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The health and working conditions of female immigrants in Sweden

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To My Mother

NOSRAT KHAVARI

CONTENTS

List of publications
Foreword

1	INTRODUCTION
2	AIMS AND OBJECTIVES
3	CONCEPTUAL ISSUES
4	THEORETICAL CONSIDERATIONS
5	METHODS
5.1.	STUDY DESIGN
5.2.	ETHICAL APPROVAL
5.3.	STUDY GROUP.....
5.4.	DATA COLLECTION METHODS.....
5.5.	DATA ANALYSIS.....
6	RESULTS
6.1.	STUDY I.....
6.2.	STUDY II
6.3.	STUDY III
6.4.	STUDY IV
7	DISCUSSION
7.1.	MAIN FINDINGS
7.2.	VALIDITY AND RELIABILITY
7.3.	LIMITATIONS AND STRENGTH OF THE STUDIES
7.4.	CONCLUSIONS AND RECOMMENDATIONS.....
8	ACKNOWLEDGEMENTS
9	SUMMARY
10	SUMMARY (In Swedish)
11	REFERENCES

ORIGINAL PUBLICATIONS

List of publications

The thesis is based on the following publications, which will be referred to in the text by their Roman numerals:

- I. Akhavan S., Bildt C, Wamala S. The health of female Iranian immigrants in Sweden - A qualitative six-year follow-up study. *Health Care for Women International*. July 2006. (Accepted)
- II. Akhavan S., Bildt C, Franzén Elsie C., Wamala S. Health in relation to unemployment and sick leave among immigrants in Sweden from a gender perspective. *Journal of Immigrant Health*, Vol 6, No 3, July 2004.
- III. Akhavan S., Bildt C, Wamala S. Work-related health factors among female immigrants in Sweden - A qualitative study on a sample of twenty workers. *Italian Journal of Public Health*. Year 4, Vol 3, No 1, 2006. (In Press)
- IV. Akhavan S., Bildt C, Wamala S. Work-related health factors among female immigrants in Sweden. *WORK - A Journal of Prevention, Assessment and Rehabilitation*. November 2005. (Accepted)

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FOREWORD

*Tell me your name,
Give me your hand,
Tell me your secrets,
Give me your heart.
I have found your roots
And spoken through your lips, for all lips.
And my hands know your hands.
I am the common pain,
Cry out me.*

*Ahmad Shamlou
Translated from Persian
“The Fresh Air”, Poetry Collection*

I received the opportunity to begin doctoral studies within the field of public health after many years of working with work-related health projects in different county councils and municipalities in Stockholm. The target groups for these projects were mostly female immigrants, primarily those with “diffuse health problems”. Further exploration of the issue showed that the incidences of sick leave and early retirement among female immigrants were higher than among native Swedes and male immigrants. I began to wonder why this was so. This “simple” question led me on a fantastic journey and to the completion of a doctoral thesis.

I began my journey with a study on female Iranian immigrants. This was because they were the largest female immigrant group from non-European countries in Sweden between the late 1980s and the very early 1990s. I began the first study without any theoretical frameworks, hoping that the interviews with female immigrants, as experts on their own lives and as a source of knowledge, would guide me on my journey. The results of the first study assisted me in developing the theoretical framework of the subsequent studies and establish the theoretical framework of the whole thesis. The results of this first study also showed that working life was an important factor that influenced health in post-migration periods. It is for this reason that the other studies in the thesis are mainly related to working life. The second study focuses on unemployment, while the two other studies focus on work-related health.

The thesis is organized as follows: Section 1 gives an introduction and Section 2 presents the aims of the thesis. Section 3 looks at conceptualization issues and in Section 4, the theoretical consideration is presented and defined. Descriptions of the research methods including study design, ethical approval, study group, data collection methods and analyses are presented in Section 5. In Section 6, the results of the project are presented and in Section 7 there is a general discussion of the main findings, validity, reliability, limitation and strength of the studies followed by the conclusions and recommendations. Acknowledgements, summaries in English and Swedish and references are included in Sections 8, 9, 10 and 11 respectively, after which the four original studies are presented.

1 INTRODUCTION

Sweden is today a multicultural society. Almost 20 percent of the Swedish population has an immigrant background, i.e., they were born abroad and became naturalized citizens, are of foreign nationalities or were born in Sweden but have at least one parent born abroad (The Swedish National Social Insurance Board, 2005; The Swedish Statistic Board, 2005). Among asylum seekers and immigrants who got the Swedish citizenship during the last twenty years, 33 percent were refugees and 11 percent were relatives of refugees (The Swedish Migration Board, 2003). During the 1980s, most of the refugees and immigrants were from Iran and Chile, however from 1993 to 2003, refugees and immigrants were mostly from the former Yugoslavian territories and Iraq (The Swedish Migration Board, 2003). It is expected that the demographic development will lead to that 30 percent of all people of working age in Sweden having their roots outside Sweden by 2020 (Leijon & Omanovic, 2001).

In 2003, 60 percent of all first-generation immigrants in Sweden were either employed or undergoing some form of training. In 2001, the proportion of African and Asian born women who had lived in Sweden for 5- 9 years and were either employed or undergoing some form of training were approximately 35 percent. The proportion was about 1.8 times higher among those among those who had lived in Sweden for more than 20 years (The Swedish Integration Board, 2003). However, female immigrants' prospects for entering the labor market have changed during the last 20 years. Since 2003 the situation for those who have been in Sweden less than 19 years has worsened. In 2005, the percentage of female immigrants who were employed or in training was lower than in 1987 (The Swedish Integration Board, 2005a).

Various reports and statistics published in the last two decades indicate that female immigrants suffer from poorer health than Swedes and male immigrants (The Swedish Social Department, 1984; The Swedish Immigration Board, 1992; The Swedish National Board of Health and Welfare, 1994; 2000; The Swedish National Institute of Public Health, 2002; The Swedish National Social Insurance Board, 2005; The Swedish Public Health Report, 2005). Poor health among these women may be due to physical and/or mental disorders. For example, musculoskeletal disorders (Vogel, 2002), anxiety, worry, anguish, depression and sleeping problems were common among female immigrants in Sweden (The Swedish Institute of Public Health, 2002). The Swedish Public Health Report (2005) emphasizes two important facts. Firstly, the number of female immigrants who reported ill health were almost twice as many as native females. Secondly, this situation continued for several years, and even increased during some years, for example during the entire period of data collection, from 1981/1982 -

2002/2003. Furthermore, reports show that the incidences of sick leave and early retirement are higher among female immigrants than among Swedish women (The Swedish National Board of Health and Welfare, 1994; Knocke, 1999; The Swedish National Insurance Board, 2001; The Swedish Ministry of Health and Social Affairs, 2002; The Swedish National Social Insurance Board, 2005). The prevalence of long-term sick leave and early retirement for medical reasons is twice as high for female immigrants as for native women (Ågren, 2000).

The number of females with immigrant or refugee backgrounds is expected to constitute a steadily increasing minority in Sweden in the coming decades. Since female immigrants are beginning to make up a larger percentage of the Swedish labor market and the total population, and as they have poorer health than the majority of native Swedes, it is becoming increasingly important to not only monitor the health status of female immigrants and find the factors that contribute to their poor health, but also finding ways in which to improve it.

2 AIMS AND OBJECTIVES

The general objective of this thesis is to understand, describe and analyze the factors that contribute to poor health among female immigrants in Sweden from the perspectives of class, gender and ethnicity.

The specific aims of the studies described in this thesis were:

- To identify and analyze female Iranian immigrants' perceptions of various factors that influence their health over time.
- To analyze health in relation to unemployment and sick leave absences among immigrants from a gender perspective.
- To study and explore work-related health factors among female immigrants.

3 CONCEPTUAL ISSUES

Class, gender and ethnicity influence the patterns of social relationships among people and are the root of social inequalities. The complex manner in which these three concepts are related to each other may vary due to differences in historical periods or/and societies. In order to describe the theoretical framework of the thesis, I begin by defining each key concept in the way they are used.

Class

Understanding class “reveals the innermost secret, the hidden basis, of the entire social structure” (Marx, 1849, 1991). Class is also one of the concepts used to explain institutionalized inequalities between social groups with regards to living conditions and life opportunities, levels of skill and material resources and relative power and privilege. The major sociological traditions that have influenced the understanding of class in relation to health are Marxian, Weberian and Functionalist (Lynch & Kaplan, 2000). Karl Marx defined social class as a group of people sharing common relations to labor and the means of production (Marx, 1867). In particular, the Marxist view of class emphasizes that antagonistic and contradictory relations will exist between classes as they mobilize and struggle over economic and political power (Williams & Collins, 2002). According to Packham (1991), the Marxist view is that the relation between class and health can be understood through access to power. Class membership leads to differential political and economic power which in turn leads to inequality in power and in health.

The Weberian view of social classes combines several criteria in delineating classes, including income, education and political influence (Lynch, Kaplan, 2000). Unlike Marx, Weber did not regard classes as potential corporate groups, he did not believe that members of social classes would necessarily have shared political interests. Weber preferred to speak of “status groups” rather than classes (Eriksen, 2002). The Functionalist approach argues that complex societies, of necessity, require stratification into sectors that are more or less valuable to the progress of that society (Davis & Moore, 1945). Functionalism forms one of the conceptual bases for contemporary arguments that understand social inequality as the result of “natural forces” (Lynch, Kaplan, 2000).

In the thesis, as in previous research in the field of public health (Wright 1996; Lynch & Kaplan 2000) I used a hybrid of Marx’s and Weber’s definitions of class. I use the

hybrid model because it could more clearly show who has and who lacks the basic material necessities of life (employment and appropriate income), who is exposed to and spared from a variety of occupational hazards (physical and psychosocial work environment), who has and who lacks control over the essential content of working life (occupational status), who occupies important institutional positions and takes part in important decision-making processes regarding private and public issues, and who benefits or is harmed by these decisions and policies (access to power and influence).

The definition and/or measures of women's class as given by public health researchers may vary. There are two main approaches (Liberatos et al., 1988; Morgenstern, 1985; Kreiger, 1991). One is a male-centered strategy in which the social class of married women is determined by their husbands' occupations and social class, while unmarried or single mothers are deemed to belong to a class of their own. The other strategy is individualistic and is applied equally to both single and married women: all women, regardless of their household or marital status, are classified according to their own socioeconomic position, which is typically judged according to education level. Housewives tend to be grouped into one category, regardless of the social class of their partners.

In the thesis I address the participants' social class objectively, as well by using the individualistic strategy. This is because the female immigrants who participated in the studies had their own income, either in the form of a salary, welfare/unemployment benefits or sick leave allowance.

Gender

Using the term "gender" as opposed to "sex" invokes various images of social relationships, power, ideology, culture and an understanding that biology is potentially just as socialized as other human characteristics (Levin and Lopez, 1999). As Rubin (1975) explains, sex refers to biological differences between men and women while gender refers to social, cultural and historical constructions of femininities and masculinities. Gender relations refer to power relations which are socially and structurally distributed (Hammarström, 2002). It also describes male and female characteristics that are socially constructed and is related to how we are expected to think, behave and act as men and women because of the way society is organized, not just or perhaps not even primarily because of our biological differences (Wamala & Lynch, 2002). The major biological difference between women and men is that it is in the woman's body that fertilization can occur. Because of this, in most societies, women are expected to bear children, be good mothers, be the primary caregivers and see this as their fundamental role in life (Lewis, 1991). To have this role as a citizen for several

months or years may contribute to the fact that women either become isolated at home doing domestic work, or begin to work part-time and become economically dependent.

In choosing to use the term gender I could:

A- Counteract the invisibility of female immigrants and give them a voice. Female immigrants have often been ignored in public health research in Sweden. Unfortunately, studies of the health of female immigrants based on nationally representative data are rare. Furthermore, studies that are based on female immigrants' own views and perceptions of health and health-related issues are almost non-existent. In the thesis there are female immigrants who have been the source of knowledge, as experts on their own lives. This approach allows giving them a chance to be heard.

B- Ask questions about issues that tend to be considered as "normal" and thus seldom questioned. For example, researchers and policymakers do not often question why the health of female immigrants is worse than that of others in the entire population. In many countries that are hosts to immigrants and refugees, there is also a tendency to more or less consciously place female immigrants in the occupations with the lowest status and with the lowest incomes and to "normalize" this process. I question this process and the taken-for-granted structures inscribed in the society through power relationships.

C- Highlight the suffering of female immigrants as well as their struggle for a better life. Moreover, it would enable me to give another impression of female immigrants instead of the one that is dominant in research and media, which presents female immigrants as incapable and as "problem".

Ethnicity

The notion of ethnicity is not established by a set of natural forces, it is a social construction and a product of human perception and classification (Cornell & Hartmann, 1998). Ethnic identity can be linked to culture, customs or/and power. An ethnic group has been defined in relation to cultural inheritance, collective historical experiences of conflicts, discrimination and adjustment, selective perception and selective preferences based on the collective identity (Hutchinson & Smith, 1996; Obidinski, 1978). From an anthropological perspective ethnicity has been defined as an aspect of social relationships and is made relevant through social situations and encounters, as well as through people's methods of coping with the demands and challenges of life (Eriksen, 2002). Ethnicity has also been defined as a measure of power or powerlessness and in relation to class and gender. According to Cornell and Hartmann (1998), the links between ethnicity and power are dependent on context. People in a subordinate ethnic group have different experiences compared to the

dominant group (Purnell & Paulanka, 1998; Higginbotham 1997; Hutchinson & Smith, 1996). Experiences can be related to status, ethnic background, religion, location or residence, education, access to resources or other factors that functionally unite them. The notion of ethnicity in public health research is obviously used for social stratification in societies and can either be understood with regards to power relations or, as Wilkinson (2005) puts it, as a mark of collective social status. Its inescapability inevitably increases its impact on health.

In the thesis, I refer to ethnicity, ethnic status, ethnic origin and ethnic background as concepts that have been used for the social classification and marginalization of immigrants and/or refugees and the children of immigrants and/or refugees in a country such as Sweden. Ethnic classification and marginalization have profound impacts on daily life experiences as well as on health. These terms capture precisely the impact of racism and ethnic discrimination or behavioral racism as some American public health researchers suggest (Clark et al. 2002). In the thesis, I discuss and analyze exposure to racism/ethnic discrimination with respect to ethnic origin. In some of the references in the thesis the concept of “race” has been applied. I have also used “race” in the same context as ethnicity, as described above.

In the thesis “female immigrants” refers to women who were either not born in Sweden, or have at least one parent who was not born in Sweden. In studies I and II, IV ethnic origin was assessed from the respondents’ self-assessment reports, and by extraction from registered data in the Study III. Female immigrants who live in Sweden are a heterogeneous group. They come from different countries and have different socioeconomic backgrounds. What they have in common is that they all experience restrictions in accessing resources and power because of their sex, skin color, accent, name, dress or occupational status. In studies II and IV, the term “second generation immigrants” was used. This refers to those who were born in Sweden and have at least one parent who was not born in Sweden. The term “second generation immigrants” is used daily in media and even in research, both in Sweden and in several other European countries with a history of immigration. The term is actually scientifically incorrect, as these people are in fact not immigrants, they simply have an immigrant background.

Instead of “female immigrants”, there are other terms that could have been used, such as women of color, minority women, foreign-born women, etc. I did not use “women of color” because it excludes white women from Eastern Europe, for example, who constitute a large group of immigrants in Sweden. Similarly, I did not use women of minority groups because some minority groups were not included in the study group, for example the “Sami” people who live in northern Sweden. Finally, I chose not to use the term “foreign-born women” because some of the women who participated in the

study were born in Sweden. The term “female immigrants” was thus the one which was most applicable to the issues that were to be addressed in the thesis.

Health

Health is a very broad concept which has different definitions that have changed over time. Some definitions reflect it as simply a biological matter. For example, Boorse (1981) defines disease as a dysfunction within an organ or the system of an individual and then health as the opposite to disease. Other health traditions suggest a holistic view. For instance, Saylor (2004) defines health as optimal functioning, well-being and quality of life. This definition includes mind-body integration, balance and harmony as well as physical, mental, spiritual, social functions. This expanded definition of health is relevant to both those who are ill and those without disease. In the thesis, health refers to a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1986).

Women’s health can be discussed not only with the aid of biomedical models, but also through social models, since women’s experiences of health and illness involve the mind, body, spirit, social relationships and working and living conditions. Women’s health cannot be separated from their roles, responsibilities and statuses in families, communities and societies (Ruzek et al., 1997a). There are various social and psychological factors in women’s lives that affect their health. In a report for WHO (2003b), Wilkinson & Marmot describe the mechanism of affection. They argue that long-term stress has powerful effects on health. Long-term stress can be a consequence of social and psychological circumstances such as continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life. They explain in detail that these factors operate physically through hormones and the nervous system and may affect cardiovascular and immune systems. In the long-term, if people too often feel stressed and tense then they risk becoming more vulnerable to a wide range of illnesses including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression.

The thesis focuses on women’s experiences of health in relation to their living and working conditions.

Data on morbidity fall mainly into three categories: self-reported illness, disease diagnosed by medical science and the social role of illness, for instance in terms of sickness absence (Alexanderson, 1998). Furthermore, poor or ill health (physical or mental) refers to a long-lasting state involving a disposition to easily become ill or to be vulnerable to becoming ill (Alexanderson, 1998). In studies I and II, health has been

based on subjective accounts and self-assessment reports. The two latter studies differed from the first and second in that the state of health was assessed from registered data as well as reports and statistics showing the extent of poor health and the high rate of sick leave absences among female immigrants in the studied municipality.

According to The World Health Organisation (WHO, 1981) mental health is the capacity of the individual, the group and the environment to interact with each other in ways that promote subjective well-being. It involves the optimal development and use of mental abilities, the achievement of individual and collective goals consistent with justice and the attainment and preservation of conditions of fundamental equity. In the thesis, the terms “mental health” and “mental disorders” refer to mental stress, depression and anxiety.

Wilkinson (2005) suggests that health can be used as a form of social indicator and provide important social and psychological insights. Studying and analyzing the health of female immigrants can provide important insights, not just to public health researchers, but also to policy-makers and politicians.

4 THEORETICAL CONSIDERATIONS

I attempt to use the intersecting "system of class, gender and ethnicity oppression" in relation to health as the theoretical framework for my thesis. According to Lynn Weber (2001), the system is a manifestation of power relations that are socially constructed, with one group gaining power and control over societally valued assets and using them to secure its position of power into the future (Weber, 2001). In this system, gendering and racialization are related to the creation of class inequalities.

The system can be seen as one of the most salient social divisions in twentieth-century societies, but their constitution and significance vary. Social stratifications on the basis of class, gender and ethnicity are powerful means by which social resources are distributed and life chances determined. It is through this complex web of power, privilege and values that the interaction between members of majority and minority groups in a society occurs (King, 1996).

In the thesis, I operate within the concepts of class, gender and ethnicity, since both class and gender, along with "race" and ethnicity, are important markers of how and where individuals or groups are located within the social structure, which ultimately determines the state of health (Wamala & Lynch, 2002). The theoretical framework of this study is based on the analyses and conceptions of the influence of class, gender and ethnicity on health (Bayne-smith, 1996; Smith 2000; Krieger 2001; Cooper 2002; Sen et al. 2002; Breen, 2002; Nazroo 2003), because according to previous research on the health of female immigrants, the women viewed their lives not just from a gender perspective, but also from the perspectives of class and race. (Anderson 2000). Some previous research (Dyck & McLaren, 2004; Anderson, 2000) on the health of female immigrants has also made use of these concepts.

This approach was chosen because:

1- As a public health researcher I believe that one of our important tasks is to develop an explicitly antiracist, class-conscious (Krieger, 2002) and gender-conscious system of public health and to identify systems of oppression that harm health and create health inequalities. Highlighting the significance of class prejudice within public health is crucial to the understanding of health inequalities. Class differences in many societies have been institutionalized, legitimized and firmly established (Skeggs, 1997). Making class visible and viewing it as a theoretical tool is vital to the understanding of the health of female immigrants. Skeggs (1997) argues that abandoning class as a theoretical tool does not imply that it ceases to exist - it only implies that some theorists do not value it. She emphasizes that class inequality exists beyond its theoretical representation.

2- In Sweden, studies on the health of female immigrants are rare. Furthermore, much of the debate tends to focus only on “cultural”¹ differences between female immigrants and native Swedes (Knocke, 1991). However, it is important to study the particular life circumstances of female immigrants, not only in terms of their “cultural” differences, but also in the context of the larger social organization which generates particular types of experiences (Anderson & Lyman, 1987). The theoretical framework that I chose allowed me to highlight the issue from another point of view. There is a place in public health inquiries for diverse voices. As a result, I have tried to expand our understanding of female immigrants’ health from another perspective, one which neither “blames the victim” nor “reinforces racist stereotypes” as Williams (1997) put it, but which instead explicitly identifies the sources of subordination of the socially disadvantaged groups. The system of class, gender and ethnic oppression operates invisibly. A first step towards understanding the system is to make it visible and thus show its existence (Weber, 2001).

3-As I have a Bachelor’s degree in laboratory sciences, it was natural that I would consider biology and genetics as important determinants of health. Biological factors and the geographical origins of ethnic minorities are two important factors that may result in poor health and/or disease. For example, persons who come from regions such as the Mediterranean and the African continent where malaria is common may be more susceptible to sickle-cell anemia (Williams, 1997). However, I chose not to focus on biology and genetics but instead on social constructs that harm health. My choice was due to a report from The World Health Organization which states that the common causes of the poor health that affects populations are environmental. The report emphasizes that the differences in health between different social groups have widened or narrowed as social and economic conditions have changed (WHO, 2003b). The health of female immigrants cannot be attributed solely to biological/genetic or cultural characteristics. It must also be understood within the context of the larger, socially-organized patterns of relationships, which may be changed through dialogue between researchers, public health policymakers and politicians.

Intersection of class, gender and ethnicity in relation to female immigrants’ health

¹ There are cultural differences between female immigrants and native Swedes, between different ethnic minorities and between individuals with a specific ethnic minority, all of which can influence health behaviours. The problem is that in a majority of instances, the cultural stories and relationships are redefined and interpreted by the dominant culture - which serves as a reference point - within the context of the hegemonic dialogue, and are in turn reinforced through negative media messages.

The theoretical framework of the thesis is an attempt to understand how class, gender and ethnicity are not only related to each other, but also related to health. Class, gender and ethnicity are constant hallmarks of inequality that are related to structural relations of subordination. They are rarely temporary, tending instead to follow people throughout their lifetime. Individual movements within the framework of these structures do not automatically imply changes in the hierarchical system at the collective level (de los Reyes & Mulinari 2005). It is known that power and privilege are distributed not only along individual, but also along group lines. Thus some groups, frequently those consisting of whites, heterosexuals, upper class and males are privileged, while people of color, homosexuals, working class, the poor and females are subordinated. The privileged group is politically, economically and socially dominant (Weber 2001).

Intersection of class and gender

The gender order in society is based on gendered division of labor, resources and control. On the labor market, occupations and wages become gendered as they are characterized by qualities, attributes and behaviors assigned to men or women. The gender division of labor in paid work takes the form of horizontal and vertical occupational segregation, with women confined to particular types of work, most often at lower levels. The term horizontal segregation implies that the segment of the labor market which is male-dominated has a higher status and better wages than the female-dominated sectors. Vertical segregation means that men are over-represented at the highest levels with regards to status and power, i.e., in decision-making, authority and control. The gender division of labor has a negative effect on how men see women and how women see themselves since it reinforces and perpetuates gender stereotypes (Anker, 1998). The division according to gender is a major determinant of male-female wage differentials (Le Grand, 1997) which not only have an impact on women's status, but also on their mortality and morbidity, poverty and income inequality (Östlin, 2002). As Kawachi (2000) argues, poverty has become feminized, particularly within households headed by women.

Another model that explains a gendered labor market, the feminization of poverty, low wages and the low social status of women is the "male breadwinner model". This model was grounded on a gendered system in which men were the beneficiaries of economic rewards. During the twentieth century, the model became both class-oriented and racialized (Williams, 2001). The male breadwinner model is characterized by the concept of women being responsible for reproductive work at home or by their discontinuous economic activity patterns. The State intervenes (or fails to intervene) in favor of a specific distribution of men and women between the economic and the domestic spheres. Men of working age are expected to devote themselves to their professional life and women, especially married women and/or mothers, are expected to

devote themselves primarily to unpaid domestic responsibilities and half or part-time work (Pfau-Effinger, 2004). In Scandinavia, where there is a high concentration of women on the labor market and public childcare (Ellingsaeter 1999; Leira 2002; Siim 2000), there is a weak version of the model in operation. This is evidenced by the fact that women are more often employed in part-time jobs and in low-paid occupations than men. Working life researcher Westberg (1998) argues that occupations within female-dominated areas such as the service and health care sectors are less well paid than occupations within male-dominated sectors.

Intersection of class, gender and ethnicity

The racialization of labor and wages is a manifestation of the intersection of class, gender and ethnicity. Female immigrants are needed on the labor markets of the industrialized countries, however they are largely employed in the occupations that are low-paid and have low status. By using the concept of racialization, I attempt to point out processes by which certain groups of people - in this case female immigrants - are viewed as different and subordinate due to assumptions based on their ethnically defined differences. Racialization creates a “them” and “us” aspect, where national belonging is made a central factor, among others. In Sweden, as Neergard (2006) discusses, the racialization process reflects a skewed power relation in which one party is able to define not only “us”, but also the other, “them”.

Deskilling is a process which aids the racialized and gendered division of labor. It is a process in which skills and qualifications gained through previous training and employment are either not used or not recognized after immigration. This process results in unemployment, long-term social exclusion, employment in low-status occupations with low incomes or working in dangerous and/or illegal sectors (Wren & Boyle, 2002). Ethno-racial studies (Mulinari & Neergard, 2004) show that occupation and income are racialized and gendered in Sweden, as it is in many other European countries. A report from The Swedish Municipal Workers Union (Kommunal, 2003) shows that female immigrant workers who were born outside of the European Union are mostly employed as assistant nurses, day care assistants and cleaners in the municipalities and receive wages that are about 500 Swedish crowns (SEK) lower than those of native female workers. Their wages are also roughly 200 crowns lower than those of male immigrants and about 1200 crowns lower than those of native male workers in the municipalities.

Racism and ethnic discrimination reinforce both racialized and gendered labor market and the deskilling process, as well as other policies which lead to more subordination and inequality in the society. Racism refers to institutional and individual practices that create and reinforce oppressive systems of race relations, whereby people and institutions engaging in discrimination adversely restrict, by judgment and action, the

lives of those against whom they discriminate (Essed, 1991; Krieger, 2000). Jones (2003) defines institutionalized racism as a series of policies which lead to differential access to the goods, services and opportunities of society on the basis of “race”. According to her, the measures of institutionalized racism are:

- * policies or unwritten norms and practices allowing segregation of resources and risks such as residential, educational or occupational opportunities

- * policies or unwritten norms and practices creating inherited group disadvantage such as estate inheritance, lack of social security for children and lack of reparations for historical injustices

- * policies or unwritten norms and practices favoring the differential valuation of human life by “race” such as curriculum, media invisibility, the myth of meritocracy and the denial of racism

- * policies or unwritten norms and practices limiting self-determination such as limitations to voting rights and limitations on representation/participation.

Racism and ethnic discrimination in combination with the problems of non-recognition of qualifications from abroad is an important explanation for the high rate of unemployment among female immigrants in Sweden. The rate of unemployment is higher among female immigrants than among native Swedes in the same age group, regardless of education or qualifications (The Swedish integration Board, 2005b).

Intersection of class, gender, ethnicity and health

In a report for The World Health Organization (WHO, 2003b), Wilkinson and Marmot emphasize that social and psychological circumstances can cause long-term stress, which in turn has powerful effects on health. These social and psychological circumstances include social deprivation, long-term unemployment, low income, social exclusion on the grounds of racism and discrimination, insecurity and lack of control over work situations.

The recognition that poor people have poorer health than wealthy people and that people’s occupations and social positions influence their health is hardly new (Antonovsky, 1967). Two different perspectives have always existed: those who view the poor as the main cause of their own poverty and poor health (e.g. because of tendencies to laziness, depravity and unintelligence) and those who place the responsibility for poverty and poor health upon the structure of the societies and the policies that are conducted according to them (e.g. low occupational status, low wages and harsh working conditions). After the 1930s, in reaction to the full-scale application of eugenics by the Nazis, overtly genetic explanations of social class gradients in health began to recede into the background (Sydenstricker, 1933; Leslie, 1990; Chase, 1977; Proctor, 1988; Oakley, 1991). Indicators of socio-economic position such as income, class, housing tenure, deprivation and lack of resources and their effect on health began

to gain attention. It became obvious that those who were worse off socio-economically had poorer health (Shaw et al. 2005; Townsend et al. 1988; Eames et al. 1993; Bartlett et al. 2004; Crawford & Prince 1999; Pamuk et al. 1998; Pappas et al. 1993).

The relation between class and health can be seen in the Swedish Public Health Report (2005). It showed that mortality was higher for both males and females with low education compare to middle and highly educated. The report emphasizes that the social differences do not decrease over the entire lifetime. Health status is an arena in which the effects of class are readily evident (Williams & Collins, 2002).

Women's health is generally determined by the social conditions they live in. Health and illness are socially and economically produced and experienced in very different ways by different women (Ruzek, 1997b). Being a woman means bearing double burdens. Women are expected to both earn their living and take care of family responsibilities (Ohlander, 1996). In other words, women are expected to be active in both the production and reproduction processes. In this respect, there seems to be a connection between women's productive and reproductive work on one hand, and patriarchal control on the other. According to Hartmann (1981), the material base of patriarchy is men's control of women's labor and sexuality. The gender-segregated labor market and unequal wages are manifestations of patriarchal patterns in productive work. Leaving housework and child-rearing to women and controlling their sexuality are manifestations of patriarchal control of reproductive work. The combination of waged work and the main responsibility for caring and domestic work has been discussed as a contributing cause of poor health (Lundberg, 1996; Östlin, 2000; Wamala & Lynch, 2002). In Sweden, it has been shown that in 25% of households with small children where the parents were both employed, it was the women did all of the domestic work. In the households that had older children of school-going age, 30% of the domestic work was done by the women (Soidre, 2002). It has also been shown that women live longer but suffer more frequently from poor health than men (The Swedish Public Health report, 2005).

The relationship between health and ethnicity can be studied using different health determinants. Previous research shows that racism and ethnic discrimination are important determinants of poor health (WHO 2003a, McKenzie 2003; Williams et al., 2002; Krieger 2000; Collins et al., 2000; Jones, 2000). Nancy Krieger (2003) argues that neglecting to study the impact of racism on health means that arguments for intervention in order to alter the distribution of health, disease and well-being throughout the population will be incomplete.

In Sweden, research in this area is very rare, especially studies on the experience of ethnic discrimination and the mechanisms behind racism and ethnic discrimination affect female immigrants' health. There is a pilot study which shows that discrimination has a negative impact on health (The Swedish National Institute of Public Health, 2005)

and another which shows that female immigrants who suffer from ethnic discrimination report ill health more often than those who do not. Female immigrants who suffer from ethnic discrimination report more problems with long-term illnesses, psychological disorders, pain and decreased body function ability in comparison to female immigrants who do not suffer from ethnic discrimination (The Swedish National Board of Health and Welfare, 2000).

5 METHODS

5.1. Study design

All studies, with the exception of Study I had a cross-sectional design. Study I was a longitudinal study in which base-line interviews conducted in 1996, with follow-up interviews six years later. Studies I and IV were qualitative studies, while Study III was based on quantitative data. A combination of qualitative and quantitative methods was used in Study II.

5.2. Ethical approval

All of the studies were approved by the Ethics Committee at Karolinska Institutet. Participants were given written and oral information about the studies. The participants in Studies I, II and IV gave their consent in writing. Study III was based on registered data. Studies II, III and IV were conducted after approval by the heads of the civil service department in the studied municipality.

5.3. Study group

In Study I, the study group consisted of female Iranian immigrants living in a large city in Sweden. In the other studies, the study groups consisted of female immigrants who lived or worked in a municipality in the suburbs of Stockholm, in Sweden (Table 1). Male immigrants were included in Study II, and native women in Study III.

Study I

The study group (shown in Table 1) consisted of ten (10) Iranian women between the ages of 25 and 50. They decided to take part in the study after having received verbal information about it at meetings held by the Iranian Association, the Kurdish Association and the Iranian women's café in a large city in Sweden. At the time of the base-line interviews in 1996, the women had lived in Sweden for between seven and twelve years. I was interested in interviewing women who had been living in Sweden for at least five years. The reason was that they would then have had time to learn the Swedish language and either begun to enter the labor market or enrolled in a course of study.

The participants constituted a relatively homogenous group of middle-class Iranian women who had emigrated from Iran in the late 1980s and at the beginning of the 1990s. At the time of their flight from Iran, four had been studying at university or high school and the others had been working as a qualified nurse, hygienist, teacher, childcare worker and secretary.

In Sweden, the ten women had worked as a printer, cashier, cleaner and home assistant to elderly and disabled persons. At the time of the base-line interviews, four women were studying at university, one was working as a childcare assistant and one as a home nursing assistant, while two were on sick leave. One woman was unemployed and another was a civil servant in a prominent position.

Four of the women were married, four women had been married but were later divorced in Sweden, one was single and one was a widow. All but three had children.

Six (6) of the ten had been politically active in Iran, two of these had been political prisoners and four had lived “underground” for a long time. Of the ten women interviewed, five had been back to Iran for temporary visits; the others do not wish to return under the conditions which prevail in Iran today.

Study II

The study group consisted of sixty (60) people (Table 1) who took part in daily group activities in the HADOK² project. The participants resided in a municipality in the suburbs of Stockholm, in Sweden.

During 2001, activities were arranged for seven groups, two of which were organized for men and women separately. Of the 60 people who participated in the project, 56 were immigrants and 4 were so-called “second-generation immigrants”. 50 people filled in the questionnaires. The dropout rate was 17 % due to lack of resources, e.g., lack of personnel or interpreters or a lack of interest on the part of the participants. Those who

² The HADOK project *Hälsa, Arbete, Dialog Och Kompetens* (Health, Work, Dialogue and Competence), began early in the spring of 2000 in association with the Social Welfare Office and the Employment Services Office in a municipality in the suburbs of Stockholm, in Sweden. The purpose was to provide additional, intensive support to those jobseekers for whom neither the Employment Office nor the Social Services had the resources with which to provide assistance within the framework of their ordinary activities. Long-term unemployed recipients of social benefits were referred to the HADOK project every four weeks in groups of 10-12, for a four-week program. Social workers and staff at the Employment Office or the Regional Social Insurance Office referred the participants to the project.

Table 1. Study group

Sex	Number	Age (range)	Ethnic origin			Working Situation			
			Born in Sweden	Born outside of Sweden	Born in Sweden Have at least one parent born outside of Sweden	Employed/Student	Unemployed	On sick leave or early retirement	
			%	%	%	%	%	%	
Study I									
(In 1996)	Female	10	25-50	-	100	-	70	10	20
(In 2002)	Female	10	31-56	-			80	-	20
Study II									
	Female	30	27-47	-	90	7	-	75	25
	Male	30	27-47						
Study III									
	Female	1441	<50	72	28	*	100	-	-
		988	>50	79	21	*			
Study IV									
	Female	20	30-58	-	90	10	100	-	-

* No information available according to the survey source

did not fill in the questionnaires had participated in group activities. The final sample group consisted of 60 people.

Study III

The study took place in a municipality in the suburbs of Stockholm, in Sweden. The study population consisted of 2,429 native and immigrant female employees who were drawn from all departments in the municipality (Table 1). These departments were Maintenance and Cleaning, Children and Youth, Nursing and Care, Education and Labor Market, Social Services, Municipal Management, Technical Services, Fire Services, Administration, Citizen Services, Environmental Services, Cultural Services and Estate Agency. A total of 3,295 employees (both male and female) filled in the questionnaire. The response rate, i.e., the number of questionnaire responses received in proportion to the number of total employees, was 57 percent.

Study IV

The study took place in the same municipality that was described in Study III. The selection for interviews was made at four departments that had high rates of long-term sickness absences. These four departments were Maintenance and Cleaning, Education and Labor Market, Nursing and Care and the Social Services. Our research group met the managers of the departments and they informed their staff about the study. We met those female immigrants who were interested in participating and gave them further information about the purpose of the study, interview method and confidentiality. Those who were interested in participating in the study were interviewed.

The study group (Table 1) came to consist of 5 cleaners, 5 teachers, 5 home-help assistants (provide nursing and care to elderly) and 5 living assistants (provide support to people with mental disabilities). Most of them were married, some were single mothers and one was single. All of the women except two had children younger than 18 years old living at home. Most of the women came from the Middle East, Africa and Latin America, with others coming from eastern and southern Europe and Finland. The women had lived in Sweden for between 5 and 27 years. One was born in Sweden and had parents with immigrant background.

Table 2. Data collection methods used in the four studies

Data collection methods	Study I N=10	Study II N=60	Study III N= 2 429	Study IV N=10
Self-administered questionnaire	-	50	2 429	-
Interviews	10	-	-	10
Observations	-	60	-	-
Group discussions	-	60	-	-

5.4. Data collections methods

The data collection methods used in the studies were interviews, self-assessment questionnaires, observations and group discussions (Table 2).

Study I

As Table 2 shows, qualitative methods have been used to study the female Iranian immigrants' perceptions of various factors which have influenced their health over time. According to Morse and Field (1996), qualitative methods should only be used when little is known about the phenomena under study. The researcher asks questions such as "What is happening here?". It also is particularly useful when describing a phenomenon from the "native's point of view" (Vidich & Lyman 1994). The study was conducted through the use of semi-structured interviews. A semi-structured interview implies that the researcher prepares a number of questions in advance. The interviewer can ask spontaneous questions and change the order of the set questions during the interview. Semi-structured interviews allow interviewees to recount their experiences with as little guidance as possible from the interviewer (Morse & Field 1996).

In the base-line interviews (in 1996) the questions treated the following aspects: the women's life history and childhood experiences, work and family life situations in both Iran and Sweden, their experiences as immigrants, concepts and attitudes towards health and health-influencing factors, current possibilities and difficulties in maintaining physical and psychological well-being, involvement in socio-political life, social networks and finally, lifestyle and living habits. In follow-up interviews (in 2002), the questions were related to the women's work and family situations, their health and factors they perceived were influencing their health at the time of interview.

The base line interviews lasted about one and a half ours hours, while the follow-up interviews lasted about one hour. The interviewed women did not want the interviews to be recorded; careful notes were taken instead. All the interviews were conducted in Persian and the notes later translated to English.

Study II

In this study, the triangulation method has been used to collect data (Table 2). The method itself involves using several different methods to collect information. The researcher methodologically combines different techniques such as questionnaires, observation and interviews to investigate one and the same subject. The motive for

using this strategy is that the weak parts of one method often prove to be the strong parts of another method. By combining methods, a researcher can maximize the advantages of each method and still have control over the disadvantages (Mathison, 1988). The triangulation method in this study was based on quantitative data that was collected from questionnaires and on qualitative information that was obtained through observation and documentation of group discussions.

The questionnaire (in Swedish) included questions about the participants' socioeconomic situation in their native country and in Sweden, the number of years they had lived in Sweden, the number of years that they had been unemployed, their language proficiency and the number of children they had. Many questions concerned the participants' physical, mental and psychosocial state of health. The participants filled in the questionnaire at group meetings.

Observations were carried out during group meetings to systematically document the participants' behavior and actions. In the program for group activities, a couple of days were planned for discussions on the subjects "Health", "Work" and "Migration". A project leader started the discussion by giving a short presentation of the subject. The participants spent a couple of days working on each subject, discussing it and making a collage to illustrate their points. Notes were taken during the group discussions as a complement to the data collection.

Study III

As Table 2 shows, data were collected through an employee questionnaire (in Swedish) which was used to map the employees' level of satisfaction with their work situation. The personnel division of the studied municipality developed the questionnaire in consultation with a statistics team and our research group. In 2003, the municipality conducted a questionnaire survey in all its departments and workplaces. The employees could respond to the questionnaires by e-mail or post. Two reminders were sent out. The questionnaire consisted of 69 questions on employees' psychosocial and physical working conditions. The nine general items in the questionnaire concerned job satisfaction, involvement, health, leadership, the physical work environment, equality and diversity, security, communication and collaboration, career development opportunities and the available time for dialog and discussion between co-worker and manager. Each item contains several variables. For example, the item "equality and diversity" consists of nine variables related to different types of discrimination in the workplace and whether the plans for diversity and equality are efficiently implemented.

Study IV

In order to get the broadest possible picture of different perceptions, semi-structured interviews were conducted with female immigrants who had worked in different departments of the studied municipality (Table 2). The interviews were conducted during the autumn of 2003. In agreement with the participants' desires, all interviews were conducted at their workplaces during working hours. The interview questions concerned the interviewees' background (age, country of birth, civil status, education and work experiences in native country and in Sweden, type of employment contract and working hours), reasons for immigration, their definition of health, the work-related factors they considered could have a negative impact on their health and the measures that should be taken to improve their working conditions. The interviews lasted between 45 minutes and 1 hour. The interviews were tape-recorded and thereafter transcribed. Two of the interviewed women did not want the interviews to be recorded, so careful notes were taken instead. All the interviews were done in Swedish.

5.5. Data Analyses

The qualitative and statistical analyses used in the four studies are summarized in Table 3.

Study I

The content analysis method was used to analyze the data (Morse & Field 1996) in the first study (Table 3). Content analysis is analysis by topic: each interview is divided into categories according to topic. Codes identify the contents of each the interview, while category labels contain descriptive names for each group of data.

To conduct content analysis, the entire interview was read several times. As each unit of data was examined, certain words or phrases were highlighted. For example, when the women answered the question about their childhood, words such as "incest" or phrases such as "I wanted to be allowed to ride a bicycle like my brother" were labeled as keywords or key phrases. After identifying all the keywords and phrases, they were cut out and sorted according to the different topics. For example, the keywords and phrases mentioned above were cut out and sorted under the topic "childhood experiences". Several topics were eventually assembled to form subcategories. In this case, the topic "childhood experiences" was linked to other topics to form the subcategory "Upbringing and patriarchal culture". Subcategories could also be linked to form a category. For example, four subcategories which were related to gender and the role of being a woman were linked to form the category "Gender". These subcategories were

“Childcare and housework”, “Divorce and domestic violence”, “Sexual and emotional experiences” and “Upbringing and the patriarchal culture”. In the latter stage of categorization, certain dimensions could be discerned. The dimensions “health concepts” and “lifestyle habits” were identified. These were in turn influenced by the categories and subcategories.

Study II

To obtain a general view of the study participants’ physical and mental state of health, the quantitative material was analyzed and the statistics assembled. The Chi-square test was performed in order to detect whether there were any significant differences between female and male participants with respect to their answers to the questionnaire items. The documentation on the observations and notes from group discussions were analyzed using the content analysis method, i.e., the information was sifted for recurrent themes and patterns and the collected data categorized (Table 3).

Study III

In this study, the items in the questionnaire that were related to health, equality and diversity, security, communication and collaboration, career development opportunities and available time for dialog and discussion between co-worker and manager were on focus. I selected these items because previous studies indicate that they can give a clear picture of the female immigrants’ specific situation on the labor market and the work-related factors which influence their health.

In some cases, the sample-specific variables were categorized according to dichotomization based on single questions, while in others, the dichotomy was based on a group of questions. For example, the possibility of holding wage discussions and participating in preventive health care activities were assessed by 3 items which measured whether the employees “have had wage discussion(s) with manager”, “have a health development plan” and “participate in preventive health care activities every week or every other week”. A “yes” was given a 0 and a “No” was assigned a 1. The same procedures were used for the statements “There is no gender discrimination at my workplace”, “There is no discrimination based on ethnicity in my workplace” and “Sexual harassment does not occur in my workplace”. The Development Opportunities index (Cronbach α coefficient = 0.60) was measured using two statements: “There are opportunities for development in my occupation” and “I get the time that I need for more training or education”. The index for Access to Information (Cronbach α coefficient = 0.70) was measured via two statements: “I have access to information about the municipality” and “We have regular meetings at my workplace”.

The impact of ethnicity on specific variables was analyzed by using odds ratios (as a relative measure of risk), as a function of the number of female employees who answered each question. The native Swedish women were used as the reference group. The odds ratio shows the degree of exposure of female immigrants to a specific variable in comparison to native females. The program Excel was used for data analysis. To deal with the confounding effect of age, we further stratified the study group according to age (up to 50 years old and over 50 years old). A 90% confidence interval was selected because there were few participants in some departments (Table 3).

Study IV

The content analysis method described in Study I was used to analyze the data (Table 3). Each individual interview was read several times, and the pages on which different problem areas were mentioned were noted. Various key words or phrases were then identified. For example, words such as “pain in my body” or “monotonous and heavy work” were labeled as keywords. After identifying all of the keywords and phrases, they were cut out and sorted, according to the different topics. To take an example, the keywords and phrases mentioned above were cut out and sorted under the topic “physical strain”. Several topics were eventually assembled to form a category. In the case above, the category “Physical and psychosocial work environment” was formed.

Table 3. Qualitative analysis method and statistical analyses

Analyses	Study I N=10	Study II N=60	Study III N=2429	Study IV N=20
Content analysis	X	X	-	X
Chi-square test	-	X	-	-
Differences of proportions (90% or 95% Confidence Interval)	-	X	X	-
Analyses of relative measures of risk (expressed as odds ratios)	-	-	X	-

6 RESULTS

6.1. Study I

The results are presented in two parts. The first part consists of the results from the baseline interviews that were conducted in 1996, while the second part consists of the results of the follow-up interviews in 2002. The results summarized in the circular diagram (Figure 1) are explained more in detail below.

Results of the baseline interviews

Class

The interviewees perceived that they had experienced social degradation in Sweden in comparison to the conditions they once had; where they had once been members of the upper middle class in their native countries, they had now become members of the poor and segregated immigrants in Sweden. The social degradation was due to the deskilling process on the Swedish labor market, which meant that most of them could not get a job that matched their education and work experience.

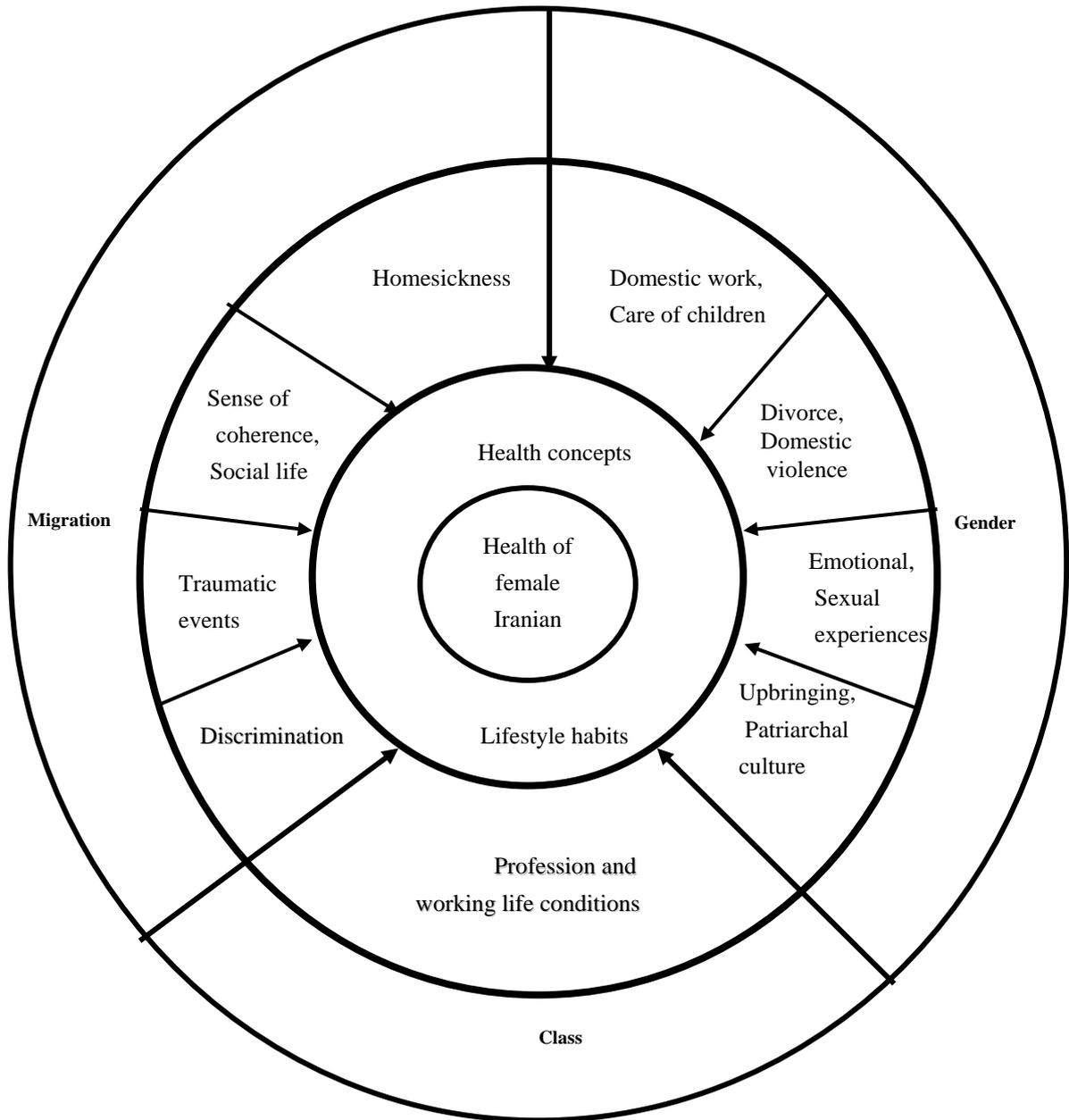
Gender

Domestic violence is another subject that was mentioned as a symbol of the patriarchal relationship within the family. Another theme which was brought up by some of the women as a symbol of the patriarchal relationships that influenced their health was that of emotional and sexual experiences. The women described the patriarchal culture that prevailed, giving descriptions of various events and periods in their lives and the resulting effects on their health.

Migration

Persecution, imprisonment, living underground and suppression of dissent were among the experiences which led to the women's flight from Iran. Several of the interviewees had migrated because of their involvement in political activities. These memories were painful and many interviewees began to cry as they related them. The women said that their experiences of being humiliated, arrested, living underground, fleeing under dangerous conditions and leaving their country had inflicted deep wounds which have

Figure 1. Summary of the results of the analysis



Source: Survey results

had long-lasting effects on their health. All of those interviewed raised the issue of the ethnic discrimination that they had experienced during the post-immigration periods, under various themes. They called discrimination the “greatest threat” to their health.

Some of the interviewees said that they suffered when they were treated differently because they have “black hair and dark skin”. Most of them felt that discrimination “hurts the soul deeply”, “affects the psyche” and made them “sad, angry and depressed”. This in turn caused “headaches”, “stomach aches”, “back and neck pain” and “sleeping difficulties”. The interviewees had different reactions to discrimination. Some of them chose to “ignore it”, some became “very sad but blamed the system” and some “responded aggressively and with harsh words”.

Involvement in social and political life was discussed as a form of adaptation to society and a means of remaining healthy. The importance of a social network and social activities was also brought up. Some of the participants in the study were involved in some form of multi-cultural socio-political activity. Some of those interviewed pointed out that “female immigrants must be strong” and “force their way into the system”. The women felt that they also needed to “organize themselves” as a group.

Health

Most of the interviewees said that they were ill, or had chronic pain due to conditions such as arthritis of the knees, fibromyalgia, ulcers, migraine, back pain, varicose veins, sciatica and lumbago. The youngest of the interviewees said that she was completely healthy. The interviewees’ definitions of health and what it means to be healthy varied, but they all agreed that, “mental health is a definite complement to physical well-being”.

Results from follow-up interviews

In 1996, the interviewed women related that they had experienced social degradation because of the deskilling process on the Swedish labor market. Results from follow-up interviews showed that most of them had obtained Swedish post-secondary school qualifications and employment by participating in work training programs over the past 6 years, in a bid to regain the social status they once had. More than half of the interviewees were employed at the time of the follow-up interviews.

They still suffered from health problems: the difference between now and then was their assessment of the significance of poor health or illness in their lives. In 2002, the health problems were still there, but the majority of interviewees did not consider them to be as significant as they had been in 1996. The result from the follow-up interviews showed that in 2002, working life had a central role in the women’s life; with the exception of the two who were early retirees, the others did not focus on health problems. The factors they identified as influencing their health in the follow-up interviews largely concerned working life and its psychosocial environment.

Table 4 shows health-influencing or threatening factors as described by the participants in both the baseline and follow-up interviews.

Table 4. Factors which influence or threaten health

In relation to Class	In relation to Ethnicity	In relation to being a woman	In a spiritual context
"safe, stable financial situation and employment"	The feeling of "being an outsider and "being discriminated" against, "to be an immigrant"	"domestic violence"	"mental calm and peace"
"low income"	Traumatic experiences for example torture	"living under the man's dominance"	"engaging in meaningful activities"
"unemployment" and "feelings of insecurity"	"to be accepted in the society"	the inability to answer to "sexual and emotional needs"	"being with my children"
"anxiety of being unemployed"	"self-confidence" and "being proud of one's identity"	Patriarchal culture	
	Absence of social network	"having time to oneself"	
	Experienced discrimination and racism in workplaces	"being aware on one's own needs and feelings"	
	Feelings of "loneliness and isolation"		

Source: Survey results

6.2 Study II

The results show that there is a reciprocal relation between health, work and migration. Immigration may cause poor health, which leads to unemployment and/or sick leave. Immigration may also lead to an inferior position on the labor market, which in turn could lead to poor health due to exposure effects. The influence on health is more marked for female immigrants than for male immigrants.

Health

Slightly more than half of the participants considered their health to be poor and had experienced physical and/or mental disorders. The female participants experienced poorer health than the male participants. Most of the participants said that they had experienced chronic pain, while less than one-fifth had not experienced any pain at all. As shown in Table 5, the participants mention unemployment or being on sick leave as a health-threatening factor. Table 5 shows factors that influence or threaten health, as stated by the participants.

Table 5. Factors which influence or threaten health

In relation to Class	In relation to Ethnicity	In relation to being a woman	In a spiritual context
”to get an education, a job, food and to be able to travel and to go and see a doctor”	Experiencing discrimination	“domestic violence”, “rape”	Not having “pain in the brain” “To have a family and to be able to be with them”
“to have a job and to manage on my own”	Traumatic experiences, for example of war		”to be able to have healthy thoughts” ”to be an optimist”
To be able “to break the cycle of unemployment or of being on sick leave”			”to experience harmony in body and soul” and ”to be able to go on with one’s life”
Anxiety over being unemployed			”to dare and to be trustworthy”
“Feelings of insecurity”			”a gift from God that demands work and care”

Source: Survey results

The results of the questionnaire are presented in Table 6. They show that slightly more than half of the women and one-third of the men felt fit and happy only rarely, or not at all. In other words, more than one-fifth of the women and almost as many men often felt depressed.

Table 6. Participants' self-reported states of mental and physical well-being

	Mental well-being Feel fit and happy		Mental well-being Feel depressed		Physical well-being Feel tired and slightly		Physical well-being Having headaches and concentration difficulties	
	Women %	Men %	Women %	Men %	Women %	Men %	Women %	Men %
Often	13	26	23	21	55	47	36	26
Sometimes	32	37	22	32	39	47	48	42
Very little or not at all	55	37	55	47	6	6	16	32

Source: Survey results

Table 7 shows the decision-making latitude that the participants have in their lives. In comparison to the female participants, the male participants most of the time felt that they had influence over their living conditions, were capable of making decisions, could cope with daily difficulties and enjoy everyday activities. However, they were less often capable of overcoming difficulties in comparison to the female participants. Although they had experienced periods of unemployment or sick leave and poor socioeconomic conditions, the majority of the participants felt that they had control over their lives and a sense of coherence.

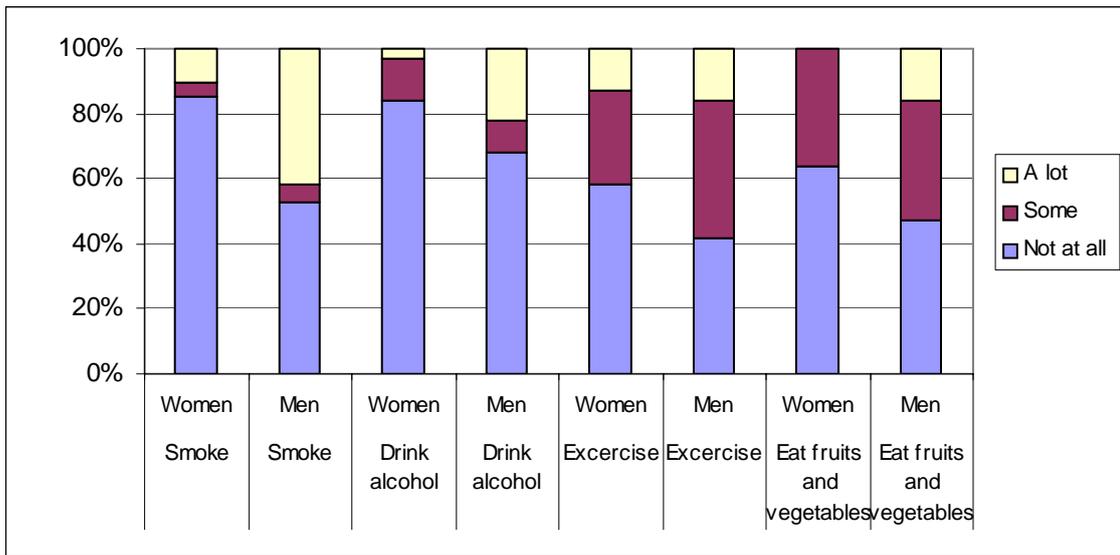
Table 7. Participants' degree of decision-making latitude

	Feel that they are able to influence their living conditions %		Feel capable of making decisions %		Feel capable of coping with daily difficulties %		Feel capable of overcoming difficulties %		Feel that they begin to lose their self-confidence %		Feel that they can enjoy everyday activities %	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Never	14	21	6	10	6	5	16	16	39	47	13	10
Sometimes	32	16	26	21	26	16	39	58	32	16	35	31
Often	32	37	29	22	33	32	32	16	19	21	29	27
Most of the time	22	26	39	47	35	47	13	10	10	16	23	32

Source: Survey results

Figure 2 shows that the majority of the participants had healthy living habits as far as smoking and alcohol consumption were concerned. Most of them did not smoke or drink alcohol, but those who did, did so excessively. Exercise and healthy eating habits, however, were very low, especially among women. In group discussions it appeared that the participants were well aware of the importance of exercise in promoting good health, but as some of them stated, "I don't have the energy" or "I don't know how to exercise". Moreover, they thought that they could "not afford to go to expensive gyms". Most of them did not eat much fruits or vegetables, according to one female participant, because "vegetables and fruits are very expensive in Sweden and we can't afford them".

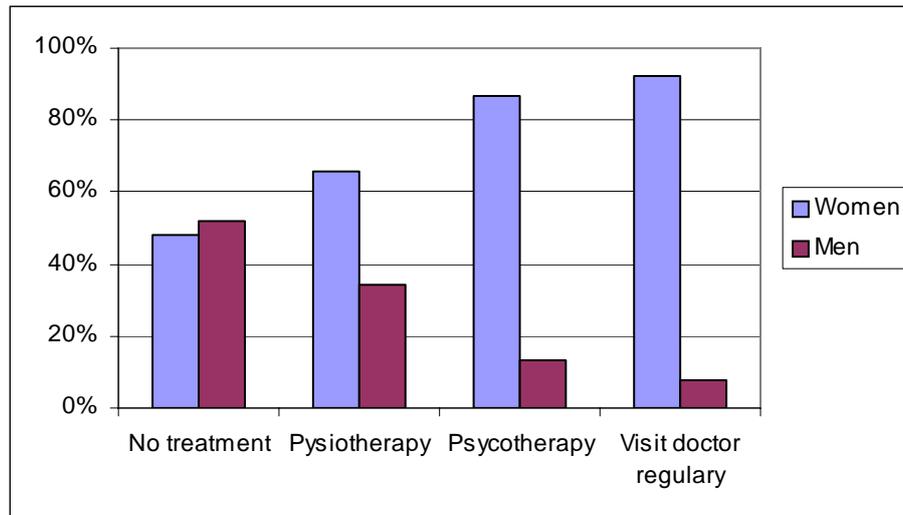
Figure 2. Living habits



Source: Survey results

Almost half of the participants consumed analgesic drugs or medicines. From the group discussions, it appeared that several of them consumed large amounts of painkillers or other kinds of drugs, they "lived on pills". It has been noticed that some participants took medication along with them and that they consumed different forms of medication during the day. The consumption of medicines was higher among women but the difference was not statistically significant. Slightly half of those who said that they were ill or in poor health did not get any treatment at all. Figure 3 shows that the women used the health care system to a greater extent than the men.

Figure 3. Use of the health care system



Source: Survey results

6.3. Study III

In the studied municipality, the proportion of native Swedish females who are permanently employed is higher than that of female immigrants. About 20% of female immigrants have temporary employment, while the proportion for native females is 8%. Most of the women in both groups are under the age of 50 and work full-time. The proportion of female immigrants in the cleaning team at the Maintenance and Cleaning department was 75%, in Nursing and Care, 34% and in other departments about 20%. There were no female immigrant employees in departments such as the Fire Services, Environmental Services and Estate Agency.

Wage-discussion opportunities

According to the policy document of the studied municipality, every employee is entitled to have wage discussions with his/her manager before wages are set for the upcoming fiscal period. These discussions do not always lead to higher salaries, but they provide an opportunity for negotiations and for employees to receive an increase in wages or other type of benefits or bonuses. The results show that 69% of female immigrants report that they had received no opportunities to discuss their wages with their managers in comparison to 63% of native women (Table 8). This comparison with the native women was significant for female immigrants under 50 years of age (90 % CI), however it was not significant for those over the age of 50 (Table 9).

Table 8. Comparisons between female immigrants and native women who answered the employee questionnaire in all departments of the municipality, regarding their perceptions of various conditions in the workplace

Conditions in the workplace	Number of immigrant women who participated in the study in all departments N (%)	Number of native women who participated in the study in all departments N (%)
Experienced gender discrimination	62 (10)	133 (8)
Experienced ethnic discrimination	85 (14)	96 (6)
Experienced sexual harassment	400 (65)	1229 (68)
Lack of access to information	77 (13)	148 (8)
Did not get development opportunities	245 (40)	633 (35)
Did not get wage discussion opportunities	423 (69)	1134 (63)
Participated in preventive health care activities	231 (38)	596 (33)
Had health development plan	136 (22)	356 (20)

Source: Survey results

Table 9. Comparisons between female immigrants and native women who answered the employee questionnaire in all departments of the municipality, regarding their perceptions of various conditions in the workplace (Odds Ratio 90% confidence intervals)

Conditions in the workplace	Immigrant women compared with native women OR (90% CI)	Immigrant women compared with native women < 50 OR (90% CI)	Immigrant women compared with native women > 50 OR (90% CI)
Experienced gender discrimination	1.40 (1.07-1.83)*	1.22 (0.90-1.69)	1.68 (1.05-2.75)*
Experienced ethnic discrimination	2.90 (2.23-3.76)*	2.37 (1.74-3.23)*	4.16 (2.56-6.74)*
Experienced sexual harassment	0.87 (0.74-1.02)	0.90 (0.74-1.10)	0.82 (0.62-1.07)
Lack of access to information	0.61 (0.47-0.77)*	0.64(0.47-0.86)*	0.62 (0.39-0.95)*
Did not get development opportunities	0.81 (0.69-0.95)*	0.90 (0.74-1.10)	0.73 (0.55-0.95)*
Did not get wage discussion opportunities	0.77 (0.66-0.91)*	0.76 (0.60-0.94)*	0.86 (0.66-1.12)
Participated in preventive health care activities	1.22 (1.04-1.43)*	1.17 (0.96-1.44)	1.32 (1.01-1.72)*
Had health development plan	1.15 (0.96-1.39)	1.12 (0.88-1.40)	1.24 (0.92-1.70)

Source: Survey results

*Statistically significant

Ethnic and gender discrimination

The results of the questionnaire survey show that female immigrants reported the occurrence of ethnic discrimination in the workplace more often than their native counterparts (Table 8).

The proportion of native females who reported incidences of ethnic discrimination occurred at their workplace was 6%, while the proportion of female immigrants who reported the same was more than twice as high, or about 14%, resulting in an odds ratio of 2.9. The number of reports of ethnic discrimination among female immigrants under the age of 50 was 2.37 times more than among native Swedish females, and 4.16 times higher than for those over age 50. The odds ratios were statistically significant for both groups.

There was a similar pattern for age and gender discrimination, with the proportion of native women who reported that gender discrimination occurred at their workplace being 8%, while the proportion of female immigrants was 10% (Table 8). The odds ratio for female immigrants was significant only for females over the age of 50. More native women perceived that sexual harassment occurred in the workplace than female immigrants, but the differences were not significant, even after adjusting for age (Table 9).

Preventive health care measures

The municipality offered one hour of the working time for participation in preventive health care activities. It also offered a sum of money to employees for participation in some form of sporting activity, for example the purchase of a workout ticket or gym membership. All employees must have a preventive health care activities plan that is drawn up together with the manager. The proportion of native women who reported that they participated in preventive health care activities was 33%, while the percentage for female immigrants was 38% (Table 8). The odds ratio for female immigrants was significant only for females over the age of 50. Furthermore, there were no significant differences between immigrant and native women who had a health development plan, even after adjusting for age (Table 9).

Skills upgrade training

According to the municipality's policy, all members of staff should have an individual skills training plan which has been formulated in agreement with their managers.

However, about 40% of the female immigrants and 35% of the native women in our study reported that they did not get any opportunities for skills upgrade training exercises (Table 8). The comparison was statistically significant (90% CI) for female immigrants over 50, but it was not significant for female immigrants under the age 50 (Table 9).

Female immigrants had less access to adequate information about the municipality as their workplace when compared with native females. About 13% of female immigrants reported that they did not get sufficient information, in comparison to 8% of native women (Table 8). The differences between native and immigrant women were significant, both for those over the age of 50, and those who were younger (Table 9).

6.4. Study IV

The results of this study give a deeper understanding of the relation between the work and health of female immigrants, how they view their health and the health-influencing factors that they experience in the workplace.

Health

The interviewed women's perceptions of influencing and threatening health factors varied as shown in Table 10. These factors are described in more detail in this section.

Table 10. Factors that influence and threaten health

Cleaners	Teachers	Home assistant	Living assistant
“to not feel powerless”	“to achieve happiness in life”	“to go to the gym, sleep well, eat right, have the energy to do more, avoid stress”	”to not only think of others all the time”, “quality of life”
		“to be able to get into society”	

Source: Survey results

Wages and professional status

The interviewed cleaners felt that higher pay and occupational status would improve their work situation and health. They felt belittled and “unfairly treated” and that their work “is not seen as valuable, which affects their health”. They mentioned “fair pay” as a health-promoting factor. One of the cleaners who was very dissatisfied with her pay said that if one of the cleaners was absent due to illness, that person would receive a lower annual income. She said “the manager says that your salary is lower than the others’ because you were on sick leave.” To be able to support themselves and their dependants, the cleaners avoided staying at home even when they were ill or in pain.

The home-help and living assistants were also very dissatisfied with their wages. They perceived that low wages and a low occupational status not only had a negative impact on their health, but could also lead to “burn-out”. The teachers perceived that they were underpaid compared to other professional groups, but that they were “compensated by long holidays, to take one example”. None of the teachers was dissatisfied with their occupational status.

Physical and psychosocial work environment

Cleaners and home-help assistants perceived that their work was “monotonous and heavy”, leading to “pain in the shoulders, back and sometimes the arms”. The teachers had problems with “noise, polluted air in the classrooms and heavy doors that had to be opened many times a day”. They all agreed that they needed better work instruments and better ergonomic training in order to improve working conditions that may impact positively on their health.

Neither the cleaners nor the home-help assistants were able to influence their work tasks or working hours. In contrast, teachers and living assistants had more freedom to plan

their individual work schedules, for example through flexible working hours. This was not only because of the type of the work they did, but also that they had “a manager who trusts (them) and gave (them) the freedom to do so”.

All of the interviewees, with the exception of the cleaners, felt that they experienced psychological strain at their workplaces. Some suffered from insomnia and thought about the working day throughout the night. Teachers and home-help assistants wished to have brain storming sessions with colleagues, as well as a professional psychologist to help the social services or school staff by discussing different cases and supporting them find solutions. However, this was not possible due to budget shortcoming.

All the interviewees perceived that they were at risk of being stressed. Teachers could become stressed because they “always have to be ready and focused on the lectures, as well as to sort out conflicts between the students”. Home-help and living assistants could become stressed because they have “too many clients to visit during a short time” and the cleaners have to clean large areas in a very short time. Furthermore, if a colleague is ill then they have to take her place, “which makes it really stressful”.

All of the interviewees agreed that leadership was an important factor for a healthy workplace. Some were pleased with their managers, because the managers “trust them”, “treat the staff fair”, “tolerate criticism”, “were active in communicating with the staff” and “gave support and encouragement”. Others said that they needed more attention from, and contact with, their managers. The comments made about the managers did not vary according to the type of employment contracts the interviewees had.

All workers were entitled to spend one hour a week participating in preventive health care activities (going to the gym, swimming, riding a bicycle, etc.) during working hours if their working conditions allowed. The cleaners, living assistants and teachers tended to make use of the opportunity every week. Home-help assistants could not do so because it was impossible to find time within their work schedule.

Skills upgrade training

The concept of skills upgrade training described in study III. The interviewees believed that the lack of opportunities for skill upgrade training had a negative impact on their health. The reason was that without skills upgrade training, they were not able to improve their position in the hierarchy on the labor market.

None of the interviewed cleaners had formulated a plan for skills upgrade training, either individually, or collectively, and no-one knew anything about it. One of the cleaners said that she had begun taking a language training course after working hours, but did not have the energy to continue as she was too tired when she was there and could therefore not learn anything.

The teachers were very satisfied with their skills upgrade training plans and the opportunities that were offered. They had also personally been active in seeking

financial support from different sources. The home-help and living assistants did not have an individual plan for skills upgrade training. Some of them attended courses; others wanted to improve their competence by continuing their education to become assistant nurses, but they said that it was not possible to do that.

Ethnic discrimination

Concerning discrimination, it appeared that many of the interviewed women perceived the ethnic discrimination that occurred in their workplace as having a negative impact on health. They had developed their own strategies for dealing with discrimination. They talked about discrimination in terms of their personal experiences, mentioning for example, a manager who is "racist, doesn't answer my questions, yells and gets angry...they treat me like this because I'm an immigrant, they say that I don't speak Swedish well". The interviewees also described their experience of structural discrimination in the society, asking "only immigrants are doing the cleaning, why don't Swedes work as cleaners? ...It's exactly like the slavery times when they used black people."

One of the teachers who experienced ethnic discrimination in the workplace said that "there is a hidden racism among pupils". She felt discriminated against because of her "pronunciation" and "different codes of communication". One of the teachers felt that female immigrants "had to be much more competent and able to do much more than native women to be able to reach the same position". Another said that "deep inside you can get a feeling of not being accepted by the Swedes, this feeling wears you down".

Ethnic discrimination could involve humiliation, for example. One of the home-help assistants said that "if something goes wrong in society or at a home, it's always the immigrants' fault". Some of the home-help assistants were Muslims and wore scarves. One of them felt discriminated against by her clients, saying "once a client asked me why I had a tablecloth on my head". This woman's strategy for dealing with discrimination was to "take off the veil when going to female customers". One of the home-help assistant's strategies was to "tell the supervisor that I don't go to that customer any more". Another home-help assistant tried to find explanations for the clients' behavior, for example that "they are old and don't understand" or "I don't care and feel sorry for them". Another home-help assistant said, "my strategy is to not get sad".

Some of the living assistants also began by saying "No", and then continued to say things like "I've been discriminated against a little" she continued "for example when I write a report and they say your Swedish is not good enough". Another said, sometimes colleagues or patients used the "wrong word, for example Negro".

Strategies that the living assistants used to deal with ethnic discrimination involved contradiction, for example by saying "nobody can treat me like this". Others blamed

themselves. For example, one woman said, “sometimes I feel that they think we come here and take their place at work; it’s a natural reaction from the Swedes”.

One of the living assistants felt that female immigrants found it difficult to learn the codes in a Swedish workplace, for example learning to “say what they think in a diplomatic way, to dare to communicate, but not make a fuss. Otherwise they will be perceived as cocky”. She thought that they “shield themselves in the workplace by not showing who they really are and that they are afraid of expressing their opinions”. Furthermore, she thought that if an immigrant does not use these strategies, “then she will not manage in a Swedish work environment”.

Gender discrimination

Several of the women brought up issues of gender discrimination as having a negative impact on health. One of the teachers thought that she was a victim of gender discrimination due to “the pay and female work tasks”. One of the home-help assistants first answered the question about gender discrimination with a “No”, and then continued, “many of the old people are trying to paw us; they give you a thousand-crown note and say come and sleep with me, come and have a cup of coffee with me and watch porno with me”. They solved these problems by talking about it in the work group. On the next visit to such a client another home-help assistant accompanied as support. Some of the living assistants said that they had not experienced gender discrimination in the workplace. They thought it was perhaps because “we don’t have a job with a high position” or “we work in a female-dominated workplace”. One of the living assistants said once when she wanted to write a report her Swedish male colleagues said she could not do that. According to her, “they needed to feel clever and capable by telling me in a nice way that I’m no good; a form of hidden sexism-racism.”

7 DISCUSSION

7.1. Main findings

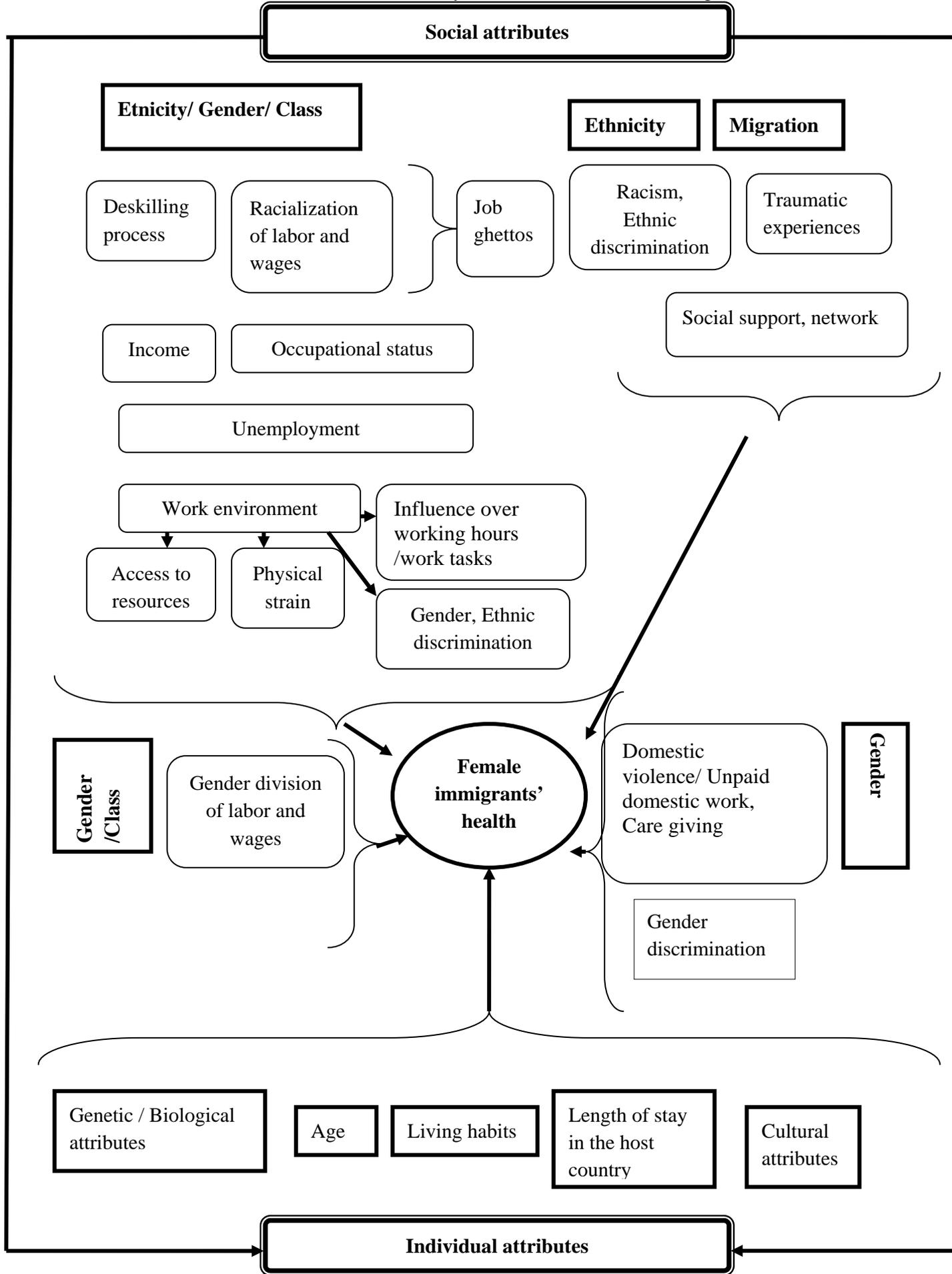
The main findings of the four studies in the thesis contribute to the empirical knowledge base of the system of class, gender and ethnic oppression and serves to understand, describe and analyze the factors that contribute to poor health among female immigrants in a Swedish context. Model I is a sketch of the results of the four studies in the thesis. It can be used as a theoretical framework for studying the health of female immigrants. According to the model, socially and individually related attributes influence the health of female immigrants. Income, occupational status, the racialization of labor and wages and the deskilling process are socially related attributes which, together with unemployment and the work environment, contribute to poor health among female immigrants along the lines of class, gender and ethnicity. The gender division of labor and wages also contribute to poor health among female immigrants. Domestic violence and gender discrimination are other factors that contribute to poor health among female immigrants. Furthermore, ethnic discrimination, racism, experienced trauma and the absence of social support and networks also contribute to poor health among female immigrants.

The main findings also show that there is an interaction between health, work and migration. Although people who migrate often have good health, the immigration process itself may cause poor health and result in unemployment and/or necessitate sick leave. Immigration may also lead to an inferior position on the labor market, which could in turn lead to poor health due to exposure effects. The effect on health is more evident among female immigrants than among their male counterparts.

Finally, the main findings of the four studies demonstrate that the work-related health of female immigrants is strongly associated with social class. The three aspects based on class are wage, professional status and position in the hierarchy of the work organization. Other factors associated with work-related health factors are discrimination due to ethnicity and gender, unfavorable physical and psychosocial work environments and the absence of opportunities for skills upgrade training.

The individual factors that may also contribute to poor health among female immigrants are living habits, the length of stay in the host country, cultural attributes, age and genetic or biological attributes. The social attributes influence the individual attributes. I will discuss some of the attributes illustrated in the model in more detail.

Model: A framework for the study of the health of female immigrants



Deskilling process

Deskilling is a process that is shaped on patterns of social relationships such as class, gender and ethnicity. Wren & Boyle (2002) state that

“...deskilling is a process where skills and qualifications gained through earlier training and employment are either not used or recognized after migration, resulting in downward occupational mobility and potential loss of skills”. (Wren & Boyle, 2002, page 40)

According to Wren & Boyle (2002), and as the results of Study I show, deskilling may lead to low levels of labor market participation and welfare dependency, long-term social exclusion and poverty. The consequences of the deskilling process may contribute to poor mental and physical health. Wren & Boyle (2002) argue that

“... the relationship between deskilling and poor mental and physical health is not a simple case of cause and effect. Instead it is a complex interaction between structure and agency, where institutional factors which impede retraining and employment (these include racism, discrimination, institutional / financial barriers to employment and relevant retraining courses etc.) interact with prior health problems (associated with the trauma of forced migration and potential torture / witnessing of genocide / murder, loss of relatives and home etc.). Thus poor mental and physical health may constitute a significant barrier to effective retraining and employment, while deskilling itself may influence mental health outcomes. The relationship between deskilling and mental health is therefore complex and often circular”. (Wren & Boyle, 2002, page 42)

Study I shows that Iranian female immigrants who were highly educated and had working experience were socially degraded in the first decade of the post-migration period. In agreement with this study, previous research (Roselius 2000) shows that Iranian female immigrants, who had post-upper-secondary education on their arrival in Sweden, could not obtain jobs that matched their qualifications. They had problems entering into the labor market and their health was threatened by the deskilling process and/or their state of unemployment. A very large group of Iranian women migrated to Sweden during 1980s. It took several years for them to learn the Swedish language, yet getting employment was not easy. A report from The Swedish National Labour Market Board (1991) shows that according to the officers of the Employment Agency, their most difficult task was that of finding a job for a highly educated immigrant. In her report, Brune (1993) discusses the fact that highly educated female immigrants have more difficulties finding a job than male immigrants. According to her, highly educated immigrants are routinely recommended to less qualified occupations and have difficulties obtaining employment in the fields in which they are qualified . There appears to be some form of “order of precedence” which runs along the lines of

ethnicity on the Swedish labor market. Previous research on the health of immigrants (The Swedish National Board of Health and Welfare, 2000) shows that compared to immigrants from Turkey, Chile and Poland, Iranians experience more ethnic discrimination in the form of being treated disrespectfully. The same study shows that compared to immigrants from Turkey, Chile and Poland and to Swedish men and women, female Iranian immigrants report poor health to a greater degree. The Iranian women who report poor health are mostly highly educated - at least to university level - but are nevertheless unemployed. The results reported by the Swedish National Board of Health and Welfare are in agreement with the results of Study I. Once again it confirms the effects of the deskilling process on the health and working conditions of female immigrants.

“Job ghettos”

The term “job ghettos” is used to illustrate workplaces within blue-collar and service jobs with the lowest wages and low occupational status (Murray 2003). The deskilling process and the racialization of labor and wages serve to strengthen and reinforce the creation of job ghettos. Studies III and IV indicate that female immigrants are mainly employed in job ghettos as cleaners or home and nursing assistants. The proportion of female immigrants with temporary employment is higher than that of native women. This is another factor that indicates the level of insecurity for female immigrants in job ghettos.

Job ghettos, in turn, create poverty and lead to poor health among female immigrants. In Sweden, as in many other countries, there is a deep gender and ethnic segregation on the labor market (de los Reyes & Winborg 2002; Martinsson 2002; Mulinari & Neergard, 2004). The Swedish public health report (2003) shows that female immigrants, particularly those from the Middle East and North Africa, are over-represented in the lowest income group and immigrant families are more dependent on social benefits than native families. Poverty³ and low income are more common among female immigrants than other groups in the society (The Swedish National Board of Health and Welfare, 1995) and their disposable income is the lowest when compared to native men and women and to male immigrants (Magnusson & Andreasson, 2005). Female immigrants, especially those from eastern and southern European countries, Africa, Asia and Latin America are unemployed to a larger extent than native males and females (The Swedish

³ “Poverty thresholds can be set at a: an income level determined inadequate for meeting subsistence needs, or b: the point at which resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities, such that the poverty line equals the point at which withdrawal escalates disproportionately to the falling resources” (Gordon & Spicker, 1999). In the Swedish context (The Swedish Governmental Office, 2003; Halleröd 1999) and in the thesis, poverty means living under welfare norms (on social benefits) and being dependent on it.

Integration Board, 2003). Those who are employed are primarily represented in the service and health care sectors, in work that is characterized as heavy and monotonous, with low status and low incomes (The Swedish National Board of Health and Welfare, 1995; de los Reyes et al., 2000; Höglund, 2002; The Swedish Integration Board, 2003; The Swedish National Social Insurance Board, 2005). A report from the Swedish Labour Union (LO, 2006) shows that the average wage for employees born abroad is, in general, 2000 Swedish crowns less per month than for those born in Sweden. Lynch & Kaplan (2000) emphasize that it has been repeatedly found that the relation between income and health indicates that an adequate income provides a general resource which provides access to a greater variety and better quality of neo-material goods and services.

“Income level has influences on health because of what money can buy. Adequate income has important implications for a range of material circumstances that have direct implications for health, quality, type and location of housing, food, clothing, transportation, medical care, opportunities for cultural, recreational and physical activities, childcare and exposure to an array of environmental toxins”(Lynch & Kaplan, page 24).

They mean that people with the least amount disposable income are subject to the largest cumulative burden of stressors and poor health.

The female immigrants in Study IV also emphasized the importance of financial income. The cleaners, home-help assistants and living assistants felt that low wages and low occupational status were harmful to their health. This is in agreement with a recent study by Wilkinson (2005), where low social status is pointed out as one of harmful social risk factors for health. Low status occupations are characterized by low levels of control, fewer opportunities to learn and develop skills and high psychological workloads which influence health negatively (Marmot et al., 1991). Wilkinson stresses that

“health is graded by social status... health standards are highest among those nearest the top of the social ladder -whether measured by income, education, or occupation - and lower as we look at each successive step down the ladder”. (Wilkinson, 2005, page 14)

Social status is thus considered by Wilkinson as an important risk factor for health. The higher people's social status, the longer they live, since they feel valued, appreciated and needed. Wilkinson argues, on the other hand, that the social consequences of low material living standards may make people feel as if they are being scorned, as if they have an inferior position in the social hierarchy, treated as insignificant, humiliated and

subordinated. Wilkinson's observations are in agreement with the views of the female immigrants who were interviewed in study IV. They confirmed that if they are "not seen as valuable" in their capacity as workers, this could have a negative influence on their health. The women who worked as cleaners, the occupational group with the lowest social status in the organizational hierarchy of work, expressed exactly the experiences and feelings that are described by Wilkinson.

Another point about "job ghettos" is that female immigrants are more often trapped in them, with few opportunities offered for better jobs or career development. Evidence that this may lead to ill health has been found (Noborisaka & Yamada 1995). One more observation related to working conditions in job ghettos comes from Study IV and shows that female immigrants in workplaces within blue-collar and service jobs with the lowest wages and low occupational status avoided staying at home even when they were ill so as not to lose a part of their monthly income. In the long run, this could mean that they run a higher risk of developing health disorders. There are strong indications that a lack of rest, recovery or recreation can be a larger problem than the intensity of stress and other strains in and outside working life (DN, 2004). If the employees cannot feel secure enough to rest and recover when they get ill, then it could lead to long-term sick leave in the long run.

Work environment

Pressing psychological demands lead to increased sick leave absences when they are combined with low decision-making latitude (Theorell, 2000). The results of Study IV are in agreement with previous research that shows both physical and psychological work environment have an important influence on health (Eriksson & Larrson 2002; Marklund & Wikman 2000). Both those who worked in occupations with low wages and low status (cleaners, home-help assistants and living assistants) and teachers perceived that they were having problems with the physical and psychological work environment, but in different ways. For example, teachers had problems with pressing psychological demands, while home-help assistants had problems with low decision-making latitude.

Other factors related to the working environment are gender and ethnic discrimination and access to resources such as skills upgrading training programs, which will be discussed in the following sections.

Discrimination and racism on the labor market and in workplaces

According to a governmental investigation (de los Reyes & Kamali, 2005) Sweden, like many other European countries, deny the presence of racism and the occurrence of discrimination in society. The investigation suggests that instead of denial, it is vital that

policy makers listen to the voices of the people who have been victims of discrimination.

One of the arenas in which ethnic discrimination thrives is on the labor market among female immigrants and/or minority women. Essed (1991) has labeled the experience of racioethnic women as gendered racism. In Sweden, gendered racism appears clearly on the labor market. Previous studies confirm that ethnic discrimination on the Swedish labor market is a major problem (Wren & Boyle 2002; Häll & Roselius 1999; Thörnell, 2003; de los Reyes & Winborg 2002): because of it, female immigrants suffer from unemployment or temporary employment contracts more than native females and males. Ethnic discrimination gives rise to the inferior treatment of immigrants in the workplaces, despite being comparably qualified in terms of education, experience or other relevant criteria. The inferior treatment (Rea et al 1999) can take several forms, for example, receiving unequal pay for the same work, being excluded from different staff activities participating in courses.

In study I, the women mentioned ethnic discrimination as the “greatest problem” and a threat to their health. Why do the interviewees experience ethnic discrimination as the most serious problem and as a threat to their health? To understand this, I will point out that for these women (due to their background) being in the labor market, earning their own money and being respected for their own qualifications have been important. To be restricted from entering the job market, to be deskilled or treated differently because of one’s place of birth, skin or hair color is experienced as being ethnically discriminated. This was an experience they had never had to confront before and that they did not know how to cope with. As the participants described in the interviews, discrimination “hurts the soul deeply” and may cause physical pain.

In study II, one participant clearly stated, “I’m black and wear a veil. Who will give me a job?” According to the law, an unemployed person, regardless of ethnic background, has the same rights as any other applicant to get a job for which he/she is qualified. But the reality is different. The rates of unemployment in the labor market are higher among foreign-born men and women and young people with immigrant background than among native Swedes (The Swedish Integration Board, 2003; Hjerm, 2002; LO, 2006).

Studies III and IV show occurrence of ethnic discrimination in the work places in the studied municipality. Discrimination can occur between individuals or institutionally, in the form of organizational structures and policies (Karlsen & Nazroo, 2002). Female immigrants experienced individual discrimination in their daily work from clients, pupils, parents, etc. They also experienced institutional discrimination by being confined to job sectors with low wages and limited access to skills upgrade training opportunities.

A Swedish study (Kamali, 2005) argues that institutional discrimination and racism on the labor market, especially against non-European immigrants, results in long periods of

unemployment or temporary employment, which in turn results in work-related health problems. Studies that have investigated work-related health factors have shown that exposure to ethnic discrimination at work causes poor mental health (Smith et al., 2005; Roberts et al., 2004). In agreement with previous research (Krieger 2000; Buka 2002; Karlsen & Nazroo 2002; Smith 2000; Williams & Williams-Morris 2000; Williams & Neighbors 2001; WHO 2003a; McKenzie 2003; Harrell et al. 2003; The Swedish National Institute of Public Health, 2005), the four studies in the thesis show that experiencing ethnic discrimination is a threat to health, both physically and mentally. The physical health problems caused by discrimination can take the form of chronic fatigue, high blood pressure and heart or vascular diseases and result in low birth weight, increased consumption of alcohol and/or cigarettes, self-reported ill health and a high incidence of sickness absences, while mental health problems involve mental stress, depression, nervousness, anxieties and psychoses (Williams et al., 2002; Krieger, 2000; Collins et al., 2000).

Access to resources, information and skills upgrading training programs

Providing access to resources means exerting control, influence and power over laws, regulations and institutional routines for all the citizens and not only the white majority (Kamali, 2005). One important arena for access to resources is within working life. For example, rehabilitation, skills upgrade training and information are important resources in working life that female immigrants have limited access to.

Rehabilitation is a resource that is supposed to be offered to the people on sick leave to help them to get back to work. Research has shown that it is quite difficult for female immigrants to get into the rehabilitation programs that are offered by the Regional Social Insurance Office (Selander, 1999). Results from Study II show that the majority of the participants who were suffering from some form of illness did not get any rehabilitation at all from the regional Social Insurance Office. The rehabilitation assistance they have received was a result of their own initiatives or those of the Social Services.

According to a report from the Swedish National Social Insurance Board (2005) the percentage of immigrants (especially non-European immigrants) who get rejected when they apply for sick leave benefits is higher than for native Swedes or European immigrants. The disparity is a source of concern to the Board and they plan to investigate the case for stopping eventual ethnic discrimination (DN, 2006).

The concept of skills upgrade training can be defined in several different ways. It could describe activities on an organization level, such as recruitment, promotion, personal mobility, formal or informal external/internal training or activities at the individual or

group level, as well as the spontaneous learning gained through work experience. Studies III and IV show that access to skills training programs are related to class and ethnicity. Female immigrants who worked in low status occupations with low wages had less opportunities for skills upgrade training. Skeggs (1997) argues that the lack of alternatives is one of the central hallmarks of the working class. The inclusion of skills upgrade training in learning and development programs that enhance professional knowledge, well-being and motivation may increase the number of opportunities for career and psychosocial development (Svensson, 2002). In agreement with our study, Knocke (1994) emphasizes that female immigrants who had the lowest positions in the work hierarchy were neither offered such opportunities nor asked whether they wished to participate in skills training programs. This leads to female immigrants remaining "stuck" at the lowest level of the hierarchical pyramid, with neither the tools nor the opportunities to climb upwards. The age-divided analyses show that female immigrants over the age of 50 (Study IV) received fewer opportunities to participate in skills training program than the younger ones. This could be due to the fact that the employers probably feel that it is not profitable to invest in them for further education or a promotion, which is an indication of age discrimination. Another tendency which is common in Sweden is to "blame the victims", for example by characterizing older female immigrants as having language problems, low levels of education, a lack of ambition and as not being active enough to warrant being given the opportunity to participate in skills training programs (Ålund, 1994 & 1999). Furthermore, the results of studies III and IV show that the number of female immigrants who did not get sufficient information about the municipality and their workplaces was higher than the number of native women. They also show that the lack of access to information in the workplace which is experienced by female immigrants occurs regardless of age. In this case, the employers cannot blame the women's poor language skills or education levels because even the younger ones who have mastered the language have the same problem.

Being a woman

The result of the four studies show that being a woman can be a threatening factor to health since women often carry out both paid and unpaid work. As shown in the four studies included in the thesis, they experience gender division of labor and wage differentials in the production sphere and consequently suffer from unemployment, low wages and low occupational status. In their workplaces they experience gender discrimination at both the individual and institutional level. Those who had experienced individual gender discrimination talked about harassment, or of clients and customers using humiliating words. The interviewees mainly focused on the institutional gender discrimination which leads to lower wages in gender-segregated low status professions (study IV).

In the reproduction sphere, some women reported that they suffered domestic violence. Studies I and II show that experiencing domestic violence had a negative influence on women's health. This is in agreement with previous research which shows that there are strong links between emotional and physical health (Elliot & Gillie 1998). Socially inflicted trauma such as mental and physical or sexual violence affects a person's health (Krieger 2000). Study I, which was a longitudinal qualitative study, made it possible to understand the experiences of female Iranian immigrants and their struggle to liberate themselves from patriarchal violence, as well as its influence on their health. Of the early post-migration period, some participants talked about being maltreated, being deprived of emotional needs, having to make sacrifices, having to obey and being asked to be loving unconditionally. All these demands were regarded as threats to their health. In the late post-migration period they moved on and appeared to have resolved these issues. This seems to indicate that the interviewees (considering their backgrounds as educated, political conscious women) had got the chance to be themselves and do things in Sweden that they would not have been able to do in their home countries. The dominant religious and cultural discourse in Iranian society has consistently promoted conservatism in gender and sexual relations (Shahidian 1996). However, this discourse does not reflect the views of educated, urbanized, politically conscious Iranian women both inside and outside of Iran. Previous research done in the United States, Canada and Sweden (Mahdi 1999 & 2001; Shahidian 1999; Eyrumlu 1998) shows that Iranian female immigrants defy the stereotypes found in the Western societies. They hold more liberal views than their counterparts in Iran, even more liberal than their husbands' opinions on these matters (Ghaffarian 1987). Migration has been a source of autonomy for these women, providing them with better opportunities for personal freedom and even divorce from difficult marriages. Migration to new countries has meant a breakdown of traditional norms for Iranian women (Kamalkhani 1988; Bauer 1991; Tohidi 1993). Comparing the situation of the interviewees in early and late post-migration periods shows that they were able to broaden their attitudes and translate their desires into practice, which may have had a positive effect on their health.

One cannot talk about women's health without taking into consideration the work that women do as wives or mothers (Payne 1991). However, none of the interviewed women in Study I or the other qualitative studies considered that domestic work was a threat to their health. This is surprising, since my own notion before the interviews was that the responsibility for domestic work and childcare could be a major threat to the health of female immigrants. A similar impression has been held and discussed by a number of other researchers such as Kindlund (1995) and Nilsson (2006), in addition to central authorities such as The Swedish National Social Insurance Board (1996). The paradox can be interpreted with help of studies I and II. In these two studies, the participants describe their children and family lives with words such as hope, the future, something

to live for. Perhaps a female immigrant who has suffered numerous losses and had countless life experiences considers having the people she loves with her and doing things for them as doing more than simply domestic work.

Being an immigrant

Pre-migration experiences of traumatic events are one of the causes of poor health (Sundquist & Johansson 1995). In studies I and II, some of the participants talked about traumatic events that had affected their health such as torture, rape or persecution. In Study I, during the early post-migration periods, most of the women mentioned such traumatic events as factors that negatively affected their health. In the late post-migration periods, however, none of them referred to these events. It appeared that the interviewees had left these terrible events behind them and that they no longer influenced their health as they did in earlier years. Considering the women's level of education, political awareness and life experiences in both pre and post-migrations periods, they have found the courage and strength to move on, to fight and establish new lives in the host country. Some of the participants in Study II, who were mostly in the late post-migration period still suffered from those terrible memories. One interpretation could be that those interviewed women in Study I who suffered of pre-migration traumatic experiences had been able to move on because they had re-educated themselves, got new jobs and organized their life as they wished while the participants in Study II still shuffled around between being unemployed, on sick leave absence or participating in various job market projects.

Previous research (Nazroo & Williams, 2005) shows that social support and networks are important for the health of immigrants or/and minorities. Studies I and II illustrate that being isolated and not having a network were a health threatening factor, especially for those who were older. Nevertheless, both studies show that the desire for a better life and a sense of coherence is strong for most of the female immigrants. In Study I they talk about a process of empowerment and "engaging in meaningful activities", which is necessary for immigrant women to be able to express their needs and improve their health. Although many of the participants in Study II suffered from financial problems and were either on sick leave absence or unemployed, the majority of them often felt that they were able to influence their living conditions, were capable of making decisions, could cope with daily difficulties and enjoy everyday activities.

Individual related attributes

Some of the individually related attributes such as living habits are somehow related to social ones. I wish to discuss living habits as an example in more detail.

Living habits have been discussed as a factor that influences health in study I. In the early post-migration periods only one of the women who had experienced terrible traumatic events talked about her unhealthy lifestyle habits. In the late post-migration periods, this woman said “I don’t smoke any more and I have better eating habits”. This confirmed that she had moved on and that the traumatic events she experienced no longer have the same influence on her health that they once had. The fact that she had experienced traumatic events can be defined as a social attribute related to her pre-migration experiences; these had affected her eating, smoking and exercise habits, which are individual attributes.

7.2. Validity and reliability

The consistencies in the results of Study I, when compared with the results of previous studies show the reliability of our study. Since the purpose of qualitative research is to describe or explain the phenomena of interest from the participant's perspective, the participants can legitimately judge the credibility of the results. The validity of the study was approved by sending the results to the participants and asking for correction/elaboration. The fact that the participants agreed to be interviewed again after six years showed that they were satisfied with the results of the initial study.

The reliability of the questionnaire in Study II have been tested in other studies before (National Institute for Working Life, 2001) and is based on often used questionnaires, as the one developed by Karasek and Theorell (Bildt, 1999; Karasek & Theorell, 1990). They have been found to be both valid and reliable enough to be used in epidemiological studies.

The reliability of the questionnaire in Study III was determined by looking at how consistent the results were for different items of the same construct within the measurements. We used the Cronbach α coefficient for internal consistency measurements. The validity of the questionnaire was later verified by interviewing twenty (20) female immigrants who worked as teachers, home-help assistants, living assistants and cleaners in the studied municipality. The result of the interviews showed that there was an agreement between the items on the questionnaire and the issues which the interviewed women listed as work-related health factors (Study IV). The consistencies in the results of Study IV when compared with the results of previous studies show the reliability of our study. The validity of studies III and IV was verified by sending the results to the participants and asking for correction/elaboration at a seminar arranged by the Institute for Working Life. The participants were satisfied with the results of the study, as is noted in the seminar’s protocol.

7.3. Limitations and strength of the studies

The limitations of Study I include the homogenous and small number of interviewees. Similar backgrounds might have influenced the study group's perceptions of health and the factors that influence their own health in Sweden.

One limitation in Study II was that since the qualitative data came from observations and group discussions, not every person would have had the opportunity to respond to any given topic. In addition, since all respondents were unemployed and were immigrants, there was no comparison group by which to define an average in these outcomes. On the other hand, that was not our aim with this study. Because of the study design - small sample and partly qualitative data - it is difficult to estimate the feasibility of generalizing from the results.

The third study had several limitations. Since the study was cross-sectional in nature, a cause and effect relationship cannot be established and the associations between the work-related factors and health disorders over time can not be studied. Another limitation of the study was the possible misclassification of the respondents' current ethnic status. The question which determined their ethnicity was "were you born in Sweden or in another country". The women who were born in Sweden but have parents who were immigrant were excluded. If they had been included in the study then we might have received more information on work-related health factors for second-generation female immigrants. A cross-sectional study of current employees may not be representative of all female immigrants who work in the municipality. This could be due to non-participation in the study because of temporary illness or transfer to another area. In addition, one of the major limitations of this type of study relates to the lack of precision in measuring both current and cumulative exposures. The items in the questionnaire, at best, represent a crude approximation of both the current and cumulative exposures sustained by female immigrants. If more detailed questions had been included in the questionnaire, a deeper understanding of work-related health factors might have been gained. For example, with regard to the assessment of discrimination, there was only one question on ethnic discrimination and one on gender discrimination on a non-personal level (does discrimination due to ethnicity or gender occur in your workplace?). Had the questions in the employee questionnaire been more specific then we might have learned, for example, how often and in what manner discrimination took place. One demographic variable (age) was included as a control variable. We could have included other confounders such as education, working hours, type and length of employment, but we chose not to do so because of the high correlations between education and working conditions, for example.

Among the limitations of Study IV are that we had only one question about discrimination and no prepared follow-up questions. We could have gained a deeper understanding of the relation between discrimination and health with a few follow-up questions. Another limitation may be due to the selection bias, i.e., that the sampling method may have affected the findings. This is because the participants in the study were drawn from a municipality in the suburbs of Stockholm and only from those departments of the municipality that had high rates of long-term sickness absences.

The strength of Study I is its longitudinal approach, which enabled us to study the experiences of ten female Iranian immigrants and their views and assessments of the various factors that influenced their health after migration. Considering the fact that the baseline interviews were conducted several years (7-12 years) after arrival, it can be assumed that some post-migration changes may already have occurred by the time of the initial interviews. The longitudinal element made it possible to reflect over the impact of migration on the health of Iranian female immigrants over time and to consider migration as a tangled web of conflicting changes; some increase the women's control over their lives, while others create additional barriers for them. An additional strength of this study is that it brings new insights to the subject area, especially in Sweden. Although Sweden is one of the European countries that has a very large number of distinct ethnic minority groups, research on these issues has been extremely limited. In particular, research on the health of female immigrants in Sweden has been limited and has often been entirely focused on "cultural differences". The main findings of this study show that the health of female immigrants cannot be attributed solely to "cultural differences", but must also be understood within the contexts of class, gender and ethnicity. From the accounts of the women participating in this study, two new insights about the factors that influence the health of female immigrants during post-migration periods can be put forward. Firstly, female immigrants may overcome some health-related factors such as domestic violence or experiences of traumatic events during the first decade of the post-migration period. However, the effects of other health determinants such as unemployment or experiences of discrimination and racism were observed even two decades after migration. Secondly, the impact of ethnic discrimination on health is not alleviated by the length of stay in the host country or by higher socioeconomic status. The only aspect that may have changed concerns the strategies used in coping with discrimination. The length of stay, entering the labor market and a more favorable socioeconomic status seem to result in better personal management and better strategies for coping with ethnic discrimination.

The strength of Study II is the triangulation method which was applied. It facilitated both an individual and a group level perspective of the study's aim. For example, the results obtained from the group discussions were reinforced by the responses to the

questionnaire. This makes the results more reliable, even though the sample size was small. The fact that results from different sources of data reinforced each other not only shows the validity of the method but also increases its reliability.

The strengths of studies III and IV are that they contribute new insights to the subject area. These studies focus on the working conditions and work-related health of female immigrants. The main findings of these studies show that ethnic and gender discrimination occurs regardless of a female immigrant's position in the organizational hierarchy. Nevertheless, the mechanism of discrimination can be different for those who work in low status professions. It also shows that class still matters and is a very important factor in public health research.

7.4. Conclusions and recommendations

In conclusion, the findings suggest that public health policies aimed at female immigrants should provide qualified orientation facilities and access to health information to new arrivals. Furthermore, the findings suggest that unemployment is more evident among female immigrants and that the influence of unemployment on their health is more marked than for male immigrants. Social authorities should also consider implementing policies to recognize female immigrants' pre-migration work experiences and qualifications and to facilitate their entrance onto the labor market. Strategies to counteract ethnic discrimination/racism are needed, particularly on the labor market and in the workplaces.

The findings also suggest that the following measures ought to be taken to improve the work-related health of female immigrants: 1) create environments where employees feel "safe" in addressing work-related issues with employers, 2) establish better channels for communicating desires and complaints and create an arena where problems such as wage increases can be discussed and suggestions for improvement can be raised, 3) increase the opportunities for skills upgrade training and job change, particularly for the women who have the heaviest, most monotonous and low-paid jobs, 4) draw up action plans that lead to concrete solutions. These plans should include systematic efforts to counteract gender and ethnic discrimination. This could begin with the creation of an inclusive, supportive and open workplace.

The thesis provides a starting-point for further in-depth research on intersection of class, gender and ethnicity in relation to health. Studies should be designed to address the questions of how class, gender and ethnicity affect work-related health and how these factors affect female immigrants' access to resources on the labor market and in

workplaces, rehabilitation opportunities, counseling with unions, health care services, etc.

Furthermore, one of the critically important issues for future research is to improve the assessment of ethnic and gender discrimination in work-related health studies. An important challenge for future research is to focus on exploring the theoretical and empirical links between ethnic discrimination, gender discrimination and work-related health. How does exposure to discrimination (considering length and duration of exposure) affect their biopsychosocial health and how the employees cope with it? How do their coping strategies affect their health? Comparative studies according to different workplaces, minority groups, sex and age could be interesting sources of knowledge.

The future studies should be able to answer this question: In Sweden, the gap between native Swedes and immigrants, refugees and the children of immigrants and refugees persists. How can public health researchers eliminate the gap?

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9 SUMMARY

Sweden is one of the European countries that has gradually changed from a mainly ethnically homogeneous society into a multi-ethnic society. This change began in the late 1940s and has increased in pace, especially since the early 1960s. In 2001, almost 20 percent of the Swedish population was classified as immigrants, i.e., they were either born abroad and had become naturalized citizens, of foreign nationality, or born in Sweden with at least one parent who had been born abroad. Reports, statistics and research have shown that the health of female immigrants is worse than that of the total population and that the incidence of long-term sickness absence and early retirement is higher in this group.

The general objective of this thesis is to understand, describe and analyze the factors that contribute to poor health among female immigrants in Sweden from the perspectives of class, gender and ethnicity.

This thesis is based on four different studies. The first study had a qualitative, longitudinal design. It was based on semi-structured interviews with 10 female Iranian immigrants aged 25-50 years. Base-line interviews were conducted in 1996 and follow-up interviews in 2002. The purpose was to identify and analyze the women's perception of various factors which had influenced their health over time. The second study had a cross-sectional design and consisted of 60 unemployed with immigrant or refugee backgrounds, 30 women and 30 men. The aim was to analyze the health of immigrants in relation to unemployment status and sick leave absences from a gender perspective. Both qualitative and quantitative methods were used for data collection. The third study was cross-sectional in design and consisted of 2,429 native and immigrant female employees in a municipality in the suburbs of Stockholm, in Sweden. The purpose was to study the work-related factors that influenced the health of female immigrants. The fourth study combined an explanatory approach with a cross-sectional design using qualitative data from semi-structured interviews. The studied group consisted of twenty (20) female immigrants who worked in different departments of a municipality in the suburbs of Stockholm. The aim of the study was to explore the work-related factors that affected the health of female immigrants.

The main findings of the four studies in the thesis contribute to the empirical knowledge base of the system of class, gender and ethnicity-based oppression and to understand, describe and analyze factors that contribute to poor health among female immigrants in the Swedish society. It was found that income, occupational status, the racialization of labor and wages and the deskilling process are socially related attributes which together with unemployment, work environment, class, gender and ethnicity contribute to poor health among female immigrants. Poor health was also found to be related to gender

divisions and wage differences on the labor market as well as the gender and social class to which female immigrants belonged. Domestic violence and gender discrimination are other factors that were found to play a part in the decline in health among female immigrants. Furthermore, ethnic discrimination, racism, experienced trauma and the lack of social support and social networks in relation to ethnicity and immigration were also deemed to be contributing factors.

The main findings show also that there is an interaction between health, work and immigration. Although people who migrate are often in good health, immigration process itself may give rise to diminished health and result in unemployment and/or the increased incidence of sick leave. Immigration may also lead to an inferior position on the labor market, which could in turn lead to poor health due to exposure effects. The influence of these factors on health is more evident among female immigrants than among male immigrants.

Furthermore, the main findings of the four studies demonstrate that the work-related health of female immigrants is strongly associated with social class. The three aspects based on class are wage, professional status and position in the hierarchical work organization. Other factors associated with work-related health factors are discrimination due to ethnicity and gender, unfavorable physical and psychosocial work environments and the absence of opportunities for skills upgrade training.

Finally, the thesis sheds new light on the subject area, particularly in Sweden. Although Sweden is one of the European countries that has a very large number of distinct ethnic minority groups, research on these issues has been extremely limited. In particular, research on the health of female immigrants in Sweden has often been focused on “cultural differences”. This result of the studies in the thesis shows that the health of female immigrants cannot be attributed solely to “cultural differences”, but that it must also be viewed and understood within the contexts of social class, gender and ethnicity. From the accounts of the interviewed women, two new insights about the factors that influence the health of female immigrants during the post-migration period can be put forward. Firstly, female immigrants may overcome some health-related factors such as domestic violence or traumatic experiences during the first decade of the post-migration period. However, the effects of other health determinants such as unemployment or experiences of discrimination and racism were observed even two decades after immigration. Secondly, the impact of ethnic discrimination on health is not alleviated by the length of stay in the host country or by higher socioeconomic status. The only aspect that may have changed concerns the strategies used in coping with discrimination. The length of stay, entering the labor market and a more favorable socioeconomic status seem to result in better management and better strategies for coping with ethnic discrimination. The thesis contributes new insights to the subject area by showing that ethnic and gender discrimination occurs regardless of a female immigrant’s position in the organizational hierarchy. Nevertheless, the mechanism of discrimination can be

different for those who are employed in low status occupations. This shows that class still matters and is a very important factor in public health research. As such, it should not be ignored in studies on health in relation to ethnicity.

The individual attributes that may also contribute to poor health among female immigrants are living habits, length of stay in the host country, cultural attributes, age and genetic or biological attributes. The social attributes influence the individual attributes.

The strength of the thesis is that it includes both qualitative and quantitative methods. It includes a study with a longitudinal approach, which enabled a study of the impressions and evaluations of a group of female Iranian immigrants of the various factors that have influenced their health over time, after post-migration. The thesis also includes a study with a triangulation method, which facilitated both an individual and group level perspective of the study's aims. For example, the results obtained from group discussions were reinforced by the results of the questionnaire.

The implications of the findings in this study suggest that public health policies aimed at female immigrants should provide a good introduction and access to health information for new arrivals. Specific measures are needed to recognize female immigrants' pre-migration work experience and academic qualifications in order to counteract the deskilling process, a process which results in unemployment, long-term social exclusion and employment in low-status occupations with low incomes. Strategies tackling ethnic discrimination/racism are needed, particularly on the labor market and in workplaces. The recommendations of this thesis include the counteraction of discrimination due to ethnicity/gender in areas such as employment, wage setting and the provision of opportunities for skills upgrade training. Policies to stimulate an increase in the opportunities for mobility for female immigrants on the labor market are needed, especially for those who work in jobs with low status and low pay.

10 SUMMARY (IN SWEDISH)

SAMMANFATTNING

Sverige är ett av de europeiska länderna som successivt har ändrats från att vara ett etniskt homogent samhälle till att vara ett multietniskt samhälle. Den här förändringen påbörjades i slutet av 1940-talet och har, framför allt sedan början av 1960-talet, haft en stor ökningstakt. Under 2001 klassificerades nästan 20 procent av den svenska befolkningen som invandrare, dvs. att de antingen var födda utomlands och sedan fick svenskt medborgarskap, var utländska medborgare, eller var födda i Sverige av åtminstone en förälder som var född utomlands. Rapporter, statistik och forskning har visat att invandrade kvinnor har sämre hälsa än övriga befolkningen, samt att långtidssjukskrivningar och förtidspensioneringar förekommer i högre grad bland denna grupp.

Huvudsyftet med avhandlingen är att förstå, förklara och analysera de faktorer som leder till ohälsa bland invandrade kvinnor i Sverige, utifrån klass-, köns- och etnicitetsperspektiv.

Avhandlingen bygger på fyra olika studier. Den första hade en kvalitativ, longitudinell design. Syftet var att identifiera och analysera iranska invandrarkvinnors syn på de olika faktorer som har påverkat deras hälsa över tid. Datainsamlingen byggde på semistrukturerade intervjuer med 10 invandrade iranska kvinnor som var mellan 25–50 år gamla. Basintervjuer gjordes 1996, med uppföljningsintervjuer 2002. I den andra studien analyserades invandrares hälsa i relation till deras förvärvssituation i en tvärsnittsstudie. Studiegruppen bestod av 60 arbetslösa eller långtidssjukskrivna personer med invandrar- eller flyktingbakgrund, 30 kvinnor och 30 män. Information inhämtades med hjälp av frågeformulär, observationer och gruppsamtal. Med andra ord, både kvalitativa och kvantitativa metoder användes i studien. I den tredje studien granskades arbetsrelaterade hälsosfaktorer för invandrade kvinnor. Studien baserades på en tvärsnittsundersökning, med enkät som datainsamlingsmetod, som gjordes i en kommun som ligger strax utanför en stor svensk stad. Studiegruppen bestod av 2 429 infödda och invandrade kvinnliga anställda. Eftersom en utforskande ansats tillämpades i den fjärde och sista studien användes kvalitativa data i syfte att få en fördjupad förståelse av hälsorelaterade faktorer i arbetslivet bland invandrade kvinnor. Semistrukturerade intervjuer gjordes med 20 invandrade kvinnor som arbetade på olika avdelningar i samma kommun där den tredje studien utfördes. Denna fjärde undersökning var också en tvärsnittsstudie.

Huvudresultaten från de fyra studierna som utgör avhandlingens bas stärker den empiriska kunskapsbasen när det gäller klasssystem, könsförtryck och etnisk diskriminering. Resultaten beskriver, förklarar och analyserar de faktorer som bidrar till sämre hälsa bland invandrade kvinnor i Sverige. Det var tydligt att inkomst, jobbstatus, rasifieringen av arbete och lön samt dequalificering är socialt relaterade egenskaper som tillsammans med arbetslöshet, arbetsmiljö leder till en försämring av invandrade kvinnors hälsa. Denna hälsoförsämring visade sig även ha ett samband med såväl könsfördelningen och löneskillnader på arbetsmarknaden som den samhällsklass som de invandrade kvinnorna tillhörde. Våld i hemmet, obetald hemarbete och könsdiskriminering är andra aspekter som visade sig spela en roll i hälsoförsämringen bland invandrade kvinnor. Dessutom ansågs etnisk diskriminering, rasism, upplevd trauma och avsaknaden av sociala nätverk vara bidragande faktorer.

Huvudresultaten visar även en interaktion mellan hälsa, arbete och migration. Trots att människor som emigrerar oftast har god hälsa kan själva migrationsprocessen leda till försämrad hälsa, som kan i sin tur leda till arbetslöshet och/eller ökad sjukfrånvaro. Migrationen kan också leda till en underordnad position på arbetsmarknaden, som kan i sin tur leda till sämre hälsa på grund av utsatthet. Dessa faktorerers effekt på hälsan är mer tydlig bland invandrade kvinnorna än bland männen.

Huvudresultaten från de fyra studierna illustrerar att invandrade kvinnornas arbetshälsa är starkt associerad med samhällsklass. De tre klassbaserade aspekterna är lön, professionell status och position i den hierarkiska arbetsorganisationen. Andra faktorer som är associerade med arbetshälsafaktorer är köns- och etnisk diskriminering, ogynnsamma fysiska och psykosociala arbetsmiljöer och brist på möjligheter för kompetensutveckling.

Till sist, avhandlingen kastar även nytt ljus på ämnesområdet, i synnerhet i Sverige. För trots att Sverige är ett av de europeiska länderna som har ett stort antal distinkta etniska grupperingar har forskning om sådana frågor varit ytterst begränsad. Framförallt har forskning om invandrarkvinnors hälsa i Sverige oftast fokuserat på ”kulturella skillnader”. Denna studie visar att invandrarkvinnors hälsa inte bara kan tillskrivas ”kulturella skillnader” utan måste även tolkas inom sammanhangen klass, kön och etnicitet. Utifrån de berättelser som kvinnorna i studien redogör kan två nya aspekter av de faktorer som påverkar invandrarkvinnors hälsa under perioden efter invandring läggas fram. För det första kan invandrarkvinnor övervinna hälsafaktorer som våld i hemmet eller andra traumatiska händelser under de första tio åren efter invandring. Däremot syntes tecken på andra hälsobestämmande faktorer såsom arbetslöshet, diskriminering och rasism även tjugo år efter invandring. För det andra påverkas inte effekten av etnisk diskriminering på hälsa av vistelselängden i värdlandet eller högre socioekonomisk status. Den enda aspekten som kan ha ändrats gäller strategierna som har använts för att hantera diskriminering. Vistelselängden, inträdet på arbetsmarknaden och en mer fördelaktig socioekonomisk status tycks resultera i förbättrad hantering och

bättre strategier för att ta itu med etnisk diskriminering. Avhandlingen bidrar med nya inblickar i ämnesområdet genom att visa att etnisk- och könsdiskriminering förekommer oavsett invandrade kvinnans rang i den hierarkiska organisationen. Diskrimineringsmekanismerna kan dock upplevas annorlunda för den vars jobb har låg status. Avhandlingen visar även att samhällsklass fortfarande är viktig och att den är en avgörande faktor i folkhälsoforskning.

De enskilda egenskaperna som också kan bidra till försämrad hälsa bland invandrade kvinnor är livsstil, vistelselängd i värdlandet, kulturella egenskaper, ålder och genetiska eller biologiska egenskaper. De sociala egenskaperna påverkar de enskilda egenskaperna.

Avhandlingens styrka är att den inkluderar både kvalitativa och kvantitativa undersökningsmetoder. I en studie tillämpades en longitudinell metod som möjliggjorde en undersökning av en grupp iranska invandrade kvinnors upplevelser av de olika faktorerna som har påverkat deras hälsa efter invandringen. Avhandlingen inkluderar även en studie där en trianguleringsmetod tillämpades i syfte att underlätta undersökningen utifrån både det individuella perspektivet och på gruppnivån. Till exempel förstärktes resultaten från gruppsamtalen av de resultat som förvärvades via frågeformulären.

Innebörden av studieresultaten är att den del av folkhälsopolitiken som är riktad mot invandrade kvinnor bör ge alla nyanlända kvinnor och i huvudsak kvinnliga flyktingar en bra introduktion till systemet samt tillgång till hälsoinformation. Den bör också upprätta ett system för att erkänna invandrade kvinnors arbetserfarenhet, utbildning och kvalifikationer före invandring för att motverka dequalificering, en process som leder till arbetslöshet, långtidsutanförskap och anställning i jobb med låg status och låga löner. Det behövs strategier för att bekämpa etnisk diskriminering/rasism, i synnerhet på arbetsmarknaden och på arbetsplatserna. Bland de rekommendationer som presenteras i denna avhandling är att köns- och etnisk diskrimineringen vid anställning, lönesättning och tillgång till kompetensutveckling bör motverkas. Det bör skapas ökade möjligheter till större rörlighet på arbetsmarkanden för invandrade kvinnor, särskilt för de som arbetar i jobb med låg status och låga löner.

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