



Norway

**Population**

5,368,000

Area309,158 km²**Capital**

Oslo

3 largest cities

Oslo (693,000)

Bergen (284,000),

Trondheim (205,000)

Neighboring countries

Finland, the Russian

Federation, Sweden

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1. Migration history

Norway, which declared its independence from Sweden in 1905, was an emigration country at first. Between 1825 and 1945, about 850,000 people left the country (mostly for the US), the second-largest emigration in Europe by population size (after Ireland). Until the 1970s, the population in Norway was relatively homogeneous. After creating a common labour market between Norway, Sweden, Finland, and Denmark in the 1950s (Iceland joined in 1982), many people migrated from neighbouring Scandinavian countries. In the late 1960s, some migrant workers came to Norway from Morocco, Yugoslavia, Turkey, and Pakistan. Labour migration and family reunification characterised immigration in Norway until the immigration ban in 1975. After that, refugee migration came to the fore for several years. While Norway accepted only 223 refugees between 1960 and 1970, there were 1,680 in 1978 and 1979, of whom more than 1,300 came by sea from Vietnam [1]. Between 1990 and 2017, labour migration and family reunification were again the central characteristics of non-Nordic foreign immigration [2]. The number of work permits for migrants increased by about 10,000 between 1999 and 2003, reach-

ing a peak of 33,000 in 2004. In 2004, 74% of all Norwegian work permits were issued to citizens of the new EU member states, most of them seasonal workers from Poland and Lithuania. From 2004 onwards, significant migratory flows came from Sweden, the Russian Federation, Denmark, and Poland [1]. In 2017, the number of immigrants was 58,200, 8,600 fewer than in the previous year, confirming the slightly declining immigration trend since 2008. By country of origin, most immigrants came from Syria (7,000), Poland (5,200), and Lithuania (2,750) [2]. In 2019, people from Poland (98,700), Lithuania (39,300), Sweden (35,600), Syria (30,800), and Somali (28,600) represented the largest groups of immigrants (foreign-born with two foreign-born parents) [3]. Except for 1989, Norway has had positive net migration every year since the late 1960s [2]. The migrant population (born abroad) more than quadrupled between 1990 and 2019 (192,600 to 867,800). At the same time, the proportion of migrants in the population has risen from 4.5 to 16.1% [4]. As of 2020, the net migration is 5.3 [5]. This indicates that Norway has developed into an immigration country.



2. Estimated number of people with a migration background with dementia

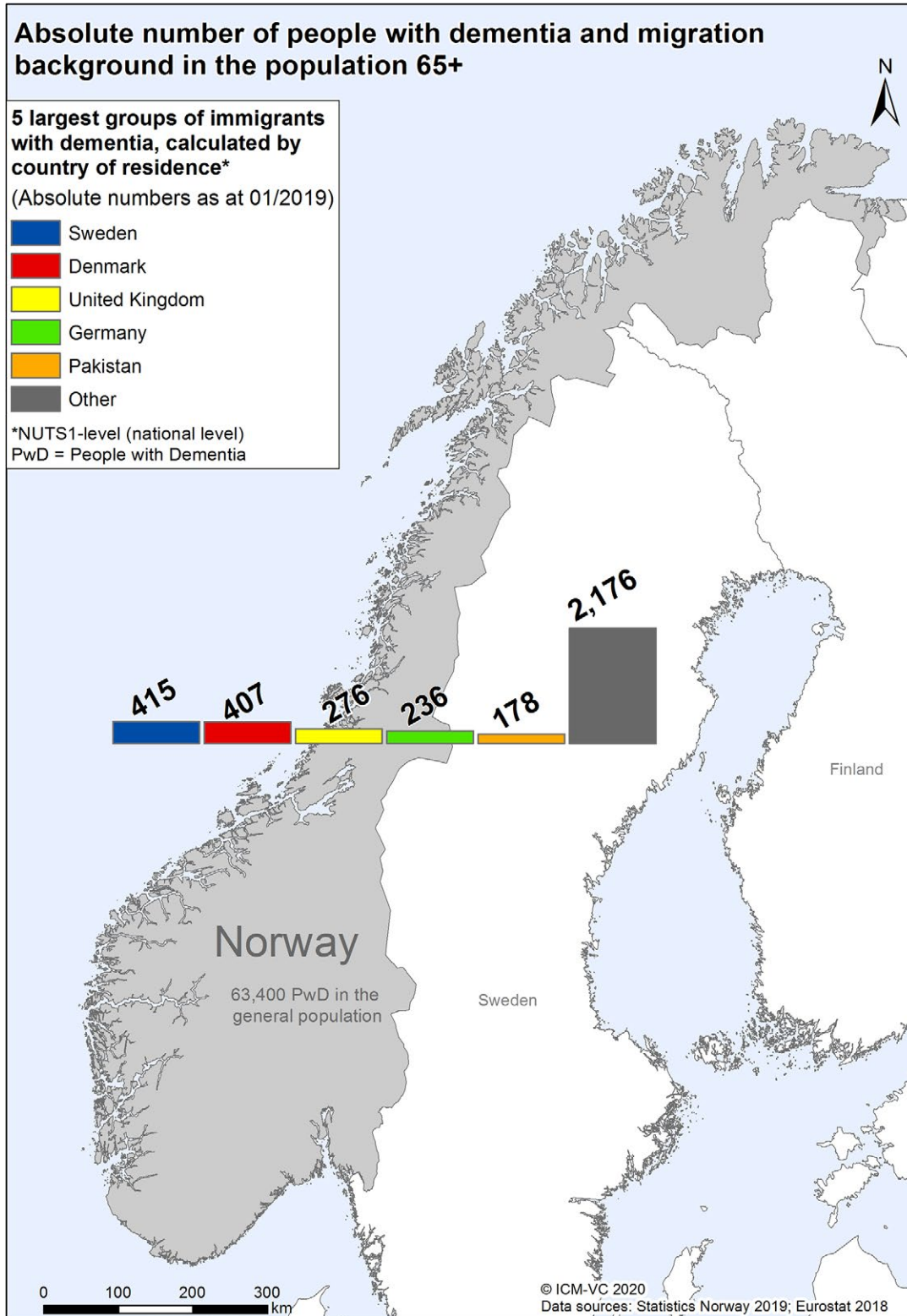


Fig. 3.7.23.1: Absolute number of PwM with dementia aged 65+ (Norway – Nation)

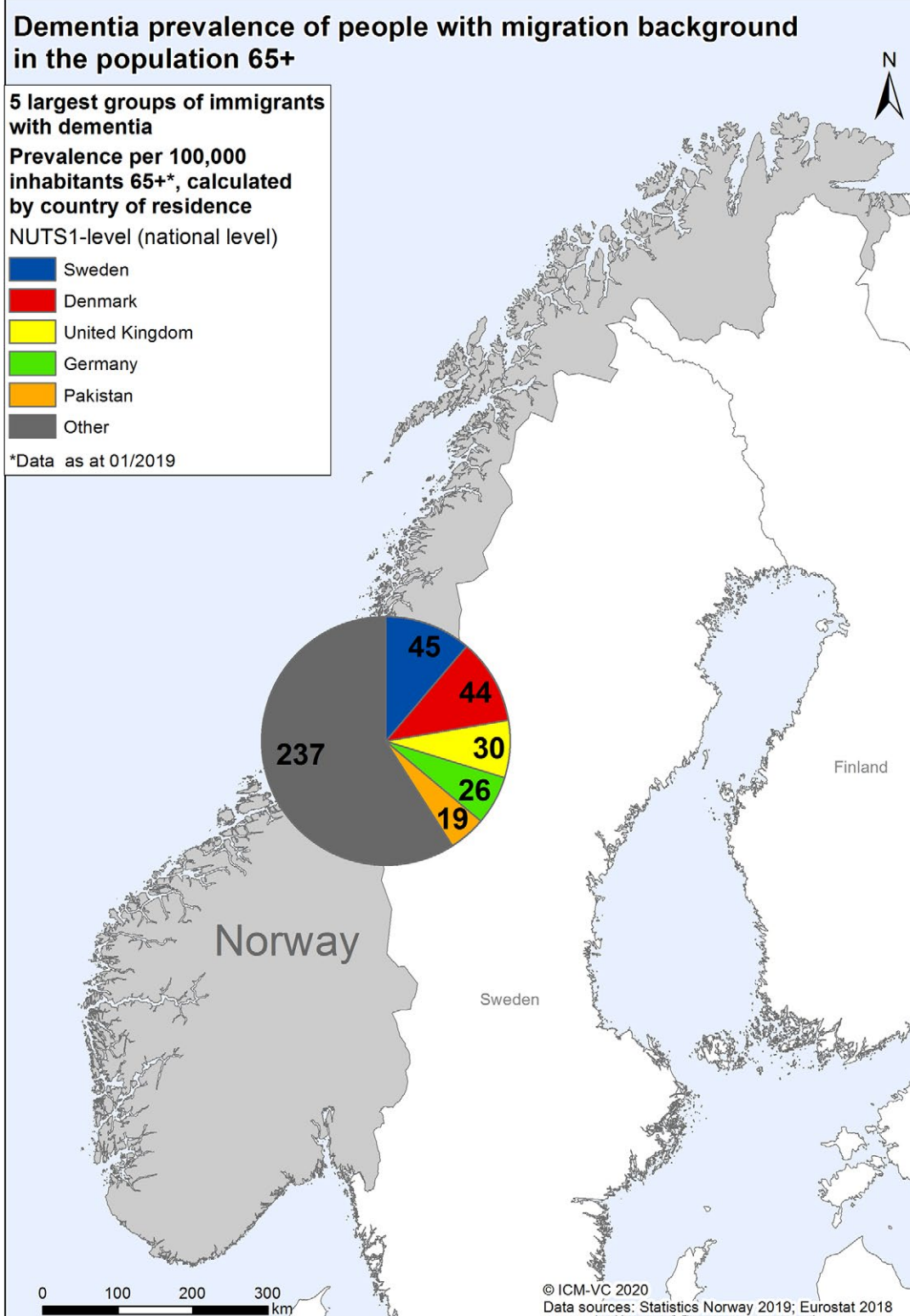


Fig. 3.7.23.2: Prevalence of PwM with dementia among the population aged 65+ (Norway – Nation)



Tab. 38: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Norway – Nation)

NUTS	Total	NO	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Norway	63,400	59,711	SE 415	DK 407	UK 276	DE 236	PK 178	2,176
Prevalence/10,000 inhabitants with migration background 65+								
Norway	11,860	-	SE 78	DK 76	UK 52	DE 44	PK 33	407
Prevalence/100,000 inhabitants 65+								
Norway	6,900	6,499	SE 45	DK 44	UK 30	DE 26	PK 19	237

Data source: Statistics Norway (2019)

There are 53,500 PwM aged 65 or older. Of those, approx. 3,700 are estimated to exhibit some form of dementia. Figure 3.7.23.1 shows that the most affected migrant groups presumably originate from Sweden (approx. 400), Denmark (approx. 400), United Kingdom (approx. 300), Germany (approx. 200), and Pakistan (approx. 200). The second graph highlights the number of PwM with dementia in

Norway per 100,000 inhabitants aged 65 years or older (figure 3.7.23.2). Table 38 displays the values depicted in the maps on the national level. The following maps show the distribution of non-migrants with dementia and PwM with dementia from Sweden, Denmark, United Kingdom, Germany, and Pakistan throughout the country in the NUTS2 regions (figures 3.7.23.3 – 3.7.23.8).

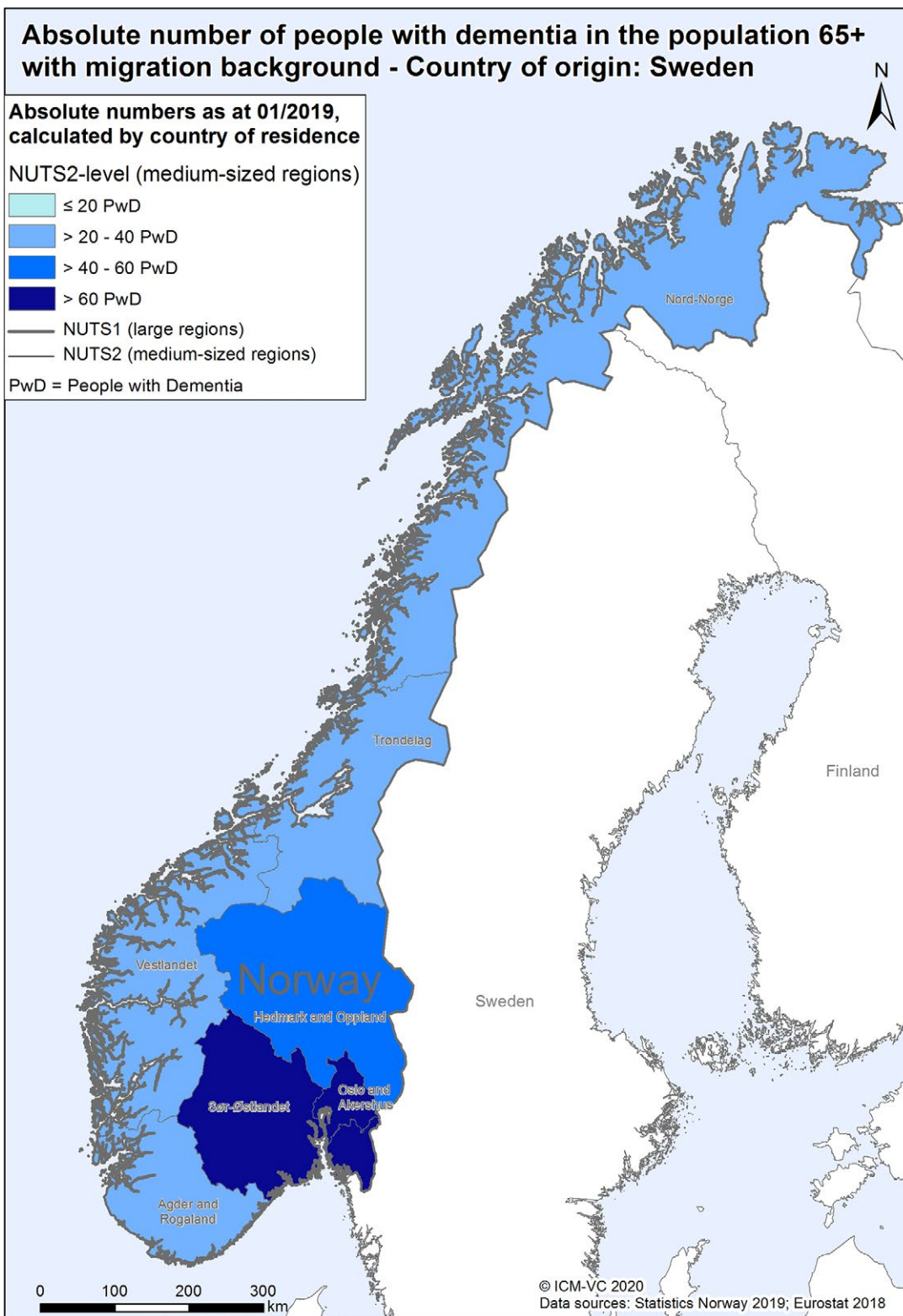


Fig. 3.7.23.3: Absolute number of PwM with dementia aged 65+. Country of origin: Sweden (Norway – NUTS2)

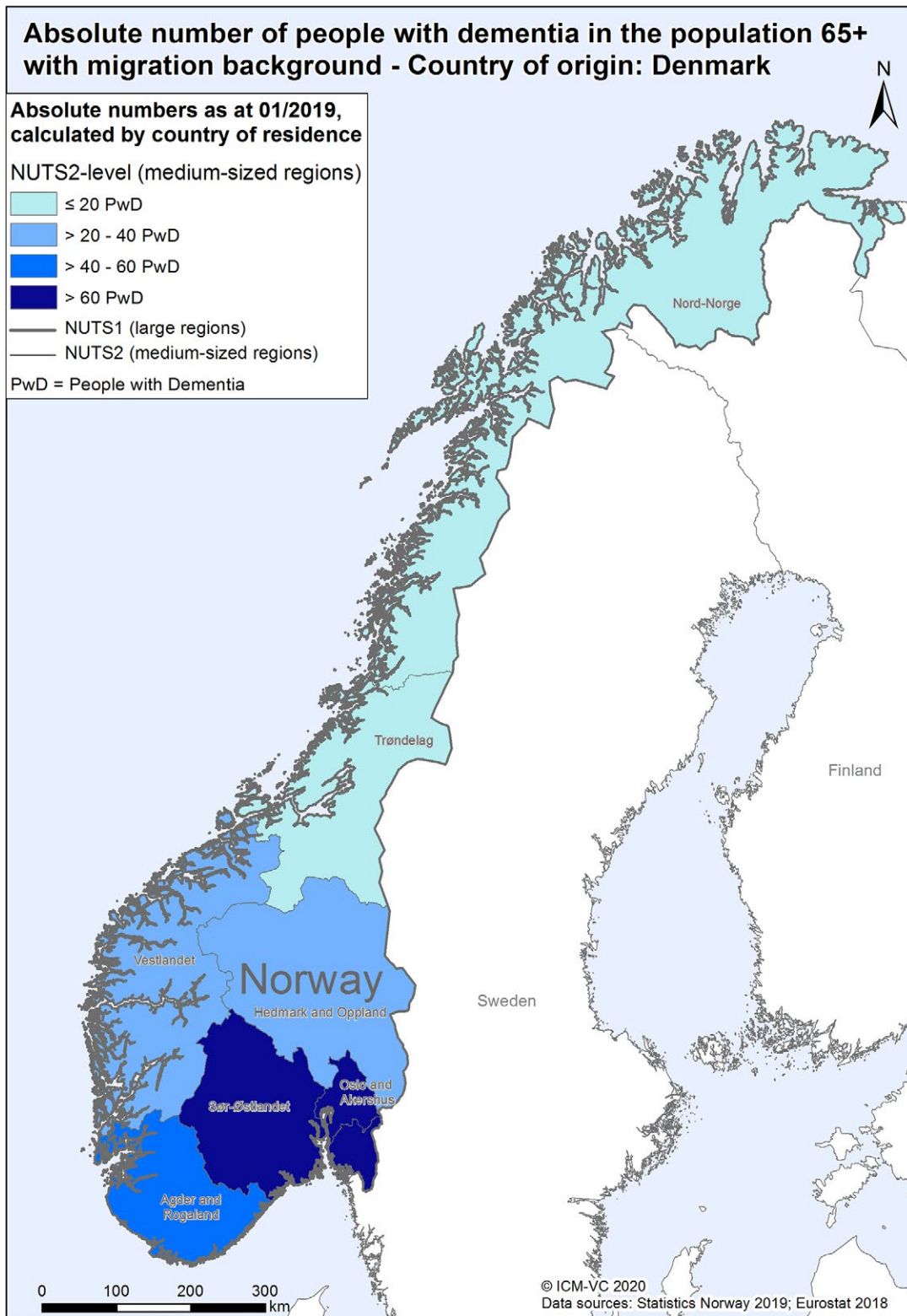


Fig. 3.7.23.4: Absolute number of PwM with dementia aged 65+. Country of origin: Denmark (Norway – NUTS2)



Fig. 3.7.23.5: Absolute number of PwM with dementia aged 65+. Country of origin: United Kingdom (Norway – NUTS2)

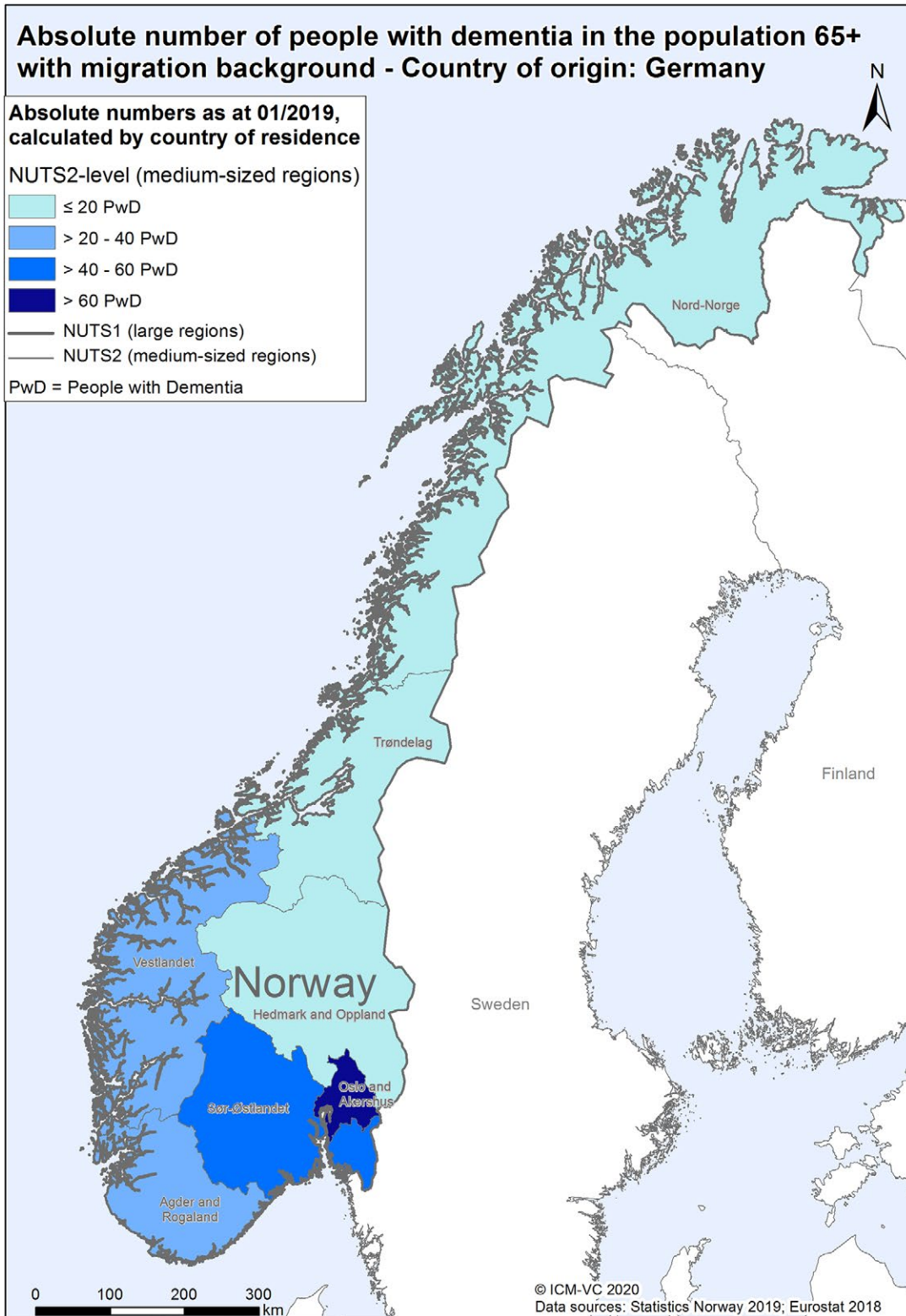


Fig. 3.7.23.6: Absolute number of PwM with dementia aged 65+. Country of origin: Germany (Norway – NUTS2)

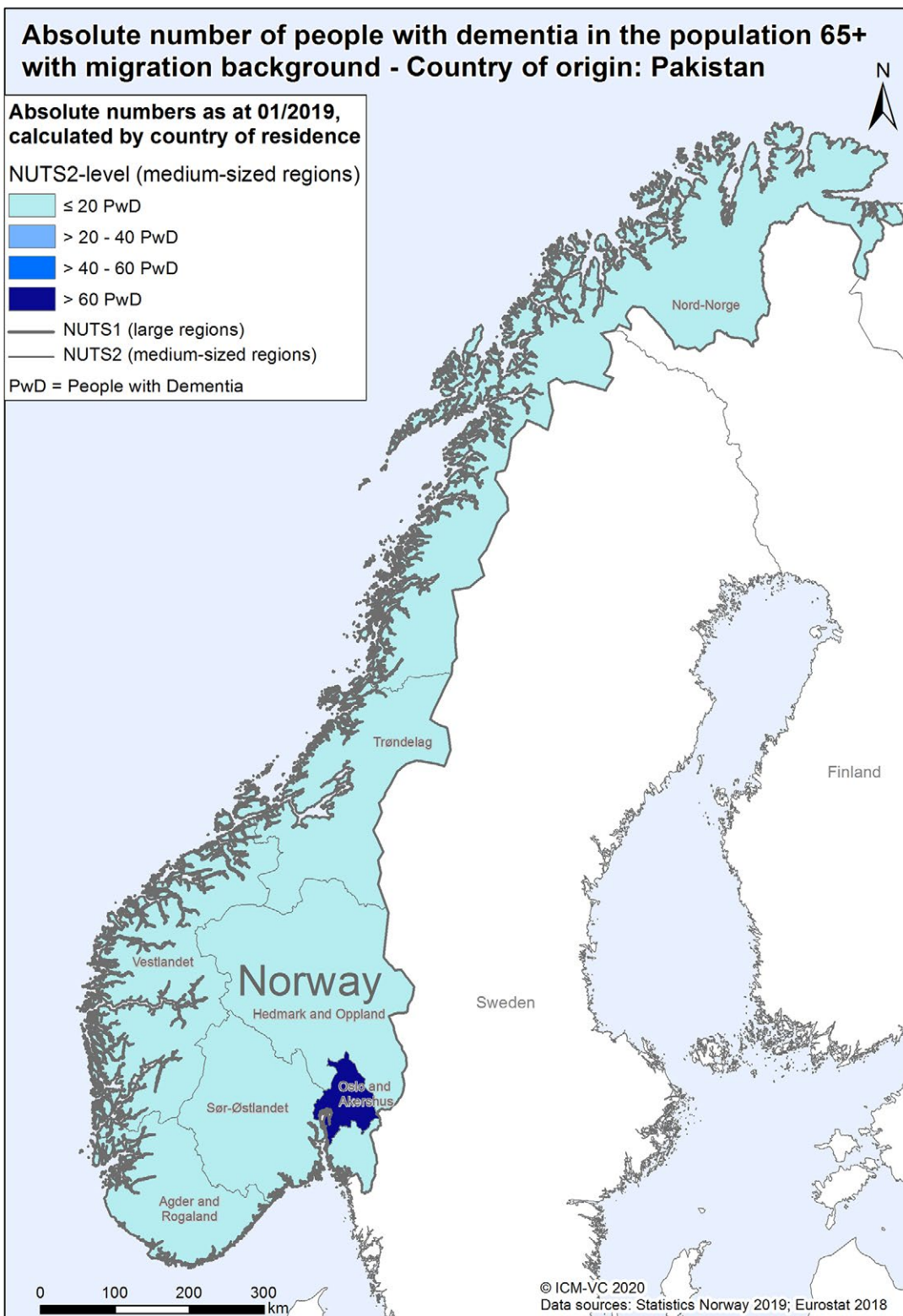


Fig. 3.7.23.7: Absolute number of PwM with dementia aged 65+. Country of origin: Pakistan (Norway – NUTS2)

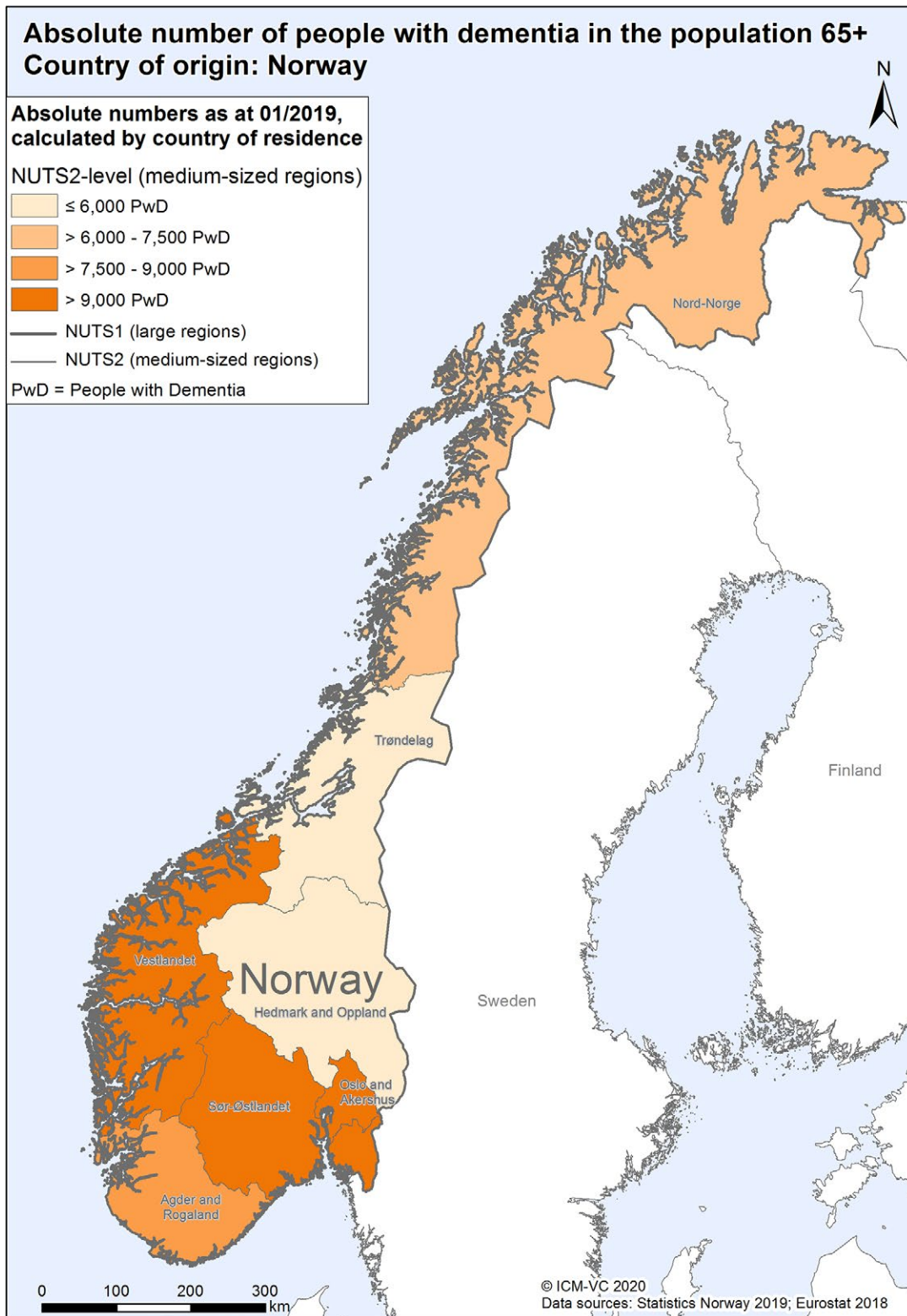


Fig. 3.7.23.8: Absolute number of people with dementia aged 65+. Country of origin: Norway (Norway – NUTS2)



Norway

The graphics below highlight which immigrant groups are estimated to be most affected at the NUTS2 level. The first map illustrates the absolute numbers of PwM with dementia in the NUTS2 regions (figures 3.7.23.9). The sec-

ond graphic shows the number of PwM with dementia per 100,000 inhabitants aged 65 or older in the NUTS2 regions (figure 3.7.23.10). The values from the NUTS2 level can be found in table 39 [6-8].

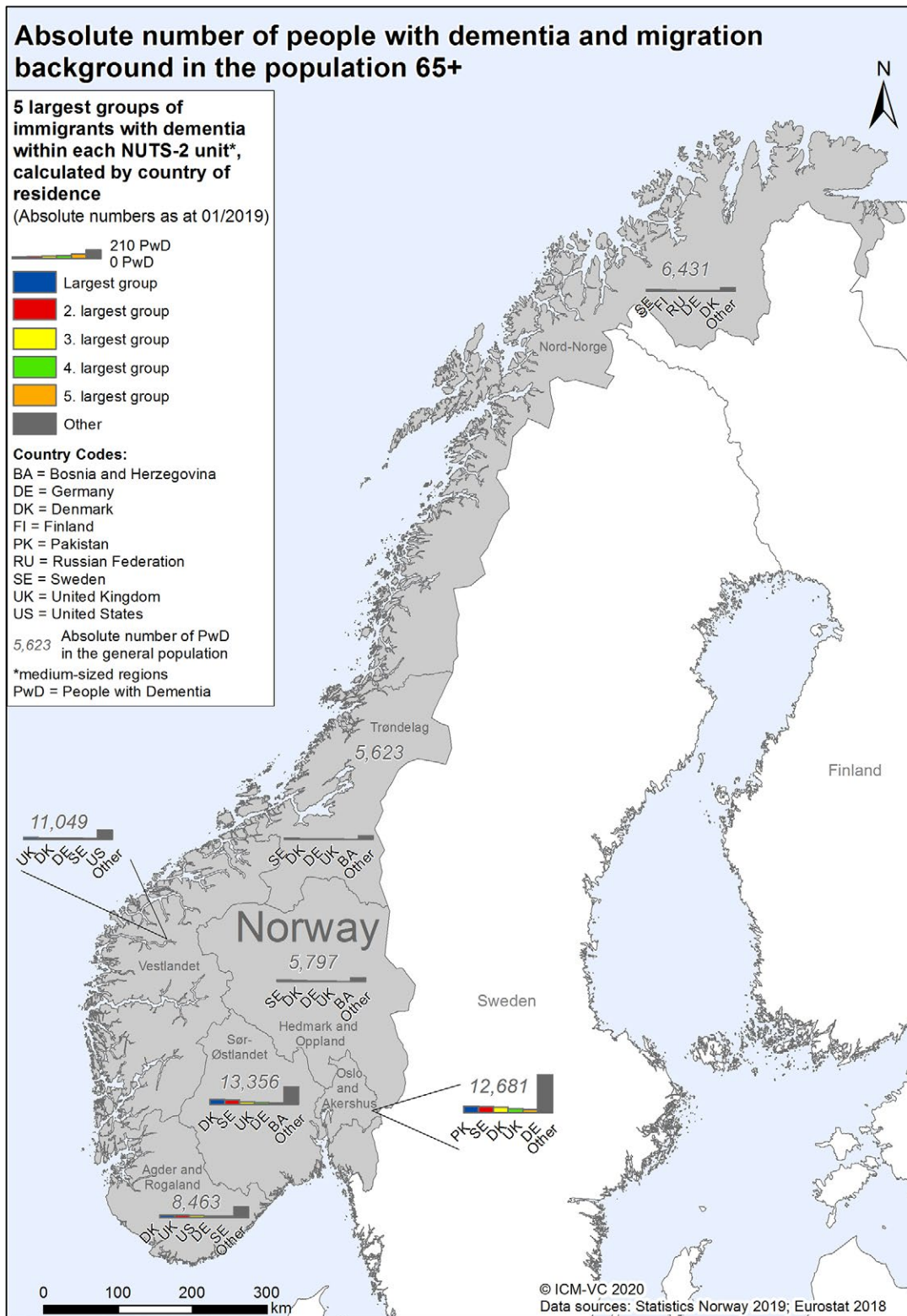


Fig. 3.7.23.9: Absolute number of PwM with dementia aged 65+ (Norway – NUTS2)

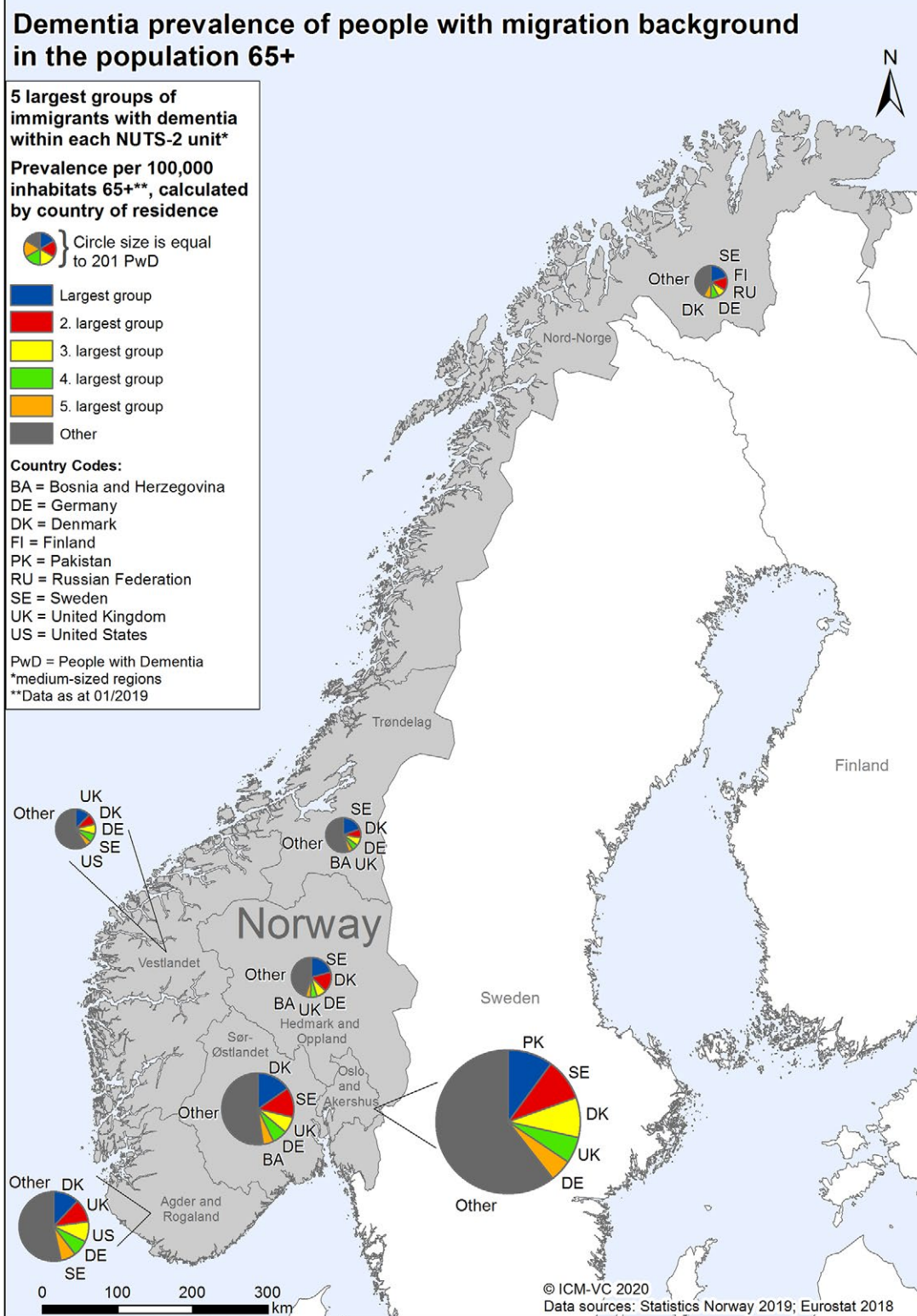


Fig. 3.7.23.10: Prevalence of PwM with dementia among the population aged 65+ (Norway – NUTS2)



Tab. 39: PwM with dementia: Absolute numbers, prevalence among PwM aged 65+, and prevalence among overall population aged 65+ (Norway – NUTS 2)

NUTS	Total	NO	1. largest group	2. largest group	3. largest group	4. largest group	5. largest group	Other
Absolute Numbers								
Oslo and Akershus	12,681	11,177	PK 151	SE 143	DK 135	UK 89	DE 75	911
Hedmark and Oppland	5,797	5,604	SE 40	DK 32	DE 15	UK 10	BA 8	87
Sør-Østlandet	13,356	12,558	DK 123	SE 107	UK 59	DE 53	BA 39	417
Agder and Rogaland	8,463	7,977	DK 58	UK 53	US 45	DE 36	SE 34	260
Vestlandet	11,049	10,677	UK 46	DK 33	DE 31	SE 25	US 18	220
Trøndelag	5,623	5,459	SE 32	DK 13	DE 12	UK 10	BA 7	90
Nord-Norge	6,431	6,260	SE 34	FI 23	RU 15	DE 14	DK 13	72
Prevalence/10,000 inhabitants with migration background 65+								
Oslo and Akershus	5,819	-	PK 69	SE 66	DK 62	UK 41	DE 34	418
Hedmark and Oppland	20,741	-	SE 144	DK 114	DE 55	UK 35	BA 30	312
Sør-Østlandet	11,547	-	DK 107	SE 92	UK 51	DE 46	BA 34	361
Agder and Rogaland	12,005	-	DK 83	UK 75	US 64	DE 51	SE 48	369
Vestlandet	20,491	-	UK 85	DK 61	DE 57	SE 46	US 34	407
Trøndelag	23,674	-	SE 134	DK 55	DE 51	UK 41	BA 30	379
Nord-Norge	3,210	-	SE 138	FI 94	RU 59	DE 57	DK 53	289
Prevalence/100,000 inhabitants 65+								
Oslo and Akershus	6,900	6,082	PK 82	SE 78	DK 73	UK 49	DE 41	469
Hedmark and Oppland	6,900	6,670	SE 48	DK 38	DE 18	UK 12	BA 10	104
Sør-Østlandet	6,900	6,488	DK 64	SE 55	UK 30	DE 27	BA 20	216
Agder and Rogaland	6,900	6,503	DK 47	UK 43	US 37	DE 29	SE 27	212



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Vestlandet	6,900	6,668	UK 28	DK 20	DE 19	SE 16	US 12	137
Trøndelag	6,900	6,699	SE 39	DK 16	DE 15	UK 12	BA 9	110
Nord-Norge	6,900	6,716	SE 37	FI 25	RU 16	DE 15	DK 14	77

Data source: Statistics Norway (2019)

3. National dementia plan

For Norway three published NDPs were identified. The 'Dementia Plan 2015', the 'Dementia Plan 2020: A More Dementia-friendly Society', and the 'Dementia Plan 2025' all address the topic of migration or language/ethnic minorities. In the 'Dementia Plan 2015' from 2008 the topic of migration is briefly addressed. In one passage it is mentioned that the Directorate of Health and Social Affairs plans to carry out research projects to gain insights into the situation of persons with minority language backgrounds with dementia in the period 2006 to 2010. A short section on 'Persons with Minority Language Backgrounds Who Develop Dementia' highlights a three-year Nordic development program for this population. This program will focus on information, diagnosis, treatment, and assistance needs. The Nordic countries are expected to provide professional expertise and funding for this program. The first NDP shows that the Norwegian government is involved in initiating or planning projects on dementia in persons with a minority language background, although there is no further substantive discussion of this topic [9]. The 'Dementia Plan 2020: A More Dementia-friendly Society' from 2015 refers to migration in several sections. In dementia care, Norway has adopted a person-centred approach that considers the cultural background. Furthermore, the second Dementia Plan refers to particular needs of the Sámi people and people from linguistic minority groups and expresses the need for more knowledge about

these groups and a better awareness of cultural differences. It also discusses the need for healthcare professionals to receive training and counselling on the diagnosis of dementia in people with special needs. A fundamental problem identified is that elderly migrants with dementia often do not use healthcare services until the disease is at an advanced stage. In the absence of linguistically and culturally appropriate services, the family burden increases. Another key issue is the language barriers between professionals and patients, which endanger patient safety. To address this problem, it is recommended that care providers employ multilingual staff. Another recommendation relates to the construction or modernisation of nursing homes and assisted living facilities, where the unique needs of people from Sámi and minority language groups should be taken into account. One particular section on research, knowledge, and competence calls for healthcare and socio-educational curricula in universities and colleges to be more strongly focused on increasing knowledge about these groups. Within the chapter on measures for the planning period 2016–2020, reference is made to a published brochure on healthcare services for elderly Sámi, which aims to improve the competence of staff working with people with dementia from Sámi or minority language groups. It is stated that in the future people with dementia from different cultural groups and their families should be involved in developing a pilot project for post-diagnostic follow-up.



The 'Dementia Plan 2020: A More Dementia-friendly Society' considers people with dementia from Sámi or linguistic minority groups as a group with specific needs that have to be considered separately. It identifies some specific problems related to diagnosis and care of people from these groups and mentions some concrete measures to tackle them. However, it also reveals the current lack of awareness of cultural differences and knowledge about Sámi and language minority groups in the Norwegian healthcare system. Besides, no data on dementia prevalence within these groups are given [10].

The 'Dementia Plan 2025' from 2020 refers in detail to the topic of migration in a total of 14 sections in 7 chapters. In several chapters, there are separate sections or paragraphs on this topic. It is pointed out several times that the proportion of older people with an ethnic minority background is increasing, and consequently, so is the number of people with dementia from this population. In different parts of the document, it is emphasised how important an adaptation of information, counselling, treatment, and care services (e.g. community day activities) to the individual language and cultural background of people with dementia and their relatives is. At first, different challenges in the care of people with an ethnic minority background and specific needs of this population are described in various sections related to migration. In this context, it is repeatedly stated that language problems, cultural differences, different perceptions of dementia, and the lack of knowledge of many older people with a minority background about Norway's healthcare system, as well as the lack of diversity competence on parts of the healthcare providers, are barriers to effective healthcare. In particular, the investigation and diagnosis of dementia among ethnic minorities can be challenging due to communication problems. This NDP concludes that people from minority

backgrounds do not receive the same health-care services as other people with dementia even as the disease gets worse. According to the document, one problem could also be that many people from these groups do not seek professional help as they feel guilty or ashamed of not being able to care for their family members without help from the state.

The third Norwegian Dementia Plan also lists some actions that have already been taken by the government and care providers as well as measures that are yet to be taken by municipalities and service providers to meet the challenges of dementia care and to ensure that people with different ethnic backgrounds have access to equal services. It is stated that the government will continue to focus on information and dissemination of knowledge about the minority language population with dementia. Furthermore, it is noted that a national competence area for culture, health, and care has been created as part of the Dementia Plans 2015 and 2020. Besides, a separate box highlights the project on the assessment of cognitive abilities and dementia symptoms in people with other language and cultural needs, which started in 2019 and finished in 2020. This project has brought together a group of clinicians from Oslo University Hospital, St. Olav's University Hospital (Trondheim), and Vestfold Central Hospital (Tønsberg) to offer adapted cognitive tests to foreign-language patients. In addition to this program, reference is made to studies that have shown that communication in the patient's mother tongue is central to maintaining functional levels of cognition and that the use of high-quality interpretation services is beneficial. It is argued that people with dementia from minority backgrounds and their relatives prefer person-centred care services wherein the staff has the required language skills and cultural understanding. Furthermore, this dementia plan shows that there is an open need



for adapted (multilingual) instruments for basic dementia assessment. People with different cultural and linguistic backgrounds should be more involved in the process of adapting such instruments, and their feedback should be systematically surveyed. Besides, the national quality and research register of treated dementia patients developed for doctors as well as healthcare staff should be expanded to include English-language register sets.

Overall, the topic of migration plays an important role in the third and current Norwegian Dementia Plan. The growing group of people with an ethnic minority/migration background as well as dementia is identified as a vulnerable population with specific needs on which the government and care providers have already been focusing for some years, but which needs to be given more attention in the future, especially by municipalities and care providers. The existing problems and inequalities in care

for minorities and immigrants are described in detail, along with a significant framework for action. In the 'Dementia Plan 2025', reference is made to measures already taken and projects completed on the topic of dementia and migration, but recommendations for action for care planners and service providers are also given [11].

Compared to other European countries, the Norwegian dementia plans from 2015 and 2020 take the topic of migration or language/ethnic minorities into account in a comprehensive manner. The fact that the scope of the migration reference, the communicated scientific knowledge, and the framework of action regarding immigrants or language/ethnic minorities expands with each publication year of the dementia plans suggests that the topic of dementia and migration/minorities is being given increasing importance at the government level in Norway.

4. National dementia care and treatment guidelines

The 300-page 'National Professional Guidelines on Dementia' from 2017 refers in detail to the topic of migration. The chapter 'Groups That May Have Special Needs: Assessment and Follow-up in Dementia', has a separate section on 'People With Minority Backgrounds With Suspected Dementia' (1 ½ pages). The term 'People With Minority Backgrounds' includes PwM, but not all people with minority backgrounds have a migration background. The guidelines also refer to dementia among migrants and people with minority backgrounds in 9 of the 18 other chapters. Notably, a representative from the Nasjonal kompetanseenhet for migrasjon – og minoritetshelse (=Norwegian Centre of Competence for Migration and Minority Health) (NAKMI) was in the task force that developed the guidelines. In 2015, the Norwegian Ministry of Health commissioned the NAKMI to research the care

situation of people with minority backgrounds and dementia. The thematically relevant sections of the document first describe the general challenges in caring for people with minority backgrounds and dementia. The focus is on the challenges associated with diagnosis. It is identified that people from minority groups are examined at a later stage of dementia. Their cultural and linguistic background may make the diagnosis difficult. Moreover, existing cognitive testing procedures are not suitable as assessment tools for migrants. Another phenomenon is the lower utilisation of formal healthcare services (primary healthcare services, prescription of medication, inpatient stays in nursing homes) by people with minority backgrounds and dementia. After the general problem description, the focus is on the identification of specific care barriers and needs. It is discussed that people who are not



familiar with the Norwegian healthcare system may need additional guidance and care. In addition, stereotyping of people with minority backgrounds can be a barrier to personalised care. Another topic discussed is the different perceptions of dementia symptoms within this group (e.g. the perception that dementia is simply a result of slight confusion, normal aging, psychological stress, family problems or migration experiences, spiritual factors (God's will), or fate). The Norwegian guidelines repeatedly identify people with minority backgrounds as a group with specific needs. They explain that people from other cultures have different ideals, ideas, and wishes regarding information and self-determination.

In addition, the guidelines give some specific recommendations for action, which are declared as strong recommendations. One recommendation addresses the medical service, which should examine whether the educational level, language, or cultural background of persons with minority backgrounds and suspected dementia represent a barrier to treatment. Besides, care providers are recommended to document a person's resources and vulnerability in terms of culture and spirituality in an individual action plan. The analysis of the recommendations, measures, and care services show that Norway is generally trying to provide integrative care for people with minority backgrounds. The aim is to integrate them into the general primary healthcare system. However, in areas where care barriers are significant, specialised services are also being developed. One area in which Norway seems to have chosen a segregative model is dementia diagnosis. As the standardised screening tests used by the majority population (e.g. MMSE) are very language and culture-specific,

the utilisation of the intercultural screening tool RUDAS is recommended for people without higher education and with other cultural and linguistic backgrounds. In general, standardised versions in the mother tongue should be used for oral tests. For people with minority backgrounds, a comprehensive assessment by the medical service is also recommended (including neuropsychological examination). This is especially important if language, educational level, or culture are a barrier to assessment. In the case of language barriers, an interpreter should be consulted. For extended cognitive assessment, there are currently no standardised tests suitable for people with minority backgrounds. Post-diagnostic care should be provided as part of general primary care. Further, efforts are underway to ensure effective healthcare to people with minority backgrounds through policy making, e.g., by enshrining in law the right to native language information on health/care and the right to have access to an interpreter. Furthermore, specialised services such as a brochure on healthcare interpreters, the information material on dementia in four languages (Norwegian, English, Polish, and Urdu), and the Norwegian version of RUDAS are provided.

Overall, the topic of migration or minority groups features prominently in the 'National Professional Guidelines on Dementia' [12].

The following parts on services and information for PwM with dementia, professional care and support for family caregivers are based on a conducted interview and a discussion round and reflect the experience and opinion of the experts. A selection bias in information and a discrepancy to results from the previous sections might ensue.



5. Services and information for people with a migration background with dementia

According to the expert who was interviewed first, dementia and migration is relatively unimportant in Norway as a whole. Currently, there are not many older immigrants in Norway. However, the proportion of the population with an immigration background varies significantly between different regions and municipalities. In Oslo, for example, the issue is much more relevant than in other parts of the country. The second expert stated that the migrant population is very heterogeneous. Within this population, there are large differences in the regions of origin, the time of immigration, the reason or purpose of migration, and the individual's educational level. These differences affect the level of inclusion in the healthcare system. In Norway, the topic of dementia and migration was first addressed in a project in 2012. The background to the project, in which the two experts were involved, was the growing awareness among doctors and other healthcare professionals about the incidence of dementia in older migrants in Norway and their specific needs. However, the number of such projects is relatively low. According to the first expert, the existing developmental centres for nursing homes and home care services as well as the care research centres do not have a particular focus on this topic. It is through the individual projects carried out that Norway has research-based knowledge about underdiagnosis problems and lower utilisation of formal healthcare services by PwM. According to the first expert interviewed, Norway uses an integrated care model in which PwM have the same rights as the autochthonous population. In outpatient and inpatient care, formal services are generally available nationwide to PwM with dementia. However, PwM often have less access to care due to a lack of knowledge about the healthcare system and a lack of cultural and linguistic adaptation

of services. According to a third expert interviewed, the central structural problem is that people from the migrant groups, unlike individual minority groups originating from Norway, do not have a legal right to culturally sensitive mother-tongue information and care services. Currently, few services in Norway are tailored to the specific needs of PwM with dementia. The first expert cited the Memory Clinic at Oslo University as a model of good practice, which has special expertise in assessing dementia in patients with a migration background. According to the second expert, a few general practitioners and nursing homes in Norway have many employees with a migration background and try to adapt their services to the needs of PwM with dementia within the legal limits. As an example of a specialised inpatient care service, the first expert also mentioned the Jewish nursing home and the nursing home for people from Denmark in Oslo.

However, these are all private initiatives and not state initiatives. It seems that a national strategy is missing, and that current specialised care services for migrants with dementia are far from adequate in terms of meeting their needs. According to the experts, the existing specialised services are not sufficiently adapted to the individual, cultural, and linguistic needs of PwM with dementia. PwM are not provided the tailored information they need about various aspects of living with dementia and they are not invited to participate in the development of services meant for them. Considering that the society in Norway has a heterogeneous migrant community, according to experts, Norway needs to continue working on ensuring diverse, culturally sensitive healthcare services for migrants in the long term. This is especially important as the number of aged PwM will continue to grow in the coming years.



6. Professional qualification and people with a migration background in healthcare

The first expert pointed out that culturally sensitive care is partly included in the healthcare professional's qualifications. Professionals who were educated many years ago probably had less contact with this topic during their education. However, a change is currently in process. The topic of culturally sensitive care is becoming more and more part of the curriculum for nurses and doctors, and there is an increasing number of presentations on this topic at universities or in the context of nursing education. However, the modules are not compulsory, and the topic is rarely part of the examinations. Thus, one of the most crucial tasks in education for the future is to include migration and diversity in the curricula as a mainstream and transversal issue that permeates the different health topics taught within the curricula. The second expert stated that the need for action on dementia and migration is still much more significant in the training of healthcare professionals than in the area of care. According to the third expert, the main problem is that the education system for professionals is not being changed in line with the social change towards more diversity. Concerning the training of healthcare professionals, the first expert reported that there is now a nationwide availability of intercultural care courses. The Oslo Metropolitan University, for example, offers a training program on multicultural healthcare, and other universities such as Bergen University have similar programs. In nursing homes and care services, the 'Dementia ABC Educational Program' for unskilled workers is available, including a module on older immigrants and dementia.

In 2017, 17% (24,700) of regular employees

in municipal care services were immigrants. In 2009 the proportion was 11% (13,700) [13]. According to the first expert, the reason for this increase is the Norwegian policy to qualify immigrants for working in care services. However, there are large regional differences in the proportion of immigrants in the care sector. In Oslo, the proportion of employees with a migrant background is 44%, whereas, in Nord-Trøndelag (Central Norway), it is 8%. The leading country of origin of immigrants is by far the Philippines. Other frequent countries of origin are Poland, Eritrea, Somalia, Sweden, and Thailand. The staff in the municipal care services originate from a total of 160 different countries [13]. The second expert stated that PwM are also well represented among general practitioners (one of five) and specialists in Norway. According to the experts, this high cultural and linguistic diversity in the care sector offers a high potential, which, is currently not strategically used. The first expert noted that many people in Norway see the high proportion of migrants in care services as a challenge rather than a resource in terms of adapting services to people with a different linguistic or cultural background. For example, current projects focus more on overcoming communication barriers. According to the expert, there is no systematic work or project on how to use these staff's resources.

Despite this positive trend in the area of training for employees in the healthcare sector, the need for culturally sensitive care in Norway, in general, is currently not met by sufficiently qualified professionals as stated by the experts. Especially in the area of healthcare education, there is a great need for action.



7. Support for family caregivers

According to the first expert, family networks, migrant organisations, religious communities, and voluntary organisations are very important in supporting family caregivers of PwM with dementia. Providers of outpatient or inpatient care currently play a rather subordinate role. For the third expert, the foreigners clubs are especially important for PwM with dementia and their family caregivers due to the presence of people they can trust and talk to in their mother tongue. This is particularly important for the transfer of knowledge on the topic of dementia and care.

The first expert pointed out that there are currently significant differences between PwM and non-migrants in terms of the accessibility of information and utilisation of services. For the general population, there is plenty of information available about dementia. However, PwM do not use the same media channels as non-migrants, and they are less familiar with the Norwegian healthcare system, which results in higher barriers to information. A survey of family caregivers showed a high demand for tailored information

in the respective mother-tongues for PwM.

According to the first expert, training courses are available nationwide for caregivers of people with dementia. As no relatives with a migration background have attended these training courses, a project was initiated to develop tailored courses for people from Pakistan and Turkey and offer them in different cities. In addition, an e-learning course was developed in which other municipalities were given recommendations on how to set up a course for relatives with a migration background. The medical staff, as well as minority organisations, migrant organisations, and key persons from the respective communities, were involved in the development of these courses.

In Norway, according to the experts, there is currently still a great lack of tailored information and accessible support services offered by outpatient and inpatient care providers. However, there are first models of good practice in the training of family caregivers from some migrant groups.

8. References

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