STATISTICAL REPORT 4/2024
1 February 2024

Health and well-being of the adult population with a foreign background – MoniSuomi 2022
One in three immigrants do not receive a sufficient amount of doctor's services

MAIN FINDINGS

- One in three immigrants felt that they had not received sufficient doctor's appointment services in relation to their needs during the past year.
- The experience of insufficient doctor's appointment services clearly increased between 2018 and 2022.
- Experiences of the sufficiency of doctor's appointment services varied greatly by wellbeing services county and by the immigrant's background country group.
- Psychological distress was significantly more common in the immigrant population than in the entire population.
- The share of persons experiencing psychological distress in the immigrant population increased between 2018 and 2022. Psychological distress was most common among those who had moved to Finland from the Middle East and North Africa and young adults.

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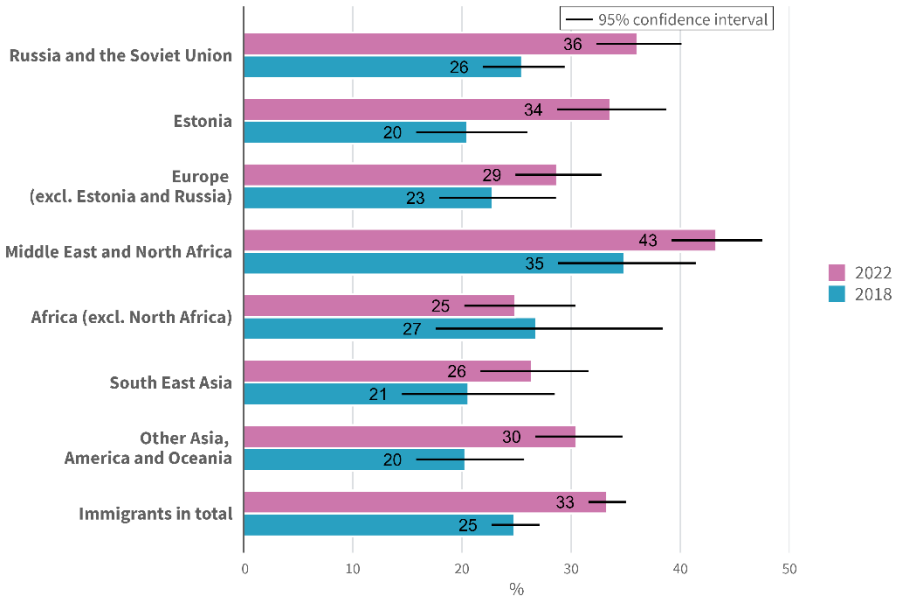
The data in these statistics are from the MoniSuomi 2022 study, which examined the perceived well-being and health of the population with a foreign background who had been born abroad (hereafter immigrant) and their service experiences.

The study revealed that one in three immigrants did not receive sufficient doctor's appointment services to meet their needs. The share increased significantly when the 2022 data was compared to the situation in 2018 (25% vs. 33%). The share of those who had needed a doctor's appointment service but received insufficient services was clearly higher among immigrants compared to the total population (33% vs. 25%).

Of immigrants, 22% reported psychological distress, compared with 18% of the entire population. The share of mentally distressed immigrants increased between 2018 and 2022 (17% vs. 23%). There were differences between country groups, but it was men who had moved to Finland from the Middle East and North Africa that most commonly experienced psychological distress (29%).

The comparison data used for the MoniSuomi survey are 1) the Healthy Finland 2022 survey (20-74-year-olds) and 2) the FinMonik 2018-2019 survey (20-64-year-olds). When examining the change over time, the analyses are limited to the 20-64 age group. Information is widely available in different areas, and this report examines two key health themes: the availability of doctor's appointment services and psychological distress in the immigrant population in Finland. Statistics are also published on THL's website as indicators.

Figure 1. Share of persons who have needed, but received insufficient doctor's appointment services in 2018 and 2022, by country group, those aged 20–64, model-standardised share, %



How this study was conducted:

The MoniSuomi study was implemented as a survey. The sample included 18,600 respondents who were themselves or whose parents were born outside Finland. The sample was extracted from the Digital and Population Data Services Agency. The persons invited to the MoniSuomi survey are aged between 20 and 74 years.

The data collection of the survey was launched in September 2022 and it ended in March 2023. The data were collected primarily using an electronic questionnaire that respondents filled out online. The data collection was complemented by a paper questionnaire and telephone interviews. The survey and interview data are also supplemented with register data.

The material for the survey was translated from Finnish into 19 different languages, which meant that the majority (76%) of the persons retrieved to the survey received the material in their mother tongue in addition to Finnish or Swedish. The response rate was 44 per cent (n=7,838).

In addition to THL, the data collection in the survey has been funded by the Ministry of Economic Affairs and Employment, the cities of Helsinki, Turku, Espoo and Vantaa, and the reporting phase of the survey also by the Asylum, Migration and Integration Fund (AMIF).

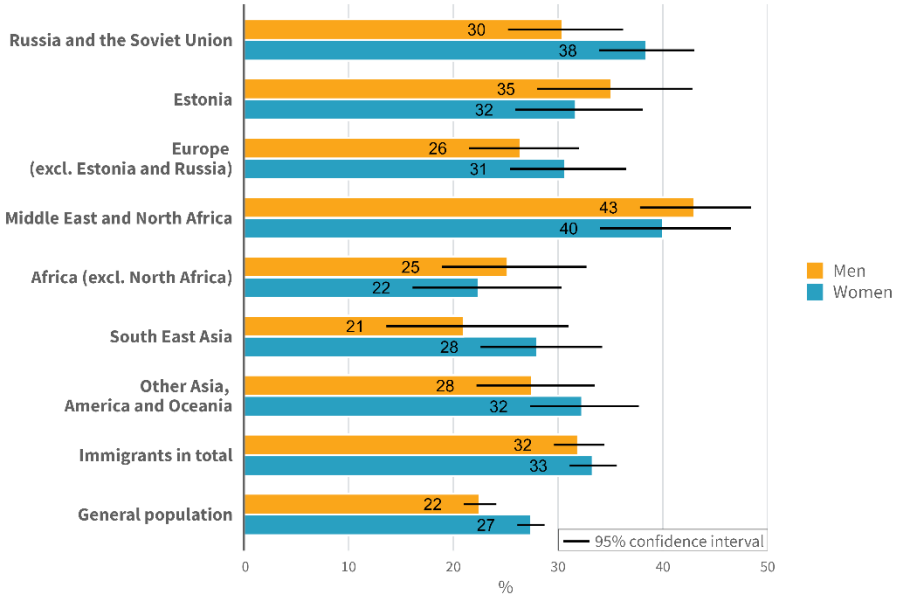
The share of those who received insufficient doctor's services grew between 2018 and 2022.

In 2018, the share of women who had needed, but received insufficient doctor's services was 27 per cent and in 2022, the corresponding share was as high as 34 per cent (Figure 1). The increase among men was from 23 per cent to 33 per cent (no Figure). The experience of insufficient doctor's appointment services increased especially in the groups Russia and the Soviet Union (26% vs. 36%), Estonia (20% vs. 34%), other Asia, America and Oceania (20% vs. 30%) and Middle East and North Africa (35% vs. 43%

One in three immigrants do not receive sufficient doctor's appointment services to meet their need

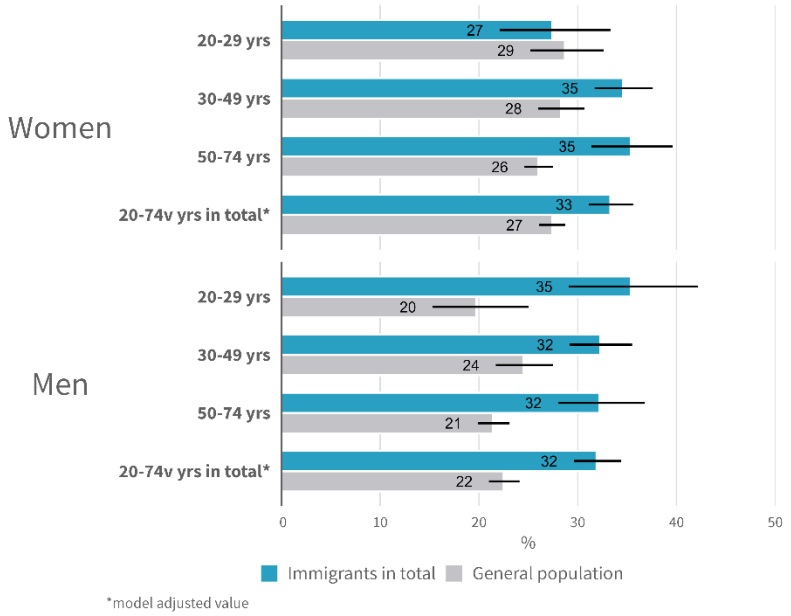
On in three immigrant men and women who needed doctor's appointment services reported they had not received a sufficient amount of them to meet their need (Figure 2). The share of immigrant men and women was clearly larger than that of men and women in the entire population (men: 32% vs. 22% and women: 33 % vs. 27 %). The experience of insufficient doctor's appointment services varied between the background country groups (men: 21–43% and women: 22–40%).

Figure 2. Share of persons who have needed, but received insufficient doctor's appointment services, by country group and gender, those aged 20–74, model-standardised share, %



When examined by age group, the share of those who had received insufficient doctor's appointment services was larger among immigrants than in the entire population in all age groups except for women aged 20–29 years (Figure 3).

Figure 3. Share of persons who have needed, but received insufficient doctor's appointment services, immigrants and the entire population by age group and gender, those aged 20–74, model-standardised share, %



Information on this report's calculation methods:

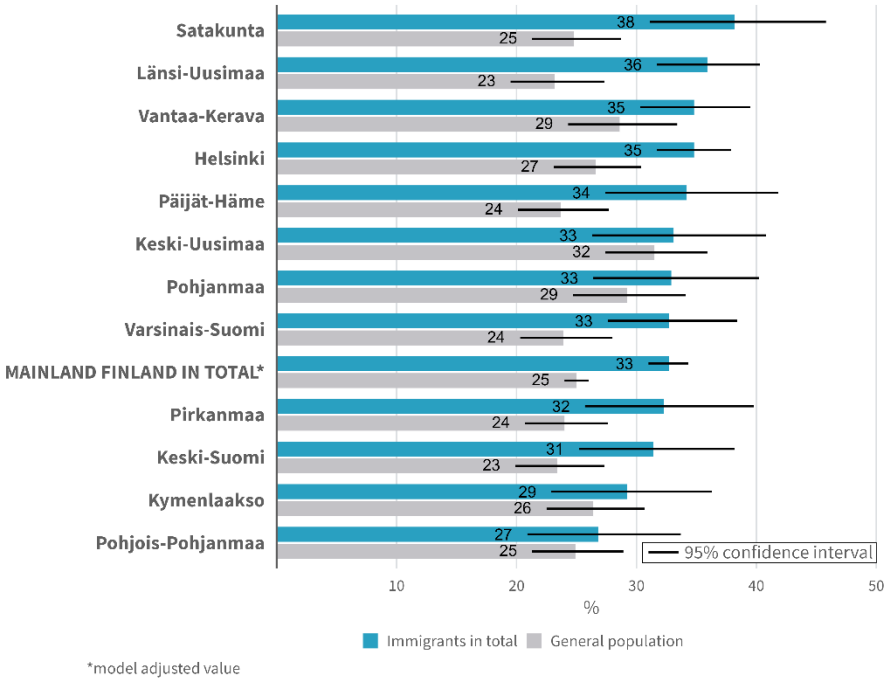
The report indicates the weighted and model-standardised percentages where possible. A 95% confidence interval has been calculated for the shares, taking into account the sample layout with weight coefficients.

When reading the results, it should borne in mind that, when comparing the data with the 2018 data, the estimates are limited to persons aged 20–64 and the entire sample has not been utilised in them. For this reason, the shares may deviate from those of persons aged 20–74 in the MoniSuomi survey.

There are major differences between population groups in the sufficiency of doctor's services also in the wellbeing services counties

Of the examined wellbeing counties, immigrants in West Uusimaa, Helsinki, Satakunta, Southwest Finland, Päijät-Häme, Pirkanmaa and Central Finland reported significantly more often than the entire population in the same county that they had received insufficient doctor's appointment services (31–38%) (Figure 4). In the other counties, the share of people who had received insufficient doctor's services varied between 27 and 35 per cent and no differences were observed when the figures were compared to the entire population of the same county.

Figure 4. Share of persons who have needed, but received insufficient doctor's appointment services in selected wellbeing services counties, immigrants, and the entire population, those aged 20–74, model-standardised share, %

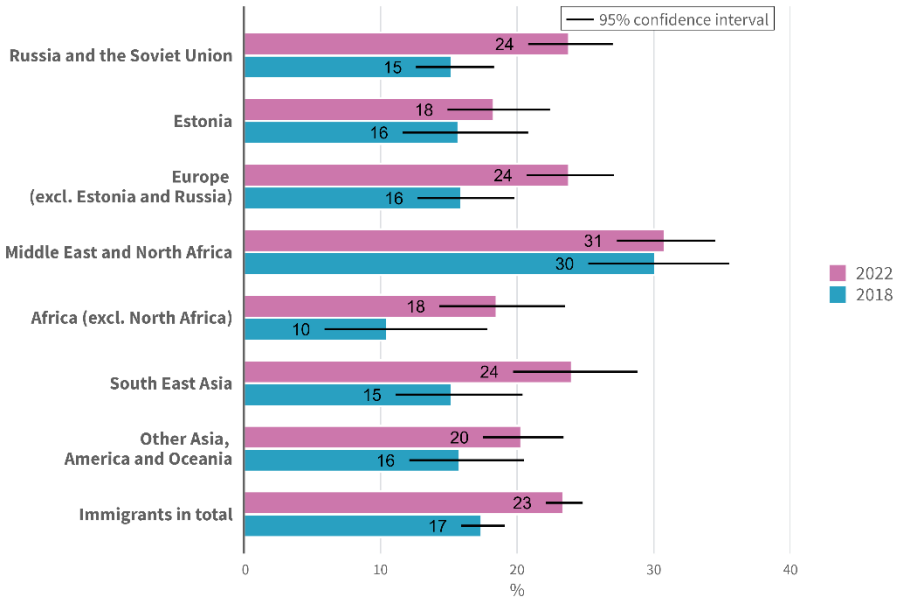


*model adjusted value

Psychological distress has become more common in the immigrant population between 2018 and 2022.

Psychological distress became significantly more common when the 2022 data was compared to the data from 2018 (23% vs. 17%) (Figure 5). Psychological distress became more common especially in the country groups Russia and the Soviet Union (24% vs. 15%), Europe (excl. Estonia) (24% vs. 16%) and Southeast Asia (24% vs. 15%).

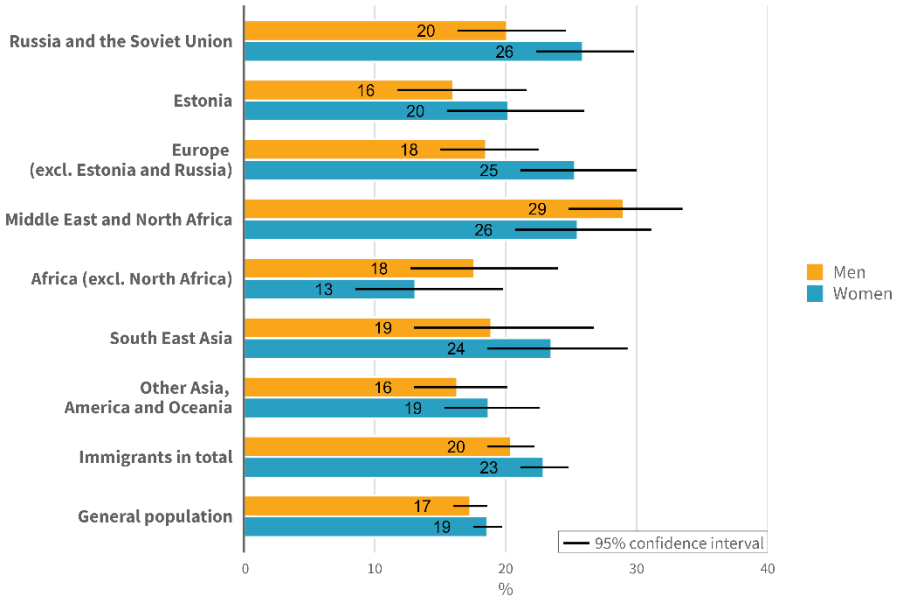
Figure 5. Psychological distress in 2018 and 2022, by country group, those aged 20–64, model-standardised share, %



Psychological distress is more common among immigrants than in the entire population

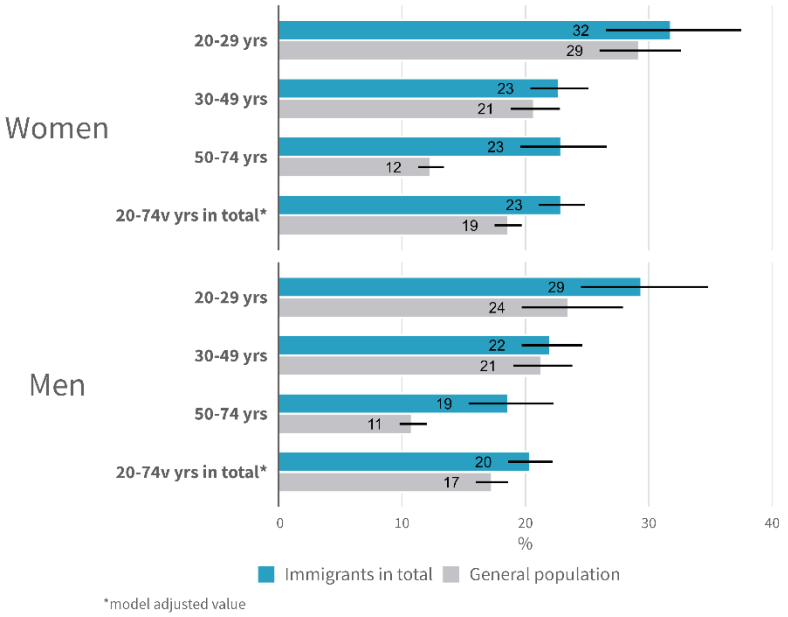
When compared to men and women in the entire population, immigrant men and women reported psychological distress significantly more often (men: 20% vs. 17% and women: 23% vs. 19%) (Figure 6). When compared by country group, the share of men experiencing psychological distress varied between 16 and 29 per cent and that of women between 13 and 26 per cent. Men (29%) and women (26%) in the country group Middle East and North Africa and women in the groups Russia and the Soviet Union (26%) and Europe (excl. Estonia and Russia; 25%) experienced psychological distress more commonly than the entire population.

Figure 6. Psychological distress, by country group and gender, those aged 20–74, model-standardised share, %



Men and women in the youngest age groups experienced more psychological distress both in the immigrant population and in the entire population (Figure 7). The difference in the shares of people experiencing psychological distress among immigrants and in the entire population was observed especially in the oldest age group, among both men and women: in the age group of 50–74-year-olds, the share of men in immigrants experiencing psychological distress was 19 per cent and of women 23 per cent, while the corresponding shares in the entire population were 11 and 12 per cent.

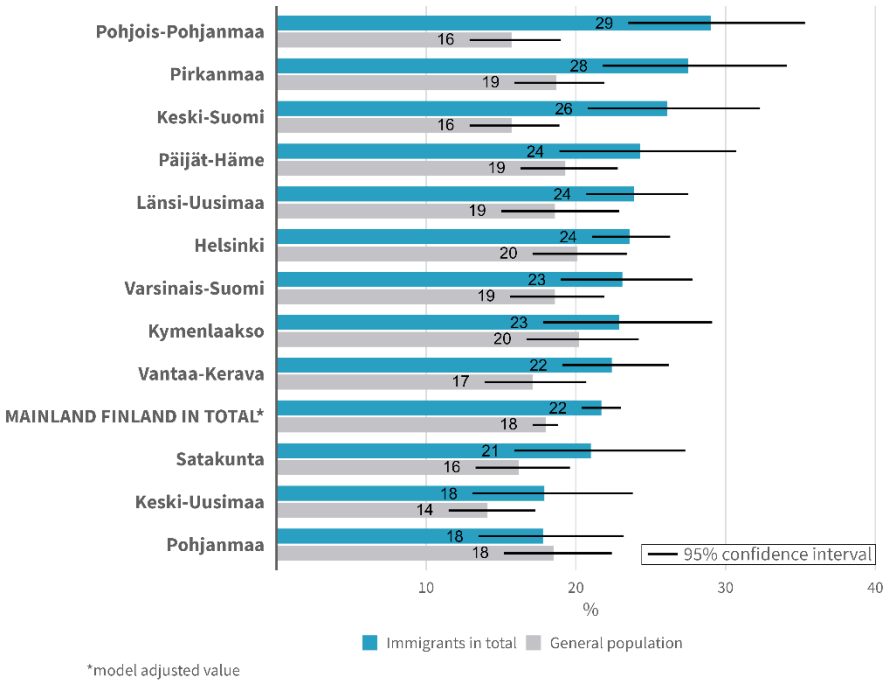
Figure 7. Psychological distress, immigrants and the entire population by age group and gender, those aged 20–74, model-standardised share, %



There are wellbeing services county-specific differences in the psychological distress experienced by immigrants

In North Ostrobothnia, Pirkanmaa, Central Finland and Vantaa and Kerava, psychological distress was more common among immigrants than in the entire population of the same county (22–29% vs. 16–19%) (Figure 8). In the other wellbeing services counties, psychological distress varied between 18 and 24 per cent and did not significantly differ from the whole population.

Figure 8. Psychological distress in selected wellbeing services counties, immigrants, and the entire population, those aged 20–74, model-standardised share, %



*model adjusted value

In Finnish

The report is published in Finnish on the thl.fi website and in the Julkari.fi archive.

På svenska

Rapporten har publicerats på svenska på webbplatsen thl.fi och i Julkari.fi arkiv.

Terms and definitions

Insufficient doctor's services

Insufficient doctor's services were mapped out with the question: "Do you feel you have received enough of the following health care services in the previous 12 months? Please note services provided by the municipality, occupational services and private service providers." "Doctor's appointment services" was asked as one sub-question in the battery of questions. The response options were 1) I have not needed these services, 2) I would have needed these services, but could not access them, 3) I have used the services, but they were not adequate, 4) I have used the services and they were adequate. Response option 1) I have not needed these services was eliminated, and after this the examination included the share of responses 2) I would have needed these services but could not access them and 3) I have used the services, but they were not adequate.

Psychological distress

Psychological distress was mapped out with the MHI-5 battery of questions. MHI -5 consists of five questions investigating the respondent's anxiety, depression and positive mood. The answer is situated on a continuum with one extreme representing psychological distress and the other representing a positive mood. "How large a portion of your time during the past 4 weeks have you spent: Please choose one alternative on each line." The sub-questions asked a) feeling very anxious, b) feeling so low that nothing could cheer you up, c) feeling serene and calm, d) feeling inferior and melancholic and e) feeling happy. The response options were 1) all the time, 2) most of the time, 3) a good bit of the time, 4) some of the time, 5) a little of the time, 6) not at all. The response to each statement is given on a scale of 1 to 6. To calculate the final score, the scores for questions (c) and (e) are converted into reverse order, after which the scores are added up (the score is between 5–30) and changed to a scale of 0–100. Psychological distress can be reported as a continuous variable or a score of 52 can be used as the break-off point, in which case those scoring 52 or fewer points have clinically significant symptoms of psychological distress. The examination includes the share of those scoring at most 52 points in the scaled score.

Background country classification used in the MoniSuomi 2022 survey and the background countries in the sample

The country groups of the MoniSuomi survey were based on the person's background country, which was the birth state of the person's parents. If the person's parents had been born in different countries, the background country was the mother's birth state. If the birth country of the person's parents was unknown, the background country was the persons' birth state.

The country groups are partly based on the classification of the survey on work and well-being among people of foreign origin (UTH, Nieminen et al. 2015). The classes Russia and the Soviet Union, Estonia, Middle East and North Africa, and Africa (excl. North Africa) have been defined with exactly the same regional division as in the UTH study. Because the number of people with Southeast Asian background has increased, the region has been made into a class of its own instead of the previous group Asia. Furthermore, the European countries have been placed to the same class. The reason behind this is the development in the countries in Southeast Europe, because of which classifying the countries on the basis of EU membership was no longer meaningful.

Appendix table 3 describes the most common background countries in each country group

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Quality description

Health and well-being of the adult population with a foreign background – MoniSuomi 2022 survey

Relevance of statistical data

The statistic published by the Finnish Institute for Health and Welfare (THL) describes the well-being, health and service use of the adult immigrant population regionally and by population group. A representative sample of foreign-born persons with an immigrant background living in Finland was retrieved for the MoniSuomi survey. The survey is a continuation of the FinMonik survey collected between 2018 and 2019.

The information published from the MoniSuomi data is both regional information and monitoring information on topics that cannot be described with the help of registers. The theme areas of the statistics are the living conditions and quality of life, education, employment, inclusion, functional capacity, health, lifestyle, intoxicants and addictions, health services, social services, services in the municipality of residence, digitalisation and experiences of discrimination, harassment and violence. The information is published by gender, age group, background country group, education, reason for immigrating and, on the largest wellbeing services counties and selected cities, by area.

The information is used particularly by actors in the field of integration, decision-makers, officials, social welfare and healthcare professionals in the counties and nationally, and by researchers. The information is used to fulfil the statutory tasks of several different administrative branches, for example, in the monitoring of integration and experiences of discrimination, the development of equitable services, the monitoring of services needs, the planning of health promotion and research on well-being and health gaps between population groups.

Description of methods

The statistics are based on the MoniSuomi survey, which is carried out every four years. The survey data was collected between September 2022 and March 2023. The survey could be responded to using an electronic form, a paper form sent by post or in a telephone interview. The sample was retrieved using a stratified random sample in August 2022. A total of 18,600 foreign-born persons with a foreign background who have lived in Finland for at least 12 months and were 20–74 years old at the time of sampling were included in the sample. The sample was divided regionally into 23 strata. An area of their own was formed by the four cities that funded the survey, the 12 wellbeing services counties with the largest immigrant population and the rest of Mainland Finland, which formed a stratum of its own. Furthermore, the City of Turku had been divided into eight areas.

Appendix table 1. Sample and participants by area in the MoniSuomi 2022 data. (pdf xxx Kb)

The survey questionnaire was approximately 20 pages long and was available in 20 languages: Arabic, Kurdish (Sorani), German, English, Spanish, Estonian, Farsi, Finnish, French, Polish, Dari, Russian, Somali, Albanian, Swedish, Thai, Turkish, Ukrainian, Vietnamese and Chinese. The translations of the Healthy Finland survey in Swedish, English and Russian were primarily used for the form. In addition, the translations of the forms used in the FinMonik and MigCovid surveys were used, which had been produced in 17 languages. The new languages, German and Ukrainian and the new questions for other languages were translated at a translation agency, where a proofreader reviewed the translated text. In addition, a third, native speaker of the language or professional translator was used to review most of the languages.

An invitation letter was sent to the research subjects by post and all later reminders in the person's mother tongue as well as Finnish or Swedish. Those to whom the questionnaire was not available in their mother tongue received the invitation in English and in Finnish or Swedish. The research subjects were approached by post at intervals of about one month until the research subject responded or refused to take part in the survey. The

research subjects were approached by post a total of five times. In the first, third and fifth letter, the identifiers for logging in to the electronic questionnaire were sent. The second and the fourth letter contained a paper form in two languages to be posted back.

Between the second and the third letter, attempts were made to reach the respondents by phone if their telephone number was found in the mass extraction. Telephone numbers were found for 24.7 per cent of the sample. A total of five attempts were made to call the research subjects until the person participated in the survey or refused participation. At the beginning of the data collection, the research subjects were motivated to respond primarily using the long paper form or the electronic form. The interview implemented over the phone was less extensive than these forms but made participation possible for illiterate persons and persons without digital skills, as well. The most important questions suitable for the telephone interview were selected for the telephone interview form from each sub-area. In addition to Finnish, efforts were made to reach the respondents in 15 languages: Arabic, Kurdish (Sorani), English, Spanish, Estonian, Farsi, Polish, Dari, Russian, Somali, Albanian, Swedish, Turkish, Vietnamese and Chinese.

Correctness and accuracy of data

A total of 7,838 persons participated in the survey, of whom 4,698 responded using the electronic form, 2,649 the paper form and 491 were interviewed by telephone. Those who according to the Population Information Register had died or moved away before the last round of letters were removed from the sample. Furthermore, persons whose invitation letters Posti could not deliver and for whom no new address could be found were considered to have moved abroad or to be overcoverage. After overcoverage had been removed, the size of the sample was 17,789 and the response rate in the survey was 44.1%.

To correct the response loss, analysis weights were calculated for the data and used to weight all the results published from the data. The weights have been calculated using the *inverse probability weighting* (IPW) method. In the IPW method, a probability for participating in the survey is estimated for everyone who participated and its inverse is combined to the information on the person's probability to be retrieved to the sample. The estimation was carried out using the *predict* function of the *ramdomforest* package in R statistical software, after which the weights were calibrated to correspond to the distributions of the whole target group using the *icarus* package in R. The register data used in estimating were gender, age, Finnish citizenship, marital status, background country group, municipality group, number of people living in the household, number of underage children living in the household, living area, the time the person has lived in Finland, age when immigrated to Finland, socioeconomic background, educational level, and number of visits to specialised health care between 7 August 2021 and 31 December 2022. The information used in the calibration was living area, gender, age and education.

The coverage is the lowest among those who immigrated to Finland before the age of 15 and among people with a low level of education. In addition, there were significant differences in the response rate between the background country groups:
Appendix table 2. Response rate (%) by gender, age group, background country group and area in the MoniSuomi 2022 data. (pdf xxx Kb)

Timeliness and promptness of published data

The study is implemented every four years. The latest collection of information lasted from September 2022 to March 2023 and the information is published approximately three months from the end of the data collection. The sample layout makes a comparison of the largest wellbeing services counties possible.

Comparability of data

The majority of the questions in the MoniSuomi survey are comparable to the Healthy Finland survey on the entire population. In addition, more than half of the questions are comparable to the FinMonik survey conducted four years earlier. The data collection methods are identical compared to the questionnaire part of the Healthy Finland 2022

survey and the FinMonik surveys. The share of telephone interviews in the whole data differs slightly between the surveys, which may affect the comparability of the survey results.

The sample layout is almost the same as in the FinMonik survey. The age group has been changed slightly from the previous survey, from 18–64 years to 20–74 years. The division has been made in a similar way by wellbeing services county/region. As an exception in the MoniSuomi survey, only the 12 largest counties form a stratified sample of their own, whereas in the FinMonik survey, each region formed a stratified sample of its own. In addition, a larger sample has now been retrieved from the Helsinki Metropolitan Area and from Turku than earlier in the FinMonik survey.

Clarity and consistency/cohesion

The theme areas in the data collection form of the MoniSuomi survey are the same as in the FinMonik 2018–2019 and the Healthy Finland (2022) surveys. A large number of the questions are also permanent in the different data collection years. Key issues related to the monitoring of integration, the well-being, inclusion, health and lifestyle of the population as well as issues related to the use of social and health services are permanent questions.

From the point of view of well-being and health promotion, the most important additions compared to the 2018 form are the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), the Experiences of Social Inclusion Scale and health literacy. Similarly, questions concerning chronic diseases, women's reproductive health and participation in organised activities were removed from the form. Several lifestyle-related questions were revised to correspond to the question formats in the Healthy Finland survey. The question concerning experiences of discrimination was revised so that the current question assesses experiences of discrimination generally and in specific public services.

Appended tables

Appendix table 1: Appendix table 1. Sample and participants by area in the MoniSuomi 2022 data.

Appendix table 2. Response rate (%) by gender, age group, background country group and area in the MoniSuomi 2022 data.

Appendix table 3. Background country classification used in the MoniSuomi 2022 survey and the background countries in the sample

Appendix table 1. Sample and participants by area in the Moni-Suomi 2022 data.

Area	Sample	Sample, overcoverage removed	Respondents
Total	**18,600**	**17,789**	**7,838**
Espoo	2,000	1,890	876
Helsinki	4,000	3,814	1,692
Turku: Varissuo - Lauste	390	384	146
Turku: City centre	370	343	168
Turku: Nummi - Halinen	370	327	159
Turku: Pansio - Jyrkkälä	350	334	121
Turku: Runosmäki - Raunistula	340	328	129
Turku: Skanssi - Uittamo	340	321	133
Turku: Länsikeskus	320	305	122
Turku: Maaria - Paattinen and Hirvensalo - Kakskerta	320	312	133
Vantaa	2,000	1,944	733
Kerava	150	143	57
Central Uusimaa	770	750	314
West Uusimaa (excl. Espoo)	240	231	112
Southwest Finland (excl. Turku)	240	230	111
Satakunta	750	700	303
Pirkanmaa	800	767	339
Päijät-Häme	770	758	355
Kymenlaakso	760	734	324
Central Finland	760	721	367
Ostrobothnia	780	749	341
North Ostrobothnia	780	750	367
Other Mainland Finland	1,000	954	436

National study on the health, welfare and service use of the foreign-born population (MoniSuomi): thl.fi/monisuomi

Appendix table 2. Response rate (%) by gender, age group, country group and area in the MoniSuomi 2022 data.

Classification	Group	Total	Men	Women	20 to 29 years	30 to 49 years	50 to 74 years
Total	**Total**	**44.1**	**41.6**	**46.6**	**37.2**	**44.3**	**47.9**
Gender	Men				34.7	41.4	47.0
	Women				40.0	47.5	48.7
Background country	Russia and the Soviet Union	**46.8**	44.7	48.2	38.8	44.5	51.4
	Estonia	**37.6**	30.8	44.5	28.3	32.7	48.2
	Europe (excl. Estonia and Russia)	**46.5**	44.5	49.2	43.3	46.1	49.1
	Middle East and North Africa	**37.3**	36.7	38.1	31.3	39.2	38.6
	Africa (excl. North Africa)	**36.6**	37.6	35.2	27.9	40.4	33.8
	Southeast Asia	**48.4**	44.1	50.1	38.2	51.8	48.3
	Other Asia, America and Oceania	**52.6**	50.9	54.6	50.2	53.0	53.9
Area	Espoo	**46.4**	44.2	48.7	42.8	47.3	46.3
	Helsinki	**44.4**	42.9	45.9	37.3	45.4	46.6
	Turku	**41.9**	39.5	44.6	34.4	41.7	47.2
	Vantaa	**37.7**	34.6	41.2	29.4	38.6	41.8
	Kerava	**39.9**	42.3	37.5	26.7	38.5	48.7
	Central Uusimaa	**41.9**	37.0	46.2	29.3	42.2	47.5
	West Uusimaa (excl. Espoo)	**48.5**	47.8	49.1	27.3	50.4	51.4
	Southwest Finland (excl. Turku)	**48.3**	44.6	51.7	45.5	44.5	58.1
	Satakunta	**43.3**	39.2	47.7	35.9	40.5	51.9
	Pirkanmaa	**44.2**	41.8	47.2	37.2	45.7	46.5
	Päijät-Häme	**46.8**	47.5	46.3	35.6	46.3	51.4
	Kymenlaakso	**44.1**	41.4	46.2	45.3	42.0	46.3
	Central Finland	**50.9**	46.0	55.0	47.0	48.5	58.1
	Ostrobothnia	**45.5**	40.5	51.0	42.8	46.3	46.1
	North Ostrobothnia	**48.9**	46.7	51.6	42.1	50.1	52.6
	Other Mainland Finland	**45.7**	44.0	47.1	36.1	45.5	50.7

National study on the health, welfare and service use of the foreign-born population (MoniSuomi): thl.fi/monisuomi

Appendix table 3. Background country classification used in the MoniSuomi 2022 survey and the background countries in the sample.

Background country group	Background country (n)
Russia and the Soviet Union	**Soviet Union (3,396), Russia (355)**
Estonia	**Estonia (2,000)**
Europe (excl. Estonia and Russia)	**Yugoslavia (565), Poland (271), Great Britain (237), Romania (221), Germany (204), Ukraine (171), Latvia (152), Bulgaria (147), Sweden (132), Italy (121), France (121), Spain (115), Hungary (109), Lithuania (81), Netherlands (70), Greece (66), Albania (64), Bosnia-Herzegovina (44), Serbia and Montenegro (37), Portugal (31), Czechoslovakia (31), Norway (30), Denmark (30), Moldova (27), Belgium (25), Ireland (25), Switzerland (25), Belarus (25), Kosovo (23), Austria (17), Czech Republic (16), Croatia (14), Slovakia (14), Serbia (13), German Democratic Republic (9), Cyprus (7), North Macedonia (7), Iceland (5), Faroe Islands[1], Malta[1], Montenegro[1], Slovenia[1]**
Middle East and North Africa	**Iraq (1 014), Iran (468), Afghanistan (463), Turkey (441), Syria (292), Morocco (147), Egypt (71), Algeria (57), Former Sudan (53), Tunisia (47), Israel (26), Lebanon (26), Jordan (17), Sudan (15), Libya (12), Azerbaijan (11), Yemen (11), Kuwait (11), United Arab Emirates (10), Saudi Arabia (9), Armenia (8), Georgia (6), Palestinian Autonomous Areas (5), Bahrain[1], Oman[1], Qatar[1]**
Africa (excl. North Africa)	**Somalia (578), Nigeria (149), Democratic Republic of the Congo (123), Ethiopia (101), Ghana (96), Kenya (73), Cameroon (60), Eritrea (59), Gambia (47), South Africa (28), Angola (23), Senegal (20), Tanzania (18), Uganda (14), Zambia (13), Rwanda (10), Sierra Leone (10), Liberia (9), Guinea (8), Republic of the Congo (8), Namibia (7), Togo (7), Zimbabwe (7), Burundi (5), Djibouti[1], South Sudan[1], Gabon[1], Central African Republic[1], Malawi[1], Mali[1], Mauritania[1], Mauritius[1], Mozambique[1], Niger[1], Ivory Coast[1]**
Southeast Asia	**Thailand (528), Vietnam (477), Philippines (352), Myanmar (69), Indonesia (44), Malaysia (25), Cambodia (18), Laos (7), Singapore (7)**

Other Asia, America and Oceania	**China (583), India (395), Nepal (231), Bangladesh (191), Pakistan (182), United States (160), Brazil (108), Japan (77), Sri Lanka (69), Mexico (55), Canada (42), Peru (40), Australia (35), Cuba (34), Republic of Korea (33), Columbia (28), Chile (24), Venezuela (20), Uzbekistan (18), Ecuador (16), Kazakhstan (15), Argentina (14), Taiwan (14), Dominican Republic (12), Hong Kong (9), Honduras (8), Jamaica (7), Costa Rica (6), Mongolia (6), Uruguay (6), Bolivia (5), Nicaragua (5), New Zealand (5), Bahama1, El Salvador[1], Greenland[1], Guatemala[1], Guyana[1], Haiti[1], Kyrgyzstan[1], Macao[1], Panama[1], Paraguay[1], Suriname[1], Tajikistan[1], Trinidad and Tobago[1], Turkmenistan[1], New Caledonia[1]**