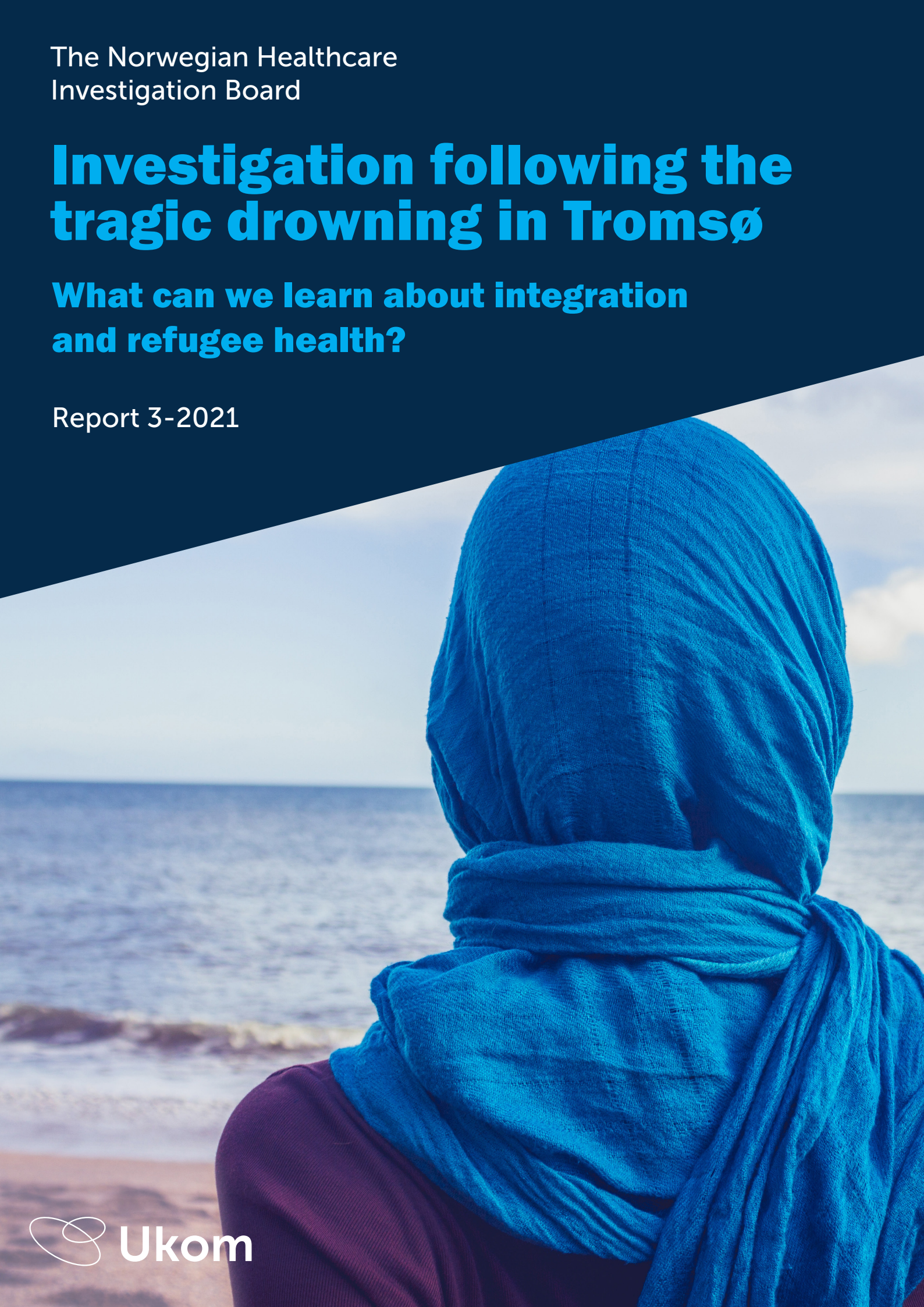
The Norwegian Healthcare Investigation Board

Investigation following the tragic drowning in Tromsø

What can we learn about integration and refugee health?

Report 3-2021



Ukom

Our mission

The Norwegian Healthcare Investigation Board, (NHIB) is an independent government agency. Our mandate is to investigate serious incidents and other serious concerns involving the Norwegian health and social care services.

NHIB will investigate the sequence of events, factors that contributed to the outcome and causal relationships. Our purpose is to improve patient and user safety by learning and taking action to prevent future serious incidents. We do not assess civil or criminal liability or guilt.

We decide which serious incidents or circumstances to investigate, as the timing and scope of the investigations, and how this will be executed.

The investigation is performed in dialogue with the parties involved, which include. employees in health care services, patients/users of health care services and their families.

Our reports are public, however we make no references to the names and addresses of individuals involved. The location for the adverse event may in some cases be disclosed. The basis for this investigation is a serious incident that is publicly known, but the individuals have been anonymised to the extent possible.

NHIB's activities are regulated by Act of 16 June 2017 no. 56 on the Norwegian Healthcare Investigation Board(1).

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Introduction

On 2 December 2019, a woman and two of her daughters died from drowning in Tromsø. The third daughter was seriously injured. The woman came from South Sudan and had been granted residency in Norway for family reunification. She had been living in Norway for just over two years.

The incident attracted great interest in Tromsø, including a torchlit vigil, memorial, fundraising for the bereaved and the launch of low-threshold initiatives. Following the police investigation, the prosecution concluded that the mother was the perpetrator and that she acted alone. The criminal case was dismissed since she had also died.

In this report, we refer to the woman as Sarah and we refer to her husband as Adam.

The investigation did not provide reliable answers as to why Sarah acted the way she did. We will also never know whether the support system could have identified her earlier and whether the serious incident could have been avoided.

Tragedies like this happen very rarely in Norway (2), (3). NHIB has chosen this serious incident as the basis for investigating the underlying reasons why newly arrived refugees may experience significant burdens and extreme psychological stress. No-one in the community had realised that Sarah found her existence to be unbearable.

The NHIB investigation seeks to provide answers as to why we are not always able to identify those who need help. The report identifies refugees who have been granted residency in Norway with family reunification which is a particularly vulnerable group.

We highlight factors that may influence whether the health and social care services are in a position to prevent and provide help.

Reunited families and other refugees are a disparate group (4). Our report looks at the situation of women from low-income countries who have been granted family reunification with refugees in Norway.

The report is aimed at employees, managers, authorities and decisi-on-makers responsible for health and social care services and other services for refugees. Employees of the child welfare service, schools, daycare facilities and others with an interest in integration and migrant health may also benefit from the report.

Content

Summary

The investigation shows that there is a risk of newly arrived refugees with special psychosocial burdens and healthcare needs not being identified. Refugees are in an especially vulnerable situation. In particular, there is a risk that the services provided are not adapted for women who are granted residence in Norway with family reunification.

The report highlights several risk areas. These relate to:

- high demands, expectations and pressure that may affect health
- obstacles to seeking help
- lack of flexibility and interaction in the services

NHIB recommends that the Norwegian Ministry of Health and Social Care facilitates all local authorities being able to fulfil their obligations pursuant to the Norwegian Health and Social Care Act and the Norwegian Public Health Act in respect of everyone who is granted residence in Norway with family reunification.

High demands may affect health

For some refugees, the demands of everyday life and the introduction programme end up being more than they are able to manage during the initial period after arrival. Refugees have been through difficult life experiences and undergo an extreme transition with complete upheaval in all areas of life. Their health may be good upon arrival, but the demands and experiences of life in Norway can become a huge burden. Some develop serious health problems.

The obstacles to seeking help are complex and linked to both the refugee's understanding of and trust in the support services and their ability to meet the needs of refugees.

Reunited families require the same close follow-up as other refugees, but the reception system is weaker and more random. The investigation shows that refugees' lives are placed under high pressure after arriving in Norway. The welfare system, including health services, is poorly adapted for the life situation and reality of refugees.

Local authorities have different approaches to how they organise services for new arrivals. There are significant variations in scale, which also varies in line with the influx of refugees. In some local authorities, refugees meet a health visitor only during their initial health check. In other local authorities, the health visitor is co-located with adult learning and easily accessible to new arrivals. Services in Norway are unfamiliar upon arrival and it is difficult to work out what is included in the different services. Refugees often arrive in the country with low levels of trust in public bodies.

The current system is designed so that new arrivals will use the regular health services as soon as possible. These services do not always have the necessary expertise in relation to migrant health.

Inadequate interaction and flexibility

There are many people involved in integration work in a local authority and the exchange of information between them may be inadequate.For example, employees in adult learning may have little collaboration with health and social care professionals. Inadequate interaction results in no-one having an overall overview of the refugee's challenges and needs. Several of the informants in the investigation suggest

that refugees should have only "one door in" to the system.

Individual refugees face several risk factors at the same time. The various systems are organised through disciplines in which participants often work independently. Inadequate interdisciplinary and interagency interaction means that those who are most vulnerable are not identified and the services are not in a position to help. Language barriers are challenging and interpreters are often not available. In order to meet the needs of refugees, it is crucial for the services to have a flexible understanding of the roles and that employees are able to assist with problems that extend beyond their own area of responsibility.

Expert communities related to migrant health are one resource that the local authorities could utilise better. Voluntary organisations also have the expertise and commitment but are not adequately utilised.

Legislation has not been adapted

Safety is paramount for women. The investigation shows that women do not know their rights. This weakens their legal protection.

Legislation and the rights of refugees are not always adapted to the needs of refugees. The purpose of the Norwegian Integration Act (3) is early integration but the act only to a limited extent takes into account the fact that refugees and reunited families are experiencing a pressurised life situation. At the same time that they have to qualify for permanent residency in Norway in a relatively short period of time, the conditions for a good life are also put to the test.

Failure of care following serious incidents

Our investigation shows that there is a risk that those who are affected by a serious incident do not receive adequate psychosocial follow-up.

CHAPTER 1

The incident

The story of Sarah and her family

The story of Sarah and her family

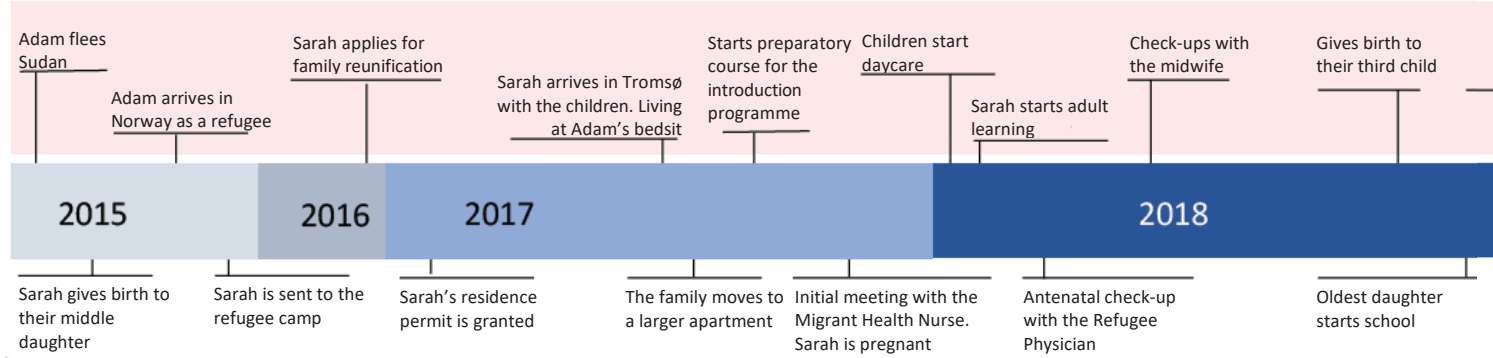
Adam arrived in Norway as a refugee from South Sudan in 2015 and the family was reunited in Tromsø in 2017. He explained that he and Sarah lived in the village where they had both grown up. Their first daughter was born in 2012. Adam supported the family through an office job.

Adam needed protection in Norway. He first arrived at a reception centre for asylum seekers in Alta, where he lived for a year and a half before his residence permit was granted in 2017. He moved to the Municipality of Tromsø, where he joined the introduction programme and started the adult learning programme. He found a job after eight months and left the school. He explains that he would have preferred to study during the day and work in the evenings.

Sarah was 23 years old and pregnant with their second child when Adam fled. She was brought home to her parents-in-law. She gave birth to a daughter two months later. The head of the village believed that her staying there posed a risk to the safety of the residents. She was therefore sent to a refugee camp together with the baby. The oldest daughter, who was three at the time, stayed in the village, where her grandmother looked after her
Sarah applied for family reunification in Norway in 2016 and, after a year, the application was granted. In the autumn of 2017, she and her daughters, who were two and five years old at the time, were reunited with Adam in Tromsø. They moved into Adam's bedsit. After a month, he found a new place to live that was more suitable for the needs of the family.

Adam explains that Sarah was a kind woman and that he never found that there was anything unusual about her after they were reunited. Their shared goal was to create a good and safe life for themselves and their children in Norway.

Sarah's initial contact with the health service was with the health visitor from the migrant health team two months after arriving in Norway. The appointment confirmed that she was pregnant with her third child. She was given an appointment for an antenatal check-up with the refugee physician in January 2018. Soon after, she was allocated a general practitioner and ongoing follow-up during pregnancy took place with the general practitioner and the local authority midwife. Communication between Sarah and the general practitioner/local authority midwife was sometimes difficult, even though an interpreter was used. Sarah visited the local authority midwife several times without an appointment and, without an interpreter, it was difficult for the midwife to understand what she wanted.



Sarah joined the introduction programme in January 2018 and received Norwegian lessons through the adult learning service. She was motivated to learn Norwegian and had a goal of undertaking studies.

She gave birth to the couple's third daughter during the summer of 2018. Sarah was on maternity leave until April 2019. A couple of months after giving birth, her husband noticed that she did not like having contact with people and that she was starting to become isolated.

Initially, the children attended the same daycare facility. The oldest daughter started school in the autumn of 2018. The staff at the daycare facility and at school perceived the children to be happy and social. The parents took it in turns to drop off and pick up the children.

Other than the introduction programme, Sarah's main activities consisted of looking after the children and keeping the house in order. Both parents participated in cooking. She told one of her friends that she did not feel entirely comfortable about everyday activities outside of the home, such as clothes shopping.

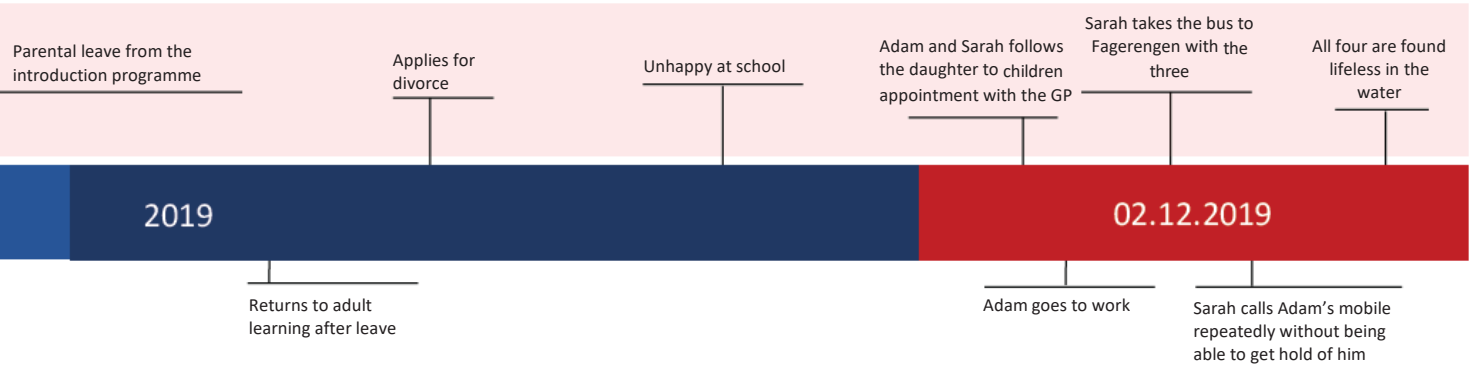
Initially, her learning went well but her satisfaction dropped and she had some absences from school. This resulted in her benefits being reduced.

She wanted to switch to a class at a higher level than the one she had been assigned to i. She found it frustrating to be taught at the level the school considered her to be at.

We are not aware that she sought any help to cope with everyday life. Healthcare professionals that the family were in contact with found Sarah to be proud of her children and that she wanted the best for them. She was concerned about being in good health, afraid of developing cancer and she was committed to ensuring that both she and the children were getting enough vitamins. She therefore asked the health centre for specific advice.

Those who met Sarah say that she was quiet and cautious. At the same time, she appeared to be focused and motivated to progress in the system and establish a life for herself in Norway.

Adam explains that Sarah seemed tired during the period immediately before tragedy struck. She would wake up late and did not want to go to school. He explained that their relationship was difficult and that they had applied for divorce six months previously. They were unsure who would be able to help them, who they could trust and have confidence in. In the last few weeks before she died, Sarah spoke a lot on the phone with her family in South Sudan and acquaintances in Norway.



Lanterns in the snow along the edge of the water following the tragedy. (Photo: Jørn Inge Johansen, NRK)

Monday 2 December 2019

Adam explains that the day started like any normal day for the family. Sarah went to the adult learning centre to sit a Norwegian test and their oldest daughter went to school. He stayed home with the two youngest children. Sarah returned home after her test and together they travelled to see the GP to check a nappy rash that was bothering their youngest daughter. Since she turned up for school and her appointment at the doctor's surgery as normal, he did not consider that she might need any help.

In the afternoon, Sarah did not want Adam to go to work. She was said to have been extremely distraught. After he had left, she took her daughters with her on a bus journey.
She tried to get hold of Adam repeatedly by calling his mobile without any success. Sarah and her daughters got off the bus at Fagereng.

Passers-by became concerned when they came across an abandoned stroller on the bike path by the shore. They feared that something serious might have happened and alerted the emergency services. During the rescue operation, Sarah and her three daughters aged one, four and seven years were recovered from the sea, lifeless. Sarah and her two oldest daughters died. The youngest girl survived.

CHAPTER 2

The new country

The family faces pressure in their new daily life, with many demands

The family faces pressure in their new daily life, with many demands

FACTS

The Norwegian Integration Act:

The purpose of the act relating to integration through learning, education and work (Integration Act) is the early integration and financial independence of immigrants in Norwegian society. The general rule is that those who have been granted residence with a possibility of a permanent residence permit have both a right and duty to participate in learning programmes. The local authorities are responsible for providing newly arrived refugees with the Norwegian lessons, education or qualifications they need.

We have investigated matters relating to newly arrived refugees in Norway and we have paid particular attention to women who arrive for family reunification. Many informants in our investigation noted that families and family members arriving in Norway are put under pressure. This is also described in research literature (5-7). The Norwegian Integration Act(8) sets clear requirements but fails to adequately take into account that new arrivals are in a challenging situation.

We have taken a closer look at how new arrivals may find the establishment phase and, in this part of the report, we will assess how the various services take into account the fact that the families are experiencing a stressful situation.

The new country

Arriving in a new country means that refugees must deal with different values to those they are used to. Both Aambø (9) and Friberg and Bjørnset (10) describe how sociocultural dilemmas are involved:

- Collectivism vs. individualism
- Patriarchy vs. equality
- Honour culture vs. dignity culture
- Religion vs. secularism

Values and standards vary and occupy different positions in different cultures. Tensions may arise between the desire to adapt to a new society and the need to preserve values and identities from home.

What is perceived as status may be different in Norway than in the country the refugees come from.

The power structures may be different. Refugees may state that they recognise that people are worth the same, while many also have values and traditions that become challenging when faced with Norwegian society.

Some refugees find this to be stressful and this can lead to poor health.

The roles of women were often associated with more restrictions and fewer rights back home compared to in Norway. As an example, few people will have experienced their husbands participating in housework and looking after young children. Some aspects of our equality values may appear threatening compared to what may have been stabilising factors for the refugees' lives in their home countries.

The Norwegian welfare state performs functions that family may have taken care of back home. The transition from a society in which family, friends, the tribe, imams and leaders dominate to a thoroughly regulated western society is not easy. The digital society can be hard to understand and cope with during the initial period in Norway. Gaining trust in systems and government agencies can also take time. Figures from Statistics Norway (8) show that refugees that have been in Norway for a long time trust the authorities.

Refugees do not always dare to trust the authorities, for example the police, when they have just arrived in Norway. This must be viewed in the context of the experiences the refugees have had with authorities back home.

The peacefulness in Norway can initially be perceived as peaceful and positive but, over time, it can become a burden because refugees have limited networks. The relief and the pleasant excitement that many experience soon after arriving can later turn into despair as they feel a sense of loss in relation to their home country, their family, friends,

traditions and everything that they know. The winter and the long periods of darkness can be hard.

Dahl (9) describes that the cultural map that refugees bring with them from home does not correspond to the new terrain. Their life situation changes suddenly and everything old has no meaning in the new country. One thing that refugees have in common is that they consciously or unconsciously bring their past and old cultural rules with them. They carry an invisible baggage consisting of a worldview that is based on standards and values that they perceive to be natural and correct. This could have an impact on their understanding of how the relationship between children and adults should be and how men and women should behave towards each other.

The migration process may have similarities to the experience of loss and grief processes. There is no single recipe for the reactions that can be expected or how individuals experience the reality of leaving their home country and living in exile in another country. Nevertheless, there are some typical traits. Individuals may move back and forth between different phases. Such an approach to migration acknowledges the fact that refugees experience loss but also that they experience something positive (9).

Refugees say that arriving in Norway can be a shock. It causes stress reactions. In many ways, these are normal reactions to an abnormal situation. Reactions may persist over time. The culture shock leads to major questions and challenges but the reactions can also consist of minor, absurd and more trivial factors. Loss and grief may be present at the same time as joy.

They also have to live up to the expectations and the explicit demands they face through the introduction programme.

There is reason to believe that the strength and duration of the stress reactions depends on how we, as a society, deal with refugees.

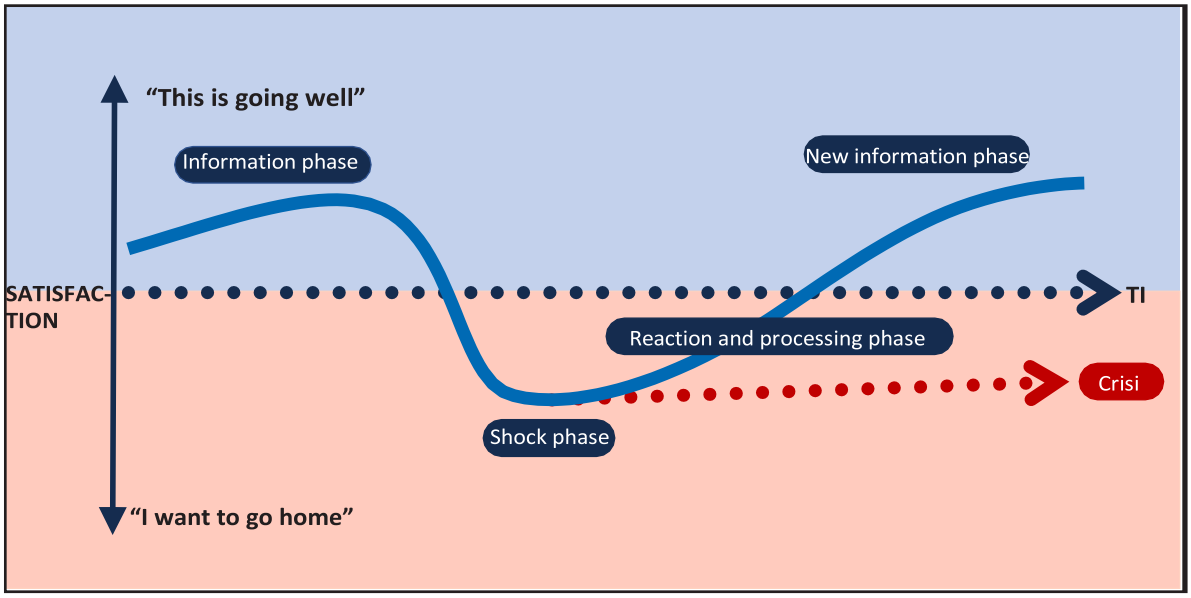


Figure 1: The change curve has been derived from the research conducted by Elisabeth Kübler Ross (Fig. 1). It illustrates a trend that is natural when adapting to a new situation. There is a risk of not being able to enter a new information phase after the shock phase and remaining dissatisfied, which can trigger a personal crisis over time.

Family reunion

It took around eleven months from the time at which Sarah applied for family reunification until she arrived in Tromsø. By that point, it had been two and a half years since she and Adam last saw each other.

Family reunification refers to being reunited as a family after a period of separation. This is most often an unwanted separation and reunification in a country other than the family's country of origin (11). When someone has been granted asylum or refugee status and receives a valid residence permit in Norway, their spouse and children may apply for a family immigration permit (12). If the application is granted by the authorities, a temporary residence permit is issued (12).

For the majority of people, reunification in Norway leads to expectations and hopes of a shared future. At the same time, the family needs to be re-established and this can require major changes from all parties. The joy of being reunited can quickly turn into problems and challenges associated with adjusting to one another in the new country (11).

Inadequate reception of reunited families

Reunited families are not housed by the authorities but most have the same rights as other refugees. Sarah and her daughters arrived directly from South Sudan to Adam's bedsit in Tromsø. She found it stressful to live that way. After a few weeks, Adam managed to find a larger apartment for them.

Both refugees and those who work in the services tell us that poor living conditions mean that life is difficult for families. Local authorities do not adequately take into account the fact that refugees need housing that is adapted to their needs.

The Norwegian Directorate of Integration and Diversity recommends that the local housing authority contacts resident refugees to plan appropriate housing solutions and other services (13).

Under the current scheme, it is not possible for the Norwegian Directorate of Integration and Diversity to know whether family members have applied for or have been granted family immigration permits and the Norwegian Directorate of Immigration does not have a legal basis for disclosing such data to the local authorities. This means that it is coincidental if the local authority actually knows that family members have taken up residence in connection with family reunification.

NHIB's assessment:

- There is a risk of neither the local authority nor the spouse being adequately prepared to welcome family members housed through family reunification.

People who are housed through family reunification often encounter less of a reception service than quota refugees, asylum seekers or other refugees. When it comes to family reunification, the spouse is expected to ensure that their partner and children are introduced to Norwegian society and everyday life

When Sarah arrived in Norway, Adam was already a step ahead when it came to integration. His everyday life was busy with work and school. At the same time, he had limited knowledge and experience of the demands of working family life in Norway and Sarah's needs for assistance.

Guidelines and distribution of responsibilities associated with family reunification are unclear to both the support system and the refugees. Since family reunification is characterised as a private matter, these refugees end up being more vulnerable than other refugees arriving in Norway. When families have been separated, they often struggle with guilt, secrets and changed roles (14).

NHIB's assessment:

- There is a risk of no-one being aware of the challenges faced by reunited families.

Family reunification is challenging

We are aware that Sarah and Adam eventually found their marriage to be fragile but they did not seek any help with this. It is not uncommon for relationship problems to arise in connection with family reunification (11).

Many refugee families carry trauma from home and need help to function as a family in Norway.

Little research has been carried out on reunification in exile. And there is little focus on the fact that problems linked to family reunification are one of the many stresses refugees experience after arriving (11). The waiting period before spouses meet again can lead to uncertainty and distrust within the family. After arrival, families must establish new roles in a society that places different demands on them, for example participation in working life and the way in which they bring up their children. This can, in many cases, be extremely demanding for both women and men.

Informants in the same situation as Sarah and Adam explain that they do not always know where to turn for help and that they cannot always trust other refugees.

Some also describe that they could have benefited from a named contact person who would have given them closer follow-up during their initial period in Norway.

NHIB's assessment:

- There is a risk of the services not identifying and meeting the needs of reunited families that need help.

The different services need procedures and systems to identify families that are struggling. In order to meet the challenges linked to family reunification, some local authorities have had positive experiences of offering family counselling. One example is the "Family reunification in exile" booklet (14). The Norwegian Directorate of Integration and Diversity recommends this booklet to local authorities, but usage varies.

Non-independent residence permit

Several informants raised the link between the regulations on residence permits for reunited families and reunited women's lack of sense of security.

During the period from 1990 to 2017, 13,933 women were granted residence in Norway through family reunification with refugees. Similarly, 3,550 men arrived for family establishment purposes (15, 16). The new arrivals' basis for residence is linked to their spouses' residence permits and the residence permits of reunited family members are generally also subject to the marriage lasting (17). In order for reunited family members to be granted independent, permanent residence, there are requirements for continuous residence in Norway for the last five years, cf. Section 62-2 of the Norwegian Immigration Act (12).

With these rules in force, it can be difficult to get a divorce. A fear of

Illustration photo: Those who are granted residence in Norway through family reunification often find themselves in extremely challenging situations. Public services are not always able to meet their needs.

"Many women live on other people's terms"
Employees in Tromsø Municipality

losing your residence permit may be an obstacle to leaving a marriage. There are reasons to ask questions about whether Norway provides reunited family members with adequate legal protection and whether it is in accordance with the applicable principles on gender equality. The reason is that those who are granted residence subject to family reunification are dependent upon on the person who first arrived in the country. Since this primarily relates to women, this also predominantly affects women.

According to the MIRA centre, inadequate legal processes for reunited female family members may lead to a high degree of insecurity during the first few years in Norway. They believe that women are affected by this both physically and psychologically and that this has an impact on their ability to enter the Norwegian work force, establish independent finances and support themselves.

An independent residence permit will, for some, be a prerequisite for being able to settle and experience a good life in Norway (15).

Section 52 of the Norwegian Immigration Act (12) includes further rules on the right to continued residence permits for reunited family members if the spouses decide to separate.

The requirement is for residence to be necessary to ensure access to children. Discretion is used in the legal consideration of such cases. It can therefore be difficult for new arrivals to know their rights. It is also difficult for those working for the local authority services to provide correct guidance regarding the regulations.

According to our understanding of the provisions, it can be difficult for reunited family members to predict their legal position. This creates insecurity in relation to their livelihood.

Derived refugee status

Those who have been granted residence subject to family reunification may apply for "derived refugee status" (19), (12) pursuant to Section 28-6 of the Norwegian Immigration Act (12), with the exceptions set down in Section 7-2 2 of the Immigration Regulations (20). None of the informants in our investigation discussed this scheme.

The provision is intended to secure a residence permit for reunited family members on an independent basis as a refugee. Such a refugee status will provide the reunited family member with the same rights as the spouse that arrived in Norway first.

The applicant will be issued with a travel document for refugees. This means that the applicant cannot return to their home country.

The Norwegian Directorate of Immigration provides information about the right to apply for derived refugee status in the decision letter when family reunification is granted. Nevertheless, we still raise the question of whether it is a well enough known fact that spouses and cohabitants that are granted residence in Norway subject to family reunification can apply for derived refugee status. Another question is whether those who are granted derived refugee status actually know what rights they have.

Sarah's right to residency in Norway was linked to Adam's residence permit. For Sarah and the children, the conditions for derived refugee status would likely have been met, but no residence permit application was submitted for them on these grounds.

There are reasons to question whether the rights linked to residency for reunited family members are sufficient to give women peace of mind in the event of divorce.

NHIB's assessment:

- There is a risk of women who arrive for family reunification not being aware of their rights linked to residency.
- There is a risk of the services not being able to provide the right advice about rights.

Local authority services for new arrivals

Sarah soon became busy with the introduction programme, meetings with various local authority agencies and the children settling in at the daycare facility.

The investigation provides clues that Sarah gradually become more and more distraught without this being identified by anyone in the services.

The local authority services are intended to provide crucial support during the establishment phase. Refugees meet with agencies that help with housing, finances, work, education and health.

Norway has obligations under international law to safeguard refugees that arrive in the country. Among other things, Norway is part of the "Convention Relating to the Status of Refugees" (21), which affirms the right of all humans to seek protection in another country. The Convention safeguards some of the rights of refugees. According to Article 23, the states shall "accord as favourable treatment as possible to refugees, and, in any event, no less favourable than that generally accorded to aliens in the same circumstances."

The Norwegian Integration Act (5) is intended to contribute to refugees' integration into Norwegian society. Other legislation safeguards refugees' rights to services in line with the Convention Relating to the Status of Refugees. For example, refugees who are legally resident in the country have an equal right to health and social care services as the general population.

The local authorities use various models to organise the introduction programme. The programme may be organised on behalf of the Norwegian Labour and Welfare Administration, the local authority refugee office or the adult learning services. In Tromsø, the refugee service has the primary responsibility for the introduction programme. Social education and Norwegian language teaching are delivered by the adult learning services (22).

We can see that there is some overlap between the areas of responsibility of the agencies involved. Upon arrival, everyone will meet with the refugee health service in the local authority.

Some local authorities refer to this service as the migrant health team/refugee health team. In Tromsø, both of these terms were used to refer to the service.

Refugees also receive other ordinary services from the local authority, such asdaycare provision, school, day care facilities for schoolchildren, health services and child welfare services if required.

The support needs of refugees can be complex and unspoken. One challenge is that newly arrived refugees often have not adjusted to the ordinary support system, which they may perceive as very rigid.

NHIB's assessment:

- There is a risk of refugees being unable to get help with their needs, as they do not know who to ask for help.

Flexible, creative local authority employees that refugees trust often see solutions and can open doors and help ensure that refugees receive the right help.

Demands on new arrivals may affect health

When Sarah arrived in Norway, she initially attended a short preparatory course. After three months, she started attending the adult learning element of the introduction programme. By this point, the children were attending a daycare facility and she was expecting their third child. The programme was interrupted when she was on maternity leave.

When refugees start the introduction programme, this triggers an entitlement to a benefit intended to cover living costs. The programme requires goals to be set for participants to qualify for work or higher education.

Individuals attending Norwegian lessons will have different qualifications and educational backgrounds and the teaching must be adapted to the needs of the individual. The Act states that the local authority must draw up an overall integration plan based on skills and career mapping. The plan must be assessed at regular intervals and in the event of significant changes to the participants' life situation, cf. Section 15 of the Norwegian Integration Act (5).

Service employees state that they are aware of the fact that family members who are granted residence subject

FACTS

Services available for refugees in the Municipality of Tromsø:

The refugee service: The main task is to house refugees and run introduction programmes for refugees. This is organised under the department for health and social care (10).

The introduction programme: A full-time programme for resident refugees, which includes Norwegian lessons as part of the adult learning service and other qualifying initiatives delivered on behalf of the refugee service (10).

Adult learning: The school's services predominantly cover three key areas: Norwegian with social education for refugees and immigrants, primary and lower secondary education for adults and special education for adults. This is organised by the department of childhood and education (22).

The Norwegian Labour and Welfare Administration: Financial benefits, allocation of temporary local authority housing, facilitation of work. Organised by the department of health and social care (23).

Housing office: : Financial benefits, allocation of temporary local authority housing, facilitation of work. Organised by the department of health and social care (23).

Refugee health service: Provides health services to new residents, refugees and reunited family members. This is organised by the department of health and social care but is not part of the same section as the refugee service. (10).

to family reunification have a lot to deal with, comprehend and manage at the beginning. Everyday life for refugees quickly becomes busy and they need to deal with a host of unknowns without being familiar with the Norwegian language and culture.

NHIB's assessment:

- There is a risk of the introduction programme and integration plan, together, entailing excessively high expectations in the beginning.

The introduction programme will last a whole year and will be full-time. There is no opportunity to attend part-time. Undocumented absences result in benefit deductions. Time off for e.g. doctor's appointments must be authorised by the school. The attendance requirement for the introduction programme may conflict with other demands and needs.

Save the Children, for example, has highlighted the fact that it can be very difficult for parents to ensure proper care and safeguarding of their own children during the integration phase when also attending this programme for 37.5 hours a week. Save the Children is calling for more adaptation and flexibility in the scope of the introduction programme for those with children (24).

NHIB's assessment:

- There is a risk of the attendance requirement being too strict during the establishment phase, as it does not allow for individual adaptation.

A refugee who is granted residency subject to family reunification faces many expectations and demands in Norway.

During the initial period, Sarah had recorded absences due to other appointments and practical responsibilities, such as meetings with the Norwegian Labour and Welfare Administration, daycare facility and midwife. She was learning Norwegian while also having experienced a major upheaval in her life and having to familiarise herself with a new life. The integration programme also includes requirements relating to attendance and progress. For Sarah, it was difficult to reach the goals she had set. Nevertheless, she wanted to switch to a higher level. The school assessed the basic literacy class as the right level for Sarah. This class is intended for those who have barely attended school before arriving in Norway.

NHIB's assessment:

- There is a risk of participants in the introduction programme failing to reach their goals and this can be perceived as an additional burden during a difficult period

The conditions for a positive learning environment are compromised for these people. Since adult learning students are not entitled to a named contact teacher, it can be difficult to identify students experiencing challenges or difficulties and to assist them in seeking help.

Section 4a-2 of the Norwegian Education Act (25) states that adults who do not get satisfactory benefit from their education are entitled to special education. Since Sarah was part of the basic literacy class, which is not part of primary and lower secondary school, she would not have been entitled to special education pursuant to Section 4a-2. If she had been able to move up to primary and lower secondary level, she would have been entitled to this.

According to the Norwegian Integration Act, (5) the individual is responsible for learning the Norwegian language and familiarising themselves with Norwegian society. They are required take final tests and must achieve certain competence goals in order to apply for a permanent residence permit (12), (26).

This means that individuals may experience significant pressure to achieve sufficient competence in Norwegian and social education. When participants are conscious of the competence requirement for residence permits and citizenship, not being able to master the learning may be perceived as an additional burden.
The new Norwegian Integration Act intends to take individual differences into account but, so far, there is no experience of how the new act is working in practice.

In the book "Asylsøkere og flyktninger" (Asylum seekers and refugees), Opaas (27) writes that concentration and memory problems are a problem for many new arrivals in a school situation. Refugees explain that this leads to a negative process that may entail low self-esteem, shame, refugees dropping out of school and becoming isolated (28). They might experience a lack of mastery and for some, the feeling of not being good enough may feel insulting.

Successful integration is often associated with a degree of employment. As an example, the government states in its draft budget that there are challenges associated with the integration of women from non-western countries and references their degree of employment in this context (24). This is also reflected by the introduction programmes, which largely focus on initiatives relating to education and competence and that are required under the Norwegian Integration Act. These are also the areas that local authorities are required to report on (29). There is much less attention afforded to other significant areas, such as health and psychosocial functioning.

NHIB's assessment:

- There is a risk that refugees might experience an overall performance pressure that negatively affects their health.

The new Norwegian Integration Act (5) includes a requirement for training courses in parental guidance and life skills. The life skills course (30) is intended to strengthen the participants' motivation and skills in relation to the new expectations and a new society. Physical and mental health, as well as psychological reactions to migration, are topics that will be covered in the course and the recommendation is for healthcare professionals to be involved in the life skills course.

Everyday life as part of the introduction programme

We have no in-depth knowledge of how Sarah experienced school but we do know that she found it socially challenging during certain periods. Teachers explain that it can be difficult to notice what is going on in the school community as they often do not speak

the refugees' language. The classes consist of people from different cultures and this, in itself, can result in some people feeling that they are left out. In some cases, reputation and rumours may also lead to refugees experiencing negative social control (31).

NHIB's assessment:

- There is a risk that women who have been reunited with their families may experience loneliness and not have anyone to share their challenges with.
  This can lead to a sense of failure to cope and increased stress.

Refugees may find it difficult to know who to trust and they may be afraid to open up and share their concerns. According to Sveaas, Reichelt and Berg, (11) social support, particularly emotional support, is one of the key prerequisites for having an optimal ability to cope and survive in difficult situations. Networks and family appear to be important protective factors. The longing for everything and everyone you have lost and having to carry many strong emotions that you are unable to share with others may lead to great internal loneliness (27).

"Reunited families are more vulnerable. This is a critical period. There are no great tools in the administration of law."
Municipality of Tromsø employee

Even when something goes seriously wrong, the external signs may be minor. Those working with refugees must therefore be sensitive and identify those who are experiencing difficulties and that find themselves in a complex life situation. Here, there may be a need for closer collaboration with health and social care professionals with psychosocial expertise. There are currently no requirements for there to be local health and social care services that can act as a low threshold initiative for new arrivals.

As with many refugees in the introduction programme, we can see that Sarah's everyday life was hectic and challenging and she faced many demands.

Child murder is rare in Norway

According to homicide researcher Vibeke Ottesen, (2) child murder rarely takes place in Norway. 61.5 percent of those who killed their own children were suicidal and 18 percent were psychotic (32). Furthermore, Ottesen has explained that parents that commit child murder do so because they love their children. Such child murders may be understood as an act the parent feels is in the best interests of the child in situations in which they feel they are not enough and want to protect them.

The tragedy in which two of the children and Sarah died can be interpreted as part of a controlled act of love by an extremely distraught mother. We assume that Sarah found life to be extremely difficult.

However, we will never gain accurate knowledge of the state Sarah was in on the day when the act was committed

Chapter 3

Service provision

Service provision

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

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

NHIB's assessment:

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

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

In combination, stressors may constitute a major burden. According to Bhopal, (4) socioeconomic status has a significant impact on refugee health.

Bhopal believes that this is something that has received inadequate attention, but recognises that it is a political issue that has not been adequately discussed.

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

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

Service provision as experienced by new arrivals

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

The Municipality of Tromsø has a dedicated refugee health service. The

service is aimed at recently settled residents who are participating in the introduction programme.

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

According to the National Strategy on Migrant Health (2013-2017), (37) the service provision for people with a migrant background must be part of the overall health and social care services. It must be designed based on local conditions and must be accessible to users. At the same time, political guidelines and the national guide for health services for asylum seekers, refugees and reunited families "Helsetjenester til asylsøkere, flyktninger og familiegjenforente" (36) state that the ordinary services must safeguard those who require assistance with mental health issues and psychosocial problems. All the time during which refugees may experience symptoms that the services do not possess the expertise or capacity to identify poses a risk of the group not receiving equal health services compared to the general population.

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

Inadequate mutual cultural understanding and language barriers make the meeting between the service provider and the newly arrived refugee that may require assistance more difficult. As an example, we can reference Eline Skirnisdottir Vik's research (38). She has taken a closer look at how migration-related conditions have an impact on stillbirths. Vik shows that there is an increased risk of complications and deaths among minority women. Documentation shows that there was

inadequate communication between the woman giving birth and healthcare professionals in 47 percent of stillbirths. Furthermore, Vik is also conscious of the fact that midwives experience difficulties when it comes to recording a proper medical history when meeting women who do not speak Norwegian and who are not familiar with the health service. This makes it difficult to make good decisions.

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

How might refugees experience the health and social care services?

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

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

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

NHIB's assessment:

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

Mental health among immigrants

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

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

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

Illusttrasjonsfoto

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

NHIB's assessment:

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

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

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

NHIB's assessment:

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

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

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

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

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

Municipality of Tromsø employee.

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

NHIB's assessment:

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

Refugee health team

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

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

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

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

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

NHIB's assessment:

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

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

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

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

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

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

service may be perceived as unsafe if the family has developed trust in the refugee health service.

NHIB's assessment:

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

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

GP services

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

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

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

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

There are reasons to believe that this plays a part when GPs meet refugees. All the time during which a significant proportion of the Norwegian population originates from other cultures, there will be a risk if doctors do not have the necessary expertise when dealing with patients from other cultures.

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

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

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

NHIB's assessment:

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

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

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

NHIB's assessment:

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

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

NHIB's assessment:

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

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

Midwifery services

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

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

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

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

It can be difficult for a midwife to follow up on matters like these because the services are organised under different agencies. There are no interpreters

available when women turn up to see the midwife unannounced. The investigation found that when the midwife, health visitor and other services are flexible and able to see the whole picture, they are also able to meet many of the needs.

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

NHIB's assessment:

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

Midwives may find that women speak with them in confidence. They may, for example, talk about a longing for their home country or that they miss their sisters and mother.

The midwifery service can therefore gain a better insight into the situation of these women than is the case for the other services.

Health centre services

Refugee families with young children have early contact with the health service through the health centre. All three of Sarah and Adam's girls followed the health centre programme and one of the children was offered additional support. The parents explained that they were concerned about showing that their children were not following normal development. They were afraid that the child welfare services would be notified. In this way, the health visitor may, by some, be perceived as a threat.

NHIB's assessment:

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

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

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

Child welfare services

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

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

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

NHIB's assessment:

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

Use of interpreters

An interpreter was not used for many of the meetings Sarah had with the services. The healthcare professionals we spoke with said that the use of interpreters can be complicated. Equal health and social care services and equal access to services require adequate language skills or the use of an interpreter (27). The right to the necessary use of interpreters is enshrined in international agreements such as the UN Racial Discrimination Convention from 1965, ratified by Norway in 1970 (56) and incorporated in the Norwegian Public Administration Act (57), the Norwegian Patient and User Rights Act (58), the Norwegian Specialist Health Service Act (59), the Norwegian Healthcare Professionals Act (60) and the Norwegian GP Regulations (Section 28) (61).

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

agencies. The act will also ensure that interpreters maintain sound professional standards (62).

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

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

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

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

NHIB's assessment:

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

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

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

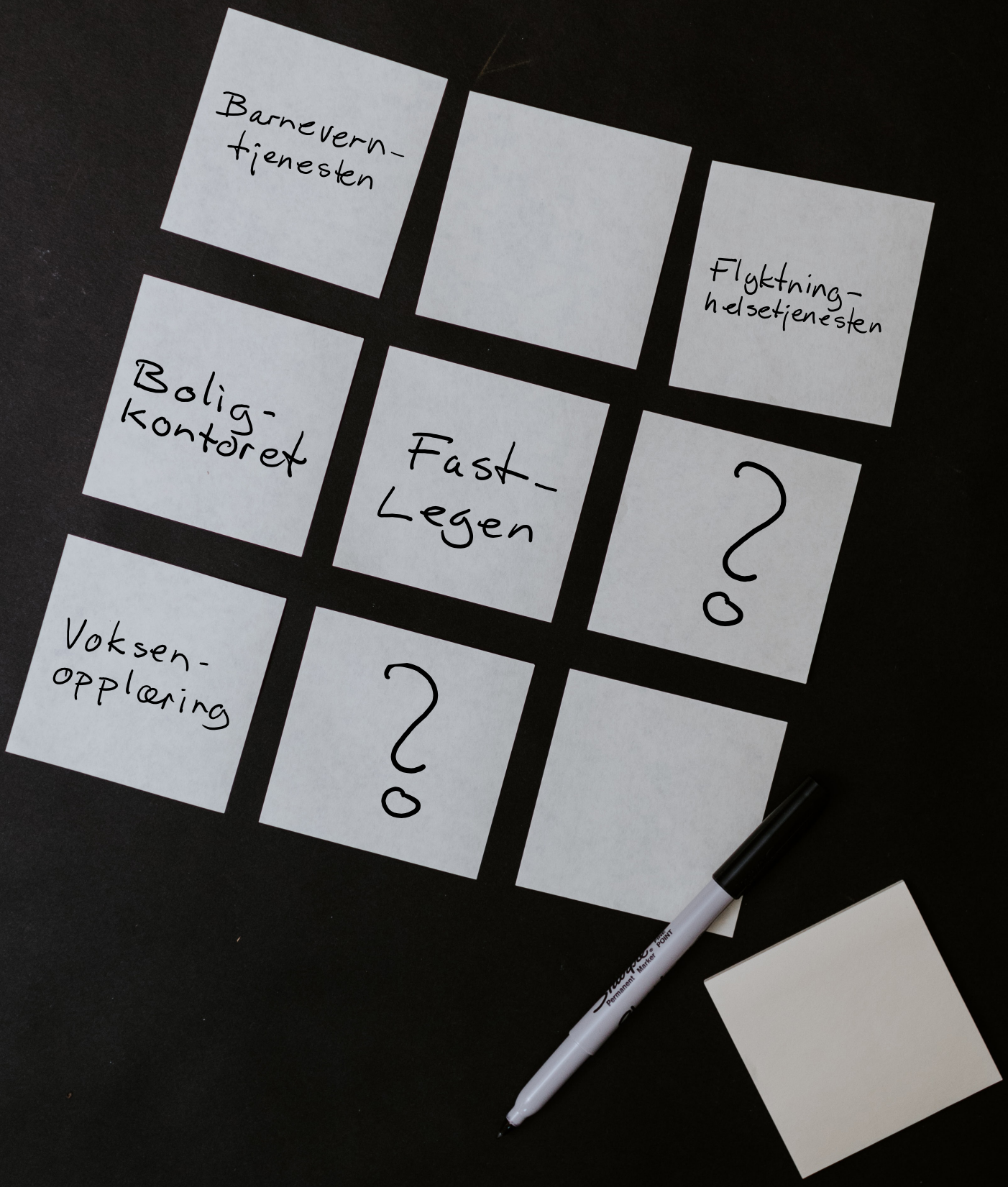
Misunderstandings may arise when someone with insuffcient language experience translates a nuanced message. There could also be a risk that the woman will not receive the entire message or all of the options if their spouse interprets.

NHIB's assessment:

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

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

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


Barnevern-
tjenesten
Flyktning-
helsetjenesten
Bolig-
kontoret
Fast-
Legen
?
Voksen-
opplæring
?

CHAPTER 4

Interaction

Interaction between various services

As described, several agencies met with Sarah and the family. These parties were not aware of there being anything serious bothering Sarah. In retrospect, several of them have asked themselves whether there was anything they should have noticed. The investigation shows that Sarah experienced major stress overall.

It transpires from the interviews that there may have been a need for greater interaction between the agencies. Employees had limited knowledge of the different areas of responsibility and dealt with different pieces of legislation. There was limited collaboration between e.g. the health service and the adult learning service.

NHIB's assessment:

- There is a risk that the frag mentation of the services will mean that no-one has a complete overview of the living situation of the individual refugee.

We find that there were several factors that the family found difficult. Together, these may have constituted a problem.

"In retrospect, I can see that there is no-one who has a complete overview of the person as a whole. There is always a focus on the introduction plan. I did not know the husband, I did not meet the children and family was the most important part of her life."

"Municipiality of Tromsø, employee"

The different services concentrate on providing support in line with the regulatory requirements applicable to their own service. Other needs for support may therefore have been ignored. One of the informants stated that he wished that the service had had a better overview of Sarah's situation.

The refugee service focused on the introduction programme and the individual plan.

Individual indicators were not enough for any individual service provider to react. The introduction programme does not adequately focus on identifying whether participants are experiencing health difficulties or are struggling in other ways. If the different service providers had had the opportunity to consolidate information, they might have realised that the family and the woman had a particular need for help.

When there is no specific system in place for interaction between the various agencies, symptoms may be ignored and refugees may not receive the facilitation and support that they need.Some providers note that the understanding they have of the duty of confidentiality also poses a hindrance to proper interaction.

There is a risk that the system does not allow for interaction that would provide an adequate overview of issues.
The services are therefore unable to identify families and individuals who require additional follow-up.

A more interdisciplinary approach may make it possible to identify those who require more support, help and facilitation. It is difficult for refugees to know who to turn to. The reasons for this may be linked to not being familiar with Norwegian services. One example of this is that many refugees raise issues relating to their housing situation with many different service providers.

NHIB's assessment:

- There is a risk that refugees do not know who to turn to with various questions

A study conducted by Agderforskning found that adult learning teachers would sometimes be constantly involved in assisting their students with everyday challenges. At the same time, teachers found that there was little flow and interaction within the services and the teachers therefore became the link between the immigrants and the services (69).

In order to provide proper services to refugees, service providers need to have a flexible understanding of their own role, both in terms of time and the duties they assume. The needs of the refugees are diverse and their understanding of the system is limited, they are also dependent upon gaining trust in the person who will assist them. This has been highlighted by both the Norwegian Association of Local and Regional Authorities (42) and in interviews with service employees and specialist communities during our investigation.

NHIB's assessment:

- There is a risk that the parties will be unable to meet the needs of the refugees if they stick strictly to their own too limited an understanding of their own role.

This means that service providers should rarely refuse an enquiry but rather assist the refugees to reach other parts of the system if there are other agencies that are more appropriate. Those who refer refugees within the system must ensure that other agencies or service providers actually address the issue. Several people called for "a single point of entry" for new arrivals.

The Norwegian Public Health Act (70) also notes local authorities' responsibility for interaction between different sectors. The act stipulates that public health is a responsibility in all sectors and at all levels of public administration. The act is based, among other things, on the principle of health in everything that we do, the precautionary principle and the principle of participation and the equalisation of social health differences. The investigation shows the importance of the entire local community when it comes to welcoming newly arrived refugees and identifying needs for support. The local authorities must promote public health and ensure that services are coordinated.

Interaction with voluntary organisations

The refugee health nurse explained how voluntary organisations can be somewhere to meet, somewhere to seek advice and a place where refugees can feel that they belong. The refugee service and the adult learning service in Tromsø collaborate with volunteers and organisations that make a difference to integration work. According to the Norwegian Public Health Act, (70) the local authorities must accommodate collaboration with the voluntary sector. The Norwegian Directorate of Integration and Diversity (71) notes that volunteers may help make the transition to Norwegian society easier for refugees. Report to the Storting no. 13 (2018-2019) "Muligheter for alle - Fordeling og sosial bærekraft (Opportunities for all - Distribution and social sustainability) (72) states that refugees' own participation in voluntary work may strengthen their influence and participation in society.

Refugees are often used to leaning more on their networks and families than public providers. Many of those we have spoken to have highlighted the importance of volunteering and have

described how they use this in their work. Several refugees explained that they use various voluntary services for language training and to get to know others.

Several voluntary organisations also work to provide guidance about the public system and the rights of refugees. The refugee health nurse provides information about the services and refers some refugees to such services. Other interviewed refugees had less knowledge of the various services that are available.

We have not been able to find a single system or procedure to ensure that refugees gain knowledge of the voluntary services that may be relevant to them. It rather seems to be somewhat random what information is provided. Collaboration between local authorities and volunteers may be more or less formalised. The voluntary organisations want the local authorities to finance the use of interpreters when they assist new arrivals.

NHIB's assessment:

- There is a risk of the potential of the voluntary organisations not being adequately known and not benefiting the refugees if there is no formalised colla boration with the local autho rity.

The local authorities have a duty to provide statutory services, but voluntary organisations are still a key resource. Even though the primary responsibility falls to the local authority, the organisations still have important expertise and experience that may help strengthen the efforts of the local authority. A knowledge summary from the Institute for Social Research (73) has called for greater knowledge of e.g. collaboration types, obstacles and success factors in collaboration between the authorities and voluntary providers.

Follow-up and safeguarding after serious incidents

In accordance with the act relating to health and social contingency (74) and the regulations relating to contingency planning, (75) the local authorities must have a contingency plan in place for how to manage crises and disasters. After the incident, the local authority mobilised crisis staff in line with the local authority's contingency plan. This is a time-limited measure. The primary task of the crisis staff was to deal with the authorities and the media. The staff also investigated whether appropriate services had been provided to the family. No irregularities were found.

A serious incident such as the one that took place in Tromsø primarily affects the family. However, the immediate network and acquaintances of those involved, local authority employees and the local community were also strongly affected.

Adam did not feel that anyone from the local authority safeguarded him after the tragedy.

Local authority employees also noted that there was a lack of systematic crisis management and follow-up. Several of them said that the interview with NHIB was the first opportunity they had had to talk about their own experiences. They were concerned that other affected parties might also not have received adequate support in the period following the tragedy. Some stated that several other refugees experienced strong reactions. This included fellow students at the adult learning service.

The local authority's psychosocial crisis team was part of the mobilisation effort and the team was in contact with some of the affected services.

NHIB's assessment:

- There is a risk that not everyone who is affected by an incident will be safeguarded by the local authority.
- There is a risk that employees are not safeguarded.

According to the Norwegian Directorate of Health's guide for psychosocial initiatives in the event of crises, accidents and disasters, (76) psychosocial crisis teams will be responsible for early intervention in connection with psychosocial follow-up. The crisis teams will also contribute to ensuring that affected individuals, families and local communities are offered proper psychosocial follow-up and support from the regular services after critical incidents.

Proper safeguarding also has an impact on the safety of employees and therefore also the quality of the service. Follow-up is part of the health and social care services' duty of care. The local authorities have great freedom in how to organise and accommodate such follow-up.

In Tromsø, the psychosocial crisis team scheme is a voluntary scheme. Capacity and response times may therefore vary and it is not guaranteed that everyone who needs the service will be able to access it. Informants give us the impression that employees, managers and staff have different understandings of who is responsible for safeguarding affected parties and the scope of such responsibility.

NHIB's assessment:

- There is a risk that local autho rities will fail to ensure follow-up at all levels within their own organisation in the crisis management of very serious incidents.

It is important to reach those who are directly and indirectly involved, as well as non-employees, such as GPs. The municipal management team was keen to discover any failures in the services received by Sarah. The crisis management and subsequent follow-up have not been evaluated by the local authority.

One of the mosques in Tromsø invited various agencies to participate in dialogue after the incident. NHIB considers this to be an important initiative, even though it did not lead to specific follow-up measures.

CHAPTER 5

Recommendations

Recommendations for the central authorities

The scope of application for NHIB is the health and social care service and our recommendations are aimed at this sector. The recommendations from this investigation are addressed to the Norwegian Ministry of Health and Social Care as the administrator of the Norwegian Health and Social Care Act (77) and the Norwegian Public Health Act (70).

NHIB recommends that the Norwegian Ministry of Health and Social Care, as the sector administrator, facilitates all local authorities being able to fulfil their obligations pursuant to the Norwegian Health and Social Care Act (77) and the Norwegian Public Health Act (70) in respect of everyone who is granted residence in Norway with family reunification.

This means that the national authorities should:

- systematically inform local authorities of refugees who are granted residence with family reunification
- set down requirements concerning health and social care expertise for the introduction
- allow for refugees' participation in the introduction programme to be adapted to the individual's state of health and care situation
- assess clearer standardisation in the field of migrant health.

FACTS

The Norwegian Health and Social Care Act (77) has the following purpose, cf. Section 1-1:

- to prevent, treat and facilitate coping with disease, injury, suffering and disability,
- to promote social security and better living conditions for the disadvantaged, to contribute to people being valued equally and gender equality and to prevent social problems,
- to ensure that each individual has the opportunity to live and dwell independently and to have an active, meaningful existence in fellowship with others,
- to ensure the quality and equality of the services offered,
- to ensure coordination and that the services offered are accessible to patients and health care users and to ensure that the services offered are adapted to the individual's needs,
- to ensure that the services offered are organised in such a way that respects the individual's integrity and dignity, and
- to contribute towards the best possible use of resources.

Section 4 of the Norwegian Public Health Act (70) formulates the responsibility of the local authorities as follows:
The municipality shall promote the population's health and well-being, as well as good social and environmental conditions; contribute to the prevention of mental and somatic illnesses, disorders or injuries; contribute to reducing social inequalities in health and contribute to the protection of the population against factors that may have a negative impact on health.

Useful tools in local authorities' work with refugees

We have found that the useful tools that have been developed are used only to a limited extent. In this context, we would particularly like to mention:

- The national guide to health services for refugees, asylum seekers and reunited families (36). In this guide, the Norwegian Directorate of Health provides, among other things, specific recommendations relating to the content of the services.
- The guide booklet "Familiegjenforening i eksil- Forebygging gjennom familiesamtaler" (Family reunification in exile - Prevention through family meetings) (14). The Norwegian Directorate of Integration and Diversity recommends that the services use this booklet. The booklet was developed by RVTS Midt in collaboration with the refugee health team in the Municipality of Trondheim, the Department of Psychology at the University of Oslo and the Department of Social Work and Health Sciences at the Norwegian University of Science and Technology.
- Ten helpful steps for the introduction programme. The Norwegian Association of Local and Regional Authorities has drawn up advice to increase the chances of success (42).

NHIB recommends raising these questions as part of the local authorities' improvement efforts.

The regulations relating to management and quality improvement (78) aim to contribute towards professionally sound health and social care services, quality improvement and increased patient and user safety. A guide (79) has been developed for the regulations and describes how organisations can work on improvements. aOur assessment is that this methodology can be useful even if the risk areas are cross-sectoral. The investigation has highlighted the fact that interaction between all local authority services is important in order to meet the needs of refugees.
As part of continuous improvement work, the services may use these questions to identify their own risk areas:

- How do we ensure an overview of who is granted residence with family reunification so that they are allocated suitable housing and immediate follow-up?
- What procedures do we have in place to provide information about the right to independent residency in Norway, particularly in relation to derived refugee status?
- How do we ensure that refugees understand the information we provide about our welfare services, including the child welfare services?
- How do we help reunited families so that they can find services and support when they need them?
- How do we ensure adequate expertise in migrant health in all services that deal with refugees?
- How do we ensure that preventive health and social care services are available to refugees as part of the introduction programme?
- How do we ensure a flexible transition from the refugee health service to the regular health service?
- How do we ensure systematic interaction and flexible understanding of roles among everyone who provides services to refugees so that, together, we can identify those who are struggling?
- How can we benefit from external expert communities?
- How do we ensure proper collaboration with voluntary organisations?

CHAPTER 6

Method

Method selection

Our investigation is based on information collected from interviews, records, police investigations, public documents, statistics, academic literature and dialogue with several professional and expert communities, as well as special interest organisations. The information has been sorted and analysed to identify any findings that may shed light on causes and risks. During the discussion, we have elevated our findings to a thematic level.

The investigation has been conducted according to the NHIB method for investigative processes. We are also inspired by and have, in consultation with the Norwegian Safety Investigation Authority, used some of the tools from their safety framework and their analysis process for systematic investigations (80).

Interviews

We initiated the investigation by contacting the spouse of the deceased and the municipal management of the Municipality of Tromsø. Between two visits to the municipality, we conducted interviews with a total of 28 people who were involved in the specific incident or were familiar with the work with refugees in Tromsø. The interviews included the spouse, refugees/students at the adult learning centre, the GP, the refugee doctor, the local authority's chief medical officer, the refugee health nurse, health visitor, midwife, refugee service employees, the adult learning service, the Norwegian Labour and Welfare Administration and the daycare facility, managers at different levels in the local authority, the regional resource centre on violence, traumatic stress and suicide prevention (RVTS Nord) and the mosque.

Audio recordings were taken at all interviews and were subsequently transcribed. In some cases, supplementary information was collected before the report was finalised. The purpose of this was to clarify any ambiguities and to quality-assure the information that was used. The interviews were semi-structured, with an emphasis on open, exploratory questions.

Written documentation and other sources

We have had access to the medical records, some of the police documentation and we have familiarised ourselves with public documents on the subject of integration. We have also followed the media coverage of the incident.

Throughout the investigation, we have been in contact with specialists at the Norwegian Institute of Public Health, the Norwegian Directorate of Integration and Diversity, the Norwegian Directorate of Immigration, the Norwegian Association of Local and Regional Authorities, the Norwegian Safety Investigation Authority, the Regional Resource Centre on Violence, Traumatic Stress and Suicide Prevention (RVTS Midt), the Norwegian Centre for Violence and Traumatic Stress Studies, the Norwegian Directorate of Health, the Transcultural Centre, the police and the following special interest organisations for refugees: INLO, NOAS, SEIF and MiRA.

We would like to thank Vibeke Ottesen and Hilde Frafjord Johnson for their input.

Analysis and causalities

Based on interviews and the documents obtained, we examined the material

to identify factors that contribute to women who settle through family reunification experiencing particular difficulties. Factors that stood out were sorted into different risk areas and analysed with regard to whether they were relevant to the investigation and whether they could provide possible explanations.

Our understanding and use of the term risk in this report is based on Aven's (81) definition of risk: "Risk: = the incidence of an event and subsequent consequences, as well as associated uncertainty (it is uncertain which events will occur and what the consequences will be)."

Furthermore, we also conducted a causal analysis of the risk areas. In this, we looked at the underlying causes at various levels (MTS (man, technology, surroundings), organisation and management factors as well as framework factors).

During this phase, we used "Why-because analysis (WBA)", which moves from the operational and technical levels to the more underlying level. The idea is to repeatedly ask the question "why" to search for explanations "because" (82).

This can also be viewed as a variant of AcciMap. The method is based on asking why the incident happened in order to identify all factors that caused the incident to occur or failed to prevent it from occurring. AcciMap analyses the surrounding factors to identify failures at system level. By asking why for each causal factor, it will be possible to identify failures. This may provide a representative, general overview of the system. In this way, we can become better at preventing events (83, 84).

Validity requirements

In questions about the reasons why an event occurred, hindsight is often a source of error that it is important to be aware of. It is not possible to test the causal explanations. In order to support our understanding of the causalities and the necessity of the recommendations, we have assured ourselves of the following:

- Descriptions, findings and recommendations have been presented to the investigated local authority and informants.
- The explanations can be linked to documentable events or phenomena as they appear in written reports, specialist literature and/or statements in interviews.
- Findings and recommendations have been discussed with several professional and expert communities, professional organisations, special interest organisations for refugees and other authorities. Overall, we have been in contact with a total of 27 different service providers throughout the investigation and the final round of input. Each service provider has been represented by one to six people during meetings with us. Several of the comments they have provided as input have been included in the report. Throughout the investigation, we have engaged in dialogue with and received useful input from NHIB's reflection panel (85).

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