

Work-related health factors among female immigrants in Sweden - A qualitative study on a sample of twenty workers

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Abstract

Aims: The purpose of this study was to explore work-related health factors amongst female immigrants in Sweden.

Methods: Qualitative methods were used in order to get the broadest possible picture of female immigrants' perceptions on work-related health factors. Semi-structured interviews were conducted with twenty female immigrants who worked in different departments of a municipality adjacent to a large city in Sweden. Most of the interviewed women came from the Middle East, Africa and Latin America, while some came from eastern and southern Europe as well as Finland. The women had lived in Sweden for 5-27 years. Content analysis, which is based on analysis by topic, was used to analyse the data. Results: Results from the interviews show that female immigrants perceived that work-related health is strongly associated with class. The three aspects of class that arose from this study were wage, professional status and their position within the organisations hierarchy. Other factors that were identified as being associated to work-related health were discrimination due to ethnicity and gender, unfavourable physical and psychosocial work environment and lack of training opportunities for upgrading their skills.

Conclusions: The public health implications of the findings in this study suggest that measures that ought to be taken to improve female immigrants working conditions and health are primarily systematic efforts to counteract discrimination because of gender and ethnicity in areas such as wage setting and opportunities for skill up-grade training. This should result in improved employment opportunities for female immigrants, particularly those who work in low status and low-paid jobs.

Key words: work, health, female immigrants, class, discrimination

Introduction

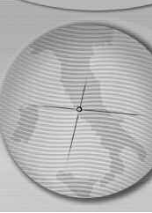
During the last few decades, immigration to Sweden has been more inclusive than ever before. Today Sweden is a heterogeneous and multiethnic society, with a large proportion of female immigrants active in the Swedish labour market. In 2004, almost 56 % of first-generation female immigrants were employed. In 2002, the proportion of employed women born in Africa, Asia or Latin America was approximately 43 % among those who had lived in Sweden between 5-9 years, and between 60-65 % among those who had lived in Sweden for more than 20 years [1].

Female immigrants from Africa, Asia, Europe (excluding the Nordic countries) and North and Middle America mainly work in areas such as childcare, elderly care, home-help services, service providers, hotels, restaurants and the retail industry [2]. Research [3,4] has shown that the health of female immigrants is worse when compared to the health of the total population. The proportion of long-term absenteeism due to sickness and early retirements is higher in this group [5,6].

What are female immigrants' perceptions about work-related health factors? In this study we operate within the paradigms of class, gender and ethnicity because both class and gender, along with race and ethnicity, are social constructors and important markers of how and where individuals or groups are located within the social structure, which ultimately determines health [7]. Class and gender, race and ethnicity are constant forms of inequality which are related to structural relationships of exploitation and oppression and are not temporary, but often follow people throughout their entire lifetime. The interplay between forms of inequality has an impact on health [8,9]. In this context, the purpose of this study is to explore the work-related health factors among female immigrants in Sweden.

Methods

Interviews were conducted in order to get the broadest possible view of the different perceptions of female immigrant who worked in different departments of a municipality. According to Morse



and Field (1996) [10], qualitative methods are used, for example, when only a 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 a "native's point of view" [11]. We used semi-structured interviews, which means that the researcher prepares, in advance, a number of questions. The interviewer can also ask spontaneous questions and change the order of the set questions as the interview goes along. Semi-structured interviews allow the interviewees to recount their experiences with as little guidance as possible from the interviewer [10].

The interviews were conducted during autumn 2003. According to the participants' wishes, all interviews were carried out at their place of work, during working hours. The interview questions concerned the interviewees' background (age, country of birth, civil status, education and work experiences in both their native country and in Sweden, type of employment contract and working hours), reasons for migration, how they define health, work-related factors that 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 from 45 minutes to 1 hour. The interviews were tape recorded and thereafter transcribed. Two of the interviewed women did not want the interviews to be recorded, so instead careful notes were taken. All the interviews were done in Swedish.

Study population

In this study, female immigrants refer to women who were not born in Sweden or who have at least one parent who was not born in Sweden. Female immigrants who live in Sweden are a heterogeneous group. They come from different countries and have different socioeconomic backgrounds, but what they all have in common is that they have all experienced the same restrictions on access to resources and power.

The study took place in a municipality adjacent to a large city in Sweden with a high density of immigrants. In 2002, approximately 5 750 people worked for the municipality whereas 25 % were born abroad. Absenteeism due to sickness in the municipality had nearly doubled in less than 3 years, to approximately 9 % in 2002, resulting in a large economic problem for the municipality.

After contacting the Personnel Department of the municipality, we were able to inform the managers of the various departments of the municipality about the study. The four departments selected for interviews were chosen as they had

high rates of long-term absenteeism due to sickness. The four departments were Maintenance and Cleaning, Education and Labour Market, Nursing and Care and the Social Services. After identifying the departments we met the managers who in turn informed their staff about the study. We met those female immigrants who were interested in participating in the study and gave them further information about the purpose of the study, interview method and confidentiality. Their consent obtained through signed concessions; after which those who were interested in participating in the study were interviewed. The study group consisted of cleaners (5), teachers (5), home-help assistants (give nursing and care to elderly) (5) and living assistants (give support to people with mental disabilities) (5) (table 1, table 2).

The ages of the interviewees ranged from 30-58 years. Most of them were married; some were single mothers while one was single. All of the women except two had children less than 18 years of age living at home. The women had lived in Sweden from between 5 to 27 years. Most of the women came from the Middle East, Africa, Latin America, while some came from Eastern and Southern Europe, as well as Finland. One of the participants was born in Sweden but had parents with immigrant backgrounds. Table 1 and 2 shows some of the background factors concerning the interviewed women.

Analysis methods

Content analysis, in which interviews are segmented into categories according to topic, was used to analyse the data [10]. We read through each individual interview several times, making a note of the pages on which different problem areas were mentioned. We thereafter identified various key or phrase words, for example, words such as "pain in my body" or "monotonous and heavy work" were labelled as keywords. After identifying all of the keywords and phrases, they were cut out and sorted, based on 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. (Figure 1).

Results

Female immigrants own definition of health

The interviewed women's own definition of health varied. The cleaners' definition of health was mostly related to working life in terms of being able to function, work and enjoy being at

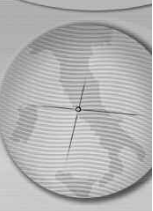


Table 1. The interviewed women's education and work-life experiences in their native country and reason for migration

Number of interviewees/profession	Education in native country	Work-life experiences in native country	Reason for migration
5 cleaners	None (1) Compulsory school education (4)	None (3) Worker (1) Dressmaker/sewer (1)	Marriage (5)
5 teachers	College education (4) Upper secondary school education (1)	Teacher (5)	Refugee (2) Marriage (2) Born in Sweden and have parents with immigrant background (1)
5 home-help assistants	Upper secondary school education (2) Vocational education (3)	None (2) Nurse (1) Cold-buffet manageress (1) Chemist (1)	Refugee (3) Accompanied parents (1) Another reason (1)
5 living assistants	Compulsory school education (2) Upper secondary school education or vocational education (3)	Saleswoman (1) Teacher (1) Recreation leader (1) Psychologist (1) Summer worker (1)	Refugee (3) Accompanied parents (1) Another reason (1)

work, and overall *"not to feel powerless"*. The teachers mentioned *"happiness in life"* in their definitions of health, as well as physical and social well-being in addition to social and political engagement. The home-help assistants defined health based on physical factors, such as *"do gym, sleep well, eat right, energy to do more"*; mental

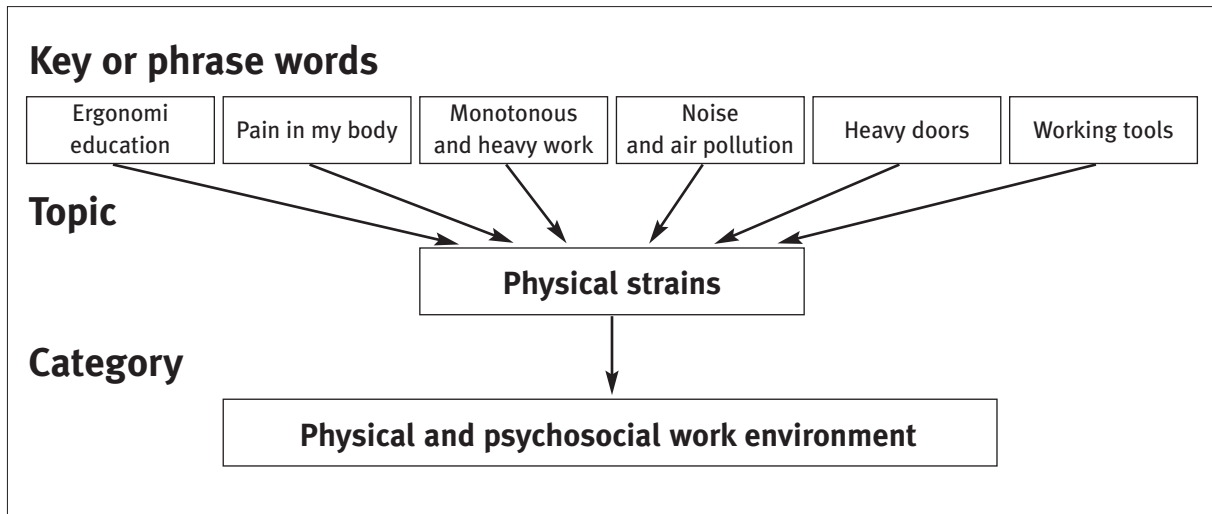
factors, such as *"not stress"*; and social factors, such as *"to be able to get into society and do something and not stand outside"*.

Other dimensions were also mentioned, such as quality of life. The living assistants' definition of health emphasised the balance between physical and mental factors, but also the importance of

Table 2. The interviewed women's education and work-life experiences in Sweden and their type of employment contract

Number of interviewees/ profession	Education in Sweden	Work-life experiences in Sweden	Type of employment contract	Working hours
5 cleaners	Studies in Swedish 2-18 months	Cleaner between 3-20 years (5) Dishwasher and has worked at a hotel (1)	Permanent employment (3) Vacancy (2)	Full-time, day time (5)
5 teachers	University School of Education	Teacher between 3-24 years (5) Researcher (1) Interpreter (1)	Permanent employment (5)	Full-time, day time (5)
5 home-help assistants	Studies in Swedish Nurse aid education Mental attendant training Nurse aid education Child minding training	Home-help assistant between 2-9 years (5) Packer (1) Mental attendant (1) Confectioner (1)	Permanent employment (5)	Full-time, day time (4) Part-time, day time (1)
5 living assistants	Studies in Swedish Mental attendant training Nurse aid education Caring training	Living assistant between 1-3 years (5) Grocery store (1) Post services (1) Elderly care (2) Social services (1)	Permanent employment (5)	Full-time, day time (4) Full-time, night time (1)

Figure 1. Description of analysis method (an example)



having your own time and "not only think of others all the time".

Wage and professional status

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

The home-help and living assistants were very dissatisfied with their wage and considered that low wage and occupational status had a negative impact on their health which could lead to "burn-out". One of the home-help assistants expressed:

"It's not possible to live on my wage and therefore I'm working night shifts in a psychiatric care unit. I have to do it to be able to manage financially."

The teachers considered that they were underpaid compared to other professional groups but

"compensated by, for example, long holidays". None of the teachers was dissatisfied with their occupational status.

Physical and psychosocial work environment

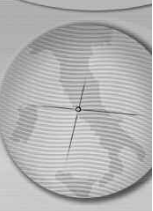
Cleaners and home-help assistants perceived their work as "monotonous and heavy", which

lead to "pain in shoulders, back and sometimes arms". Teachers had problem with "noise, polluted air in the classrooms and heavy doors that should be opened many times a day". All agreed that they needed better work tools and better ergonomic education to improve working those conditions that might have a positive impact 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 own working schedules, for example through flex-time working arrangements. The reason was not only the type of work that they do but also managerial support, "a manager who trust us and gave opportunity to do so".

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

All of those interviewed perceived that they could suffer from stress. Teachers suffered stress because they "always have to be ready and concentrated for the lectures and have to solve out the conflicts between the pupils". Home-help and living assistants were stressed because they have "too many clients to visit during a short time" and the cleaners have to clean a large area in a short time, further more, if a colleague is sick they have "to clean instead of her which make really stressing".



All the interviewees agreed that leadership was an important factor for a healthy workplace. Some were pleased with their managers, because the managers *"trusts them", "treat the staff fair", "tolerate criticism"* and *"were active in talking to the staff"* and *"gave support and encouragement"*, other said that they needed more attention from, and contact with, their managers. The comments made about the managers did not vary according to the interviewees employment contract.

When working conditions permit, all co-workers should spend one hour a week participating in preventive health care activities, such as, going to the gym, swimming, riding a bicycle, etc. The cleaners, living assistants and teachers tended to make use of this opportunity weekly. Home-help assistants could not do so because it was impossible to do so within their work schedule.

One of them stated:

"There are girls who are 20-23 who have an aching back. It ought to be obligatory for the staff to train during working hours just like firemen. This is how the levels sickness absence could be reduced".

Skill upgrade training

The concept of skills up-grade training can be defined in several different ways. It can describe activities such as recruitment, promotion, personnel mobility, external/internal training and learning at work on an individual or group level. According to the municipality's policy, all members of staff should have an individual skills training plan which has been prepared in agreement with their managers.

Those interviewed perceived that the lack of possibilities for skill upgrade training had a negative impact on health, as with out it they were not able to improve their position in the hierarchical labour market.

None of the interviewed cleaners had prepared a plan for skill upgrade training, neither individually, nor collectively, and nobody knew anything about it. One of the cleaners said that she had began 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 not learn anything.

The teachers were quite satisfied with their skill upgrade training plans and the opportunities that were offered. They had also themselves *"been active in searching financial support from different instances. For example, we had applied for grants to attend courses, study visits or seminars both in Sweden and abroad"*.

The home-help and living assistants did not have an individual plan for skill upgrade training. Some of them attended courses, and some of them would like to develop their competence by continuing their education to become assistant nurses, but they said that it was not possible to do that. One of them said,

"I would like to go on courses but there are no resources. I would like to take a computer and nursing course".

Ethnic discrimination

Concerning discrimination, it appeared that many of the interviewed women perceived that ethnic discrimination that occurred in their workplaces had a negative impact on health. Furthermore, it was found that they had developed their own strategies to deal with it.

One of the cleaners who felt her manager discriminated against her expressed:

"The senior manager is a 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".

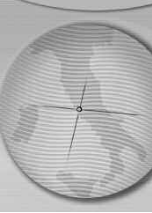
Another cleaner explained that within the society there was a structural discrimination: *"Only immigrants are doing the cleaning, why don't Swedes work as cleaners? ... It's exactly like the slavery times when they used the blacks."*

One of the teachers who had experienced ethnic discrimination in the workplace felt that *"there is a hidden racism among pupils"*. She felt discriminated against because of *"pronunciation"* and *"different codes to communicate"*.

At first one of the teachers answered *"No"* to the question whether she had experienced ethnic discrimination in her workplace, then she answered *"No, but..."* and continued *"I don't look so dark, but sometimes my name has given rise to discrimination"*.

One of the teachers experienced 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 considered that *"deep inside you can get a feeling of not being accepted by the Swedes, this feeling wears you down"*.

The home-help assistants heard from their Swedish-born colleagues that many Swedish-born clients *"don't want to have immigrants as assistants"*. The discrimination could, for example, involve humiliation. One of the home-help assistants said that *"if something goes wrong in society or at 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 and said that *"once a customer asked me why I had a table cloth on my head"*. This woman's strategy to deal 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 superior that I don't go to that customer any more"*. Another home-help assistant tried to find explanations for the clients' behaviour, for example *"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 not to get sad"*.

Some of the living assistants also started their responses by saying *"No"*, and then continued by saying, for example, that *"I've been discriminated against a little"*, one person continued *"for example when I write a report and they say your Swedish is not good enough"*. Another said, sometimes colleagues or patients used *"wrong word, for example Negro"*.

Strategies that the living assistants used to deal with ethnic discrimination could be for example to counteract what was being said, for example by saying *"nobody can treat me like this"*. Others would blame 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 considered that female immigrants had difficulties in learning the ways of a Swedish workplace, for example, to learn to *"say what they think in a diplomatic way, dare to communicate, but not make a fuss or else they will be perceived as cocky"*. She thought that they *"protect 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 you do not use these strategies, *"then you will not manage in a Swedish work environment"*.

Gender discrimination

Several of the women brought up issue that gender discrimination had a negative impact on health.

One of the teachers considered that she experienced gender discrimination due to *"the pay and female work tasks"*.

One of the home-help assistants answered the question about gender discrimination first with a *"No"*, and then continued, *"Many of the old 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 this kind of

problem by talking about it in their working group and the next time they had to visit such a client another home-help assistant accompanied them as support.

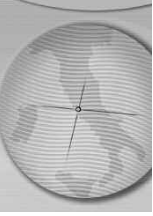
Some of the living assistants said that they had not experienced gender discrimination in the workplace. They thought it could be due to the fact that *"we don't have a job with a high position"* or *"we work in a female-dominated workplace"*. One of the living assistants said once when she wanted to write a report but her Swedish male colleagues said she couldn't do that. According to her, *"They needed to feel clever and capable by telling me in a nice way that I'm no good, some kind of hidden sexism-racism."*

Discussion

Results from the interviews show that female immigrants' work-related health is associated with class. The two aspects of class that arose from this study were low wage and occupational status. Some of the interviewed female immigrants who were employed as cleaners, home-help assistants and living assistants worked in the "job ghettos" [12] or workplaces that are over-represented within blue-collar and service jobs with the lowest wages and status.

They considered that low wages and occupational status were harmful to their health, which agrees with a recent study [13] that named low social status as one of three intensely social risk factors for health. Wilkinson emphasises "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 argues that the social consequences of low material living standards may make people feel as if they are being looked down upon, have an inferior position in the social hierarchy and subordinate; which agrees with the perception of the interviewed female immigrants, that if they are *"not seen as valuable"* as a worker then this could have a negative influence on their health.

Another consequence of having a low occupational status was associated with having the fewest opportunities for skill upgrade training. Previous research [14] shows that low status occupations are characterised by low levels of control, fewer opportunities to learn and develop skills and high psychological workloads which influence health negatively. It has also been shown that female immigrants are stuck in the lowest hierarchical positions [15] which may consequently lead to ill health.



Female immigrants also considered that low wages harms their health and avoided staying at home even when they were ill in order to not lose some part of their monthly income. In the long run, this could mean that they run a higher risk of developing health disorders. A research report showed that in today's society, there are strong indications that lack of rest, recovery or recreation can be a larger problem than the intensity of stress and other strains in and outside working life [16]. If the employees do not feel secure enough to rest and recover when they get ill, in the long run it could lead to long-term absenteeism due to sickness.

Our results confirms the outcomes of previous research that has shown that the physical and psychological work environment has an important effect on health [17,18]. Both those who worked in low wage and low occupational status jobs (cleaners, home-help assistants and living assistants) as well as teachers perceived that they had problems with the physical and psychological work environment, but in different ways. For example, teachers had problems with noise while home-help assistants had problems with heavy patients.

Results from the interviews show that female immigrants perceived work-related health to be associated with ethnic discrimination. Perhaps what was one of the most remarkable outcomes of this study was the discussion on work-related health factors in association with ethnic discrimination. Researches in these areas have shown that racism and ethnic discrimination are harmful to both physical and mental health [19,20]. Discrimination can occur between individuals or institutionally in the form of organisational structures and policies [21]. In this study, the interviewee experienced individual discrimination in their daily work from clients, pupils, parents, etc., and they experienced institutional discrimination in the form of low wages and limited skill upgrade training opportunities. This concerns, above all, those female immigrants who had low-paid jobs and low professional status. Higher pay and skill upgrade training are two important tools in working life that these women had no access to, and as such they will remain in the lowest paid jobs with the lowest professional status throughout their working lives.

During the interviews, it became apparent that it was not easy for everyone to talk about discrimination. It also emerged that the women had developed various strategies to deal with ethnic discrimination in the workplace. These included ignoring, denying, mitigating, internalizing and

blaming themselves. Researchers in this field consider that people's reactions to racism and discrimination can have a negative effect on health. These reactions can vary from internalisation of oppression to reflective handling, active resistance or organised struggle for social justice [22-24].

Gender discrimination was also experienced at both the individual and the institutional level. In the interviews, all of the cleaners and most of the other interviewed women said that they had not experienced individual gender discrimination in their workplace. This may be due to the fact that many of the women who were interviewed worked in female-dominated workplaces.

The women who had experienced individual gender discrimination in the workplace talked about harassment or the use of humiliating words from clients and customers. Those interviewed focused mostly on institutional gender discrimination, which lead to lower wages in gender-segregated low-status professions.

One of the limitations of this study is that it is not representative of the population due to the limited number of participants. Another limitation is that we only included one question about discrimination and did not have prepared follow-up questions; with these we could have gained a deeper understanding of the connections between discrimination and health. Furthermore, another limitation may relate to selection bias, i.e., that the sampling method may have affected the findings. This may have arisen due to the fact that study participants were chosen only from one municipality, adjacent to a large city and only from those departments that had high rates of long-term absenteeism due to sickness.

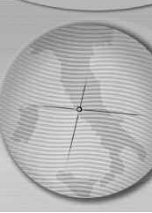
The strength of this study is that provides new insights into the subject area.

It shows that ethnic and gender discrimination occurs regardless of a female immigrant's position in the organisational hierarchy. However, the mechanism of discrimination can be different for those who work in low occupational status professions. It also shows that class still matters and is a very important factor in public health research.

One of the critically important issues for future research is to improve the assessment of class, ethnicity and gender discrimination in the work place in relation to health issues. Comparing studies according to minority groups, gender and age can provide knowledge to further improve our understanding of these matters.

Acknowledgements and funding

We acknowledge The Swedish National Institute for Working Life- research project "Working life in



the urban areas" for both financial and scientific support. We would like to thank the participants in the study. Without their support, it would not have been possible to undertake the research.

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