. 286 til skriftlig besvarelse; 2011 Nov 24. [cited 2015 Jul 29]. Available from: https://www.regjeringen.no/no/aktuelt/sporsmal-nr-286-til-skriftlig-besvarelse/id664681/

57 Stortinget.no [Internet]. Oslo: The Norwegian Parliament. Skriftlig spørsmål fra André N. Skjelstad (V) til helse- og omsorgsministeren; 2015 Feb 04. [cited 2015 Jul 29]. Available from: https://www.stortinget.no/no/Saker-og-publikasjoner/Sporsmal/Skriftlige-sporsmal-og-svar/Skriftlig-sporsmal/?qid=61869

58 Nowhereland.info [Internet]. Krems: Health care in nowhereland; c2008. Improving services for undocumented migrants in the EU. [cited 2015 Nov 29]. Available from: http://www.nowhereland.info/

60 Helsetilsynet.no [Internet]. Oslo: Statens helsetilsyn. Endring til Fylkesmannen [2012 Nov 29; cited 2015 Nov 17]. Available from: https://www.helsetilsynet.no/no/Regelverk/Forskrifter/Forskrifter-helse-og-omsorgstjenester/Endring-Helsetilsynet-til-Fylkesmannen-div-forskrifter-HOD-/

61 Spesialisthelsetjenesteloven. 1999. Lov om spesialisthelsetjenesten av LOV-1999-07-02-61. Available from: https://lovdata.no/dokument/NL/lov/1999-07-02-61?q=spesialisthelsetjeneste

62 Bymisjon.no [Internet]. Kirkens Bymisjon, helsesenteret for papirløse migranter. Årsrapport 2014 –det skjulte helsebehovet. Årsrapport for Helsesenteret for papirløse migranter; 2015 [cited 2015 Aug 15]. Available from: http://www.bymisjon.no/PageFiles/15350/%c3%a0rsmelding%20Helsesenteret%202014.pdf

63 Kirkens Bymisjon. Protokoll fra Styremøtet i SKBO 13. oktober 2008. Sak 22/08. JPID 09/126. Dok.nr 08/257-9

64 Kirkens Bymisjon. Vurdering og oppfølging av sak 22/08. Udatert.

65 Eick F. Helsesenter for papirløse migranter. Beskrivelse i mottak [online]. E-mail to Ida Marie Bregård (ida.bregaard@nakmi.no) 2015 Aug 10 [cited 2015 Aug 12].

66 Helsedirektoratet [internet]. Helsefaglige kodeverk. 2015-05-12 [hentet 2015-07-03. Tilgjengelig fra]https://helsedirektoratet.no/helsefaglige-kodeverk/icpc-2-den-internasjonale-klassifikasjonen-for-primerhelsetjenesten

67 Helsedirektoratet.no [internett]. Helsefaglige kodeverk, kodeverk ICD-10. Helsedirektoratet; 2015-04-30 [cited 2015-07-03]. Tilgjengelig fra https://helsedirektoratet.no/helsefaglige-kodeverk/kodeverket-icd-10-og-icd-11

68 Bymisjon.no [Internet]. Kirkens Bymisjon, helsesenteret for papirløse migranter. Årsrapport 2015 –det skjulte helsebehovet. Årsmelding for Helsesenteret for papirløse migranter; 2016 [cited 2016 Apr 4]. Available from: bymisjon.no/PageFiles/15350/%c3%85rsmelding%20Helsesenteret%202015.pdf

69 Bymisjon.no[Internet]. Oslo: Kirkens Bymisjon. Hiv-prosjekt - Helsesenteret for papirløse migranter, Oslo, høsten 2011 [Cited 2013 Mar 21]. Available from: http://bymisjon.no/PageFiles/15350/Sluttrapport_hiv-prosjektet.pdf

70 Achkar JM Macklin R. Ethical Considerations about Reporting Research Results with Potential for Further Stigmatization of Undocumented Immigrants. Clin Infect Dis. 2009 May 1; 48(9): 1250–1253. doi: 10.1086/597587

71 Uio.no [Internet]. Oslo: Universitetet i Oslo. Ovid (Embase/Medline). [2012 Nov 7; cited 2016 May 2]. Available from: http://www.ub.uio.no/fag/naturvitenskap-teknologi/bio/ressurser/endnote-fra-skrive-referere/ovid/

72 Nb.no [Internet]. Oslo: Nasjonal biblioteket. Norske og nordiske tidsskriftartikler [Undated; 2016 Mar 3]. Available from: http://www.nb.no/baser/norart/

73 Svemedplus.kib.ki.se [Intnernet] Stockholm: Karolinska Institutet. Sök artiklar i SveMed+ [undated; cited 2016 Mar 4]. Available from: http://svemedplus.kib.ki.se/Default.aspx?

74 Doctorsoftheworld.org.uk [Internet]. London: Doctors of the World. About Us. [Undated; cited 2016 Mar 4]. Available from: https://www.doctorsoftheworld.org.uk/pages/about-us

75 Msf.org [Internet].Paris: Médicins sans Frontières. About MSF. [undated; cited 2015 Mar 5] Available from: http://www.msf.org/en/about-msf

76 Icrc.org [Internet]. Gèneve: International Red Cross and Red Cresent Movement. The International Red Cross and Red Crescent Movement [Undated; cited 2016 Apr 1]. Available from: https://www.icrc.org/en/who-we-are/movement

77 Woodward A, Howard N, Wolffers I ·Health and access to care for undocumented migrants living in the European Union: a scoping review. Health Policy Plan. 2014 Oct;29(7):818-30. doi: 10.1093/heapol/czt061. Epub 2013 Aug 16.

78 Ehmsen BK, Biswas D, Jensen NK, Krasnik A, Norredam M. Undocumented migrants have diverse health problems.Dan Med J. 2014 Sep;61(9):A4897. Available from: http://www.danmedj.dk/portal/page/portal/danmedj.dk/dmj_forside/PAST_ISSUE/2014/DMJ_2014_09/A4897

79 Wahlberg A, Källestål C, Lundgren A, Essén B. Causes of death among undocumented migrants in Sweden, 1997-2010. Glob Health Action. 2014 Jun 3;7:24464. Doi: 10.3402/gha.v7.24464

80 Schoevers MA, van den Muijsenbergh ME, Lagro-Janssen AL. Self-rated health and health problems of undocumented immigrant women in the Netherlands: a descriptive study. J Public Health Policy. 2009 Dec;30(4):409-22. doi: 10.1057/jphp.2009.32.

81 Dorn T, Ceelen M, Tang MJ, Browne JL, de Keijzer KJ, Buster MC, Das K. Health care seeking among detained undocumented migrants: a cross-sectional study. BMC Public Health. 2011 Mar 28;11:190. doi: 10.1186/1471-2458-11-190.

82 Keygnaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Cult Health sex. 2 12;14(5):505-20. Doi: 10.1080/13691058.2012.671961

83 Sebo P, Jackson Y, Haller DM, Gaspoz JM, Wolff H.. Sexual and reproductive health behaviours of undocumented migrants in Geneva: A cross-sectional study. J Immigr Minor Health. 2011;13(3):510-7. Doi:10/1007.s10903-010-9367-z.

84 Casillas A, Bodenmann P, Epiney M, Gétaz L, Irion O, Gaspoz JM, Wolff H. The border of reproductive control: undocumented immigration as a risk factor for unintended pregnancy in Switzerland. J Immigr Minor Health. 2015 Apr;17(2):527-34. doi: 10.1007/s10903-013-9939-9

85 Jackson Y, Sebo P, Aeby G, Bovier P, Ninet B, Schrenzel J, Sudre P, Haller D, Gaspoz JM, Wolff H. Prevalence and associated factors for Chlamydia trachomatis infection among undocumented immigrants in a primary care facility in Geneva, Switzerland: a cross-sectional study. J Immigr Minor Health. 2010 Dec;12(6):909-14. doi: 10.1007/s10903-010-9354-4.

86 Wolff H, Epiney M, Lourenco AP, Costanza M, Delieutraz-Marchand J, Andreoli N, Dubuisson JB, Gaspoz JM, Irion O. Undocumented migrants lack access to pregnancy care and prevention. BMC Public Health 2008, 8:93. Doi:10.1186/1471-2458-8-93

87 Keygnaert I, Vettenburg N, Roelens K, Temmerman M. Sexual health is dead in my body: Participatory assessment of sexual health determinants by refugees, asylum seekers and undocumented migrants in Belgium and The Netherlands. BMC Public Health. 2014 may 1;14:416. doi:10.1186/1471-2458-14-416

88 Kvamme E, Ytrehus S. Barriers to health care access among undocumented migrant women in Norway. 2015 Dec 21; Vol 6 (15).Society, Health & Vulnerability. Available from: http://dx.doi.org/10.3402/shv.v6.28668

89 Teunissen E van den Bosch, van Bavel E, van den Driessen Mareeuw F, van den Muijsenbergh, ven Weel-Baumgarten, an Weel C. Mental health problems in undocumented and documented migrants: a survey study. Fam pract, 2014 Oct; 31(5):571-7. Doi: 10.1093/fampra/cmu038. Available from: http://www.ncbi.nlm.nih.gov/pubmed/25416057

90 Teunissen E, van Bavel E, van den Driessen, Mareeuw F, Macfarlane A, ven Weel-Baumgarten E, van Den Muijsenberg M, van Weel C. Mental health problems of undocumented migrants in the Netherlands: A qualitative exploration of recognition, recording, and treatment by general practitioners. Scand J Prim Health care, 2015 May 11, 1-

9. doi: 10.3109/02813432.2015.1041830 Available from: http://www.ncbi.nlm.nih.gov/pubmed/25961462

91 Teunissen E, Sherally J, van den Muijsenbergh M, Dowrick C, van Weel-Baumgarten E, van Weel C. Mental health problems of undocumented migrants (UMs) in The Netherlands: a qualitative exploration of help-seeking behaviour and experiences with primary care. BMJ Open. 2014 Nov 21;4(11):e005738. doi: 10.1136/bmjopen-2014-005738.

92 Pace-Asciak A, Mamo J, Calleja N. Tuberculosis among undocumented boat migrants to Malta: implications for a migrant tuberculosis policy. Int J Tuberc Lung Dis. 2013 Aug;17(8):1065-70. doi: 10.5588/ijtld.12.0622.

93 Bodenman P, Vaucher P, Wolff H, Favrat BB, de Tribolet F, Masserey E, Zellweger JP. Screening for latent tuberculosis infection among undocumented immigrants in Swiss health care centres; a descriptive exploratory study. BMC Infect dis. 2009 Mar 24;9:34, doi: 10.1186/1471-2334-9-34.

94 El-Hamad I, Pezzoli MC, Chiari E, Scarcella C, Vassallo F, Puoti M, Ciccaglione A, Ciccozzi M, Scalzini A, Castelli F. Point-of-care screening, prevalence, and risk factors for hepatitis B infection among 3,728 mainly undocumented migrants from non-EU countries in northern Italy. J Travel Med. 2015 Mar-Apr;22(2):78-86. doi: 10.1111/jtm.12176. Epub 2014 Nov 26.

95 Fresk M, Ganslandt H. Vårdbehov hos papperslösa. Erfarenheter från Röda korsets Sjukvårdsförmedling för papperslösa. [ST-uppsats i allmänmedicin]. 2009.

96 Lakareutangranser.se [Internet]. Médecins Sans Frontieres.Experiences of gömda in Sweden: Exclusion from health care for immigrants living without legal status; 2005 [cited 2011 May 15]. Available from: lakarautangranser.se/publikationer/rapporter/2005/gomda

97 Hprt-cambridge.org [Internet]. Cambridge, Massachusets: Harvard Program in Refuge Trauma. Hopkins symptom checklist-25; [cited 2012 Jul 12]. Available from: http://hprt-cambridge.org/screening/hopkins-symptom-checklist/

98 Helsebiblioteket.no [Internet]. Oslo: the Norwegian Electronic Health Library. HSCL-25 – Hopkins Symptom Checklist-25; [cited 2012 Jul 12]. Available from: https://www.helsebiblioteket.no/psykisk-helse/felles/sk%C3%A5ringsverkt%C3%B8y/hscl-25-hopkins-symptom-checklist-25#

99 Chauvin P. Parizot I. Simmonot S. doctorsoftheworld.org.uk [Internet]. Médicins du Monde. Access to healthcare for undocumented migrants in 11 European countries; 2009. [cited 2011 May 13] Available from: https://www.doctorsoftheworld.org.uk/lib/docs/121111-europeanobservatoryfullreportseptember2009.pdf

100 International centre for migration and health. The process of social insertion for migrants, refugees and asylum seekers in the context of access to and use of health and social services. Genève; 2004.

101 Rosengrenska.org [Internet].Göteborg: Rosengrenska stiftelsen – Fakta om Rosengrenska [Cited 2015 Jul 03]. Available from: http://www.rosengrenska.org/om-oss/

102 Jansson S. Koch P. Overmeer J, Andersson D. rosengrenska.org [Internet].Göteborg: Rosengrenska stiftelsen –vård for papperslösa. Papperslös, men inte tandlös; 2011 Mar 21 [cited 2015 Sept 10]. Available from: http://www.rosengrenska.org/pdfs/ExamensarbeteVT2010PapperslosMenInteTandlos.pdf

103 Kristiansen O. Undocumented immigrants and the experiences of Norwegian general practitioners with this group of patients. Master thesis University of Oslo 2008.

104 Aarseth S. Kongshavn T. Kristiansen O. Allmenmedisinske utfordringer: Går papirløse innvandrere til allmennlege? Utposten 2009 04. [Cited 2011 May 12] Available from: http://utposten-stiftelsen.no/LinkClick.aspx?fileticket=1jgs58wvgho%3D&tabid=480&mid=1117

105 Aarseth S. Kongshavn T. (2011). Norske allmennlegers utfordringer i møte med papirløse migranter. Presentert på NSHs konferanse: Minoritetshelse - lik rett til god helse og likeverdige helsetjenester; 5. mai 2011; Oslo. Hentet fra https://www.nsh.no/db/doc/0000002895.pdf

106 Hjelde, KH. Jeg er alltid bekymret. Om udokumenterte migranters forhold til helsetjenestene i Oslo. NAKMIs skriftserie 1/2010. Nasjonal kompetanseenhet for minoritetshelse; 2010.

107 Brunovskis A, Bjerkan L. Research with irregular migrants in Norway. Methodologigal and ethical challenges and emergin research agendas. In Learning about Illegals: Issues and methods. Utlendingsdirektoratet, 2008.

108 Regjeringen.no [Internet]. Oslo: The Norwegian Government. Årsrapport 2014 – Tilsynsrådet for politiets utlendingsinternat, Trandum; 2014 [cited 2015 Apr 22]. Available from: https://www.regjeringen.no/globalassets/departementene/jd/arsrapport_tilsynsradet_politiets_utlendingsinternat_trandum2014.pdf

109 Rutledal AL. Den skjulte hverdagen: En studie av hvordan papirløse migranter beskriver forstår sitt hverdagliv i det norske samfunn. Masteroppgave Høgskolen i Oslo og Akershus 2012.

110 Sønderland I. Foreldreskap i Ingenmannsland. Masteroppgave Høgskolen i Oslo og Akershus 2014.

111 Hansen AS. Et liv i skyggen Papirløse migranters livssituasjon i det norske samfunn. Høgskolen i Buskerud og Vestfold 2015.

112 Johnsen E. Den kritiske diakonale stemmen i samfunnet. En kvalitativ analyse av Kirkens Bymisjons stemme for papirløse migranter. Det teologiske Menighets fakultet 2013

113 Nesje-Sletteng AS. Stikker for papirløses helse. Bioingeniøren Årg 50, nr. 2, (2015.

114 Johnsen H. Papirløse: Stort behov for fysioterapi. Fysioterapeuten 1/12.

115 Dolonen KA, Bloch Helmers AK. Pasientene strømmer til hemmelig legesenter[2010 Dec 20; cited 2016 Mar 22]. Available from: https://sykepleien.no/2010/12/pasientene-strommer-til-hemmelig-legesenter)

116 U. S. National Library of Medicine [internet]. The International Classification of Primary Care Source Information. [cited 2015-07-03]. Tilgjengelig fra http://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/ICPC/

117 Unhcr.org [Internet]. United Nations High Commissioner for Refugees. Convention and protocol relating to the status of refugees; United Nations;1951[Cited 2015 Jul 15]. Available from: http://www.unhcr.org/3b66c2aa10.html

118 Appendix 1 Bekreftelse på frivillig arbeid på Helsesenteret for papirløse migranter for Ida Marie Bregård (Confirmation of volontary work at the Health Center for Undocumented Migrants for Ida Marie Bregård)

119 Unesco.org [Internet]. United Nations Educationl, Scientific and Cultural Organization. Universal Declaration on Bioethics and Human Rights [Cited 2015 Jul 20]. Available from: http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html

120 Hhs.gov [Internet]. The Belmont Report 1979. [Cited 2015 Jul 21]. Available from: http://www.hhs.gov/ohrp/humansubjects/guidance/belmont.html

121 Cioms.ch [internett]. Council for International Organizations of Medical Sciences. International Ethical Guidelines for Biomedical Research Involving Human Subjects CIOMS; 2002 [cited 2015-07-03]. Available from: http://www.cioms.ch/publications/guidelines/guidelines_nov_2002_blurb.htm

122 Wma.com [Internet].World medical association; Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. Brazil: 2013. Available from: http://www.wma.net/en/30publications/10policies/b3/index.html

123 De nasjonale forskningsetiske komiteene [internet]. De nasjonale forskningsetiske komiteene; Udatert [cited2015-08-13]. Available from: https://www.etikkom.no/vart-arbeid/

124 Helseforskningsloven. 2008. Lov om medisinsk og helsefaglig forskning av 2008-06-20 nr 44 Available from: https://lovdata.no/dokument/NL/lov/2008-06-20-44?q=helseforskningsloven

125 Helseforskningsloven. 2008. Lov om medisinsk og helsefaglig forskning av 2008-06- 20 nr 44. Available from: https://lovdata.no/dokument/NL/lov/2008-06- 20-44?q=helseforskningsloven

126 Appendix 2. Avtale om bruk av data fra Helsesenteret for papirløse migranter (Agreement on use of data material from the Health Center for Undocumented Migrants).

127 Appendix 3. Tilbakemeldig fra Regional Etisk komitee (Confirmation from the Regional Ethics Comitee)

128 Personopplysningsloven. 2000. Lov om behandling av personopplysninger av 2000-04-14-31. Available from: https://lovdata.no/dokument/NL/lov/2000-04-14-31

129 Appendix 4. Tilbakemelding fra Personvernombudet for forskning (NSD). Confirmation from the data Protection Officer for Research)

130 Pandey RN. The use of induced abortion as a contraceptive: the case of Mongolia. J Biosoc Sci. 2002 Jan;34(1):91-108. Available from: http://www.ncbi.nlm.nih.gov/pubmed/11814215

131 Helsedirektoratet.no [Internet]. Oslo: Helsedirektoratet. Abort. [2016 Apr 16; cited 2016 May 2]. Available from: https://helsedirektoratet.no/folkehelse/seksuell-helse/abort

132 Picum.com [Internet]. Platform for International Cooperation for Undocumented Migrants; c2015. PICUM's Main Concerns about the Fundamental Rights of Undocumented Migrants in Europe; 2010. [Cited 2015 Aug 23]; available from: http://picum.org/picum.org/uploads/publication/Annual%20Concerns%202010%20EN.pdf

133 Tolkeportalen.no [Internet]. Oslo: Directorate of Integration and diversity. Kvalifikasjonsordninger for tolker. [Undated; Cited 2015 Oct 20]. Available from: https://tolkeportalen.no/no/Om-Nasjonalt-tolkeregister/Godkjenningsordninger-for-tolker/

134 Tolkeportalen.no [Internet]. Oslo: Directorate of Integration and diversity.Tolkens yrkesetikk [Undated; Cited 2015 Oct 20]. Available from: https://tolkeportalen.no/no/For-tolker/Tolkens-yrkesetikk/

135 Helsedirektoratet.no [Internet]. Oslo: Helsedirektoratet. Veileder om bruk av tolk for ansatte og ledere i helse- og omsorgstjenestene IS-1924. [Cited 2015 Oct 20]. Available from: https://helsedirektoratet.no/retningslinjer/veileder-om-kommunikasjon-via-tolk-for-ledere-og-personell-i-helse-og-omsorgstjenestene

136 Tolkeportalen.no [Internet]. Oslo: Directorate of Integration and diversity. Søk. [Undated; Cited 2015 Oct 20]. Available from: https://www.tolkeportalen.no/Web/TP/Templates/Pages/FreeSearch.aspx

137 Prosenteret.no [internet]. Oslo: Prosenteret. Om oss. [Undated; cited 2015 Mar 15]. Available from: http://prosentret.no/om-oss/

APPENDIXES

KIRKENS BYMISJON | HELSESENTERET
FOR PAPIRLØSE MIGRANTER

Røde Kors Oslo

Til den det måtte gjelde

19.04.16

Bekreftelse

Det bekreftes med dette at Ida Marie Bregård, f. 21.07.1983, hpr. 9966358, er vært frivillig sykepleier på Helsesentret for papirløse migranter fra oppstart i 2009 til dagens dato. Frivillige sykepleiere på Helsesenteret har 5 timers vakter 1. gang i mnd. De inngår i et tverrfaglig team på Helsesenteret med leger, fysioterapeuter, psykologer, jordmødre og bioingeniører. Helsesenteret for papirløse migranter gir gratis helsetjenester til personer uten oppholdstillatelse i Norge og er basert på frivillig innsats fra helsepersonell.

Ida sine primære oppgaver har vært registrering av pasienter i «mottak» og kartlegging av deres hjelpebehov. Denne registreringen og andre oppgaver som tilfaller «mottak» er utført i henhold til de til enhver tid gjeldende «Rutinebeskrivelser for mottak».

Ida har i 2010 også mottatt datamateriale fra Helsesenteret til bruk i sin masteroppgave. I denne forbindelse har hun også anledning til å bruke egne erfaringer fra Helsesenteret i oppgaven såfremt det er innunder etisk godkjenning og helsepersonells taushetsplikt.

Vennlig hilsen

Frode Eick
Daglig leder

HELSESENTERET
FOR PAPIRLØSE MIGRANTER

Røde Kors Oslo

Oslo,14.03.2011

Avtale om bruk av data i forbindelse med masteroppgave

Herved bekreftes at masterstudent Ida Marie Bregård født 21.07.1983
Får tilgang til statistiske data gjennom vårt journalsystem på Helsesenteret for papirløse migranter. Studentens veileder, Ursula Småland Goth, har også tilgang til de data studenten henter ut fra journalsystemet.

All data skal oppbevares på en minnepinne som er innelåst i henhold til gjeldende regler for oppbevaring av sensitiv data. Data som hentes ut skal destrureres etter bruk. Studenten forplikter seg til kun å hente ut relevante data, og ikke bruke data på annen måte enn etter avtale. Ved eventuelle brudd på avtalevilkår opphører avtalen med umiddelbar virkning.

Denne avtalen forutsetter godkjenneing fra REK før forskning igangsettes.
Dersom REK har innvendinger, vil disse bli etterfulgt.

Signatur virksomhetsansvarlig

Celine Blom
Daglig leder
Helsesenteret for papirløse migranter

Signatur student

Ida Marie Bregård
student, International community health
IASAM

HELSESENTERET
for papirløse migranter
Postboks 3483 Bjølsen
0406 Oslo

Appendix 3

1/6-11
mb

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst A	Jørgen Hardang	22845516	30.05.2011	2011/831
			Deres dato:	Deres referanse:

Ursula Småland Goth
Nasjonal kompetanseenhet for minoritetshelse (NAKMI)
Ullevål

2011/831a Hvem er brukere av helsesenteret for papirløse migranter?

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk i møtet 5. mai 2011. Søknaden er vurdert i henhold til lov av 20. juni 2008 nr. 44, om medisinsk og helsefaglig forskning (helseforskningsloven) kapittel 3, med tilhørende forskrift om organisering av medisinsk og helsefaglig forskning av 1. juli 2009 nr 0955.

Prosjektleder: Forsker Ursula Småland Goth, Nasjonal kompetanseenhet for minoritetshelse (NAKMI)

Forskningsansvarlig: Oslo universitetssykehus HF

I 2008 estimerte Statistisk Sentralbyrå at det finnes ca 18 000 papirløse migranter i Norge. Av disse er 2/3 asylsøkere med endelig avslag. Papirløse migranter har rett til nødvendig helsehjelp etter kommunehelsetjenesteloven § 2-1.

Helsesenter for papirløse migranter, ved Kirkens Bymisjon og Røde Kors, ble startet oktober 2009 for å tilby helsetjenester til papirløse migranter. Etter ett års drift har senteret 450 brukere og hadde utført 1200 konsultasjoner.

Søkerne ønsker å kartlegge hvem som er brukere av helsesenteret med hensyn til alder, kjønn, språk, diagnose etter IPCP kode, antall konsultasjoner per person, fødeland, oppholdstid i Norge og oppholdsgrunnlag. Målet er brukerkartlegging av helsesenteret og kartlegging av de problemstillinger som senteret blir oppsøkt for. Underordnet mål er å se om myndighetenes antagelser om helsesenterets brukere stemmer med data registrert på helsesenteret.

Studien skal baseres på informasjon om inkluderte pasienter som er samlet inn i tidsrom 25. oktober 2009 – 27. april 2011 i det lokale pasientjournalsystemet Soma. Det søkes om godkjenning for ikke å innhente samtykke fra de registrerte.

Komiteens vurdering
Komiteen oppfatter fokus i studien som mer samfunnsfaglig enn medisinsk og at den derfor ikke kommer inn under helseforskningslovens virkeområde, jf helseforskningsloven § 2, som gjelder medisinsk og helsefaglig forskning.

I henhold til delegasjonsfullmakt av datert 2.7.2009 fra Helse og omsorgsdepartementet, er REK gitt myndighet til å kunne dispensere fra taushetsplikten i henhold til helsepersonelloven § 29 og forvaltningsloven § 13 d for tilgang til helseopplysninger til bruk i annen type forskning.

Hvis opplysningene gis senterets ansatte "som fra før av er kjent med opplysningene" for anonymisering til forskningsformål, så trengs det heller ikke dispensasjon for å kunne gjennomføre denne aktiviteten, jf helsepersonelloven § 23 nr 1.

Besøksadresse:
Gullhaug torg 4A
0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no

Appendix 3

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Slik søknaden er utformet er det uklart for REK hva det søkes om tilgang til, hvem det søkes om tilgang for og hvorledes dataene skal behandles. Er det anonymiserte data som forskerne skal ha tilgang til, så er det ikke behov for dispensasjon fra taushetsplikten. REK viser også til at graden av personidentifikasjon skal ikke være større enn nødvendig for å nå formålet med studien, og hvis det kan gjennomføres på anonymiserte data så er det ikke behov for dispensasjon fra taushetsplikten.

Vedtak:

Prosjektet framstår som i hovedsak som et samfunnsfaglig forskningsprosjekt, og det faller derfor utenfor helseforskningslovens virkeområde, jf. helseforskningsloven § 2. Prosjektet kan gjennomføres uten godkjenning av REK.

Komiteens vedtak kan påklages til Den nasjonale forskningsetiske komité for medisin og helsefag, jfr. helseforskningsloven § 10, 3 ledd og forvaltningsloven § 28. En eventuell klage sendes til REK sør-øst A. Klagefristen er tre uker fra mottak av dette brevet, jfr. forvaltningsloven § 29.

Med vennlig hilsen

Gunnar Nicolaysen (sign.)
professor dr. med.
leder

Jørgen Hardang
seniorrådgiver

Kopi: Oslo universitetssykehus HF:oushfdlgodkjenning@ous-hf.no

Besøksadresse:
Gullhaug torg 4A
0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Bernadette Kumar
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 16.09.2015 Vår ref: 44113 / 3 / LT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 30.07.2015. Meldingen gjelder prosjektet:

44113	*Hvem er brukere av helsesenteret for papirløse migranter?*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Bernadette Kumar*
Student	*Ida Marie Bregård*

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Katrine Utaaker Segadal

Lis Tenold

Kontaktperson: Anne-Mette Somby tlf: 55 58 24 10
Vedlegg: Prosjektvurdering
Kopi: Ida Marie Bregård ida.bregaard@nakmi.no

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 44113

Personvernombudet viser til e-post mottatt 08.09.2015.

Vi kan ikke se at det behandles personopplysninger med elektroniske hjelpemidler, eller at det opprettes manuelt personregister som inneholder sensitive personopplysninger. Prosjektet vil dermed ikke omfattes av meldeplikten etter personopplysningsloven.

Det ligger til grunn for vår vurdering at alle opplysninger som behandles elektronisk i forbindelse med prosjektet er anonyme.

Med anonyme opplysninger forstås opplysninger som ikke på noe vis kan identifisere enkeltpersoner i et datamateriale, verken:
-direkte via personentydige kjennetegn (som navn, personnummer, epostadresse el.)
-indirekte via kombinasjon av bakgrunnsvariabler (som bosted/institusjon, kjønn, alder osv.)
-via kode og koblingsnøkkel som viser til personopplysninger (f.eks. en navneliste)
-eller via gjenkjennelige ansikter e.l. på bilde eller videoopptak.