Determinants of health among Muslims in Norway

MUSLIM RELIGIOSITY AND PERCEIVED DISCRIMINATION AMONG MUSLIMS IN NORWAY – IMPACT ON HEALTH AND HEALTH BEHAVIOUR

BUSHRA ISHAQ

Abstract

Background: Although the "healthy migrant effect" seems to be evident among individuals from Muslim countries in Norway, this population also experiences certain health domain disparities. While most Muslims report that religion is an important part of their life, increased Islamophobia is also a concern. As other health determinants have failed to explain health disparities among Muslims with an immigrant background in its entirety; it is relevant to assess the roles of both religion and perceived discrimination (PD). The overarching aim of this thesis was to investigate religiosity and discrimination as potential determinants of poor health and poor health behaviour among Muslims in Norway. Applying the social determinants of health framework, the thesis also investigated whether religiosity may contribute to poor health by facilitating low community belonging and trust in society. This potential upstream pathway represents a segmental pathway without health as an outcome[1]. Specifically, this thesis examined: 1) How Muslim religiosity relates to health and health behaviour; 2) The magnitude of PD and how it is related to self-rated health (SRH) and mental health among Muslims[2]; and 3) The associations between Muslim religiosity and both community belonging and trust in society.

Samples and methods: Data from two cross-sectional studies were used. The first study included a representative sample of 5,484 men and women with immigrant backgrounds in Norway, aged 16–74 years, retrieved from Statistics Norway's "Survey of living conditions among persons with an immigrant background 2016". The second study used a random sample of 1,129 men and women, aged 18–85 years, originating from eight selected Muslim-majority countries and currently living in Norway. Participants in the latter study were recruited from the Norwegian Central Population Register for "The survey of attitudes among Muslims" from 2016.

All the variables were self-reported. Religiosity was operationalized through items measuring religious belief and practices. PD encompassed experiences with being treated differently in 12 settings. SRH, mental health problems (measured with five items from the Hopkins Symptoms Checklist), diabetes, neck and back illnesses, cardiovascular diseases, sleep disorders, smoking, and alcohol consumption were the health and health behaviour outcomes. Community belonging was operationalized as the level of identification with Norwegian society, and trust in society was identified through measures of general trust and institutional trust (i.e., trust in political power, political authorities, the media, and the monarchy).

Descriptive analyses were used to report sample characteristics. Multivariate logistic regression models were used to answer the research questions. The results are reported using odds ratios (OR) with 95% confidence intervals (CI), adjusted for confounders. In the investigation of PD prevalence, Pearson's chi-squared and Fisher's exact probability tests were supplemented by relative risk as an effect size measure.

Results: Logistic regression analyses, adjusted for confounders, revealed that the level of importance of religion was associated with good SRH (OR=1.04, 95% CI: 1.01–1.10) and inversely associated with sleep disorders (OR=0.92, 95% CI: 0.88–0.96), mental health problems (OR=0.94, 95% CI: 0.91–0.98), smoking (OR=0.88, 95% CI: 0.86–0.93), and alcohol consumption (OR=0.66, 95% CI: 0.64–0.70). However, the level of importance of religion was not significantly associated with diabetes (OR=1.07, 95% CI: 0.98–1.20), neck and back illness (OR=0.97, 95% CI: 0.93–1.01), or cardiovascular diseases (OR=0.96, 95% CI: 0.91–1.02).

A relation between the degree of religious attendance and good SRH (OR=1.10, 95% CI: 1.03–1.20) was found, as were inverse associations with neck and back illness (OR=0.91, 95% CI: 0.86–0.96), cardiovascular diseases (OR=0.89, 95% CI: 0.83–0.96), sleep disorders (OR=0.87, 95% CI: 0.82–0.94), mental health problems (OR=0.89, 95% CI: 0.86–0.96), smoking (OR=0.82, 95% CI: 0.80–0.86), and alcohol consumption (OR=0.56, 95% CI: 0.52–0.61). The level of religious attendance was not significantly associated with diabetes (OR=1.07, 95% CI: 0.97–1.20).

The prevalence of PD among Muslims was 45%, significantly higher than among non-Muslims. PD was related to mental health problems among both immigrant Muslims (OR=2.20, 95% CI: 1.74–2.80) and Norwegian-born Muslims (OR=3.81, 95% CI: 1.77–8.22), and inversely associated with good SRH among both immigrant Muslims (OR=0.75, 95% CI: 0.61–0.93) and

[1] The full pathway, including health as an outcome, was not investigated (i.e., health variables were not available in Sample 2).

[2] Comparison groups are also included in this study.

Norwegian-born Muslims (OR=0.47, 95% CI: 0.26–0.83).

The degree of Muslim religiosity was not significantly associated with general trust in society (OR=1.00, 95% CI: 0.91–1.10), trust in political authorities (OR=0.96, 95% CI: 0.87–1.06), or trust in the monarchy (OR=0.92, 95% CI: 0.84–1.00). However, Muslim religiosity was negatively associated with trust in political power (OR=0.91, 95% CI: 0.83–1.00) and trust in the media (OR=0.80, 95% CI: 0.73–0.87). A positive association between Muslim religiosity and community belonging (OR=1.11, 95% CI: 1.01–1.21) was also found.

Conclusion: This thesis does not provide any evidence indicating that the degree of Muslim religiosity is a determinant of poor health or poor health behaviour. Instead, Muslim religiosity is shown to be related to favourable health outcomes. Furthermore, the findings suggest that the degree of Muslim religiosity seems not to be a barrier to community belonging and trust in society. Although Muslim religiosity itself might not contribute to poor health among Muslims, how Muslims might be approached by the society in which they live, can be a potential determinant of poor health, as PD is related to poor health among Muslims.