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Health promotion in the integration of newly arrived migrants in northern Sweden

Background: Migrants, especially forced migrants, have an increased risk of ill health. Having a structural focus on health is crucial for battling health inequities. Actors outside the healthcare services are important to promote health, and both policy and political context are thus key to promoting the health of newly arrived migrants in Sweden. The aim of this thesis was to explore approaches to health promotion within the multi-level governance of the integration of newly arrived migrants in northern Sweden.

Methods: Different methods of data collection and analysis were used in the thesis. For Study I, policies relevant to Sweden's Establishment Program were analyzed using discourse analysis. For Studies II and III, a questionnaire on politicians' views on their roles, responsibilities, and possibilities to promote the health of newly arrived migrants was created based on interviews with politicians. In total, 667 politicians answered the questionnaire, and both bivariate and multivariate analyses were used. For Study IV, a secondary analysis of focus group interviews was performed. The interview transcripts were analyzed using content analysis. Finally, Study V consists of interviews with civic communicators who work within the civic orientation for newly arrived migrants in Sweden. Thematic analysis was used to analyze the transcribed interviews.

Results: The policy documents that described the Establishment Program in Sweden contained no explicit definition of health. The discourses of health showed a medicalized and individualized view of health, where ill health was considered a risk (Study I). Politicians more often considered health effects for the general population as a whole, rather than for newly arrived migrants specifically. Factors contributing to whether they considered health effects for newly arrived migrants included self-rated knowledge, attitude, being female, and having previous experience working in public health (Study II). Further, politicians rated societal responsibility and the

possibility to promote health as higher for the population as a whole compared to newly arrived migrants specifically. The odds of rating societal responsibility and the possibility to promote health as high were associated with the factors attitude, specific knowledge of newly arrived migrants' health status, personal interest in public health, being a municipality politician, and being female (Study III). Authority officials considered health promotion to be desirable within the Establishment Program, but the study results also raised complex issues within the existing organizations. The respondents described unclear roles but also organizational changes that could improve the possibility of working to promote health (Study IV). Finally, the civic communicators described that they viewed and approached health promotion through wanting to prepare the participants for a healthy life in Sweden. They described knowledge, but also their role as a guide for the participants, as important parts of their work (Study V).

Conclusion: Within the integration of newly arrived migrants in Sweden, health promotion (and the possibility of health promotion) was invisible within the policy context. Within the political context, the focus on migrants' health (specifically newly arrived migrants) tended to be invisible. This situation caused various uncertainties, such as a lack of definitions and assignments, for officials who worked directly with newly arrived migrants. Those who work closely with newly arrived migrants tended to have a better view of how health could be promoted through integration in Sweden.