A Qualitative Study of Psychosocial Health and Service User-Driven Organized Social Activities at the Health Center for Undocumented Migrants in Oslo, Norway

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Abstract

This study´s aim is to produce knowledge about the process of implementing a service user driven organized social activity initiative at the Health Center for Undocumented Migrants, and to generate insight into its potential for enhancing psychosocial wellbeing. Irregular migrants living in Norway often experience challenging lives, including everyday vulnerability and exclusion. This, combined with the traumas that many have experienced prior to seeking asylum, results in a potentially high risk of mental health problems and distress. Experiences from a mental health project (2011-2014) at the Health Center for Undocumented Migrants in Oslo indicated that service-users might benefit from organized social activities that facilitate fellowship, belonging and social interaction. The Health Center therefore, in conjunction with this study, organized and implemented a social activity initiative. The activities were mostly organized and implemented by service-using participants. All the service users at the Health Center who showed an interest, regardless of gender or background, were welcome to participate in the activities. The data collection period corresponded to the activity initiative period and spanned from May 2018 to December 2018. Data collection included observations and ongoing conversations conducted at the planning meetings and during the activities, as well as six in-depth, semi-structured interviews with both service using and non-servicing using participants. Approximately 34 participants were included. Findings indicate that the initiative entailed sources of both potential benefit and harm for the participants. It became a challenge to maintain the sustainability of the planning group, as service-using participant attendance was presumably dependent on both identifying with the initiative and having material needs covered. There was also a seeming tension between the Health Center and the service users, as there seemed to be differences in covert notions of deservingness and who the ideal activity participants were. The activity initiative included several “silent participants” who were potentially exposed to harm in terms of exclusion, rejection, obligation, disappointment and frustration. On the other hand, among a group of participants with the same ethnic background who frequently attended, these activities were identified as potentially contributing to well-being, fellowship, and positive psychosocial moments. There is a growing emphasis on user involvement in the service provision context and an increased focus on psychosocial initiatives within the humanitarian field. This study can therefore be of potential contribution to a service concept and field of practice that are growing in relevance.

Keywords: Irregular migration, undocumented migration, psychosocial intervention, service user-driven organized social activity, empowerment.

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List of Abbreviations

CIOMS - Council for International Organizations of Medical Sciences

DPS - District Psychiatric Center

EU – European Union

IOM - International Organization for Migration

MSF – Médecins Sans Frontières /Doctors without Borders

NGO – Non Governmental Organization

NRC – Norwegian Refugee Council

NSD – Norwegian Center for research Data

PTSD – Post Traumatic Stress Disorder

REC – Regional Committees for Medical health Research

SOC – Sense of Coherence

UIO – University of Oslo

UN – United Nations

Glossary

Throughout the thesis, I will use terms such as “irregular migrant”, “activity initiative”, “planning group”, “planning group participants” “service using participants”, “non-service-using participants”, ” and “activity participants” when addressing the happenings and story of the project.

Irregular migrant: There are several terms used when addressing people who live in a country without a residence permit. I have, as many before me, chosen to use irregular migrant. The term reflects an irregular life situation, in addition to referring to this situation as constructed and produced (Näsholm, 2014a; Brux, Hilden & Middelthon, 2018). I am purposefully not using the term illegal to avoid language of stigma. I do use the term undocumented migrant in Chapter 2.1 “The Health Center for Undocumented Migrants” as this is what the Health Center use. However, irregular migrants often have loads of documents, making the term “undocumented” misleading.

Activity initiative: The psychosocial project that the Health Center has initiated.

Planning group: The planning group consists of the people who have agreed to organize and implement the activity. The group consists of both service using participants and non-servic-using participants.

Planning group participants: All participants who are a part of the planning group

Service using participants: The participants in the planning group who uses the Health Center when needing health care, as they do not have a residence permit.

Non-service-using participants: The participants in the planning group who have a residence permit. One volunteer, the coordinator and I are the ones included in this category.

Planning meeting: The planning group had a meeting before every activity to organize and invite people to join the activity. In addition, they met up to organize and discuss the schedule and what types of activities to offer. These meetings are called planning meetings.

Activity: The different excursions that took place after the planning group had invited service users from the Health Center to join. “Organized activities” has, in this thesis, been the most accurate word to use when describing that activities were planned for a group of people. I am aware that organized activities is a term mostly used when talking about after school extracurricular for adolescents, and it is not my intention to compare this activity initiative with such activities.

Activity participants: The participants who were invited by the planning group to come to the activity, the participants who were invited by other activity participants and the service using participants who had both a role in the planning group and the activity.

Introduction

Å flykte
[...]
Det er så tungt å være alene i en liten
leilighet søndag kveld og dine tanker vandrer
som løvetannsporer mange kilometer til
hjemlandet [...]

To flee
[...]
It is hard to be alone in a small apartment
Sunday evening, as your thoughts wonder as
dandelion spores miles away to your home
country [...] (translated)

Excerpt from poem by Nasim Alimoradi, from «Kunsten å flykte: Fortellinger om flukt og menneskerettigheter» (Dahl, C., 2017, p. 52-53)

War, persecution and conflict caused 68.5 million people to forcibly be displaced in 2018 (NRC, 2018a). Of them, 40 million people were internally displaced, meaning they have fled their home town but not crossed an international border. Africa and Asia are the areas where most people flee from their homes, and the countries in these continents are also the ones that receive the most people fleeing (NRC, 2018b). Numbers from 2018 show that 10.4 million people have entered Europe as refugees or asylum seekers (NRC, 2018c).

Many of the people fleeing have been exposed to a number of happenings that potentially affect their physical and mental health (Teodorescu, Heir, Hauff, Wentzel-Larsen & Lien, 2012). While refugees or asylum seekers who arrive in Norway and are granted a permit get access to treatment programs and support provided by the welfare state, the people who are not granted a residence permit are often left with the same potential experiences of trauma but without the provision of what the Norwegian system would see as adequate services.

Irregular migrants live in the shadow of the Norwegian welfare system, their lives exist within the society but without the entitlements and care that the rest of the population receives. The Health Center for Undocumented Migrants provides a primary health care service in order to ensure that these people also have access to health care. After a mental health project at the Health Center, conducted from 2011-2014, there seemed to be an unmet need for social support, fellowship and belonging. As experiences from “Project mental health” indicated, organized social activities could potentially have psychosocial benefits for the service users of the center. As the poem describes, being alone and lost can be the brutal reality of many people who flee to a different country, especially if you flee to a country that does not grant you residence. The Health Center therefore, in conjunction with this research project, started an activity initiative for all the service users of the center. Activities such as going to the park, the movies, cooking food and hiking were organized and implemented from May to December of 2018. Organizers mostly consisted of volunteering service users, with the overall aim being for the initiative to become a self-driven activity offer, run by and for the service users of the Health Center.

I followed the organizing and implementation of the activity initiative by participating in planning meetings and activities. I collected data through observation, ongoing conversations and in-depth interviews. As the months went by, I gradually became aware that what was set out to be a study of an initiative solely aiming to increase the participants’ psychosocial health, very much had become a study about an initiative that in many ways went wrong, as the potential did not only consist of value for the participants but also aspects of harm.

Thus, this study´s aim was to produce knowledge about the process of implementing the service-user driven organized social activity initiative at the Health Center for Undocumented Migrants, and to generate insight into its potential for enhancing psychosocial wellbeing.

The following chapter introduces the topic of irregular migrants living in Norway, it gives insight into theory on psychosocial health, salutogenesis, empowerment and humanitarianism. All theories relevant when discussing the potential of the activity initiative.

Chapter Two contextualizes and discusses the reason for the Health Center to engage in the development of an activity initiative. It presents the history of the Health Center for Undocumented Migrants in Oslo. Further it includes a thorough description of “Project mental health”, which became the rationale for both the activity initiative and this study. Information from Chapter Two also contributes to the findings and discussion chapter. Finally it identifies the knowledge gap and introduces the project´s aim and research questions.

Chapter Three gives a detailed description of methodological choices and consideration, as well as ethical challenges. As transparent as possible, the reader is presented with information needed to assess the credibility and transferability of the study.

In Chapters Four, Five and Six findings are presented, and discussions based on theory from Chapter One and experience reports presented in Chapter Two are provided.

Chapter Four presents the happenings of the planning group. It provides insight into participants' perceptions of the group and the variety of motivation for being a part of the planning group. Different motives were identified: indifference or ambivalence in terms of saying yes because the Health Center asked, identifying with the initiative and wanting to contribute, to create network or participating to find a sense of purpose. These perceptions shaped the dynamic between the participants in the planning group. It discusses the moral discourse of trying to create an initiative suited for all the service users at the Health Center, but then ultimately ending up assessing the participants' deservingness. It unpacks the group´s vulnerability that was present from the very beginning, and with it the potential harm and value the planning group held. Finally a discussion about the empowering aspect of the planning group, and whether the planning group really served the purpose of participant empowerment, is had.

Chapter Five addresses the happenings at the activities. It presents the participants' perceptions of own well-being, which lays the ground for further exploration of the participants' rationale for attending. It unpacks the groupings emerging within the activity, leading some participants to gain psychosocial benefits such as network building and getting a "break" in their everyday lives, while other participants were left with potential harm in terms of rejection, exclusion, obligation, disappointment and frustration.

In Chapter Six, two overall discussions are had. The first addresses the psychosocial shift within humanitarian aid. It reflects upon how the activity initiative created paradoxes, such as providing psychosocial aid to service users who identify their problem to be elsewhere. And how the Health Center wanted participants to become empowered but at the same time needing them to act the role of the suffering and deserving. The second discussion brings up the question of whether it is taken for granted that psychosocial moments that promote well-being can be produced through organized social activities, and to what extent there is a potential for creating a "breathing space" within the frames of the initiative.

CHAPTER ONE: Literature Review and Conceptual Framework

1.1 Undocumented migrants

“Undocumented migrant”, “irregular migrant”, “clandestine”- and “illegal migrant” are all terms used when describing a person who is living in a country without a residence permit. In Norway, migrants can end up in an irregular situation if their asylum application is rejected, by entering the country illegally and not applying for asylum or a visa, or by overstaying their visa (Myhrvold & Småstuen, 2016; Huma network, 2009; Brux, et al., 2018). A person can, for example, become irregular by entering Norway after having gotten his or her asylum application rejected in another European country. Because of the Dublin agreement, the person cannot apply for asylum in Norway, and will be sent back to the European country the person first registered in (UDI, 2018a). To avoid being sent back, the person might not register in Norway and, as a consequence, may end up living as an irregular migrant in Norway.

Another example of how migrants shift from the status of asylum seeker to irregular migrant is if the migrant has received a temporarily residence permit that potentially can have been extended several times. The person might have established a life in Norway over several years. Still, the temporary permit can be withdrawn, leading the person to become irregular if he or she stays in Norway. These are just some examples showing the variety, though there are several other ways in which a migrant end up in an irregular situation.

The International Organization for Migration (IOM) has estimated that there are around 1.9 to 3.8 million people in Europe who live as irregular migrants (Vogel, Kovacheva & Prescott, 2011). Numbers presented by Statistics Norway (SSB) indicate that around 18 196 people in Norway live as irregular migrants. Of them, 12 325 are understood to be former asylum seekers (Zhang, 2006). These most recent figures are from Statistics Norway´s publication in 2008. One can speculate whether the numbers are higher after the refugee crisis in 2013-2016 where nearly 5.2 million people entered Europe as asylum seekers from the Middle East and other countries, after having fled from war, violence and persecution (UNHCR, 2018). Or lower, after the restrictions that Europe and Norway have implemented in recent years, making it harder for people to enter Europe and through this harder to apply for asylum. Seeing as irregular migrants often live unstable lives in "limbo" and seldom settle in one place (Øien, C. & Sønsterudbråten, S., 2011), one can also imagine that the numbers are stable and that the irregular migrants living in Norway are constantly on the move, being replaced by others.

1.1.1 Irregular migrants' applied entitlements: Norwegian law and human rights

As emphasized above, the numbers of irregular migrants living in Norway are approximate and uncertain. The important fact is that irregular migrants in Norway do exist. The estimates confirm that people living in Europe and Norway as irregular migrants is a global and national issue; these people need to be heard and the matter needs to be addressed, especially within the frame of irregular migrants' entitlements and the implementation of human rights. In practice, one can say that people who live as irregular migrants in Norway are excluded from the goods of the welfare state. Their rights to education, work, social services and health care are very limited, making it difficult for many to cover basic needs.

Norway has consented and agreed to the 1950 European Convention on Human Rights and the 1966 United Nations Covenant on Economic, Social and Cultural Rights. In 1999, these human right conventions were, among others, incorporated into the Norwegian Law through the Human Rights Act with the purpose of ensuring that Norway follows the human rights by giving them superiority over the Norwegian law. To which extent these rights are applied to people in Norway living without a residence permit is much debated in both international and national politics (CESCR, 2013, Ministry of Health and Care Services, 2017, JussBuss, 2013 & Slagstad, 2017). This chapter will present the laws and regulations together with the access and utilization of rights that frames irregular migrants living conditions in Norway.

Education

Under the Act Relating to Primary and Secondary Education (Opplæringsloven) it is stated that children who will stay longer than three months in Norway are both entitled and obligated to attend primary and lower secondary school (school between 6-16 years of age). This includes all children in Norway and therefore also children who live with an irregular status (Opplæringsloven, 1998, § 2-1). However, the utilization of this is questionable seeing as parents to irregular migrants are often afraid of the school reporting them to the authority. In addition, the access for the children depends on the awareness of the individual school, which differs depending on the knowledge of the teachers and school staff (Ottesen, 2008). Other than this, irregular migrants do not have rights to higher education or Norwegian lessons.

Social services, food and shelter

The Social services in Norway has the responsibility of securing the basic needs of the people living in Norway, and are often described as the people of Norway's last resort or "safety net"; helping the ones who are, for various reasons, not able to cover their own basic needs (Øien & Sønsterudbråten, 2011). The social services provide services that include, among other things, consultations and financial help to cover the service user's needs. Everybody who live in Norway are entitled to the service they provide (Sosialtjenesteloven, 2009). However, in the circular published in 2012, which is a tool within managing and utilizing the law (Sosialtjenesteloven), it is emphasized that people who do not have a legal residence permit in Norway are excluded from entitlement to the service. The circular underlines in chapter one, article four: "*§ 4. For people who do not have legal residence permit in the kingdom*", that irregular migrants do not have the right to social services other than financial support or temporary material assistance in situations in which their lives can be endangered, such as overnight shelter when temperatures drop dangerously low in the winter. It is specified that people living in Norway without a residence permit only have the right to emergency material support up until the point at which they can be understood as practically able to leave the country (Directorate of Labour and Welfare, 2012). In practice this means that their rights to financial support are almost non-existing, seeing as the entitlement is removed when the person has had the opportunity to be transported by train or plane back to their home country, and with the transportation network that exist in Norway the opportunities to be transported out of the country are many (JussBuss, 2013). This means that irregular migrants have few real legal entitlements to the social services and provision for basic needs such as food and shelter.

Health care

The right to health is an undisputed human right that irregular migrants living in Norway are, as a result of the exclusion from the welfare services, only partly entitled to. The Act on

Patient’s Rights (Pasient- og brukerrettighetsloven) states under chapter § 2-1, that people living in Norway have the right to health care within the municipalities (primary health care) and the state (specialized health care) (Pasient- og brukerrettighetsloven, 1999). This entitlement is an offer only fully accessible to the people who are included in the welfare system. Therefore, irregular migrants are not encompassed within the legal frame of the complete health care coverage that the Norwegian state provides its citizens. The regulation on the right to health care services to persons without permanent residence (Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket) regulates which part of “the Act on Patients’ Rights” that are applied to irregular migrant`s entitlement to health care services (The Law Department, 2017).

Irregular migrants have the right to treatment for communicable diseases, “emergency health care” and “necessary health care that cannot wait”, as well as maternity care. The assessment of what “emergency health care” and “acute need” include, are defined by the individual health professional (Forskrift om tjenester til personer uten fast opphold, 2011), leading to variations within what “acute” constitutes. As Slagstad (2017) points out, categorizing prevention, assessment and curative care is both difficult, not expedient and goes against health professionals ethical code of commitment. Untreated depression might lead to acute suicidal crisis and a type 1 diabetic can quickly develop to a life-threatening ketoacidosis if left untreated (p. 2). This shows how what is defined as “acute” is not clear cut.

Studies have shown that many migrants are reluctant to seek health care because of lack of knowledge concerning their rights and where health care can be provided. In addition it is reported that they do not seek health care because of fear of being rejected or reported to the authorities, and that they are marginalized when seeking care. Health professionals often do not have enough knowledge about the rights of irregular migrants, which can lead irregular migrants to not get the consultation in which they are entitled to, confirming their fear (Øien & Sønsterudbråten, 2011; Straßmayr et.al., 2012; Kvamme & Ytrehus, 2015).

With few exceptions, irregular migrants are forced to cover the cost of all health services (Folketrygdloven, 1997). In theory, this means that irregular migrants must pay out of own pocket for the health care services provided for them. In reality, the institutions are obligated to pay for the services if the patient does not. But, before this happens the patient will be asked if he or she is able to pay. In addition, the patient will likely receive several notices from the hospital asking for payment, leading to potential fear, anxiety and misunderstandings for the migrant seeking health care (Øien, C. & Sønsterudbråten, S., 2011). Treatment for communicable diseases is the exception, as such care is, in the interest of public health, provided to irregular migrants free of charge (Smittevernloven, 1994, §§ 1-2 & 6-1).

The United Nations Covenant on Economic, Social and Cultural Rights stated in a report from 2013 their concerns for the lack of health coverage of irregular migrants in Norway, based on the human right that people are entitled to health care without discrimination (CESCR, 2013, p. 6). In 2017, this was brought up as an argument for expanding the health care entitlements in a suggestion from the governmental "Health and Care Services Committee", but the suggestion was declined by the parliament, leaving irregular migrants with the minimum of health care coverage within the kingdom of Norway (Ministry of Health and Care Services, 2017, p. 2).

1.1.2 Living conditions in Norway – The welfare state

The people who live in a situation of irregularity in Norway constitute a diverse group that includes migrants from different parts of the world. The various backgrounds, educational levels, coping mechanisms and networks lead them to exist under different circumstances and living conditions. Some live in an apartment with a partner who has a residence permit, some live from day to day sleeping on friends couches, some stay in overcrowded apartments with precarious conditions sharing the space with several others, while some do not have any other option than to sleep outside (Myhrvold & Småstuen, 2018; Khosravi, S., 2010). Irregular migrants are therefore not a group that can be categorized as one. What they do have in common is the lack of rights and the consequences of it, which includes exclusion and marginalization from the welfare state and seemingly the institutions of the Norwegian society. Ultimately, what seems to predominantly decide their actual living conditions is their network within Norway and how this is used (Øien, C. & Sønsterudbråten, S., 2011).

There are different reasons and situations that lead to people staying in Norway without a residence permit. They are often complex and vary from person to person, but the feeling of being stuck and not having a real option of leaving is often present. Some of the reasons for staying might be health related, that a family member is sick and they feel obligated to stay and support the family member. They might themselves be sick and worried about treatment back home. Children of irregular migrants might never have been in their "home" country, they might not know the language or the culture and their parents may not want to take them out of school. They might feel that it is impossible to return home because of the situation in the country or their personal situation with the community or family (Øien & Sønsterudbråten, 2011; Myhrvold & Småstuen, 2018). In addition, they might not be financially able to return due to lack of ID papers and potentially unpaid fees within Norway, which renders them ineligible for the International Organization for Migration's (IOM's) voluntary organized home travel. The practical feasibility of returning home can also be a reason, if the Norwegian government and the country the migrant is from might not have a return agreement. This can lead the return country to not accept the return of the migrant, and these people are often called "un-returnable" (Näsholm, 2014a, p. 2; JussBuss, 2013). Many do not perceive themselves as having viable possibilities for safe return. They fear their lives and the lives of their family, and they stand by the need for protection that they asserted in their asylum applications, even though these were not recognized by the state (Mburu, Middelthon & Hilden, 2015). The reasons for staying are many but one can say that they are a mix of own and others' needs, bureaucratic factors and the perceptions of the future (Øien & Sønsterudbråten, 2011, p. 89).

Irregular migrants' lack of legal residency leads them to not have a Norwegian identification number. This poses bureaucratic obstacles in registration systems, which excludes most of irregular migrants from accessing the legal labor market and complicates the process of enrolling children in school or seeking health care. The importance of work or education evolves not only around earning an income or developing competences within a field that potentially set the ground for future work. Work and education are also the means by which one has somewhere to be, something to fill time with and something to contribute to and be valued for. In Øien & Sønsterudbråten's (2011) study, participants describe not having a place to go everyday as difficult and bad for their physical and mental health. Work can include having something stable and predictable when nothing else is, it can give a feeling of normality and be an important factor for a person`s psychological well-being. Findings in Øien & Sønsterudbråtens (2011, p. 15) study revealed that participants associated work with feeling useful, contributing, being an active participant in the society and as an important purpose of life. In addition, they describe having somewhere to be as a way of forgetting their situation and a means to stay healthy, by interacting and getting recognition from others. Lack of school or work isolates people and can, over time, make it even harder to activate oneself. Irregular migrants are often forced into the unregulated labor market as the only chance of getting an income and surviving. Women are especially vulnerable for exploitation as they can experience having to engage in sexual transactions as their primary means of subsistence (Mburu et al., 2015). Khosravi (2010, p. 100) describes a working environment for irregular migrants that includes exploitation, migrants getting wages much lower than the minimum and long working hours with no room for negotiation. The work is often accessed through personal social networks within the ethnic community.

Limited options for supporting oneself often lead irregular migrants to become dependent on a network of friends and family, often together with ethnic communities and acquaintances. Some irregular migrants live with their family while others do not have any family in Norway, thus leading them to be more dependent on their extended network (Øien & Sønsterudbråten, 2011, p. 13). Many come from cultures more collective oriented than those of Western countries. Family is regularly prioritized more than the individual itself and is often what makes up the entire support system. Living as an irregular migrant and not in your home country can therefore mean losing your family network and support, together with the feeling of failure towards meeting the responsibility one has to the family and community back home (Miller et al., 2009). Irregular migrants might experience that the network they had during the asylum period withdrew from them when they found out that their application was rejected (Øien & Sønsterudbråten, 2011, p. 31).

Finding housing and work are often dependent on their network and often leads them to frequently move around. This puts them in a situation of constant uncertainty and instability in their everyday life (Khosravi, 2010). Irregular migrants are criminalized as a consequence of their status. In Khosravi’s (2010) study, he describes illegality as something that is physically embodied in the human, causing irregular migrants often to have trouble starting new relationships or relations due to the feeling of being “defective”, shame and fear of other people’s perception of them living in the situation of irregularity (Khosravi, 2010, p. 110). The feeling of being trapped or caught within asymmetrical relations of financial debt or gratitude of debt is, for many, a present reality. Myhrvold and Småstuen (2016) emphasize the value of relations that are evolving around being taken seriously and not being in debt to each other, as these relationships potentially seem to be rare for migrants in an irregular situation. Such relations can emerge from private relationships, through work or organizations providing support.

The constructed illegality of irregular migrants can force them to be especially careful not to do anything “wrong” within the legal and moral sphere. This is both to avoid police and the risk of deportation, but also due to the need to emphasize one´s dignity and worth through not confirming the accusation of being criminal. Not leaning on a car with the fear of the alarm going off, not taking public transportation without a ticket, not being out late at night etc. For many, the fear of being caught by the police restricts their mobility and results in them staying away from public areas (Khosravi, 2010, p. 99). Human's socio-economic- and political situation, living conditions and social life all have an impact on the physical- and mental health of the individual. Irregular migrants' precarious situation affects all the factors stated above, which potentially puts them at a higher risk of decreased health and quality of life (Øien & Sønsterudbråtens, 2011; Myhrvold & Småstuen, 2016).

1.1.3 Mental health status

Studies done on the mental health of refugees, asylum seekers and undocumented migrants, together with the Health Centers experience, underline the potentially increased risk of mental health issues and distress for migrants who come from areas of conflict and currently live in temporary and unstable situations (Teodorescu et al., 2012; Myhrvold & Småstuen,, 2016; The Church City Mission & Red Cross Oslo., 2014b). In addition to possible experience of persecution, violence and financial difficulties in their home country, asylum seekers are potentially exposed to trauma during their journey to Europe (Øien & Sønsterudbråtens, 2011). Most of the participants in in this study were former asylum seekers, complying with statistics of the majority of irregular migrants in Norway being former asylum seekers (Zhang, 2006) and the majority of the Health Centers users being former asylum seekers (Mburu et al., 2015). Hence, irregular migrants at risk of mental health issues in Norway very likely consist of a large number of people.

In all the annual reports (2009-2018) from the Health Center of Undocumented Migrants, a high prevalence of mental health issues among the Health Centers service users has been detected (The Church City Mission & Red Cross Oslo, 2009; 2010; 2011; 2012a; 2013a; 2014b; 2015a; 2016; 2017; 2018). Myhrvold & Småstuen (2016) conducted a study on mental health care needs with the use of the Hopkins Symptoms Checklist, based on participants recruited from the Health Center. Their findings showed that 87% of the participants were exposed to psychosocial distress (2016, p. 830). Participants expressed feelings of loneliness, constant fear, uncertainty, being trapped, powerlessness and being dependent on others. All of these factors contribute to poor psychosocial health and well-being, in addition to being stress factors that can contribute to mental illnesses. As pointed out in Myhrvolds & Småstuen`s (2016, p. 833) study, even though work usually is a factor that contributes to securing mental health through material and psychological support, the working conditions for many irregular migrants are unhealthy and can, because of the high risk of exploitation, lead to more stress, outweighing the potential benefits.

Lack of rights and poor living conditions constitute precarious life circumstances characterized by a high amount of stress-related factors. As described in the chapter 1.1.1 "Irregular migrants` applied entitlements: Norwegian law and Human rights", access to health care is very limited. Access to mental health care is associated with even bigger barriers. Factors such as lack of resources and awareness in the health system, complicated treatment, cultural perceptions of mental health and complex living situations all contribute to the feasibility and utilization of existing mental health care treatment for this group of people, thus making it even more complicated and difficult to receive adequate quality treatment (Straßmayr et.al., 2012; Myhrvold & Småstuen, 2016; The Church City Mission & Red Cross Oslo, 2014b).

1.2 Psychosocial health

The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2019). Further, mental health is defined as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2014). Biomedicine is leading in addressing health issues in our society, breaking health down to microbiology, diagnosis and medicine. The WHO`s definitions on health contain a broader perception of factors, including biological, psychological and social, that need to be covered to reach the state of complete health. While physical illness and mental diagnosis are left for the doctor to treat, the preventative health aspect of well-being is often left for the individual to cover on their own. Psychosocial health belongs to this category of health, the well-being part (Nissen & Skræbæk, 2014). Well-being is individual, social and contextualized within the surroundings and society (Nissen & Skræbæk, 2014). The Oxford English dictionary states that psychosocial health consists of social factors and individual thoughts and behaviors (OED, 2007). The different explanations on the term “psychosocial health” are many, but they all speak to the importance of the individual and its context. It is an umbrella term allowing us to look at health in a holistic, individual and contextualized way. A person’s perception of own psychosocial health is individual, causing the factors that potentially increase or decrease psychosocial health also to be individual (Martikainen, Pekka, Bartley & Lahelma, 2002). The need for being recognized, acknowledged and seen as a unique human being is universal, and a big part of our own perception of health. Socializing and connecting with other human beings, engaging in activities, hobbies and social life, are for many a way to cover the aspect of feeling well-being and thereby gaining health. This is health-promoting self-care behavior that often leads to a higher quality of life through identifying self-purpose and self-worth (Nissen & Skræbæk, 2014).

In Martikainen`s et al. article “Psychosocial determinants of health in social epidemiology" (2002) an example of psychosocial processes from a health perspective is given. They look at the psychosocial process of a person losing their job. Bad health outcomes as a consequence of financial hardship and difficulties covering basic needs does not include in factors affecting the persons psychosocial health. However, the potential consequence further can include decreased emotional well-being, such as low self-esteem and feeling of worthlessness, which will be a part of the psychosocial health aspect (p. 1092). To explain psychosocial health further the article uses the example of socializing and building network. The material benefit that might be a consequence of networking, such as getting goods (food, free tickets etc.), is not a psychosocial process. The benefits in terms of emotional support and conversational stimuli is, however, categorized as a psychosocial process, potentially leading to higher psychosocial health (Martikainen et al., 2002).

1.2.1 The potential of psychosocial health initiatives and migration

In Willen`s article about an “Inhabitable space of welcome”, she describes factors like juridical, sociological, moral and existential dimensions in which the condition of migrant illegality is framed (Willen, 2014, p. 87). Irregular migrants are at all times faced with these dimensions, likely affecting not only their physical but also psychosocial health. Her description of an “inhabitable space of welcome” shows the possibilities in which a person whose life is heavily affected by the dimensions above still can, and might actively seek, experiences that produce feelings of existential grounding, comfort and safety, such as by seeking out places that focus on the acceptance of the human being: NGOs, religious communities or private places with people who practice acceptance. She also argues that the juridical and sociopolitical dynamics are often over emphasized when exploring the situation of irregular migrants, and argues that human experience should be brought into the discussion. She emphasize that how a person lives in the individual reality of the world ultimately is a choice (Willen, 2014, p. 96-97).

In Brux et al. (2018) article; "Klokka tikker, tiden går: Time and irregular migration" possibilities and limitations of meaningful experiences within irregular migrants living in Norway is brought up. The article identifies how experiences can be expressed as a means only to pass time, as a way of being controlled, or a means to produce reassuring existential thoughts. Producing existential thoughts is ultimately what the activity initiative was aiming for.

Even though the diversity within the group of irregular migrants is big, there seems to be one common perception: the fact that not having a residence permit is the predominant reason for one´s challenges. In a report from the Health Center for Undocumented Migrants in Oslo, a patient stated that "I am coming with a headache and you treat an arm (translated from Norwegian)" (The Church City Mission & Red Cross Oslo, 2014b, p. 26).

Experiences from a group therapy initiative at an asylum reception center organized by Rec Cross include some of the same challenges; that many of the participants needed structure and security and that this would eliminate their concerns and issues. In addition, dignity and safety were brought up as lacking. The participants did not see the benefit of talking about their mental health; they wanted help with concrete things to raise their functional life quality, such as shower curtains and better regulation of the heat system at the reception center. That the psychologists were volunteers seemed to be important for the participants; this motivated them to participate and contributed to the trust developed between the two parties. The group therapy concluded with four factors that should be emphasized and discussed to ensure that they are jointly agreed upon by both participants and psychologists in order to benefit most from the group conversations. This included a common understanding of the problem, the situation, the system and the solution (Buvik & Hansen, 2017).

Médecins Sans Frontières (MSF) report on "Psychosocial support for asylum seekers in Sweden" (2018) experienced that a psychosocial support initiative contributed to increased well-being for the participants through counselling, psycho-education and activities. Their experience with activities included a lower attendance rate when activities were not conducted at the asylum centers. They concluded with the importance of having the activities in a safe and trustworthy place, easy for the participants to access (p. 10-11)

1.2.2 Salutogenesis

Salutogenesis is a theory about what is promoting health and what is keeping us healthy. The theory is a shift in focus from pathogenesis, learning about what is causing sickness, to salutogenesis, learning about what is causing healthy individuals. The Israeli sociologist Aaron Antonovsky (1923-1994) presented the theory of salutogenesis, in which he identified mechanisms and qualities that he linked with being able to cope with stress. “Sense of Coherence” (SOC) is the term used when adding all the factors that contribute to handling stress and unexpected life events. The mechanisms or resources of a person’s SOC is dependent on culture, social support, religion and values, physical and biochemical resources, consistency and control, and knowledge and intelligence (Lønne, 2018). These factors are connected to how a person perceives actions to be perceivable, manageable and meaningful (Dahl, U., 2014, p. 119).

A strong SOC will potentially lead to increased resilience towards disease by maintaining resources that are associated with psychosocial health. A person’s SOC can be strengthened or weakened depending on a person’s social relations, existential thoughts, individual emotion and what activities the person’s everyday life consists of (Dahl, U., 2014, p. 112). As salutogenesis emphasizes the individual’s ability to cope with stressors of life, through strengthening the individual’s resources, the theory offers potential for understanding how a psychosocial initiative can be beneficial for the users of the Health Center. While there are tools developed to measure the SOC of a person, this is not my intention with including the theory in the discussion chapters. Salutogenesis has been applied by therapists at the Health Center when teaching participants about coping mechanisms during the “Project mental health”. And while I am not going to measure the potential increased well-being of participants in the activity initiative, I see it as beneficial to include the theory when discussing the potential benefits the initiative can have contributed with, as the theory focuses on the individual development of resilience, which can counter stressful situations, though with less focus on the actual stressful situation itself. Salutogenesis illustrates why some people are able to cope better than others, and argues that you can build your coping strategies through building your SOC (Walseth & Malterud, 2004).

1.2.3 Empowerment

The concept of “empowerment” within social work and health care refers to a broad understanding of, as the name indicates, the transmission of power (Askheim, 2003, p. 230). In a health care setting, this often means transferring power from the provider to the patient. Guidance and knowledge can for example be transferred from a service provider to a service user, which can empower the service user to gain control of his or her situation. Empowerment can help the service user to take control and to be in charge of own health, and gain tools to act beneficially for own good (Walseth & Malterud, 2004).

Slettebø (2000) describes “empowerment” as a goal, an approach and a process, indicating the broadness of the term. The different descriptions all have the same goal of ensuring the user’s dignity and acknowledging their perception of needs, concerns and solutions. It is based on a principle of equality where services are adjusted for and made beneficial to the individual through mutual communication and cooperation (p. 75). It is also a means to ensure quality of care, by giving users an opportunity to voice their wishes (Askheim, 2003). The empowerment principle fits well into the Norwegian democratic welfare system, potentially giving everybody with stakes a platform to be heard (Slettebø, 2000).

“Empowerment” has become somewhat a buzzword, used in settings where it can be questioned if it actually was realized. Even so, as mentioned earlier, “empowerment” is a broad term and it can therefore be easy to claim that a service offer is based on empowerment without fully backing it up. Thus, an interesting and fruitful aspect of basing an offer on empowerment is examining if and to what extent the concept has led to any benefits or challenges, rather than related to it as only a theoretical idea that all service offers often must include in their guidelines (Leonardsen, 2007).

There are different ways of implementing empowerment within a service offer, and listening to the voices of the service users through a council consisting of users has become a well-established means to meet the empowerment requirement often existing within the health sector. Jordan (2004) argues for a possible disempowering aspect when inviting users to contribute with developing their own care. He states that inviting participants to have a say in their service offer without following through on their wishes will work the other way around and lead to disempowerment. User involvement can also lead to advocating for the most resourceful and to a situation in which the best-spoken users are heard and get their needs covered, while the most marginalized groups' needs remain unexplored and unmet (Owren, 2008, p. 5). In addition to this, the concept has been criticized for over-estimating the service users' actual power gain, when most empowering processes are based on inviting users to identify their needs and solutions within a frame in which the service provider already has identified an issue (Slettebø, 2000).

A professional health worker and a patient will often have different areas of concern when it comes to mental health issues. The health professional will approach the patient with a biomedical framework while the patient will often contextualize his or her issue through everyday life. They will both have to adapt to each other, but within a more user perceptive driven approach, the patient's perception of importance will be addressed, rather than having the professional fit the everyday life of the patient into biomedicine (Mishler, 1984). The idea of the user driven activity initiative is very much a theory of addressing psychosocial health through a user perceptive.

The activity initiative at the Health Center for Undocumented Migrants was constructed in a way that aimed to empower all the service user participants throughout the process. This was attempted through the role of the planning group developing the initiative and being in charge of organizing and implementing activities. The activity initiative participants were potentially gaining tools to be better equipped in taking charge of their own social capital.

In a study by Valenta & Berg (2010) about "User involvement and empowerment among asylum seekers in Norwegian reception centers", empowerment is looked at through the reception center's use of a cooperative council (what is called a planning group in this thesis), activity offers and language courses. The study is relevant when discussing the findings from the activity initiative because the similarities between the life of an asylum seeker and an irregular migrant are present within the frame of both being in limbo and not knowing how the future will look. Findings show that the cooperation councils were often vulnerable because of the high turnover of people in and out of reception centers, as well as people not wanting to be a part of the cooperation councils. The reasons for this were grounded on both relational and structural levels. The variety of residents including gender, background, family situation etc. made it difficult for the representatives in the council to please all the residents living in the reception center, which again exposed them to critique for lack of objectivity. The structural level included participants not seeing the point of participating, as waiting for their approval or rejection of the asylum application was all-consuming.

The experience with motivating residents in the form of language classes, hobbies and activities was positive, as the study reports that participants became more independent and that residents gained confidence and skills to increasingly interact with the Norwegian society. However, there were also reported instances of residents seeing it as meaningless to engage in such activities (Valenta & Berg, 2010), reasoned with the same argument as in 1.2.1 “The potential of psychosocial health initiatives and migration”, that their challenges resulted from their situation and activities were thus not the solution.

1.3 Humanitarianism

“Humanitarianism” as a concept is situated with respect to the inequality of different lives, and is based on a neutral, impartial and independent moral principle of acknowledging that all people are equally important and that one therefore has the responsibility to intervene in crisis with the aim of saving lives and reducing suffering (Fassin, 2011). The Health Center for Undocumented Migrants in Oslo exists because of the humanitarian responsibility they see themselves as having. While the traditional medical humanitarian aid provides lifesaving medical help, there has been increasingly more focus on and development of psychosocial interventions within the field. NGOs such as MSF and the Red Cross are increasingly aiming to address the psychosocial aspects of crisis, both in conflict areas and among refugees (Pupavac, 2004).

The activity initiative is an example of a psychosocial intervention based on humanitarian principles. This shift to a psychosocial focus emerged on a basis of needing to “see individuals” and their human experiences within the growing bureaucratization of humanitarian aid. Recognition of feelings of loss of meaning and thus reduced life quality for populations in war-afflicted communities was introduced to the agenda because of ethical considerations. While material aid essentially can completely leave out the emotional aspect of happenings, a psychosocial approach will potentially humanize experiences. The shift has therefore gone from resilience to acceptance and even encouragement of emotional vulnerability. It has been criticized for promoting emotional well-being based on the idea that there is a psychosocial dysfunctionalism that should be restored, which ultimately is a Western understanding of normal needs and reactions to suffering and trauma (Pupavac, 2004).

Another critique of humanitarianism relates to the ethical challenge of handling the almost always unavoidable asymmetrical power relationship between care provider and care receiver (Fassin, 2007), and implicit expectations about how the different actors are to behave and react to each other. The care receiver might feel pressured into performing their deservingness, in the form of presenting oneself as helpless and suffering rather than empowered. The care provider may believe that non-discriminatory care is given, but encounters with the receiver might affect the perception of deservingness in cases in which the care receiver is not “acting out” their deservingness in the ways expected (Pupavac, 2004).

2 CHAPTER TWO - Background, study rationale and research questions

In this chapter, I will introduce the Health Center for Undocumented Migrants, their previous experience with psychosocial health initiatives through a mental health project and the activity initiative that this thesis is set to explore. This chapter will give insight into the understanding of the Health Center's reasoning for the activity initiative. The Health Center`s implementation and development of psychoeducational- and coping groups, self-help groups and network/social groups are the closest to similar projects having been conducted before. A collection of annual reports and project- and service reports document these experiences, and together with book chapters about "Project mental health" (Näsholm, 2014b & Mburu et al., 2015) inform the discussion in this chapter. These were essential sources when mapping out the knowledge gap, and they enable a richer discussion when introducing the findings in the last chapters.

2.1 The Health Center for Undocumented Migrants

The Health Center for Undocumented Migrants opened in October 2009, and is run by the Oslo Church City Mission and the Oslo Red Cross. The Church City Mission has been politically engaged in the discussion about the rights and needs of undocumented migrants in Norway since 2005, but until 2008, little research had been conducted on the topic. The report "Papirløse migranter: En undersøkelse av situasjonen for mennesker uten lovlig opphold i Norge, og humanitære tiltak for denne gruppen i andre europeiske land (Undocumented migrants: documenting the situation for people without legal residency in Norway, and humanitarian means implemented for undocumented migrants in other European countries)" by Solveig Holmedal Ottesen (2008), was written on request from the City Church Mission, with the aim of mapping the situation of undocumented migrants in Norway. It compared the rights and living situation of undocumented migrants in Norway to other countries in Europe and revealed the barriers that undocumented migrants experienced when seeking health care in Norway. The report was the first extensive research done on the group living in Norway, and it made it clear that undocumented migrants in Norway did not have adequate access to health care. The findings laid the foundation and confirmation of the humanitarian need, the

Red Cross and Church City Mission's responsibility to act and, through this, the opening of the Health Center (The Church City Mission & Red Cross Oslo, 2009).

The Health Center has five main goals:

1. To provide health care to undocumented migrants
2. To give health information to undocumented migrants
3. To facilitate undocumented migrants' access to the ordinary health care system in Norway
4. To document, raise public awareness about and advocate better conditions for health among undocumented migrants
5. That the rights of undocumented migrants are extended to cover general health care, so that they can get services from the ordinary health care system. Therefore, their overall aim is to finally be of excess and to close the Health Center.

These goals have been the same since the opening in 2009. In all the annual rapports written, from 2009-2018, the Health Center has pointed out that goal number five: "To not be needed", does not seem to be realistic, considering the political situation in Norway (The Church City Mission & Red Cross Oslo, 2009; 2010; 2011; 2012a; 2013a; 2014a; 2015a; 2016; 2017; 2018). The Health Center wants to avoid being a parallel health care system, and to facilitate instead a way in to the already existing health care system in Norway. They are providing an interdisciplinary primary health care service, and refer patients to "Diakonhjemmet hospital" with whom they have a referral agreement for specialty level somatic health needs beyond that which the Health Center can provide (The Church City Mission & Red Cross Oslo, 2017).

Because of the large number of people who have needed health care, the Center's opening hours and patient numbers have grown rapidly. In 2010, the Health Center had three employees who shared 2.2 full positions and 75 volunteer health professionals (The Church City Mission & Red Cross Oslo, 2010). In 2018, the Health Center consisted of seven employees (business manager, doctor, coordinating nurse, mental health coordinator, health secretary and two project managers for a dental health initiative and a counselling initiative for family planning) who share four positions, and a volunteer staff of 180 people. The awareness of the Health Center has been growing every year and the opening hours have gone from drop-in sessions one afternoon a week early in the start-up, to drop-in sessions Tuesdays and Thursdays, as well as the possibility for pre-set appointments on Wednesdays and organized group service offers in the evenings. The volunteers logged 7200 working hours in 2018, adding up to the hours of four full positions. The 180 volunteers consist of doctors (with different specialties), nurses, social workers, dentists, physiotherapists, midwifes, pharmacists, bioengineers, phycologists and 40 interpreters who are available through phone.

During opening hours, volunteers with different professional backgrounds, such as doctors, psychologists and physiotherapists, are available to see patients. The patients stay in a waiting area before their consultations, where tea, coffee and snacks are available. Social workers are also present in the waiting room and are in charge of the registrations and offer conversation. Because many of the patients have irregular and unstable lives, the Health Center has arranged its service offer so that it is possible for patients to have consultations with different health care professionals on the same day. This makes it easier for the patients to address many health needs simultaneously, seeing as appointments and follow-up can sometimes be challenging to see through (The Church City Mission & Red Cross Oslo, 2018).

In 2018, 797 patients from approximately 60 different countries were registered at the Health Center for consultations (The Church City Mission & Red Cross Oslo, 2018). The majority of the Health Center`s users are people from Afghanistan, Somalia, Romania, Mongolia, Ethiopia, Iraq, Iran, Nigeria, Eritrea and Pakistan (The Church City Mission & Red Cross Oslo, 2017). Ethiopia, Eritrea, Syria, Afghanistan, Iraq and Turkey are the countries most represented among asylum seekers in the latest years (UDI, 2016; 2017; 2018b). While people from Syria and Eritrea were almost always granted residence in 2017, with a percentage of approved applications of 99 and 98%, people from other countries in the Middle East and Ethiopia were not, with around 50% of the asylum seekers from Afghanistan, Iraq, Iran and Ethiopia being rejected (NOAS, 2017). The countries most represented among the users of the Health Center therefore, to some extent, reflect the most common countries that asylum seekers come from and the countries from which applications are typically rejected.

The Health Center users' needs for health care are described by the Health Center as similar to the needs of the rest of the Norwegian population, but because of late treatment, their health problem has often developed further and has therefore become more complicated to treat. In addition, many of their patients are dealing with the physical and psychological consequences of often difficult and traumatic experiences from living in a conflict area, the journey to Norway and their current living situation (The Church City Mission & Red Cross Oslo, 2016).

One of the main issues that the Health Center emphasizes in their annual report is the mental health challenges that the users of the Health Center face (The Church City Mission & Red Cross Oslo, 2009; 2010; 2011; 2012a; 2013a; 2014b; 2015a; 2016; 2017; 2018). Both the patient’s previous life experiences and their current living situations are pointed to as possible reasons for the seemingly high rate of distress and mental health problems (The Church City Mission & Red Cross Oslo, 2015a; Mburu et al., 2015; Näsholm, 2014b). In 2018, psychological and social consultations made-up 638 of the 3179 total consultations (The Church City Mission & Red Cross Oslo, 2018). Patients described being worried about the future and feeling anxious, sad, stressed and depressed. Some of the Health Center´s users have serious mental health conditions such as psychosis, PTSD (Post-Traumatic Stress Disorder) and suicidal thoughts (The Church City Mission & Red Cross Oslo, 2012a).

Health personnel have reported that it is often challenging to ensure adequate mental health treatment for the users of the Health Center because, among other things, treatment is both resource demanding and time consuming, including certain possibilities for follow-up, stability and continuity as important factors. The personnel are volunteering approximately once every month, and it is therefore difficult to ensure that the patients talk to the same health care professional every time. In addition to this, as mentioned earlier, the service users live unstable and irregular lives, often making it difficult for them to engage in follow-up consultations and pre-set appointments (Mburu et al., 2015). The Health Center has experienced that almost all referrals to DPS (District Psychiatric Center) are declined, leading them to only refer five patient to DPS in 2018 (The Church City Mission & Red Cross Oslo, 2018).

Challenges experienced trying to cover the patients’ mental health needs led the Health Center to start a mental health project in 2011 called “Prosjekt psykisk helse (Project mental health)”, with the aim of expanding and increasing the quality of the Health Centers’ offer through a different and new approach (The Church City Mission & Red Cross Oslo, 2011; Näsholm, 2014b).

2.1.1 “Project mental health”: 2011-2014

Through “Project mental health” the Health Center explored different means to address their patients’ needs for mental health support. In addition to the individual consultations that the center already offered, they developed psychoeducational- and coping groups, self- help groups and network/social groups. The project organizers and volunteer practitioners developed the content of the different sessions and offers, often basing strategies on principles such as empowerment and salutogenesis. The initiative started in cooperation with a PhD project, and the process was therefore closely mapped out and feedback was continuously given. *Extrastiftelsen: Helse og Rehabilitering* funded the project.

Throughout the period, five psychoeducational- and coping groups were implemented. The aim was to give the group participants “mental tools” to help them cope with everyday life in a better way. The participants of the different groups were organized with respect to their background, language and gender. One group included Ethiopian and Eritrean women, one was for Pashto speaking men from Afghanistan, one was for both Ethiopian and Eritrean men and women, one was for Arabic speaking men and one was for Persian speaking women and men. All the groups met with volunteer practitioners every other week for approximately eight sessions each (The Church City Mission & Red Cross Oslo, 2014b). Social activities were arranged during the weeks in between the psychoeducational- and coping group sessions for several of the groups (The Church City Mission & Red Cross Oslo, 2015b; 2014b).

The feedback from the participants was mostly positive, including participants saying that they expanded their network and felt seen, respected and treated with dignity, which they had not experienced often while living in Norway. Participants also reported that it was good to have an appointment and a place to be (The Church City Mission & Red Cross Oslo, 2015b; 2015c; 2014c; 2013b; 2012b; Näsholm, 2014b).

The Health Center outlines some factors that they believe were essential contributors to the fruitfulness of the psychoeducational- and coping groups. The Health Center and its staff and volunteers were regarded as trustworthy and safe, which became important for the participants and contributed to feelings of fellowship and a sense of ownership. The Health Center points out that continuity and stability with respect to both the group content and the coordinator’s presence made it possible to ensure trust and create a safe space. The importance of trying to use the same translator every session is also pointed out. It was beneficial for the group dynamic and fellowship that the translator was included and, to some extent, participated in the group discussion throughout sessions. The individual consultations held as a part of the group mental health offer were believed to be of importance for the participants. The individual consultations seemingly made it easier for the participant to understand the potential and limitation of the group sessions. It was also reported that individual consultations were an important recruitment area (The Church City Mission & Red Cross Oslo, 2014b).

Several challenges throughout the project period were mentioned in the project reports written during “Project mental health”. Some of them were that the participants’ expectations and the actual group offer did not always match. Participants wanted help with their residency permits and living situation. When the Health Center offered courses in coping mechanisms for everyday life, participants expressed the frustration of feeling like the Health Center put resources into the wrong area, as many of the participants felt like their mental health problems were purely based on their permit status. Determining how much space should be given for discussing sociopolitical factors that the therapist could not help with became a challenge. Letting participants talk about previous life experiences and personal difficulties was also an issue. The therapists found that, for some of the participants, it had a therapeutic effect, but for others, it led to emotional destabilization. Flashbacks and the re-experiencing of trauma can be a part of trauma treatment. However, without the resources to properly follow up this treatment or stability in the surrounding life situation, the therapists worried that it could lead to even further traumatization (Mburu et al., 2015). Therefore, finding the balance between the therapeutic conversation and the social aspect of the group session was often challenging.

The variety in the service users’ backgrounds, cultures, languages, and socio-economic, educational and mental health status were also difficult to deal with in group sessions, and the therapists struggled to adapt the content so that it suited for everybody. The participants’ unstable living situation also led participants to not attend sessions, which, in some cases, made the group dynamic unstable (The Church City Mission & Red Cross Oslo, 2014b).

The self-help groups were also organized and conducted during evening hours at the Health Center. Each meeting addressed a theme, such as tooth health or hygiene. The aim was to create a space for people to socialize and develop relations, as well as to provide information about matters that the Health Center understood as potentially relevant for its users. The attendance at these meetings decreased with time. A cooperating council consisting of users of the Health Center with different gender, ages and backgrounds was created to discuss what a meaningful and beneficial offer might look like, so that more people would show up. The group discussed the suggestion of a support group as a means to create a space for relationship- and network building. This resulted in the founding of “Mennesker i Limbo”, a political support group, run by both volunteers and undocumented migrants, who regularly meet to both discuss political challenges and to be social.

Throughout the period, the Health Center has become more aware of the wish and need for psychosocial support. The Health Center has mapped out the different local service offers that the users can benefit from, such as the MIRA center for minority women and the PMV (Primærmedisinsk Verksted), where different activities such as cooking and fitness classes are offered. The Health Center has somewhat divided experience with introducing both these offers to its service users and with providing its own activity offers. Some of the people who express the need and wish for such offers show up. However, many say that they will attend but then never show up (The Church City Mission & Red Cross Oslo, 2014b).

2.1.2 The user driven activity initiative

“Project mental health” contributed to the development of the Health Center’s mental health services and the development of psychosocially oriented treatment services. Psychoeducational- and coping groups, individual consultations, “self-help” sessions, mapping out supportive arenas beyond the Health Center and sporadically organized activities were all means that were implemented and that are still offered at the Health Center. The resources available, in terms of money, staff and volunteers, are however, limited. While the need for addressing the mental health of the Health Center’s users is still very much present. Therefore, the Health Center’s staff are still trying to find new ways to address their patients’ needs. The shift from the Health Center has been one from a more strictly clinical primary health focus to a more flexible and socially-oriented psychosocial health focus, which has included some creative negotiations given the dependence on volunteerism and very limited resources. As a result of “Project mental health”, it became clear that the users of the center themselves had a wish and were motivated to be part of a fellowship and community with people who were in the same situation.

With the base of the mental health service offer’s focus on empowerment and salutogenesis and their experience with this, an idea of making a platform for undocumented migrants to organize on their own, through social activities, seemed feasible. The Health Center wanted the activity initiative to be organized and run by people who were users of the Health Center, and therefore a planning group was created. In the beginning of 2018, the coordinator started to recruit users of the Health Center to join the planning group. Altogether, the planning group for the activity initiative included six people, including the coordinator. During their first couple of meetings, they discussed the need for an activity initiative, what kind of activities they saw as potentially beneficial and how the initiative should be organized. The Health Center's idea was that the planning group was supposed to be responsible for organizing, overseeing and implementing an activity initiative for the rest of the Health Center's users. When the planning group is addressed in the findings and discussion chapter, this is what is being referred to.

The Health Center's rationale for focusing on a service user driven activity initiative was stated in the rough initiative draft and grounded in experiences from "Project mental health". The aim included the potential benefits for both the planning group participants and the activity participants. The aims stated were:

- To create a network, fellowship and relations within the patient group and through this reduce loneliness and isolation.
- To create positive experiences, memories and a "breathing space" or a "safe space" where worry and stress can be forgotten for a period.
- To give the users of a Health Center a place to go to, to have somewhere to be and to look forward to.
- To create a group that can go to activities together and through this reduce the barrier for going to an activity. As it is easier to go together than alone.
- To expand the awareness of different offers that exist for the users of the center.
- To amplify empowerment and peer support among the Health Center users and create a platform for the users to explore and develop their resources, to feel useful, to empower their identity, and to increase the feeling of mastering and dignity.

The coordinator had made a timeline for the project, in which the planning phase was supposed to be from January-August. A sign-up sheet was made and left on the tables in the waiting room. On the sign-up sheet, patients at the Health Center could write their name, phone number and language, together with what kind of activities they would want to participate in: sports, hiking, culture or other. The planning group decided on starting with activity every second Sunday and decided to organize the activities through planning meetings on the Fridays prior to the activity, which is when they would invite people and arrange the practicalities, such as grocery shopping or games. Because of the high engagement within the planning group and their wish to start the activity sooner, the first planning meeting was held at the end of May, with the first actual activity implemented just days after.

2.3 Study rationale, aim and research questions

Annual- and project reports from the Health Center (The Church City Mission & Red Cross Oslo, 2015b; 2015c; 2014b; 2014c; 2013b; 2012b), the reports from MSF (MSF, 2018) and Red Cross Sweden (Buvik & Hansen, 2017), the article about empowerment initiatives at an asylum reception center (Valenta & Berg, 2010), the articles about psychosocial health (Willen, 2014; Brux et al., 2018), together with the book chapters written about "Project mental health" (Mburu et al., 2015; Näsholm, 2014b), all address the potential within a psychosocial activity offer targeting the predominantly vulnerable migrant population of either asylum seekers or irregular migrants.

These reports give some insight into the potential of both experiencing happenings that can create psychosocial well-being, as well as how these happenings can be created. The absence of health professionals and the focus on a purely service-user driven activity initiative contribute new ingredients to the creation of a psychosocial offer. Most psychosocial activities have previously been in cooperation or have previously been a parallel offer to other service offers that include health professionals and mental health targeted treatment.

The research aim is therefore to produce knowledge about the process of implementing a service-user driven organized social activity initiative at the Health Center for Undocumented Migrants, and to generate insight into its potential value for psychosocial well-being. To gain insight into this, five research questions are developed with the purpose of covering the overall aim.

Research questions:

- How do the participants reflect around motivation and expectations towards the service offer throughout the period?
- How do participants identify and describe their psychosocial well-being, needs and concerns?
- How do the participants experience the activities and how do they perceive their value?

- What challenges do the participants potentially encounter, and what aspect of the offer do they experience most benefit from?
- What challenges to the participants organizing the activities potentially encounter, and what do they perceive as most valuable or successful?

3 CHAPTER THREE – Methodology

> *I rang the doorbell to the main entrance of the Health Center. An older man, a volunteer, opened the door. He smiled at me, said hello and asked if I had an appointment. I told him that I did not, but that I was meeting the group who arranged activities, he let me in. The leader of the Health Center was standing behind him, he looked confused and I understood that nobody had told him that the planning group was meeting up today. "Maybe nobody told you", I said, "but we were supposed to have a planning meeting today". He shook his head, nobody had told him. I apologized but he smiled; "do not worry, we are used to unpredictability here!". He seemed busy and quickly disappeared into his office. I sat down in the waiting area, no one from the planning group was there. I took one of the half-finished orange knitted scarfs from the table, poured myself a cup of coffee and sat down. Twenty minutes later the first participant in the planning group showed up and the meeting could start.* Excerpt from observation, Planning meeting 3, The Health Center for Undocumented Migrants

The excerpt is from a planning meeting that was held during opening hours at the Health Center. While I came on time, the rest of the planning group came later. This would often happen and it allowed me to get to know the Health Center and its practitioners in a different way. I would quietly sit and observe as the everyday life of the Health Center was unfolding.

To trust the research and the knowledge presented, it is essential for the reader to understand the processes by which this knowledge has been acquired (Maxwell, 2013). With the intention of giving the reader tools to assess the trustworthiness or validity of the study, I will in this chapter, as transparently as possible, introduce the methodological choices made before, during and after the research was conducted.

The idea for the research project was discussed during the late months of 2017 and early months of 2018. Migration and health, access to health care and the psychosocial aspect of health are topics that have had my interest since I started nursing school, and entering the International Community Health program I knew that these topics would be of interest to me.

I was set in contact with Christina Mburu Brux, now my supervisor, who conducted research in collaboration with a mental health project for her PhD at the Health Center for Undocumented Migrants. She contacted the Health Center about possible areas of research that could be of interest for the Health Center, as well as feasible for a master student. I was given different options of topics from the Health Center, including a review of their history, exploring the motivation of their volunteering translators and the possible idea of developing a psychosocial activity project that I could follow. The idea of a psychosocial project was exactly what I wanted to be a part of. While the coordinator of the Health Center started the planning and development of the initiative, I was held in the loop and was present at a couple of idea meetings together with the Health Center and my supervisor before the data collection started at the end of May 2018.

3.1 Study design

Qualitative research allows you to gain knowledge about phenomena such as social processes, experiences, meanings and understandings (Kielmann, Cataldo & Seeley, 2011). This project aimed for exploring just that; social processes of organizing and implementing an activity initiative and the experiences, understandings and meanings that participants associated with the initiative. The explorative and flexible nature of qualitative research allows gaining of knowledge that the researcher did not know the importance of from before. This means that the researcher should be ready for the unknown, engage in broad discussions and look into the "why" and "how" (Moen & Middelthon, 2016). Flexibility within the design and towards the fieldwork is key in qualitative research, as it allows the researcher to stay open minded in the field and enables the research to develop from the process (Green & Thorogood, 2014). This approach became important throughout the process as the activity initiative did not develop in the direction that the Health Center wanted it to.

Access to participants became more complicated than initially expected and, while the aims and objectives originally developed had focused on the participants of the activities and their potential health benefits, the study developed to emphasize knowledge production about the process of implementation and the potential within the activities. All these changes confirmed the need for a qualitative, exploratory nature and allowed me to become aware of my preconceptions as well as the impact that I potentially had on the activity initiative.

As the research project revolved around the exploring of an activity initiative, it became both natural and expedient to let the research be inspired by action research. This type of research design allows the researcher to take part in the processes being explored, which became essential for the feasibility of the research. It aims to empower the participants by conducting research together with rather than "on" them. The original idea for the activity initiative was to include a feed-back loop or a cyclical research design that would provide the Health Center and the planning group with new knowledge about the process so that the activity initiative could adjust and evolve throughout. This only partly happened, because although there was a planning, observing, acting and reflecting cycle, the acting phase was often not beneficially implemented (Green & Thorogood, 2014). However, feedback from the activity participants was discussed within the planning group, which again directly shaped both the initiative and the research.

3.2 Data collection

The data collection period was mainly from May to December 2018. Within this period, data from observations, ongoing conversations and in-depth interviews were collected. In addition, information from e-mails exchanged during the start-up period of the activity initiative and a Facebook messenger group that included the planning group participants contributed to complete the data about initiative happenings. The methods applied to the data collection was expedient and necessary for the research I had planned to conduct, and exploring the various aspects of the activity initiative with just one of these methods would not have generated the insight needed to thoroughly explore or holistically interpret the study phenomena. Observations and conversations helped me become a part of the study context and allowed me to more broadly understand the social phenomena acting out (Green & Thorogood, 2014). In addition, choosing three different methods gave the research the benefit of triangulation (Kielmann et. al., 2011).

Flexibility also applies to the choices of research methods (Moen & Middelthon, 2016). Seeing as I was attending both the planning meetings and the activities, I had foreseen that observations and ongoing conversations would be the predominant methods used. What was not foreseen were the difficulties I encountered when recruiting for interviews, which led to an even bigger emphasis on conversations during the activity initiative.

While observations and ongoing conversations gave me a deep insight into the perceptions, motivation and experience of the participants, and a broad overview and understanding of the dynamic and potential risk of such an activity, the in-depth interviews contributed to richer empiricism and understanding of the individual concerns, as well as a better understanding of existing relations between participants. Triangulation allowed me to get a deeper understanding of the connection between what people do and what they say (Kielmann et. al., 2011). The observations at the activities together with interviews enabled me to, for example, uncover the reason for participants saying that everybody is welcome but, at the same time, not fully including everybody in the actual activity.

3.2.1 Study site

To better contextualize the settings in which the research was conducted I will present the different study sites where data was collected. This will help the reader to assess whether the research can be applied to other sites and, perhaps more importantly, it will contribute to a broader impression of the environment and setting, which can in turn give the reader a better understanding of the findings (Malterud, 2001). The activity initiative was planned and organized at the Health Center for Undocumented Migrants in Oslo, and this is also where the interviews were conducted. Activity participants were greeted at a joint meeting place at the National Theatre in Oslo, and activities were explored at different locations around in the city of Oslo.

The Health Center

The Health Center for Undocumented Migrants was a place where most participants felt comfortable and ‘at home’. The planning group mostly met after the center’s opening hours, when we could gather in the waiting area that consists of a table with comfortable chairs and a couch, as well as a small kitchen. We would often sit there until the staff were leaving for the day, at which point we moved to a park if we had not finished inviting people for activity.

The National Theatre

The crowd around the National Theatre made the activity group blend in. People of all ages, gender and background use it as a meeting place and for walks through the open area between transit. The activity group had a set place next to the steps of the theatre. Here, the meeting point sometimes became invisible as I was the only one standing there. But, when the group came, we did not blend in and became, rather, quite visible, and the atmosphere for the activity was quickly set. While often waiting for 45 minutes, food was passed around and music was played either through a phone or a proper speaker brought by one of the participants. Plastic bags of food and drinks were spread around us, attracting enough attention for participants to see us.

The activity spots

As the activities were set in different places, the environment changed each time: the beach, a museum, the park, by a lake, inside at a City Church mission location or at the movies. We would first either walk or take the tram or bus to get to the destination, during which time the participants would walk together in small groups, either knowing each other from before or getting to know each other. During the summer of 2018, the weather was warm and sunny, and we were a group of people enjoying the weather just as the rest of the population in Oslo. During the autumn and winter months the group became smaller, as we spent the hours together inside.

3.2.2 Observations and ongoing conversations

As the research was inspired by a participatory action approach, participatory observations and ongoing conversations was my main data collection strategy. I attended 17 planning meetings out of 20 meetings held. I did not attend the three first meetings because of waiting for approval from both the planning meeting group and the Norwegian Center for research Data, NSD. Out of 13 activities, I attended ten of them. I was not able to attend two and I deliberately chose not to attend one, in an attempt to underline my role in the activity initiative as a researcher rather than a lead social worker and organizer.

Participant observation allows the researcher to gain access to settings that contribute to the understanding of particular social realities. It creates space for exploring different aspects in its natural "context". This is done through the researcher taking part, and the data is produced via both observing behavior and natural conversations and activities undertaken during observation (Green & Thorogood, 2014, p. 46). The observations were direct, mostly unstructured and overt, meaning that they were conducted in "real time" and that I as a researcher was as open minded as possible, only deciding on the event and process and not explicitly deciding on what to look for in advance (Kielmann et. al., 2011, p. 43).

An overt observer includes the researcher being open about their role in the field. Observing people who may be unfamiliar with the concept of research can lead to misunderstandings in terms of participants' perception of what the researcher's role is (Green, & Thorogood, 2014). I introduced myself as a researcher and student when meeting participants, as I noticed that many participants connected me to the Health Center when only saying I was a researcher.

The planning meetings and the activities included participants with different first languages and different second languages. Some spoke English, some Norwegian and some neither. Even though there was a big variation in verbal communication, because of language, I did not use an interpreter during the observations or conversations. This was because I wanted to interact with the participants on their terms and as a natural part of the activity initiative. Using a mediator would also mean that I would have to decide on what languages the mediator was bilingual in, which again would have made a statement about who I saw as the most rightful participants in the activity; this I wanted to avoid.

Even though I was not able to understand everything said during the activity initiative, I was able to observe and further ask participants about things I wondered about. They would often speak English or Norwegian in the group to include me, and in the beginning of the activity initiative I did not think of language as a barrier for accessing information. During the project period I did, however, become more aware of this, as different layers and aspects of the initiative appeared. While there is a possibility that information got lost because of difficulties communicating, my seven months with the activity initiative unpacked and gave me insight into several aspects of the potential of the activity initiative.

I only observed at the planning meetings and activities, and not during the participants' everyday lives, as I saw this as going beyond the scope of this thesis. Therefore, I politely declined invitations from participants to meet outside of the activity.

The initiative focused on relation building, and while I asked participants about relations made outside of the actual activities, I was not able to observe this. Not understanding some of the conversations due of language barriers and not being able to fully observe the participants in their everyday life might have led to not identifying all the relational aspects of the activity initiative.

The observations and conversations were written as bullet points during activity or planning meetings, and were fully written out in a notebook right after the encounters. Kielmann et. al. (2011) differentiate between fieldnotes that are descriptive, analytical and reflexive. My fieldnotes were later transcribed to a computer, and when doing this, I identified descriptive, analytical and reflexive aspects within the transcripts. This allowed me to properly interact and familiarize myself with the data set several times.

While I was not able to observe participants in their everyday lives I was able to follow the activity initiative closely, as the activity initiative period lasted for seven months, the interactions had with participants developed into relations and trust. Ongoing conversations had with both the planning group and the activity participants developed throughout the initiative, and the more the participants got to know both me and the research, the more they opened up and wanted to share their experiences.

3.2.3 In-depth, semi-structured interviews

Interviews are a planned and more structured way of having a conversation, and the most widely used data collection method within qualitative research. Interviews are conversations in which the researcher has the possibility to direct the conversations towards relevant topics for the study (Green & Thorogood, 2014).

I conducted six semi-structured in-depth interviews in the period from October to December. Participants were invited to meet me at the Health Center for the interview. I saw this as most appropriate, as the Health Center was our joint connection and a place both the participants and I were familiar with. I am aware that conducting the interviews at the Health Center might have had an impact on the data generated, and it became necessary to underline that I was not working for the Health Center, as some participants started to talk about the Health Center instead of the activity initiative.

Within the frames of a semi-structured interview, the researcher sets the topics for the conversation but lets the interviewee steer the conversation towards what they see as important. In the period of writing the project protocol, I formed an interview guide; this guide was based on assumptions of what would be important based on the literature review and experiences from the Health Center. I changed some of the questions in the interview guide before the first interview, and during the first interview I realized that some of the questions were too narrow. I therefore skipped questions during the first interview and used the interview guide as inspiration rather than a set plan for the rest of the interviews. Interviews had with the non-service-using planning group participants and the coordinator at the Health Center were conducted with the use of a guide that outlined main topics, rather than an interview guide.

I interviewed two of the service using planning group participants, and these interviews were conducted in Norwegian and English. The two last interviews were with two activity participants, and for these interviews a translator was present. The same translator was present at both the interviews. The translator received the consent form, interview guide and a summary of the research project in advance, so that he would understand why the interview was conducted.

Language is important when collecting and analyzing data; a cross-cultural setting challenges the understanding of topics discussed. Although the risk of misinterpretation and misrepresentation in qualitative research is always present, the risk is assumed to be even higher when data is translated (Green & Thorogood, 2014). While rich data was shaped through the interviews, the potential misunderstandings because of cultural differences and language were present. Two interviews were first translated and transcribed to Norwegian, one interview was conducted in English and the last three were conducted in Norwegian. Quotes excerpted from the Norwegian transcriptions were translated to English and are therefore not firsthand quotations.

Participants interviewed were people who had been a part of the activity initiative from the beginning of the project; therefore, they knew me and the research well. In addition, I had the chance to ask them supplementary questions after the interviews, as I met them at the planning meetings and in activity settings. This helped both me and the interviewee to feel more confident that I had understood their message, and it became a strategy to ensure trustworthiness, as much of the data in the interviews were later respondent validated (Maxwell, 2013).

Four of the interviews were recorded and later transcribed; two of these interviews were with the translator who directly translated the entire conversation. Although I did not speak the language of the participants, they did understand some Norwegian, which became a safety net, as they understood the main themes of my questions in addition to getting everything that I said translated. The interview with the Health Center representative was not recorded, but notes were taken during the conversation and thoroughly filled out right after the conversation. One of the irregular volunteers did not want me to record the interview, as it made him nervous; I therefore asked him if I could write down our conversations during our interview, and he did not have a problem with this. In the thesis, I include quotes from this interview. The quotes are from parts of the interview in which I explicitly asked him to repeat or talk slowly so that I could write everything down.

While I did have an interview guide, I let the participants bring up topics they found important and did not steer them back to the topics I had written down until they had said everything they wanted to say. Therefore the interviews lasted from one and a half hours to two and a half hours.

Participants were compensated for travel expenses and were given enough money to buy lunch after the interview. All of the participants initially did not want to accept the compensation; they all said that they were doing the interview because they wanted to contribute and that payment was not necessary. After having assured them that the money did not come from my own pocket but from funding given to me for the purpose of the research, they accepted the compensation.

Obtaining access, recruitment and sampling

Access to the activity initiative was gained through the Health Center for Undocumented Migrants. As mentioned, my supervisor put me in contact with the coordinator of the Health Center, which, for this study, was what Green & Thorogood (2014) call the formal gatekeeper. The gatekeeper is the person, or people, who control the access to potential participants and the research field (Green & Thorogood, 2014), For this study, the gatekeepers included both the coordinator and the leader of the Health Center. After having recruited participants for the planning group and discussed suggestions for the activity initiative, the coordinator introduced the planning group to the idea of a student joining the initiative to conduct research, which they were all positive towards.

Recruiting participants for the observational data collection was done though the planning group informing the participants over the phone and via text message. At each activity, I talked to all the activity participants and explained why I was there; participants were positive to the research and did not mind being a part of the study. The sample of observational methods and ongoing conversations included, with some exceptions, everybody in the planning group (seven people) as well as everybody present at the activities (approximately 26 people). Participants mostly consisted of users of the Health Center, but there were exceptions. Some activity participants were irregular but had not yet been a patient at the Health Center. In addition, some participants did have a residence permit and therefore did not use the Health Center, but had been invited by others who did. Even though I talked to everybody at the activities, I only collected data and personal information from the participants who had irregular status. I wrote down approximate age, country, living situation and other demographic and background information about 15 participants. But, this information was slightly changed to maintain anonymity, also in the transcripts.

While recruiting participants to be observed and reflect around the activity initiative while at the activity did not lead to problems, recruiting for the interviews did. My initial plan was to purposefully recruit participants from both the planning group and the activity. Within the activity, I wanted to include both participants who regularly came and the participants who only showed up a few times or once. Purposeful recruitment means that the researcher selects the participants with a set intention. My strategy was to recruit participants representing different aspects of the activity, thus potentially contributing to rich interviews and data (Kielmann et. al., 2011, p. 21). However, during the summer months of the activity, I spent time building relations instead of asking activity participants for interviews. In addition, I wanted the activity initiative to be properly implemented and up and running before I started conducting the interviews. During the autumn months when I wanted to start recruiting for interviews, participants did not show to the activities. Because of ethical considerations, I was not able to contact the participants I had hoped to recruit, since I only had access to their phone numbers through the Health Center sign-up sheet and had not asked for this myself.

In the autumn, four participants were still included in the planning group; all four agreed to be interviewed, but I was only able to interview three of them. Interview plans with the last participant were made several times, but he stopped responding when I tried to arrange a set time for the interview, and eventually I saw it as ethically questionable to ask again. I had exchanged numbers with the participants who had previously been a part of the planning group, but they either did not want to be interviewed, were no longer in the country or said yes but then stopped replying to my texts.

Recruiting activity participants for interviews became more complicated than initially foreseen. After having contacted NSD, I received approval to use snowball sampling and to have the Health Center contact participants asking if they would meet me. Asking the Health Center to contact participants was not feasible, as this would take too much time and required one person from the Center to follow up the text messages. Based on experience from sending out activity invitations, I knew that it would be difficult to get answers from potential participants. I therefore asked the planning group if they could contact participants for me, but this also became challenging because the planning group only had the activity participants' phone numbers though the sign-up sheet. The planning group was already doing time-consuming work to plan and implement the activity, and it did not feel right to ask them to start the process of recruiting participants for me. One participant in the planning group did however have the phone number for one of the participants I wanted to interview, and through him an interview with one of the two activity participant interviews was planned.

The other activity participant was recruited for an interview during an activity. In late October, one of the activities was held on a Sunday, and many of the participants who had regularly come during the summer attended. At this activity, I handed out yet another consent form to everybody, and told them in plenum that I wanted to interview them. I then talked to the participants I had initially included in my planned purposive sample individually and asked for their numbers. Four of the participants I wanted to interview were present. Two of them gave me their number while the other two wanted to contact me themselves, so I told them that my number was written on the consent form. The two that did not give me their numbers did not contact me, and there were only two more activities after this and they did not attend these. I contacted both the participants I had gotten numbers from; one of them was not available as she was no longer in the country. The other participant was available and, through Google Translate and help from family to translate, we were able to schedule and conduct a meeting.

Participants who were recruited for interviews were the participants from the Middle East. While I only interviewed two activity participants, two of the participants from the planning group were both planning group participants and activity participants. I was not able to recruit the participants that I talk about in the findings and discussion chapters as “The silent participants”, and one can argue that this further outlined their invisibility within the activity initiative. The sample that I did end up getting was a purposive random sample, meaning that the ones I recruited were a random selection of the ones I had initially purposefully picked out to recruit. Although I ended up with a smaller interview sample than expected, I did manage to avoid convenient sampling, which Kielmann et. al. (2011) describe as recruiting the most accessible samples, and which they suggest can lead “to poor quality data and lack of intellectual credibility” (p. 21).

That being said, while recruitment for interview sampling did not go as planned, data collected from observations and ongoing conversations with participants, together with the empirical data and relational insight that the interviews contributed with, did give me the information and data set needed to address the aim and research questions. The adequate sample size in qualitative data is a size needed to accurately answer the study question (Marshall, 1996, p. 523). This sounds easier to address than it actually is, but indications that a data set has reached the saturation point are if minimal relevant data emerge, and if the categories are well established and developed (Kielmann et. al., 2011, p. 22). I do argue that, by the end of December, when both the activity initiative and the fieldwork came to an end, little new relevant information about the organizing or implementation of the initiative had emerged for a while. The data I retrieved from both the activities and the planning meetings by the end of the period started to confirm the information already collected. Data started to contribute to more examples of the aspects and categories that had emerged throughout the initiative.

While the data set gave me enough information to address the aim of the study, I did identify aspects of the initiative that I did not explore further due to both the time frame and the size limit of the master thesis, as well as the challenges had when recruiting. Some of these aspects were the gender dynamic within the group from the Middle East and further exploration of the relational dynamics. In addition, I was not able to properly voice the silent participants, which would have given the findings and discussion chapter yet another dimension.

3.3 Validity – Establishing credibility

Validity, trustworthiness, authenticity, quality, correctness and credibility are all words used in qualitative research to address the question of why the reader should believe the findings and conclusions the researcher represents. To earn the trust of the reader, transparency and reflective thoughts are key. Ensuring credibility does not include arguing for complete objectivity or a conclusive assertion of ultimate truth, but rather the opposite (Maxwell, J., 2013).

Throughout Chapter 3, I have presented the methods and rationale for the methods chosen as transparently as possible. I have already addressed the use of triangulation and the collection of rich data by writing detailed notes. I have mentioned that my “long-term” involvement in the study made it possible for me to include respondent validation throughout both ongoing conversations and interviews. However, the definition of what “long-term involvement” entails does not have a clear answer, and in ethnographic investigations, long-term involvement often includes the researcher living in the field for longer periods, often an entire year or more (Green & Thorogood, 2014, p. 155).

While this study did not go in-depth in that sense, I was able to follow the activity initiative from its very start to end. In this chapter, I will further address the credibility of the study, by reflecting on and discussing other potential validity threats.

3.3.1 Researcher bias and reflexivity

> *After we had danced for a while I joined Elise outside, she wanted a smoke. She seemed frustrated and said that the activity was chaotic and that she was not sure if people were bored or if they enjoyed themselves. [...]. She said she felt the activity was meaningless and "not working". [...]. She questioned the need for this type of initiative and that the target group was not actually interested. I told her I disagreed, that the last months had contained so many happy moments, laughter, gratitude, engagement and curiosity.* Excerpt from observations, Activity 7 "Bollywood dance".

Reflecting upon my involvement and impact on the research, I identified a turning point in the study. The conversation had with Elise, a planning group participant, made me especially aware of my bias towards the activity initiative. I have a background in nursing and social work, and a strong belief in promoting health through psychosocial means. When talking to Elise, I realized that my wish for the activity initiative to be a success story was strong. Further into our conversation, I told her about how the Health Center had experience with similar initiatives, and that the participants had expressed the wish for more service offers just like this one. So, the "need" I said, was definitely there. Maxwell, J. (2013) describes researcher bias and the potential validity threats to be that the researcher collects data that fit existing theories, goals or preconceptions (p. 124). Realizing that this was exactly what I was doing made me reflect critically upon my data set and contributed to exploring the notes from new angels. In this situation, I realized that the detailed observational notes and the different data collection methods (triangulation) helped me when rethinking the data collected. While I had not realized it myself, the data collected did address the potential of both risk and benefit that the initiative had contributed to.

The researcher impacts not only what data is collected and what information is contrived from it, but impacts the actual setting and participants as well. The goal is not to eliminate this influence, as this is impossible, but rather to understand *what* impact the researcher has had on the phenomenon and further use it expediently. In participant observation studies, the impact that the researcher has on the participants is often not as high of a validity threat as one might think, seeing as being present over a longer period will often lead to the researcher becoming a natural part of the study site (Maxwell, J., 2013). While participants might not have changed their behavior in a noticeable way while I was present, my impact on the actual organizing and implementation of the activity initiative was apparent.

Throughout the project period, there were blurred lines between my roles within the activity initiative. While my aim was to be an observer at the planning meetings and an observing activity participant at activities, this was not always simple. While I was always observing and collecting data, I did this within the roles of a researcher, planning group participant and social worker.

> *During the meeting, I followed the coordinators lead. My role in the initiative has not yet been set, I do not know them and they do not know me (talking about the planning group participants). Several times, I wanted to come with suggestions, conclude so that we could move forward with the meeting. The service using planning group participants wanted the activity to include a barbeque and tried to make a shopping list, which to me seemed easy and quick to make. They spent a lot of time discussing what and how much to buy. I really wanted to write the list for them, but the health coordinator was also present and she did not say anything during the discussion. So, I did not either.* Excerpt from reflective observations, Planning meeting 1.

While trying to minimize the influence that the researcher has on the field of study is not necessarily a goal in itself, understanding *how* the researcher has had an impact is. Already from the first planning meeting, I found myself in the position of trying to figure out and adapt to my role in the activity initiative. As this has been my first time conducting research, I found myself trying to go back to the role of being a social worker, which is a role that I am comfortable in. Wanting to be a part of the group quickly, I spent a lot of time reflecting on how to “fit in” but at the same time not take a leadership role within the group. I quickly noticed that the group looked at the coordinator for confirmation and advice, and this was seemingly transferred over to me when the coordinator was not present at meetings, which was most of the time. Therefore, I explained my role as a researcher to the participants several times. I decided that I would help with practical things if asked, and that I would come with suggestions if the planning group asked me directly.

I made sure not to take a leading role within the activity initiative. If participants would mistake me for the leader, I would explicitly describe again my role as a researcher and participant, even though I had already done this. I asked participants in the planning group to contact each other instead of me when having questions about the organizing, I tried not to attend an activity in an attempt to show the planning group that I was not the leader and I made sure not to talk in plenum, with one exception, as none of the planning group participants did this and I suspected that, by doing so, I might have been put in the role as a leader.

As mentioned, the participatory research design allowed me to be a part of the processes in the activity initiative. Conducting research on an activity initiative with little resources in terms of both funding and people made being a part of the initiative “a way in”, creating trust and relations with the planning group. It would have been, if not ethically wrong, at least morally wrong not to include myself in the processes, helping out where it seemed fitting. While this gave me “a way in” as well as a feeling of being of use, it also became clear that my presence in the planning group impacted the feasibility of the activity initiative. I was the only participant in the planning group that attended all the planning meetings and almost all the activities. Two planning meetings and activities were cancelled during the summer, after I had said that I was not able to attend. During this period, there was only one planning group participant who regularly came to the planning meetings and drove the activity initiative forward, and he did not want to plan and implement the activity alone.

The activity initiative was grounded on the principle of being service user driven, and my presence impacted this as I am not a service user. Data collection and reflections around this issue throughout the project period has seemingly ended up in findings and discussions that address this issue, but ultimately it is difficult to know for sure whether the activity initiative would have implemented in a different way without my presence.

After having analyzed the data, I identified a tension between The Health Center and the service using participants. I unpack this tension in the findings and discussion chapters Four and Five. It is only in hindsight that I have realized that I was, although not always, contributing to the arguments that the Health Center made and not the ones of the service using participants during discussions had at the planning meetings.

3.3.2 Disseminations and transferability

To understand if the findings can be relevant or applicable in other settings says something about the study´s “transferability” or “external validity”. Even though no study, regardless of methods used, is universally transferable, discussing this matter is important for understanding the study`s relevance. The descriptions and transparent accounts provided throughout the thesis will help the readers to determine for themselves whether the findings are transferable to their field of interest (Malterud, 2001, p. 484-485). I argue that the findings and discussion can have potential relevance with respect to knowledge of implementing initiatives aiming to involve and empower service users and in discussions about the psychosocial shift in humanitarian fields of practice. I will further discuss the potential transferability in the concluding remarks.

This thesis will be shared with the Health Center for Undocumented Migrants and will hopefully be of potential use for them when trying to develop psychosocial initiatives in the future.

3.4 Analysis

Analysis is making sense of data through placing and interpreting data within a given context (Kielmann et. al., 2011, p. 64). It is rarely sufficient to present the data collected; to fully understand and analyze the data, it needs to be situated in a broader perspective in terms of history, social structures and potentially comparative studies (Green & Thorogood, 2014, p. 204).

The analysis of data was an ongoing process parallel to the developing of the activity initiative. Seeing as the design was inspired by action research, feedback and evaluation were given and discussed by both me and the participants in the planning group. Observations and reflections were brought up at planning meetings as well as in discussion with the Health Center and with the participants. Even though the feedback loop often did not result in adjustments of the initiative, it did give a basis for rich analysis.

The ongoing process of analyzing and the coding of data was conducted before reading up on and deciding upon a theoretical framework, as I tried to let the initial process of findings analysis be predominantly inductive. However, potential theories and thematic fields were developed and reflected upon during the writing of the project proposal, and potential emerging themes did lead me to associate my interpretations with pre-existing theories and literature that I already was familiar with, leading the analysis in a deductive direction. I did however wait with deep-diving into readings until after the first period of analysis and coding. The analysis therefore had both a deductive and partly inductive approach (Green & Thorogood, 2014). Being aware of predetermined knowledge made it easier to not immediately fit data into the pre-existing concepts, but to let themes emerge from the data and not the other way around.

The analysis process started by writing down themes emerging from the transcripts and notes; this I started with right after the last activity. After two weeks of distancing myself from the data, I started the coding. All fieldnotes and interviews were read through, and themes, happenings and key words were written down in a separate document. Emerging themes from reflections during the fieldwork and emerging themes from the coding were put together in a document and new themes were developed through grouping all the findings. During this process, I discussed potentially emerging themes with my supervisors and peers, and explored excerpts from the data set in a workshop with other peers. These discussions enriched the dataset by adding diverse perspectives, looking into different potential meanings and challenged me to think further.

After having identified the main themes and developed ideas for thematic chapters, I started reading up on frameworks and theories that would allow me to further explore the findings. Since this study is a study of an activity initiative, it was expedient for the analyses to engage with theories supporting the Health Center's rationale for developing an activity initiative in the first place. This included theory about psychosocial health, salutogenesis and empowerment. As the Health Center is founded on the basis of humanitarian principle, this also became a theoretical field that was interesting to engage when reflecting upon the findings. In addition, experiences that the Health Center has had with similar initiatives become important for the analysis.

3.5 Ethical considerations

Ethical considerations and reflections are an ongoing process that starts during the project planning and ends once the research is written up, as well as after the process of dissemination of accounts is finished (Kielmann et. al., 2011). To 'do no harm' is an overall ethical principal in research. However, the potential of doing harm is almost always present in research. The Council for International Organizations of Medical Sciences (CIOMS) addresses the question of harm by stating that one should evaluate risk and benefit with respect to social, physical, economic and psychosocial aspects (CIOMS, 2016, p. 9-13). Seeing as this research is conducted parallel to the activity initiative, risks and benefits for both the research and the initiative were closely related. The risks within the activity initiative are therefore thoroughly addressed within the findings and discussion Chapters Four, Five and Six. The potential risks identified during the planning of the study, such as participants expressing frustration over resource placement that they see as meaningless (Mburu et al., 2015), as well as the presence of the researcher being harmful for participants' potential psychosocial benefit, ended up to seemingly not be the case for the study after all. However, being a researcher within an activity initiative that consisted of potential risk for its participants did, at times, lead to ethically challenging situations.

3.5.1 Risk and benefit – Knowing when to interfere

According to CIOMS (Council for International Organizations of Medical Sciences) (2016) guideline 15 “Research involving vulnerable persons and groups”, irregular migrants are perceived to include in the category “vulnerable research participants”. This is reasoned with respect to their lack of entitlements to medical care, being marginalized, being displaced, potential difficulties covering basic needs and potentially dependent relationships. Participants perceived to be in vulnerable situations need to be accounted for and the researcher should be especially sensitive to ensure protection from potential harm, as this harm can be exacerbated due to vulnerability (CIOMS, 2016, p. 57).

This leads me to the discussion about the responsibility of the researcher. A researcher’s role is to unpack the phenomenon of the study, which, in this case, is the potential of the activity initiative. The researcher will often advocate for the participants, giving them a voice and sharing the knowledge produced (Green & Thorogood, 2014). Since participants in my study were in a vulnerable situation, and since the activities were conducted on behalf of the Health Center but without anyone employed at the Health Center present, I argue that my responsibility went beyond this. As mentioned in chapter 3.4.2 “Researcher bias and reflexivity” my role in the research went further than being a participant observer. The four principles of autonomy, beneficence, non-maleficence and justice are core ethical principles within health care ethics (Green, J. & Thorogood, N., 2014, p. 66). With a background in nursing, these principles are implemented in both my personal and professional life and have guided me when addressing the issue of knowing when to interfere.

While my aim was to be an observing participant and help the planning group with practical doings, I sometimes found myself in situations where the choice between social worker and researcher was challenged by ethical considerations. Examples of times that I acted more as a social worker was when the planning group wanted to barbeque in a park, but did not know about the ban on all open fire because of the dry period. During activities in which some participants did not have anyone to interact with, I would spent almost all my time with them, trying to make them feel seen and at ease. I did buy extra bus tickets a couple of times when participants made me aware that not everybody had tickets after we already had gotten on the bus. I also made sure to refer participants to the Health Center or the emergency room if they came to the activity talking about health related issues.

In addition I, by the end of the project period and after having understood that participants sometimes came to the meeting place but could not find the activity group, end up asking people at the National Theatre if they were there for the activity organized by the Health Center, as I saw it as a too big a potential risk and ethical danger for participants to show up for an activity but not find the activity group. I did however, as mentioned in 3.3 “Researcher bias and reflexivity”, not talk in plenum to the entire group, hold up a sign at the National Theatre, or wear a reflective vest to show participants where we were meeting. I did not interfere in these situations because of two reasons: First, it was an attempt to minimize my impact on the activity initiative and further the study findings. But, mostly, it was to avoid the already sensitive situation of ensuring that I was not associated with the Health Center as a social worker or a leader in the activity initiative, but was rather understood and related to as a participant observer and researcher.

3.5.2 Ethical approval, data storage and confidentiality

An internal ethical committee at the University of Oslo (UIO), Institute for Health and Society, assessed the research project and suggested that the study be preliminarily assessed by the Regional Committee for Medical and health Research Ethics (REK). A “fast track” application to REK, sent by my supervisor, concluded that the project fell outside the mandate of REK. Therefore, a notification form was sent to the Norwegian Center for Research Data (NSD), which approved the project. As the planned study did change in some ways during the project period, further communication with NSD was necessary.

Firstly, the activity initiative started earlier than initially intended, and the NSD application had not yet been approved. After having cleared it with NSD´s case manager for the research project, I was allowed to follow the project without collecting personal data while waiting for the clearance. In addition, NSD approved the change in recruitment method for interview participants. They approved using snowball sampling and asking the Health Center or planning group members to initiate first contact with participants to invite them for interviews. However, feasibility made it inappropriate to ask the planning group and the Health Center, and this recruitment method was therefore only used once.

To ensure anonymity and confidentiality, field notes and audio recordings were kept locked and destroyed after having transcribed them. Transcriptions from all data collected (observational notes, interviews and audio recordings) were stored on a password protected (:M) server provided by UIO, only accessible to me. The data set included non-nominal linked information, meaning that participants and data were linked through pseudonyms and not their real names to ensure anonymity (Richards & Schwartz, 2002). Using excerpts and examples from the field to underline arguments led to possible identification of participants by both themselves and others. This potentially puts participants at risk, and their privacy is therefore especially important. Thus, I have anonymized participants further by altering information in the thesis that could potentially identify them and endanger confidentiality. In certain excerpts, I have chosen to sometimes include the participants' pseudonyms and sometimes not; this is in order to minimize the possibility of linking all of the data associated with individual participants and, through this, potentially identifying them and determining who said what.

3.5.3 Consent and voluntary participation

Core ethical principles within health research are informed consent and voluntary participation. While these principles can be perceived as simple to ensure in theory, there are often aspects of complication when implementing them in practice (Richards & Schwartz, 2002). Further means to ensure confidentiality entailed participants giving oral and not written consent. While employees at the Health Center who contributed as informants signed a consent sheet, participants who were of undocumented status did not do this, as both NSD and I saw it as potentially risking discomfort among the participants. The translator also signed a data protection agreement form standardized by NSD, stating his responsibility of destroying all notes taken during interviews and ensuring his responsibility of confidentiality.

Ensuring informed consent and voluntary participation was an ongoing process throughout the project, both to ensure that participants were still agreeing to participate but also because new participants were introduced to the research in the project period. When inviting service users to the activities, the planning group agreed to tell everybody on the phone that a student who was writing a paper about the project was going to be there, that she will tell more about it at the activity and that they could choose to decline participation in the study. Because of language barriers, it was difficult to ensure that everybody understood, and therefore this information was also included in the text message sent out to everybody on the list. At the activity, my initial plan was to talk to everybody in plenum at the National Theatre, and then hand out the consent form. However, because of reasons stated above, this was not feasible. Therefore, I talked to each participant during the activity and told them why I was attending, they got the consent form in either Norwegian or English and I told participants why I was there and asked if they approved. I asked other activity participants or planning group participants to translate if there were communication issues.

Many of the participants were interested in the study and asked me how I was doing with the paper when meeting them again at activity. Others agreed to me being there but were not that interested in discussing the study.

While talking one-to-one with participants helped me to secure proper informed consent, it did lead to challenges as well. At some of the activities, I was not able to speak to everybody there, and I did not collect information about these participants. Some of the participants that I describe as “the silent participants” never came to the activity, and even though I did include them in the study, I never collected their personal information or other information that would require informed consent.

The principle of voluntary consent was an ethical aspect of the study that I have been aware of and tried to address constantly. The asymmetrical relationship between the participants and the Health Center did have the potential of participants not feeling that they could say no because of a sense of gratitude and debt to the Health Center. This issue was not only concerning with respect to experienced possibilities for participants to decline participation in the research, but also to decline the actual activities, which is addressed further in Chapter Five. I am aware of the power dimension between me and the participants, as my role as a researcher and partially a planning group member could have, if now managed adequately, endangered voluntariness in the project. I explained to the participants several times that they could say no to research participation and still be part of the activity initiative. I did experience participants in both the activities and the planning group telling me not to include something in the study. These remarks did, to some extent, confirm the accomplishment of informed consent and voluntary participation.

I did, however, encounter other ethical dilemmas concerning this when recruiting for interviews. Not getting answers from participants who had initially said yes to being interviewed raised the question of whether they did not answer because they had regretted saying yes or if it was a consequence of their often unstable living situation. I did experience participants who initially had stopped answered my texts getting back in contact with me weeks after my last text, but then after having replied not getting an answer again. Having experienced that participants had trouble saying no to participate in the activity initiative, I did conclude with not initiating more contact with the participants who stopped answering me, as I saw it as a potential risk of recruiting people who did not enter the interview completely voluntary.

3.6 Funding and outputs

The research was funded by a scholarship from Osloforskning. I received 15.000 NOK in April and will receive another 15.000NOK after having handed in the thesis. The scholarship made it feasible to hire a professional licensed interpreter from “Salita tolketjeneste”. Further, it was spent on relevant literature for the thesis and a recorder used when conducting interviews. In addition, it allowed me to buy extra bus tickets, bring food to the activity as a gesture that many of the other participants also practices, as well as ensure compensation in terms of covering bus-tickets and lunch expenses for interview participants. The scholarship was also used for a farewell lunch at a restaurant with the planning group, which was the last meeting we had after the activity initiative had finished.

4 CHAPTER FOUR – The planning group – Different people, same goal?

> *During the planning meeting Mehadi asked me what we needed to bake ginger bread, he said he had never done it before. I wrote him a list of groceries we needed: dough, candies for decorating, food coloring. I rushed to the activity the day after, I had been to a birthday party and was an hour late. I entered the room expecting to smell ginger bread and sugar, my expectations were not what met me. The group was sitting at a big table in the middle of the room. When I entered they all stood up, smiled, waved and hugged me. The atmosphere was light, they were playing cards and laughing. No food on the table, no ginger bread making. I asked why they were not making ginger bread. Mehadi said that they were waiting for me. I was a bit surprised, I had explained how to do it the day before and I knew that Moin had done it before. I asked if anybody wanted to join me, one of the guys said he could help me if I needed it. Again I was surprised, need help? I did not need help, I thought making ginger bread was the activity? I tried to explain, "No, I do not need help but it is a social and fun thing to do! Making different figures and frost them with candy and food-color!". As an answer, I received smiles before they kept on playing cards. Mehadi asked me to make the ginger bread in the kitchen. I again told him that it was supposed to be a social thing, something to do together. He said the others were busy playing cards. I still brought the ginger bread stuff out to the others but set it up on a different table. Moin`s son was exited and wanted to help me. Mehadi also said he would help me, I got the feeling he was being polite. It was clear that the concept of baking ginger bread together was not known or valued for the participants. This activity was suggested at a meeting a couple of weeks before, I suggested it with the enthusiasm from Elise and the coordinator, both non-service-using participants.* Excerpt from observations, Activity 12 "Ginger bread baking".

The idea of a planning group was, from the Health Center's perspective, grounded in the simple context of empowering the service users through an initiative that they themselves would be in charge of. The planning group was also a means to ensure that the activities were fitted to the service users of the Health Center. Assuming that baking ginger bread, a Norwegian tradition often meant for kids, would be a fun and meaningful activity for the service users turned out to be, in many ways, a classic "social worker trap". Where what was perceived for the non-service-using participants in the planning group as a social activity with room for connecting in an unformal way, was very much perceived as a chore for the participants at the activity, saying that they could help with the baking if needed. For the group at Activity 12, the social aspect evolved around what was happening at the table, playing cards, telling stories and laughing. They were connecting and enjoying themselves, on their own terms and not as a consequence of the facilitation of non-service-using participants.

Throughout the findings and discussion Chapters Four, Five and Six, I will use activity 12 to illustrate the different aspects of both the activity initiative`s potential and missing threads. While the planning group participants had some common ground when it came to their motivation and expectations for participating, there were also often differences that sometimes lead to misunderstandings and frustration. These differences shook of the group dynamic, making the planning group both potentially valuable and harmful. The potential harm and value will be addressed in the chapters to come.

4.1 Presentation of the planning group and its participants

The participants in the planning group were recruited through the coordinator and had the role of representing the users of the Health Center. The Health Center's goal was to recruit people from different countries and areas of the world, just as the composition of the cooperation council that the Health Center had previously founded during "Project mental health" (Mburu et al., 2015). The planning group was told that saying yes to participating was not binding and that they could contribute with what they had the energy and resources for.

Throughout the project period, there were nine people participating in the planning group. The planning group consisted mostly of service using volunteers/participants, but also three non-service-using volunteers/participants: one who joined the group from September to November, me (the researcher) and the coordinator at the Health Center. In total, 17 planning meetings were held. Four of them were general planning meetings organized by the coordinator at the Health Center with the aim of discussing the way forward. The rest of the meetings were held for organizing and inviting service users to the activities. The coordinator attended six meetings, including the general planning meetings. The attendance of the service using participants varied between one to four people. There were seven planning group participants excluding the coordinator and me during the initiative period. The seven participants were not a part of the planning group at all times. The group consisted of four service using participants in the beginning and then eventually one non-service-using participant and two service using participants were recruited. The planning meetings held to invite service users to the activities mostly consisted of two or even one service using planning group participant.

I will present the participants of the planning group together to ensure their anonymity. As mentioned, the planning group consisted of nine people, aged 30-45. The group represented women and men from Iraq, Norway, Ethiopia, Eritrea, Iran, Mongolia and Afghanistan. Some came to Norway on the grounds of family reunion, some had lived in other European countries before they came to Norway, some came through the Mediterranean passage and some with plane. Two of the service using participants lived with their family and had their basic economic needs covered. Two stayed with friends, and one had her own apartment. All the participants spoke either Norwegian, English or both. The period they had lived in Norway varied from two to nine years. Two were involved in other volunteer work, and all except one had unregulated work within the construction or cleaning business. Work was often one of the reasons for why the service using participants either came late or did not attend the meetings.

The participants brought all of themselves to the planning meetings, meaning that the planning group experienced each other's joys, disappointments, despair and frustration. There was a high turnover within the planning group, partly because of their irregular situation that sometimes led to constant adaptation in order to get by, such as leaving Oslo for a while because of housing or work. One can say that participants in the planning group represented the diversity present among irregular migrants. Their different personalities, feelings of belonging and having a say within the group, gender and stakes in the initiative, together with all of them never being present at one joint meeting, affected the outcome of both the potential within the planning group and the activities.

I have named the participants Mehadi, Moin, Zane, Selma, Tuya, Elise, Navid and Nora.

4.2 The planning group: Perceptions, stakes and motivations

The perception of what the planning meetings included, how long they should last and what was expected from the different participants seemed to vary within the planning group. There was a big variation in, and sometimes what seemed to be random, attendance during planning meetings. Some would always show up late, some always on time. Some participants would send a text to tell the group that they were not able to come, while others never did. Throughout the period a pattern in the participants' different perceptions of the planning group function appeared. The pattern partly explains the dynamic of the planning group and unpacked challenges that were underlying throughout the project. While, in retrospect, one might say that these challenges should have been addressed by the Health Center in the beginning of the activity initiative to get all the participants on "the same page", the challenges were grounded in factors difficult to foresee and maybe even more difficult to change, as they were substantiated in not only misunderstandings and perceptions, but also life circumstances, stakes and core moral principles. Some of the different perceptions potentially and in part were likely also complicated by the limited resources that the Health Center had access to.

4.2.1 Planning group function - Participants perception

The planning group participants perception of the groups function was, as mentioned, divided. The non-service-using participants mostly saw the planning group as a practical meeting space to organize the activities, with an emphasis on efficiency. This was not, however, how the planning group was viewed by the service using participants. Some of the service using participants did indeed have the focus of organizing and planning the activities during the meetings, and they were just as absorbed in targeting the activity to its users and developing the initiative in a beneficial way as possible as the non-service-using participants. They did however, not emphasis efficiency in the sense that the meetings needed to be of a certain structure with a set timeframe, and they often had the entire day cleared to attend the meeting. These participants, with some exceptions, consisted of two service using participants who were the ones who regularly showed up to both the planning meetings and the activities, and who drove the activity forward.

Most of the service using participants had a rather casual approach to their role in the planning group and its function. While they did observe and at times contribute inputs and ideas during the planning meetings that they attended, they did not seem to perceive their role as entailing responsibility for organizing or implementing the activity. Most of the service using participants would come and go to the meetings and to the activities as they pleased; their presence at the planning meetings was similar to their presence at the actual activities, implying that they may not have distinguished between their motivation and tasks when attending the planning meetings and attending the activities.

The different expectations did sometimes cause frustration and mistrust among participants. One of the service using participants who would almost always attend meetings expressed this after a meeting during which he and non-service-using participants, including me, the Health Center coordinator and a non-service-using volunteer were the only ones at the meeting. The two non-service-using participants had thought that the meeting was over after having discussed ideas for the schedule for the autumn. The service-using participant had thought the meeting agenda was to invite people for activity, and that coming up with ideas for the schedule was just the beginning of the planning meeting.

> *At 15.00 Nora, the coordinator, said that she had to leave, her working hours were up. Both me and Elise nodded, showing that we understood that she had to leave. Mehadi looked at her and said that he had skipped work today to be able to come to the meeting, so maybe she could stay even though she had finished work. He wanted us to call and invite people. Elise looked at her watch and said she had to leave as well, she had not planned the meeting to last for this long and had other plans. Mehadi again said he had skipped work to come to the meeting, he had cleared his schedule and expressed how he wanted the others to do the same. Even though they both said they did not have time to help, Mehadi kept saying that he would be grateful if they stayed to help him. Elise said she would be happy to help next time. The meeting ended, no activity was planned for that Sunday.* Excerpt from observations, Planning meeting 7.

The example shows the different mindset of the participants. While the service using participant was prepared to spend the entire day at the meeting, the two non-service-using participants had other plans. They were bound by working hours, with the goal of having short efficient meetings and spending their time in an adequate way. One of the reflections made in the report from a group therapy initiative at a reception center, organized by the Red Cross, was that it seemed to be of importance for the success of the initiative that the therapists in the group were volunteers. This had created trust between the two parties and motivated the participants to attend (Buvik & Hansen, 2017). One can speculate that the different roles of the planning group participants became a challenge, and a possible barrier towards the planning group’s potential. Even if the different roles of the participants, including some having more time and resources to put into the initiative had been discussed in the group, the different stakes between the non-service-using participants and the service using participants would most likely not have been erased. The non-service-using participants would still have been framed by having a set time to spend at the meetings. While the coordinator was bound by the working hours of the Health Center, the other non-service-using participant also sat time limits on her participation at meetings because she had other plans during the day.

The boundaries that were set by the non-service-using participants seemed to be, for some of the service using participants, a reminder of how people were present at the planning meeting for different reasons, with the non-service-using participants not being there for, as a service using participant said; “[…]right reasons, they are more about math, pros and cons”. All the participants had a perception of the planning group function and their own practical function in the planning group. The differences can partly be explained by cultural differences, different stakes and different information given to the group in advance. But, they might also be partly explained as a consequence of tension created when participants’ possessed distinct roles, such as being an employee or being a user of the Health Center, and such as between having a busy schedule and fitting the activity initiative into this schedule or joining the activity initiative to try to fill the days so as to not have an empty schedule.

The blurred line between organizing and socializing often led to long meetings, in which the non-service-using participants often were the first to leave. The long meetings meant that more people ended up attending the meetings, as participants would sometimes show hours late, after the non-service-using participants had already left. This again led to some meetings having room for connection and interaction, which gave participants not only a place to be but a seemingly meaningful space and company to occupy themselves with. As the months went by, the participants who regularly came to meetings developed a social bond.

> *It was only Moin and Mehadi present at the planning meeting today. When I came to the Health Center they were both there. They were laughing when I came, I get the feeling they have gotten closer the last couple of months. Mehadi asked if I wanted coffee, I said yes but that I could make it while they started the planning. The kitchen and the table where we usually sit are next to each other so I observed while they were planning. Moin said he was hungry, he usually eats a big breakfast but had not had time this morning. Mehadi found bread and spread in the refrigerator and brought it to the table. We all sat down to eat and spent half an hour just talking. Both the men have kids and they talked about how they were doing in school. They are both proud fathers.* Excerpt from observations, Planning meeting 13.

The excerpt is not unique for the planning meetings. I would often be puzzled over how comfortable the planning group was while at the Health Center. I would sometimes get the feeling of coming into the participants' office or home. The feeling of being comfortable was not only observed among the two participants from the example above who were the ones who regularly showed to meetings. One service using participant came to a meeting and looked for a phone charger the minute she entered the Health Center. She grabbed a coffee without hesitation and looked through her phone while only sporadically participating in the conversation. Another woman who joined the planning group a couple of months after the initiative had started arrived two hours late. Without even acknowledging that she was late, she put food that she had brought from home on the table and immediately engaged in the conversation. Even though this practice can be interpreted as a cultural matter, as bringing food and not letting the clock decide your day is a common practice in many areas of the world, Nissen & Skræbæk (2014) describes this practice as self-care behavior that potentially increases the psychosocial health of humans.

The service using participants were seemingly engaging in a psychosocial process of putting in the time and effort to potentially gain the benefits that Martikainen et al. (2002) explains as emotional support and conversational stimuli, a psychosocial health benefit of networking. The sense of security that the service using participants experienced during the planning meeting has already been observed during initiatives implemented in “Project mental health” (Mburu et al., 2015) and was one of the reasons for creating the activity initiative in the first place.

One might also imagine that some of the participants were not motivated to join the planning group for any of the reasons stated above, as the initiative was conceived and rationalized by non-service-users (the Health Center and our research team), and then handed over to the service users who were then expected to relate to it as their own. Knowing that many feel gratitude and debt to the Health Center, one can question participants’ motivation for getting involved further. Perhaps some joined only because the Health Center asked and therefore felt responsible to say yes, and maybe some joined rather ambivalently, not really caring one way or another. These motivations should also be taken into consideration when considering some of the participants’ perceptions of the planning group function. Although it was clear that some service using participants genuinely identified with the initiative and wished to invest in it as their own, it was equally unclear whether some participants joined because of a sense of responsibility and/or with ambivalence.

4.2.2 Sustainability – Basic needs

As earlier mentioned, saying yes to participate in the planning group was a non-binding commitment. Even though seven people had been recruited and confirmed their participation in the group, there was a high turnover among the planning group participants. The high turnover and the low attendance of the participants who had agreed to be a part of the planning group all made the organizing and implementing of the activity initiative vulnerable and potentially not sustainable as an ongoing, self-running activity initiative, which was what the Health Center originally had set as a goal.

Two of the service using participants who were the ones who would attend regularly expressed how they were motivated to attend for the sake of being able to help others. Irregular migrants are often in the position of receiving, from friends, charitable offerings or nonprofit services (Øien & Sønsterudbråten, 2011). Being a part of the planning group offered a potential for reciprocal relations, having somewhere to be, being able to contribute and being valued, which are all of importance for well-being in general, and which are often lacking among irregular migrants specifically (Mburu et al., 2015).

> *I think I came with a very big heart here to help. To be a big person.[…]. So when I came here I wanted to be someone who could help others.* Excerpt from Interview with Moin, service using participant.

The service using participant is answering the question of why he wanted to join the planning group. In his home country, he had worked within the health sector, and being part of the planning group advocated and confirmed his identity and perception of who he wants to be. Helping those who have less than oneself was also emphasized.

> *I want to help. A lot of people are much worse than me, so even though I can not participate in activity then maybe I can help them. I have good clothes and lot of shoes, maybe other people need this. At least I can bring some that has it worse than me to change their mind.* Excerpt from interview with Moin, service using participant.

The two service using participants had their material needs covered. They were the only service using participants in the planning group who were in a situation of irregularity, but at the same time had access to financial means. They had permanent housing because they were living with a partner who had a residence permit, they also had enough food and clothes. Mehadi said this when asked about what made him feel good during a week:

> *Today, nothing makes me happy. Yes, what makes me happy is when I can be an asset for others.* Excerpt interview with Mehadi, service using participant.

The non-service- using participant and the two service using participants who regularly attended were not spending their energy on covering material needs, and it could seem that this gave them the freedom to seek a sense of purpose and existential value for their lives. These three participants were the ones in the planning group who attended the planning meetings, activities and the interview they were all invited for. Given the sporadic attendance among the other service using participants, we cannot know all of the reasons for why they rarely attended. It could of course be that some did not believe in the project in the first place and/or had merely said yes because the Health Center asked. Identifying the clear factors separating the life circumstances of the attending service using participants from the others, one can also speculate that one reason for not attending was potentially the prioritization of material needs. One service using participant stopped attending planning meetings and answering phone calls during the summer period; the assumption was that he no longer wanted to be a part of the initiative. However, he did pick up the phone when a participant in the planning group called him in September. He said he had been away for the summer; he had gone to a different place in Norway to stay with friends, so that he had a place to stay. Now that he was back, he wanted to be a part of the planning group again. The same participant also said yes to an interview but asked to do it after his three weeks of work was up. But, then when they were, he again stopped answering text messages. The psychoeducational coping groups at the Health Center had the same experiences (The Church City Mission & Red Cross Oslo., 2014b), that practical needs trump social or therapeutic needs. When work opportunities conflict with Health Center-associated engagements or when one is simply too busy dealing with the chaos of everyday life, practical needs overrule. Those who fear deportation may prioritize material safety over existentially valuable engagements, thus staying put rather than going out.

Another service using participant who joined the group in late September was engaged and enthusiastic towards attending both the planning meetings and the activities. In November, she stopped answering messages and showing up to meetings. It was not until Christmas when she sent a message on Facebook saying merry Christmas that we came to know that she was back in her home country, for reasons unknown, as her Facebook account was deleted days after the message was sent.

The vulnerability of the planning group´s sustainability was present already from Planning meeting 2, when the coordinator, one service using participant and I were the only ones who attended. The coordinator sat with us for half an hour before she had to leave. Already after this meeting, trying to recruit more people to the planning group became necessary, but turned out to be difficult. In the study “User involvement and empowerment among asylum seekers in Norwegian reception centers” (Valenta & Berg, 2010), challenges in the use of a cooperation council were acknowledged. Relational aspects were identified as a reason for the cooperation council to be fragile. The big variety of people in the asylum reception center; ethnic groups, families, single people, age, gender and prospects of whether one would gain asylum or not, created different perceptions, needs and interests. This made it difficult for the councils to represent everybody, which again led to conflict among the residents when deciding which interests to address. The planning group for the activity initiative consisted of participants with different backgrounds, and there were few of them who took on the job and responsibility of organizing the activity. This made it fragile both because of lack of people but also because of conflicts of interest between the service using participants and the non-service-using participants, as well as among the service using participants. The Health Center and the service using participants disagreed about who to focus on when recruiting. The service using participant who regularly attended and who was the one who recruited almost all the participants from the Middle East was the only one who really voiced his opinion. He was potentially the only one with enough ownership to the initiative to do so, but this left the sporadically attending service using participants to not be heard.

Within the frame of living as an irregular migrant, one is partially invisible in society, and networks of social recognition and acknowledgement are often restricted. Being a volunteer creates a space in which one can potentially be visible and feel useful (Näsholm, 2014a). The participants reasoning for attending the meetings because they felt a “sense of meaning” and “self- worth” was potentially both a result of helping others and the social recognition received at the planning meetings. While one can imagine that this was some of the reasoning behind the planning group participants confirmation of wanting to be a part of the group, only the ones who had their material needs covered were able to see the wish to participate through. The strong voice of both the Health Center and the regularly attending service using participant might have overshadowed the voice of the other planning group participants. There is, therefore, a potential that the ones who only attended sporadically did not experience a feeling of ownership or usefulness, which may have, if they had, potentially motivated them to attend more often.

4.3 The ideal participant – Who is the target group?

During the planning meetings, the question of how to adjust and develop the service offer so that it corresponded to the needs and attracted the attendance of the “target group” was often discussed. And, talking about how to recruit more people to the activity reveled yet another difference in the way the service using participants and the non-service-using participant understood the aims of the activity initiative.

During Planning meeting 14, six participants were present: three service using participants and three non-service-using participants (the coordinator, the non-service-using volunteer and me). It was the beginning of October and fewer people had started showing up to activity. During the last activity, only three activity participants had attended. The coordinator talked about potential ways of reaching out to the Somali community, suggesting that more people would come if we recruited a person from Somalia to the planning group. At the same time, a non-service-using participant brought up her reflections about how she did not feel that the people showing up to activity really needed it. A service using participant contributed to the discussion by arguing for having the activities on Sundays, seeing as how, in the beginning of the summer, all the activities were held on Sundays and this is when the most activity participants attended. Between 10-20 people had come during these first months, but then, when the schedule for the autumn activities was set, there had been arranged activities on Fridays and Sundays as well. While the matter of having activities on different days had been discussed when setting up the schedule, the decision was made to try out different days, as Sundays excluded everyone who went to church. The service using participant said that the “target group” only had time for activities on Sundays, and that this was why so few people were coming for the activity.

The discussion during Planning meeting 14 suggests that the participants in the planning group were advocating for different people to come to the activities. While everybody was talking about the “target group”, it seemed like they perceived the “target group” for the activity initiative to imply different people.

4.3.1 Everybody is welcome – Recruitment and feasibility

The Health Center saw the activity initiative as a platform through which all of the users of the Health Center could, if they wanted, be included in a fellowship and experience peer support. Even though their previous experience had emphasized how significant gender and language often were for creating a trusting environment (The Church City Mission & Red Cross Oslo, 2013b; 2014c), they wanted this initiative to include all the users of the Health Center. To achieve recruitment of users with diverse ethnic backgrounds, the Health Center purposively recruited people with different ethnic backgrounds to join the planning group. As one of the largest patient groups (users from the Middle East) were already represented, the Health Center wanted to recruit people from the other main patient groups, such as Somalia and Ethiopia. The idea behind this was that it would make it easier to recruit a variety of people, given that planning group participants could then call and invite the people with whom they shared a language and culture of when recruiting for the activities. Many of the planning group participants did indeed feel like their biggest contribution in the group was to call and invite the people who they spoke the same language as. And their perception of how they were contributing was therefore very much in compliance with the Health Center's strategy of recruiting people with different backgrounds to the planning group.

This strategy was working to some extent. When a service using participant from Mongolia called the participants from Mongolia who had signed up on the sheet indeed, there were activity participants from Mongolia showing up to activity. But, when the service using planning group participants did not call the ones they spoke the language of, often these participants did not attend, even though they had been invited by another person in the planning group.

The participants would always divide the phone numbers of the ones they were inviting between themselves based on language. The people they were calling who no one knew the language of were often called last, and sometimes the planning group would text them instead. The non-service-using volunteer said this when I asked her why she did not want to call the activity participants:

> *Well, I can only talk about my experiences but when I make the calls, either they do not pick up the phone or it was very difficult to communicate if they actually picked up. It is different for Mehadi, he can communicate on his own language. If I had spoken with a Norwegian woman I am sure I could have communicated in a different way.* Excerpt from interview with Elise, non-service-using planning group participant.

Language and cultural differences made it difficult for the planning group participants to communicate with other activity participants than the ones they spoke the language of. Elise points out the importance of not only being able to communicate through language but also through cultural norms. The people she called would often understand Norwegian but she still felt like she did not "reach" them through the phone. The wish to include everybody seemed to be an ideal that turned out to be difficult to see through. The challenges of inviting the Health Center users to activity did reflect on the lack of connection and communication difficulties occurring throughout the initiative. When a simple call was socially challenging, one can imagine that there really was no reason to believe that these participants would be "reached" if showing up to activity.

The people who did come to activity were a group of people from the Middle East who all spoke the same language and were invited by the service using participant who regularly attended meetings and activities throughout the project. The people he recruited, the people who showed for activity, were the people he saw as the “target group”. Several times, he talked about knowing how the “target group” felt and how he wanted to help with what he could.

> *What I´m thinking is that my experience might be useful, to develop the project better. I will not say 100% but it can be important. To be able to read or understand their background and culture [..] we have the same background or culture so as long as I understand those people.* Excerpt from interview with Mehadi, planning group participant.

The service using participant is confirming how his contribution to the activity initiative and his competence towards developing the initiative is based on his knowledge and understanding of the people he feels like he understands. He took his role in the planning group seriously, felt great ownership to it and devoted time and thought to implement the initiative. A potential danger of creating a cooperation council (planning group) is indeed that the people representing the users are not able to represent the full variety existing among the users of a service, and that the most well-spoken and resourceful people often are the ones who end up representing the users, potentially leaving the needs of the most marginalized unrepresented (Owren, 2008). The planning group were already underrepresented in regards to the variety of the Health Centers users, seeing as only two of the service using participants regularly attended, leading the initiative to predominantly only have resources and competence to include the participants from the Middle East.

4.3.2 To need it, deserve it and want it – An unspoken moral discourse

The question of whether Mehadi’s “target group” needed the activity was raised by both the non-service-using volunteer and the coordinator. They believed that the people who came to activity were already meeting up at other arenas. They would hang out anyways, and therefore they worried that the Health Center was, through the activity initiative “funding a group of friends meeting up”. And the question of whether they “needed” an activity group was raised. If they were that busy that they were only able to come on Sundays, and they met other places outside of the activity, was this group really within what the Health Center saw as a "target group"?

> *I thought that maybe we could try other days than Sundays a couple of times, just to give the others a chance. But it looks like they do not have the same need, I cannot say 100% but I believe they do not show up because they have a more well-functioning social life. While the target group do not have that, in the exact moment on that day they felt lonely. That is why they joined us.* Excerpt from interview with Mehadi, service using participant.

Here Mehadi is talking about "they" as the people who are invited but never show up. His reflection is that not showing up means that they do not need an activity offer. While the group that he relates to, the participants from the Middle East, are the ones who do need the activity initiative.

The competences of the non-service-using participants and the service using participant were related to different fields. While the non-service-using participants has experience with interacting and providing services for the users of the Health Center, the service using participant has the experience of being just that, a user of the Health Center. Inadvertently, an underlying discussion of who deserves it was had.

Are the ones who have already attended the most deserving, or are they not deserving given that they possibly would meet up in other arenas? Or, are the ones who have not yet attended the most deserving, seeing as how the Health Center's ambition was to reach the irregular migrants that, based on theory and the "Project mental health", are isolated, with little network and in "real" need of emotional relations and healthy social interactions (Myhrvold & Småstuens, 2016; Myhrvold, 2010; Straßmayr et.al., 2012; Øien & Sønsterudbråten, 2011)?

There seemed to be just as much reason for believing that both the participants who did attend the activity and the users of the Health Center who did not were equally deserving and maybe also in "need". Still, the perception of this was most likely inadvertently different among the planning group participants, as they each advocated for their personal visions of the "target group"; the non-service-using participants advocated for the vision of the isolated, lonely irregular migrant, while the service-using participant advocated for the participants similar to himself. Assessments of deservingness are often based on stereotypical perceptions of what suffering and need consist of and the ways in which these are acted out, as has been described in the literature (Huschke, 2014). The group from the Middle East seemingly had friends, met at other places and hence did not "need" or, as potentially understood by some, "deserve" an organized activity, as the perception was that this group would meet up anyways. These assumptions however, were based on the resources and entitlements that the group seemingly possessed. It was for the very reason of trying to create a fellowship, a “friend group”, that the Health Center undertook the initiative in the first place. And, while the group from the Middle East did fit into the aim and wishes that the Health Center had for the participants at the activity, they did not fit into the preconceived notions of “need” or suffering, and therefore seemed to lack the deservingness required for the Health Center to truly vouch for them.

The question of who wants an activity initiative also needs to be raised, as this discussion was lacking within the planning group. The assumption was, based on experiences from the Health Center’s side and the service using planning group participant’s side, that an activity initiative was something that was wanted, and that it was only a matter of motivating the service users to attend. If they could be motivated to attend, the idea seemed to be that they would eventually realize that this was something that they needed, wanted and could benefit from. While the discussion about who needs it and who deserves it was a moral discourse that the Health Center initially tried to avoid by aiming to include all its users, it ended up being, although covertly rather than explicitly, very much present throughout the initiative and at the planning group discussion meetings.

4.4 The missing links

Basing the activity initiative on a planning group with the wish for it to eventually become self-driven were, in theory, a means to give irregular migrants increased control over the social aspect of their life, given a situation in which control often is something that many of the users rarely have or feel. It was a way for the Health Center to acknowledge its users, contributing to increasing autonomy and validating their feelings, needs and concerns. There was very much a potential for good within the planning group, evolving around empowerment and achieving increased psychosocial health through socializing, experiencing self-purpose, having a place to be and feeling fellowship. That being said, throughout the process, there was also an atmosphere and a feeling within the planning group that something was missing to fully achieve the Health Center’s aim for the activity initiative. There seemed to be a missing link, a factor that would make sure that all the components were working together and connecting the different truths, perceptions and realities that the planning group participants identified with and represented.

> *The person that do the organizing maybe. Bring someone from Ethiopia or Eritrea. They could give a good reason and talk the same language. And maybe bring someone that everybody trust.[...]. Someone that people are more certain and comfortable with, someone that they meet at the Health Center all the time. I do not know but the coordinator is maybe too busy, when we have meetings she does not attend.* Excerpt from interview with Moin, service using participant.

The service using participant is identifying challenges that the planning group has had: lack of people, lack of variety of people, and something that creates safety, trust and clarity so that the planning group could work towards one joint goal. The importance of a common understanding of the problem, the situation, the system and the solution (Buvik & Hansen, 2017) was seemingly not present, as the planning group participants were discussing on different terms, with different stakes, about different areas of importance and from different competencies.

4.4.1 Potential barriers to the psychosocial process

First, one can wonder whether the service users themselves should have been more involved in the conceiving of the initiative. Even though the Health Center did intend to let the service users articulate priorities, in reality, the initiative became a responsibility that the center handed over to the service users, with only a couple of service users partaking in the process. Practical clearance in the form of structure within the planning group roles, structure within the meetings in the form of a set time and plan for the meeting, clear information, enough participants in the planning group and a leader to ensure the practical frame, were all potential factors that could have been beneficial for the planning group to work together. In the very least, it might have contributed to a more unified sense of ownership and initiative ambitions as, for example, when discussing the target group. It might have provided a more stable foundation, which potentially could have prevented both the barriers experienced and enhanced the empowering potential.

As discussed, several participants did express a wish for this structure, but their wish was never seen through. The lack of a leader, and the need for one, was present throughout the initiative. Having a leader was discussed several times at planning meetings, but no one took this role, as no one felt like it was their place. The Health Center did not want to assume the leader role, as the initiative had the aim of being self-driven. The non-service-using volunteer did not take the leader role, as she did not see it as her place, because she became a part of the planning group later in the initiative and because she did not, as mentioned, believe that the initiative was targeting the right participants. The service using participants who only sporadically showed up did not take the role, probably for that same reason, not seeing it as appropriate, reasonable or a real option to be the leader. The final person in the planning group that potentially could have taken on the role as the leader, and that was in many ways already doing so, was the service using participant Mehadi. He invited the planning group to meetings, he did most of the grocery shopping before activities and he drove the activity forward. Without him, it is likely that the initiative would not have been implemented. But, as we discussed the need for a leader in the group, he did not want to be addressed as one, neither at the planning meetings nor at the activities. Not wanting to be a part of a cooperation council with the fear of others seeing them as opportunistic and not as 'one of them' was reported in the study about empowerment at the reception center (Valenta & Berg, 2010). The same thinking seemed to be a reason for the reluctance among service using planning group participants in the activity initiative to take any steering role. During Planning meeting 9, Mehadi was clear: "there are no good leaders in this world". He was not a leader. Like him, most of the service using participants were former asylum seekers, having potentially experienced conflict, trauma and war caused by leading figures in their home country (UNHCR, 2018). Further added to this experience is the rejection and locked doors from the government and institutions in Norway (Lysaker, Fangen & Sarin, 2011). One can only assume, as Mehadi also expressed after I had said that he was the closest to a leader that the planning group had, that authorities and leaders are not always associated with trust and that participants therefore did not relate to or want to be in the role of taking control in that sense.

The service using participants were constantly looking at the coordinator, me or the non-service-using participant to lead, and the reason is potentially grounded in the same rationale; the service using planning group participants wanted to be a part of the activity group. Being included in the fellowship and viewed as equal in the eyes of the activity participants is difficult if put in a leading position.

One can question whether gaining more structure within the planning group would have made it more sustainable. Maybe if it had led to consistency and trust, which is what both the "Project mental health" report (The Church City Mission & Red Cross Oslo, 2014b) and the planning group participants themselves identified as important for well-being and further attendance. Or was it the lack of clear frames that created the potential for social

connection between participants? After all, the relations developed after having to sit together for hours at meetings, trying to figure out how to plan the activity together.
Does one exclude the other? The Health Center envisioned empowerment as the initiative being service user driven and led. To some extent, it could seem that this conflicted with the desire of the service users themselves, who often did not identify with or want that responsibility in the first place, meaning that there seemed to be few threads advocating for the service users to be the ones who drove the structure.

4.4.2 The empowering potential – Who is empowered?

Limited resource access at the Health Center did limit the possibility of contribution from the Health Center staff. This was both a reason for why the Health Center was engaging in the development of service-user driven psychosocially oriented treatment alternatives in the first place, but also one of the reasons that the Health Center has been reluctant to start such an activity, as the importance of quality primary health care is the center's priority. Slettebø (2000) emphasizes the social workers' responsibility to mobilize resources when the users need them when addressing the empowerment concept. This became a paradox throughout the project. While a planning group was created to give voice to the users of the Health Center and through this empower its participants, it was also created because the Health Center itself did not have the means to drive the initiative forward. This resulted in the Health Center being unable to contribute with and fund what the service using participants asked for, while nevertheless voicing its own rationale, opinions and visions for the initiative, ultimately wanting to steer the activity in the direction of this vision but, at the same time, not having the means to do so and therefore partly and covertly putting this responsibility on the service using participants.

A health professional and a patient will have different approaches to addressing mental health. According to Mishler (1984), power transmission, and thus potential empowerment, can be present if the issue is addressed in accordance with what the patient finds important. This can be transferred to how the social worker and the service users look at the psychosocial process and what components need to be present. Using Mishler´s (1984) argument, one can question the actual empowerment of the service using participants in the planning group. Since there were only really one to two service using participants who did attend regularly and through this drove the initiative forward.Tthe Health Center seemingly took the role of advocating for the other service users who were not present, as the aim for the initiative was to include everybody from the Health Center. The findings indicate that the individuals of the planning group had the majority of the influence regarding who actually came to the activity, which was one of the reasons that the majority of the activity participants came from the Middle East. So, while the service using participants who were organizing and implementing the initiative advocated for the activity participants, the Health Center advocated for the service users of the center that were not yet participants in the initiative.

As a means to voice the non-participating service users, the recruitment of service users to the planning group evolved around including people with different backgrounds. When Mehadi offered suggestions of activity participants who had expressed interest in joining the planning group, they were not invited to do so. This was to avoid over representation of the group from the Middle East. The point was probably to give space for others, but these ‘others’ were not attending. What was an attempt to empower and increase the chance of inclusion among a broader variety of participants, thus became a disempowering action towards the service using participants who were already attending. Jordan (2004) forewarns empowering initiatives against inviting people to have a say in a service offer without following through on their wishes, as he argues that this will lead to disempowerment. In addition, The Norwegian Directorate of Health (2006) identified a lack of support from health personnel as a potential risk of participants feeling unsuccessful and powerless, which also became a potentially disempowering aspect of the planning group.

During the ending months of the activity initiative, the service using planning group participant from the Middle East changed his way of discussing. His arguments became more defensive and he seemed uncomfortable when discussing how the activity could be better. He would often say that everything was under control, and that everything was going well. He did not share the goal of having to include everybody in the activity, and he therefore perceived the initiative as a success. So, when the planning group was discussing ways to increase the quality of the activity, he was really the only one actually implementing the activity, which seemingly led him to feel targeted, unsuccessful and powerless in the planning group.

That being said, one can argue that the same service using participants did become empowered by the initiative through the actual implementation of the activities. Going back to the example of Activity 12 “Ginger bread making”, the perceptions of what the psychosocial process included; baking ginger bread together vs. playing cards, ended with the service using planning group participants not baking the ginger bread. This indicated that, at the activities, they were in the lead, felt secure and had the power and confidence to take ownership of the initiative. The difference here was that all of the activity participants decided what to do, not only the service-using planning group participants. This indicated that the power dimension present within the planning group potentially dissipated or was at least lessoned within the activities themselves.

The fact that some of the planning group participants did feel a strong ownership to the initiative, that the planning group did change plans during Activity 12, that planning group participants did express that they felt good about themselves, that they felt useful, and that they acknowledged the wish to have somewhere to be during the day all indicates that the planning group did involve psychosocial gain and empowering factors. However, that the Health Center advocated for goals that the planning group participants did not have the ability to reach, as well as the limited resources that lead to a lack of follow-ups from the Health Center, and the vulnerability of having only a few planning group participants, were all potential barriers to the positive psychosocial potential within the group. And the presence of potential harm and disempowerment were very much a reality throughout the project period.

5 CHAPTER FIVE – The potential of the social space - Increased psychosocial health and possible hidden endangerments

> *The first thing that met me when I arrived for activity 12 "Ginger bread making" was a woman sitting with her baby on a small couch. There was a big projector in front of her, dividing her and the rest of the activity participants. While the other activity participants were playing cards and laughing she was sitting with her son, playing a children's song from her phone. I sat down with her, she was from north-east Africa. Her name was Helen, she did not speak much Norwegian or English. We communicated through short sentences, smiles and body language. It was her first time at activity, she was 28 years old and her son was only 5 months. After a couple of minutes talking to her I went into the kitchen where I met one of the service using planning group participants. I asked if the women had been sitting there alone for a long time, he said that she did sit with the others at first but that she had moved to the small couch an hour ago. He said he had told her to go sit with the group but that she did not want to. [...]. I asked Helen if she wanted to join me making ginger bread. First, she said no but when I asked her for a second time she sat down at the table with me. One of the planning group participants said he could hold Helens baby for a while, he then asked her if she had any friends she could call that could come. She shook her head. A child and his son sat down together and started making different figures with the dough. Me and Helen did the same, we tried to make figures by cutting out the flat dough with knifes, I made a star and Helen made a heart. We laughed and smiled when we showed each other the results. Helen seemed more comfortable and relaxed after a while. She started to tell me about her journey to Norway, how she had travelled from Sudan to Uganda to Sweden to Norway.[...]. Helen went back to the couch after an hour.[...]. She started rubbing her chest saying that it was sore and painful, she said her baby would not hold the food in his stomach and that he was throwing up. She wondered whether she should go to the emergency room and asked when the Health Center opened.* Excerpt from observations, Activity 12 "Ginger bread making".

The excerpt introduces yet another aspect of Activity 12, "Ginger bread making". While the group from the Middle East were socializing and playing cards, Helen who did not know anybody from before, was sitting alone behind the projector, out of sight from the rest of the group. The two excerpts of observations presented, first in the introduction of Chapter Four and now in Chapter Five, demonstrate not only the social aspect and potential therapeutic benefits from a successful activity initiative, but also the possible risk of such an activity initiative. Activity 12 gives many good illustrations of the initiative's potential. It brings up questions of the potential with including all the service users at the Health Center, if a social worker is needed or not, ethical dilemmas and finally, the consequences and happenings occurring when organizing an activity initiative through the Health Center without the Health Center having full insight into the happenings.

The aim of the initiative was to extend the security that was readily observed among service users at the Health Center during “Project mental health” (Mburu et al., 2015), and that was now observed during the activity initiative´s planning meetings, to spaces and relations beyond the Health Center. Experiences from the Health Center suggest that this previously has been a difficult thing to achieve. In this chapter, I will present the many aspects of the implementation of the activities and the initiative’s potential.

5.1 Presentation of the activity participants

All together, 13 different activities, in the time span from May-December, were organized and implemented. During the summer months, the activity group went to the beach, hiked to lakes in the woods and visited parks. In the months of autumn, they went to the Norwegian Museum of Cultural History, attended a culture night and were introduced to Bollywood dance, and had quiz nights and movie nights at a location accessible through the Church City Mission. The planning group participants had 26 show-ups all together, divided among the 13 different activities. The number of activity participants showing up varied from 2 to 21 people each activity. There were approximately 24 different activity participants who attended throughout the initiative, and their attendance spanned between showing up once to attending up to nine activities. There were approximately 128 activity participant show-ups in total.

The involvement of the coordinator varied throughout the period, but the approach was mostly “hands off”. The coordinator would sometimes attend the planning meetings, sometimes be present at the beginning of the meeting and sometimes not be there at all. Inspired by action research, the coordinator was kept in the loop by me sending a small sum-up after most of the activities.

During the summer months, the participant attendance was at its highest. A large group consisting of people from the Middle East came regularly. Many of them knew each other from before and were active in other areas, such as church fellowships or volunteer work in NGOs. In addition to the participants from the Middle East, there were participants from other cultures and backgrounds who sporadically attended. They sometimes came alone, sometimes with a friend. Some of them attended more than one activity and some only came once. Some came because a participant from the planning group that was from the same country as them had called and invited them.

The activity participants consisted of people with different backgrounds, genders and ages, and the majority of the participants were men in their thirties or forties from the Middle East. People from Mongolia, Ethiopia, Eritrea, Iran, Iraq, Afghanistan and Morocco were present at least for one activity. The countries represented within the planning group and activities accurately reflect the countries where the majority of asylum seekers who come to Norway are from (UDI, 2016; 2017; 2018), together with the representation of the countries that are represented at the Health Center (The Church City Mission & Red Cross Oslo, 2017).

Activity Participants represented both irregular migrants and migrants with a residence permit. The Health Center only invited users of the center, but the planning group emphasized that activity participants could bring friends as a means to get more people to come. This resulted in everyone being welcome. Some came with their partner, where often one of the two had a residence permit. Some brought their children and some brought their friends or acquaintances. The variety in living situation and everyday lives within the activity participant group were similar to the variety within the planning group. Some lived with a partner who had residence permit, some slept on friends' couches and moved around, some lived in an apartment with several others also without a residence permit, while a couple of participants had no housing, slept outside in the woods and had been doing so for several years. Most of them had work, either permanent or moving from job to job within the unregulated economy. Participants worked within the car-wash business, some cleaned houses or went grocery shopping for elderly, some worked non-profit as volunteers in NGOs and churches. Only a couple of people did not work; reasons for this were that their spouse covered their financial needs and that their experience with available work had been challenging. Two participants spoke about feeling exploited and treated with no respect. Because of not being financially dependent on the work, they had quit. All of the participants I asked were former asylum seekers, or had come to Norway because they had family or friends here, or because they had heard that Norway was a good place to be.

5.2 Perception of own well-being:

> *Mostly I am home, this leads to a lot of disease. A lot of problems are created by just staying home. Back pain, chest pain, knee problem, sometimes my eyes and hair loss has come after I got to Norway. When you are far from family, you are stressed. No one will be fine if you let them be at home alone and not do a lot of stuff.* Excerpt from interview, service using participant.

The participants' perceptions of health, their own physical health and their well-being was expressed throughout the activity initiative in different forms. The topic was often brought up, and participants expressed that they had both physical and mental health problems. There are blurred lines between mental health and psychosocial health or well-being. The WHO's (2014) definition of mental health shows how psychosocial health in many ways includes the factors that potentially prevent people from developing mental health diseases. The definition consists of realizing ones potential, coping with normal stress, working productively and being able to contribute to the community (WHO, 2014). There are obvious challenges for irregular migrants to achieve this state of well-being. Irregular migrants often experience more stress through their living situation, and they do not have access to legal work and are therefore, in many ways, not able to contribute to the society. To understand how the activity initiative potentially impacted the participants' health, one needs to understand their own perceptions of and reflections on health, and specifically with respect to their psychosocial health or well-being. The participants' perceptions of own well-being can identify both their strengths and weaknesses associated with their "sense of coherence" (SOC). According to this theory, their weaknesses can further be addressed by building up their resources, which again can create a stronger SOC that can increase the ability to cope with the stressors of life, which ultimately can give a better health outcome (Walseth & Malterud, K, 2004).

One activity participant was constantly walking or standing because of back problems. Another had a swollen knee and because of this had trouble walking. His knee was particularly bad the day we were going to Vettakollen, a peak in the forest of Oslo. We had taken the tram and walked from the end station, an hour walk up a steep hill. He seemed to be in pain by the expression on his face and I asked him if it was a good idea for him to attend. He looked at me with seriousness and said that he did not have a choice. He would always have some pain in his body, that was just how it was living like he did. But the important thing was to stay active, to keep moving. A bad knee or a headache could not keep him from being social, and if he stayed at home “bad thoughts” came quickly. An understanding of the connection between physical and psychological issues, such as this, was often present in the conversations we had about health. The excerpt from the interview stated above shows how one participant expressed how he had started to lose his hair and how his eyesight had worsened after he arrived in Norway; he understood it as a consequence of his stressful and unpredictable life. Another participant told me about how she was unable to function or work because of her condition. I asked her what her condition was. She was depressed: “You know, it is so difficult getting up when I have no hope”. She smiled at me and gave me a hug: “you remind me of my daughter”. Her daughter lived in another European country, and the two of them were not able to see each other often. Her daughter did not have the money to travel to Norway, and the participant did not dare to travel far on public transportation in fear of being caught. Participants expressed the feeling of hopelessness and to “have no one”.

> *10 years have passed, my life is ruined. What kind of life is this? [...]. You have no rights, I do not know, I´m so despairing, life is a waste.* Excerpt from interview, activity participant.

The connection between well-being, or lack of it, and life situation is present for almost all the participants. Even though there is a diversity and span in life situation and health status for irregular migrants, they often have a common perception of the fact that not having a residence permit is the reason for their challenges (Øien & Sønsterudbråtens, 2011). While some participants seem to manage financially, through working as a cleaner or through living with a spouse, others expressed financial hardship, having to take jobs that include long working hours, bad environmental conditions and strict employers. One participant said she had been taking smaller jobs for people from her ethnic community; they had forced her to work long hours and treated her as though she was no one. She said that this made her frustrated and sad and that she had started looking at life in a darker light. Luckily, her husband had a residence permit and a regular job, so she was not financially dependent of the job and quickly quit.

During one of the first activities, we went to the beach. We all took off our shoes and sat by the water. The guy I sat next to had swollen feet, and there was a lot of excess skin and sores on them. He noticed me looking at them and told me that he used to work in a garage, cleaning and repairing cars. The chemicals had caused his skin to react and he told me he did not work there anymore. Again, the connection between health and life situation were present.

Almost everybody I talked to expressed how life was difficult and how they would feel sad, hopeless or trapped living in an everyday life that either consisted of not having anything to do or having work that made life hard.

When talking about feeling good, family was often brought up. Family represented having someone to support you and not being alone. Many of the participants did not have their family in Norway but expressed how being with people with a close relation made them feel safe. Many talked about childhood memories including the feeling of being “worry-free”. Even though family often was related to not being alone, participants also expressed that family was related to responsibility, expectation and concern about not reaching the expectations. One participant who had two children said he was happy when he was with his children. After having used the word happy he corrected himself “maybe not happy, more relaxed”. He was constantly worried about his children, their expectations and him not being able to reach them because of his life situation.

Participants reflected openly and unsolicited about their own well-being, both during interviews and during conversations had at the activities. They expressed not feeling safe, financial hardship, difficult living situations and complicated family relations as some of the reasons for feeling down, hopeless and passive. Physical and mental issues were connected and reasoned with respect to their difficult life situation. The psychosocial activity initiative was in many ways a means to address these weaknesses of their SOC by giving them resources to better cope with their situation through building networks and gaining social support from a fellowship, potentially increasing their access to resources that could keep them healthy (Walseth & Malterud, 2004).

5.3 Reasons for attending the activity: Participant rationale vs Health Center rationale

> *I wish to go to a gym, or swim or play tennis. But I do not have the power to go, there is no motivation. Now it is growing again, this idea, this dream. [...]. As usual I get lazy and when it is not so fine at home it is difficult. This country is so dark and noisy, the people are so cold you know. In France people are open and social. But here it is not like this. Maybe people are uncomfortable when they go outside but then they are comfortable inside. They get a break when they are home. But for me it is not.* Excerpt from interview, service using planning group participant.

The Health Center's goal or wish for the activity initiative was to create fellowship, "a breathing space", a mark in the calendar, and a platform to explore and develop the service users' resources. Several of the participants expressed just this need. The excerpt illustrates how the participant identified a need for "a break", for something or someone to motivate him to go out and explore his resources and potential. Many of the participants describe Norway as cold and closed. Their "way in" seems even more difficult to find in Norway than perhaps other countries. Many of the participants came from countries where social interaction and everyday life evolves around being outside, meeting and talking to neighbors or people who pass on the street. The participant illustrates the isolation experienced in Norway when he says that people are comfortable inside; "inside" is where the "social space" and relations are explored. People invite each other in; interactions rarely develop on the street. Most irregular migrants are not invited "in", but are rather excluded from the welfare system and left marginalized, often with a fear of telling people about their status as irregular and their difficult life situation (Näsholm, 2014a).

The need for an organized, constructed "social space" seems present for irregular migrants, the users of the Health Center and many of the participants of the activity initiative. The Health Center's current aim and previous experience matched the participants view of own psychosocial health and their reasoning for attending the activity. That being said, there were more factors that contributed to the motivation to attend activity and the different motivations contributed to the group dynamic and the development of the activities throughout the project period.

5.3.1 Existential motivation

Participants voiced the wish to build relations and network; this was expressed through several conversations about the importance of staying active, changing environment, not being isolated at home, talking to people in the same situation, being with their own culture and not being alone.

The atmosphere during the activities was always easy-going, and the laughter and quick comments were constant as participants seemed to enjoy each other’s company. The group from the Middle East would often speak their mother tongue. I did not interfere too much when they did, but I made sure to ask different participants what they were talking about after.

> *We are joking you know, not talking about anything serious or specific. We want to relax and just have fun.* Conversation with activity participant, Activity 5.

The answers were often similar to what this participant told me when asked what they had been discussing while we all were playing cards. It seemed to be a joint understanding of creating “a breathing space” with uncomplicated thoughts and dialogues, keeping the heavier conversations to other settings. This understanding of keeping it light was the same approach that the health professionals and many of the participants of the Health Center`s psychoeducational group sessions had. They tried to avoid talking about previous experiences to avoid reliving trauma; the health professionals would rather focus on the “here and now”, giving participants knowledge that potentially could help them cope with difficult situations and feelings (The Church City Mission & Red Cross Oslo, 2014b). While the activity initiative did not include learning about coping skills, other similarities to the psychoeducational sessions from “Project mental health”, such as the social support, fellowship and understanding of being in the same situation, seemed to be important factors that motivated participants to attend activities.

5.3.2 Material motivation

In addition to participants attending the activity initiative for reasons corresponding to the Health Center's aim, several participants did express an additional material motivation. The planning group would always organize a free meal. The importance of this meal was underlined when interviewing an activity participant who answered this when asked about what he would change with the activity initiative;

> *Maybe the food?[...]. When we eat pre-made food it is not as nice. In the winter, maybe concentrate on the cooking. And in addition to a warm meal, maybe something sweet after as well. I think more people would come if you offered this.* Excerpt from interview, activity participant.

Irregular migrants often spend their everyday life trying to cover their material and essential basic needs, such as getting enough food. In Myhrvold and Småstuens (2016) study, 60% of the respondents reported going to bed hungry at least once a month. Some of the participants in the activity initiative mentioned having had to eat grass to fill their belly. It is undoubtedly that food is an important factor for attending when organizing an initiative for people who struggle to meet needs essential to survive. The psychoeducational sessions implemented during "Project mental health" applied the same principle and made a point out of people not being able to "heal mentally" if physical hunger was present (The Church City Mission & Red Cross Oslo, 2014b). Eliminating this part of the activity to ensure that participants came for the fellowship would be potentially ethically wrong and lead the participants who were motivated by both material and existential needs to potentially not come, seeing as it would be almost impossible to prioritize social needs above urgent physical needs. Excluding the meal at the activity would potentially leave only the ones who already have their essential material needs covered to show up.

Some of the reasons for not attending the activity, often even though they had initially said yes, reflected on the participants' rationales for showing up. They expressed reasons to be because of the weather, not feeling up to it or suddenly getting other plans that seemed more fun. Several of the participants referred to these reasons when explaining why they themselves or others did not show. One participant came with a suggestion about how to get more people to come to activity. He was a part of the group from the Middle East and would almost always show to activity. His suggestion was to invite people to the activity and saying that we were making food as the activity. Then, as a surprise, the activity should be that everybody was going to the movies. He then said that he could tell everybody after that they went to the movies. He was sure that this would make people so scared of missing out on another movie night that they would always come. It became clear that the content of the activity was an important factor in determining whether people would attend or not.

When bringing up how to get more people to attend at the planning meetings, finding activities that the users of the Health Center were not normally able to do was a central solution. While discussing if it could be possible to get access to a swimming pool, an activity participant who was randomly present at the planning meeting raised her hand and pointed out that it should not matter what activity service users were invited to. People should want to come anyways, she implied. Attending because you have nothing else to do and nowhere else to be seemed to be the rationale for some of the participants, as well as the Health Center, and this illusion of being in desperate need, and the idea about how the initiative should be for the ones who need it most and thus deserve it – seemingly the ones who had nothing else – was an underlying moral discourse when discussing the development of the initiative.

While experience and theory explicitly suggests that relation building is an unmet need (Myhrvold & Småstuen, 2016; Mburu et al., 2015; The Church City Mission & Red Cross Oslo., 2014b), there was still a need for making the activity look attractive and suggestions of even tricking people into showing up. This idea that both the Health Center and other participants know what is best for all the users of the Health Center and are responsible for helping them to understand this themselves is a way of thinking that could potentially lead to the actual wish of participants getting lost. While the activity initiative was created for everybody at the Health Center with the intention of not excluding anyone, it seemingly became a reason to keep working towards actually include everyone, even though nobody knew if everybody did feel a need for the activity. The ones who had experienced the initiative being beneficial for themselves or others were seemingly sitting with the blueprint for all the participants. This again became a paradox for the underlying principle of the initiative being based on empowerment for its users, as deciding what is best practice for all of the users of the Health Center is in fact the opposite of empowerment.

The different motivations or rationales for attending the activity initiative seemingly led to complications. Attending for both the material good of getting a meal and for the social aspect would not have become problematic if all the participants viewed it the same way. But, the fact that the activity initiative included services that potentially would cover basic needs such as food and the more existential basic need of fellowship, drew participants with different rationales and not necessary both the motives. This created frustration and disappointment for some of the participants who came for the fellowship and met others who came for the material goods. Many of the people who came for the meal were from the Middle East and seemingly already had a fellowship, while a participant who had expressed that he was coming to the activity to meet new people and to be social expressed how he found it difficult that the activity initiative consisted of groups that he was not included in. He had experienced the same a couple of years ago.

> *Two, three years ago I went to this place. It was a church and we came every week and learned Norwegian or culture and stuff. It was really nice and everybody was talking to each other. After a couple of years, they started serving supper and people came in groups and spoke their own language and came there to eat [...] I stopped going because I could only speak English and had nobody to sit with.* Excerpt from interview, service using planning group participant.

The reflections of the participant show how different motivations lead to exclusion of some participants. Based on the findings, it can seem that the group from the Middle East already had the fellowship that the Health Center was aiming for and used the activity initiative to both expand their network and create an even tighter fellowship, as well as to receive a meal. The group`s motivation did fit with the Health Center’s aim, and they did in several ways benefit from the activity initiative. However, their quick establishment of a fellowship and additional material motivation led the participants who had their material needs covered but not their social or existential ones to feel excluded and out of place.

5.4 The group dynamic - “Maybe they should find their own group?”

“Maybe they should find their own group?” Aina, an activity participant from the Middle East, had just explained how she had noticed that Helen was sitting alone for most of activity 12. She had mainly looked at the mediator during our interview, but now she looked straight at me. Both she and her husband had separately walked over to Helen to engage in

conversation, but had quickly given up because of language barriers. The participants often emphasized that everybody was welcome, and that we are all humans and that it was good to get to know new people. Even so, there seemed to be a growing barrier between the group from the Middle East and the other participants. During the summer months, participants with various backgrounds and cultures would attend the activity. There were clear groupings from the very start of the activity initiative, but in the beginning, the diversity of people participating was bigger, and it was therefore seemingly easier to attend without knowing anybody.

The weather was partly a reason for why people stopped attending; several of the participants would express that, when it was raining and when the weather was getting colder, they stayed inside. In addition, fewer people attended the activity further out in the initiative period likely because of having initially just attended out of curiosity. The Health Center had previously experienced a similar pattern of fewer and fewer people showing up to initiatives, and it could seem that when initiatives were no longer new and exciting and people were no longer curious, they stopped attending (The Church City Mission & Red Cross Oslo, 2014c). Finally, other main reasons for participants not attending reflect upon the wrongs of the activity and how the group dynamic developed. These reasons could be that the activity did not give all the participants what they wanted, as it developed in a way that facilitated one specific target group at the Health Center. Aina explained and confirmed the perception of this in a clear way in our conversation about why she thought only participants from the Middle East came to the activity initiative:

> *We have been thinking, that maybe, the same way we who speak Persian get a call and are asked to come to the activity, maybe they should get their own days and activities?* Excerpt from interview with Aina, activity participant.

As the months went by, it became clear that both the participants from the Middle East and the participants who had stopped attending all saw the activity initiative as a service offer for people from the Middle East. They were, as discussed in Chapter 4, represented as the most dominant in both the planning group and at the activities.

5.4.1 The participants from the Middle East – Recreation as therapy

The participants from the Middle East represented 19 of the 24 activity participants. Eight of them came regularly while the rest would attend more sporadically, often recruited by the other eight and not necessarily by the planning group. Some knew each other from before or knew of each other. Some were friends who met outside of activity, some had seen each other at the Health Center, some had met years before in asylum reception centers, while others did not know anyone from before. While most of the participants knew someone from before, the participants from the Middle East who did not were included and welcomed by the others. An activity participant explained why she wanted to attend the activities:

> *The participants at the activity, both the men and the women. It is nice and I like the atmosphere, everybody participates in what we are doing, we work together. We eat and have a good time, laugh and maybe even make fun of each other. Not in a mean way, in a positive way. Yes, this is why I want to come.* Excerpt from interview, activity participant.

The group from the Middle East often expressed how it was important to laugh and have fun. As discussed, the Health Center's rationale for what they wanted the participants to experience from the activity initiative was very much a match with what the participants from the Middle East reported. They met new people and expanded their network, they became closer and seemingly created, or at least further developed, a fellowship. They focused on the light atmosphere creating a space in which they were able to concentrate on matters other than their difficult life situation.

Myhrvold and Småstuen´s (2016) study underlines the asymmetrical relationships that often characterize the network of irregular migrants. The activity initiative being solely driven by service users resulted in a platform for the participants from the Middle East to indulge in relations grounded at the same level. They were comfortable and saw the activity as their own, as a place they fit into and belonged. "Project mental health" experienced challenges when therapists were to teach participants coping tools during the psychoeducational sessions. Many of the participants understood the therapists to have a well-known position in the society and saw more benefit in the possibility that the therapists might talk with the government and politicians about their situation instead of teaching them coping mechanisms that would not be needed if they were not in the situation of living as irregular (Mburu et al.,

2015). This dynamic was not present at the activities, as all the participants were in the same situation, which meant that there was also a space for sociopolitical dimensions to be discussed without any of the participants getting the false hope that their conversations would contribute to changing their situation. The social platform created by the participants from the Middle East was empowering and independent in the form of them taking control.
One can speculate about the potential psychosocial health benefits these participants experienced, as their behavior could be interpreted with respect to the theory of salutogenesis and, namely, the ambition of producing resources that can increase the coping mechanisms of a person and, through this, enhance health. The participants from the Middle East engaged mechanisms like social support, material resources and control, which are mechanisms that potentially increase a person's SOC, according to the theory, which again can ultimately build a better ground for coping with stress (Lønne, 2018).

Irregular migrants are often worried about others' perceptions of them, because of the fear of stigmatization of their situation (Näsholm, 2014a). Many have experienced that people cut contact once they realize that they do not have a residence permit (Øien & Sønsterudbråtens, 2011, p. 31). The network that was created through the activity initiative enabled participants to give each other support, and they vented their relief about being with people in the same situation and not having to keep their status a secret when socializing. Seeing as they often find themselves in difficult social situations because of their status, a network based on principles of non-judgment and fellowship can be especially important for irregular migrants as a means to increase positive self-identity, self-worth and, through this, increase their "sense of coherence" (SOC) (Dahl, U., 2014).

Conversations between the participants also included tips about, among other things, where to get food, where to find internet access and NGOs that would not reject irregular migrants. In November, one participant brought a sheet that he had gotten from a children's store; it was meant for parents who did not have the finances to buy their children Christmas gifts. He handed the sheet around and helped the ones who had children to fill it out. The fellowship grew stronger as the months went by and it became clear that the participants wanted to help each other, share knowledge and means to get by in their everyday lives.

It also became a platform to tip each other about where one could find work. It could seem like some participants were recruited into a Facebook page for their ethic community, where offers of unregulated work would be posted. Khosravi (2010) states in his research that it is common for irregular migrants to obtain illegal work through their ethnic community. He and several others (Khosravi, 2010; Øien & Sønsterudbråtens, 2011; Myhrvold & Småstuen, 2016; Cleaveland, 2010) also point out that employers who hire people for unregulated work often exploit the employees. One participant explained that she had gotten work through the Facebook page, but found the employers disrespectful and uncomfortable. This was the same participant who was not financially dependent on work, as her spouse had a residence permit and was working. Therefore, she quit and did not experience difficulties with this. Irregular migrants have previously reported being threatened by employers when wanting to quit and being forced to keep working (Khosravi, 2010). One can argue that the participant was lucky, both because she was able to quit with no consequences and because she was not dependent on the work, as many irregular migrants are.

Helping each other within the network of the activity group to get work can be a potential arena for exploitation and danger for the participants. But, having to engage in the unregulated economy to cover basic needs is the reality for many irregular migrants. This aspect of the activity initiative could thus potentially help or hurt the participants, and it would likely be very difficult and maybe not expedient to stop this form of help and knowledge exchange.

5.4.2 The silent participants

While the fellowship, network and psychosocial benefit was developing throughout the project period for the activity participants from the Middle East, the other participants were left outside without the tools to be included.

As mentioned, 24 different people attended activities during the period, many of whom had been invited by friends and not the Health Center. There were 58 people who had signed up for activities on the sign-up sheets left in the waiting area of the Health Center. One can assume, seeing as the social workers do not speak all the languages of the service users sitting in the waiting room, that the understanding of the sign-up sheet and what it meant might have varied among the persons who wrote down their information. At each planning meeting, 58 phone numbers were divided between the planning group participants to call. After this, a text message with necessary information about the activity was sent out to all the numbers. For each planning meeting, the planning group would write down how many had said yes or maybe; often, 20 people said yes to attend. Even so, the turn up from the people who said yes on the phone was almost non-existent. One can speculate that feelings of gratitude, a wish to give back to the center or even obligation contributed to this, led users to not feel like there was a real option to say no when invited. There was a potential risk of users feeling uncomfortable being called and invited again and again, after not having shown up to any activity. Some asked the planning group to stop calling, but this was voiced by very few, and there is a potential of more people not wanting to be called but not finding the words to say so.

While some people said yes but then never attended, others did come but could not find us at the National Theatre, only to go back home again. Some left when they saw who was going to participate in the activity, some attended once but never again and one participant came but left the group because she felt excluded. All of these people, including everybody who never showed but were still invited, became the silent participants.

When the planning group participant from the Middle East called to invite the activity participants from the Middle East, conversations were long and friendly, often ending with laughter and the promise to talk more when they meet at activity. These phone calls seemed to be everything they were meant to be: motivational, friendly, informative. But, during each planning meeting, the planning group also called people with whom they did not share a common language. This resulted in misunderstandings and sometimes potential danger in terms of causing more fear, frustration and confusion among an already vulnerable group.

> *Moin was calling the participants from the list of phone numbers he had been handed at the planning meeting. After a conversation with a woman he spoke the same language as, he came out in the waiting room of the Health Center where I was sitting. He said he had talked to a sad woman on the phone. Her husband was sick and she had thought that the Health Center called her to let her know the result of her husband's test. I asked Moin what he had answered her. He said he had told her to call the main number for the Health Center, then he gave her the number to call.* Excerpt from observation, Planning meeting 9.

The planning group participant handled the situation in a good way, compliant with what the Health Center had instructed the planning group to do. The reason for him to be able to do this was because they spoke the same language. Planning group participants had many conversations in which they tried to invite people to activities without being able to communicate properly. They expressed that people might not understand what they were trying to say. The potential that there were other service users waiting for a phone call from the Health Center, getting a phone call and then not understanding what the Health Center was trying to say, was present at every planning meeting.

All the silent participants were potentially exposed to several different feelings that might lead to further despair and psychosocial defeat, such as frustration due to not being able to communicate or because the Health Center kept reaching out to them without them wanting to. Or worry, due to not understanding what the Health Center explained when calling. Disappointment, for not finding the activity group after having come to the National Theatre to participate. Obligation to say yes or let the Health Center call because of the power and the role that the Health Center has. And finally, the uncomfortable discouragement when going to activity and finding oneself excluded from yet another aspect of the social society.

5.5 The Health Center for Undocumented Migrants: Role and responsibility

The participants in both the planning group and the activities all had something in common, the trust in the Health Center. Participants commonly talked about how the Health Center would help them anonymously, not including the police, and about how the Health Center was their loophole and a safe space. In Valenta and Berg´s (2010) study, the government and Norwegian system was emphasized as a barrier when trying to motivate residents to participate in potentially empowering activities. Many residents reported feeling like the system is “against them”, resulting in residents not wanting to contribute or be a part of initiatives organized by the asylum reception center. The participants at the activity initiative expressed the same view of the Norwegian system being against them and mistrust in the government. Having been denied a residence permit and finding themselves in a position of few rights and difficult living situations, one can understand their mistrust in the government.

The Health Center had a different standing among the irregular migrants; most of them gave the Health Center their full trust and gratitude. One can argue that the trust the users give the Health Center puts the Center in a high-power position. And, because of this, the Health Center has a broad responsibility to ensure that its users are not exposed to situations of danger, increased vulnerability or decreased psychosocial health, in situations in which the Health Center is represented. Being able to match the expectations when organizing an activity without being in full control and at the same time having both organizers and participants with different motives, anticipations and resources made it difficult for the Health Center to ensure the quality and safety of the people participating in the activity initiative.

5.5.1 Potential risk

In addition to the potential endangerment inflicted on the silent participants, as discussed in chapter 5.4.2 “The silent participants”, there were other potential risks connected to the Health Center having the users trust, and using this trust to recruit participants.

As discussed in the previous chapters, the activity initiative was, in theory, supposed to represent a space for everybody to come and be included in a fellowship. In practice, the activity initiative developed to be a safe space for the group from the Middle East. While the recruitment strategies and discussions still evolved around recruiting as broad a sample of the service users at the Health Center as possible, the actual activities implemented were more and more tailored to the interests and needs of the users from the Middle East. The quality of the activity for the rest of the users of the Health Center was seemingly not good enough. Neither the planning group nor the activity participants were able to create a safe space or include others in their fellowship. Recruitment happened through both the Health Center staff, the planning group participants and the activity participants from the Middle East. After a discussion about whether or not the activity initiative was necessary, participants from the Middle East recruited even more people both irregular and with a residence permit to show the Health Center how popular and necessary the activity initiative was. The activities would therefore sometimes include 20 participants mostly from the Middle East, which again potentially made it even more difficult for others to attend and to be included.

Khosravi (2010, p. 99) identifies the constructed illegality of irregular migrants and the consequence of restrictions in mobility and often constant fear of being caught. The activity initiative did include several potential factors that could have led to either being caught or participants’ potential fear of being caught. There is a need to discuss whether these factors should have been eliminated or not and whether the Health Center had a responsibility to do so. Resource restrictions made the Health Center unable to cover bus tickets for the participants. In addition, the activity initiative include meeting at a very public arena. Both of these are factors that potentially made participants uncomfortable or dissuaded them from showing up at all. There is a diversity within the group of irregular migrants with respect to the extent to which they potentially live in fear. The ones who are “unreturnable” often live with less fear, seeing as the Norwegian government cannot send them out of the country (Øien & Sønsterudbråten, 2011).

The participants had different perceptions of whether being out in public was safe. During one activity, the participants found themselves at a public activity where a camera team representing a Norwegian media channel wanted to film everybody. While some had no trouble with this, some became uncomfortable and asked me to talk to the film crew about not filming them. Other examples of potential discomfort for activity participants were when the activity included setting up a barbeque during the summer months when Oslo had banned all use of equipment including fire, thus creating a situation where the activity group could have been contacted by the police. A planning group participant also took photos on his phone and posted these on the messenger group on Facebook, which not all of the participants were okay with. Incidents like this often happened, and most likely excluded people who were anxious to be in public and put participants in potentially uncomfortable situations.

In addition, the lack of the Health Center financially covering the bus tickets became an issue. Some had no trouble paying for bus tickets and saw it as important to do so. Some said that they could not come because they did not have the financial means to buy a bus ticket. Some said they were fine with the risk of taking the bus without a ticket. Some worried that if others did not pay for tickets the whole group would be caught. There were also incidents where participants thought that the Health Center had covered the tickets.

> *The bus was packed with people, I stood in the hallway of the bus next to an older woman. The activity participant did not speak much Norwegian or English, and we mostly communicated through body language and short sentences. I bought a bus ticket and the older woman looked at me and communicated that she did not have a ticket. Another participant explained to me that she thought the Health Center would pay for tickets. I bought an extra ticket and told the older woman that she needed to buy her own ticket next time*. Excerpt from observations, Activity 7.

Because of the many misunderstandings and miscommunications during the inviting to activity, one can assume that several participants were under the impression that the Health Center was paying for bus tickets, particularly given that the Health Center had paid for food and other expenses relating the activities, such as movie and museum tickets. This misunderstanding could have, in the worst case, led to participants being reported to the police and sent out of the country.

A consequence of including everybody in the initiative was the potential challenge of mixing genders. The perception of whether mixing genders was unproblematic or not varied among the planning group participants and the activity initiative participants. While one woman said that she would not have appreciated the activity as much if genders were not mixed, another woman said she often did not come to activity because she felt uncomfortable not knowing who she could talk to or not. The different ethnic communities are small and the participant had experienced that people would talk about who had talked to who after the activities. In addition, another woman decided not to attend after having shown up to the National Theatre but then only saw me and two male participants. She later explained that she would be uncomfortable going to an activity with only men, and since I was Norwegian, I was not considered a “woman” it that sense. Many participants talked about wanting to go swimming, and some of the activity participants did this during the summer activities when we were close to lakes or the ocean. However, only the men went swimming, while the women sat on the beach and watched. One said she would have gone into the water if other women did. Another woman expressed the wish to go swimming but explained that this was not an option as long as there were men present. While mixing gender was not a challenge for everybody, it was clear that some were not able to fully participate because of the attendance of both genders. And although this was not unpacked in-depth during the initiative period, there is a possibility of gender having had a significant impact on the group dynamic and who attended and not.

The main point made here is that there were several potential endangerments within the activity initiative, such as a lack of adequate services for the majority of the users of the Health Center, activities that potentially put participants in uncomfortable and even dangerous situations in which police could have been involved and challenges of mixing genders. Giving the planning group’s full access to the service users of the Health Center and their full responsibility for organizing and implementing the activity initiative, the Health Center did not have a full overview or control. And, while the solution was not necessarily to end the activity initiative, means could have been introduced to ensure that the only people who were invited and recruited were people who would not be excluded by the participants already attending.

There are genuine dilemmas regarding the balance of the initiative design being beneficially developed or developed in a feasible and convenient way. First, there was a seemingly unresolved tension between the desire for a user-driven initiative in the interest of empowerment and the necessity that it be organized this way due to limited resources. Secondly, it is not clear that the aim of including all the service users was feasible – neither on the basis of believing that they would automatically connect on the grounds of shared residency status nor given the well-intended desire to offer inclusion in the interest of providing equal services. As mentioned, one of the arguments against psychosocially oriented activities at the Health Center has related to concerns about resources and the importance of prioritizing responsible, quality primary health care. Seeing how much trust the users give the Health Center, there was a lack of ensuring oversight of the initiative, as it ultimately did include risks for harm, albeit with the potential for good.

5.5.2 Equal service – Residence status as foundation for connecting

> *Maybe sometimes, when we go out and they make other small groups within the group. I am not so comfortable with this, I think other people are not so comfortable with this.* Excerpt from interview, service using planning group participant.

As discussed in Chapter 5.3 “Reasons for attending activity: Participant rationale vs. Health Center rationale”, the different motivations for attending the activity led to frustration and disappointment for some of the participants. The service using planning group participant points out what was clear from the very first activity: participants at the activity initiative did divide into groups, making it difficult for people without a group to be included. Irregular migrants have various backgrounds, languages, educational levels, networks, living situations and coping mechanisms (Khosravi, 2010; Øien & Sønsterudbråten, 2011). The variety and diversity of people who are included in the category of irregular migrants is so expansive that one can argue that the only factor linking them all together is their lack of a residence permit in Norway. Participants did not, however, connect on these grounds alone, yet did often state that it was relaxing to be with people in the same situation, even though this was not valued high enough to be the only factor connecting participants. For example, the group from the Middle East expressed that they did want everybody to be included, but that they were present at the activity to have fun and relax. Trying to communicate with people from unknown cultures, with whom they do not share a language, was not relaxing or recreational.

Previous experiences do, however, emphasize that residency status may be an important common ground with respect to ensuring a safe arena for participation (The Church City Mission & Red Cross Oslo., 2014b; Näsholm, 2014a). However, the assumption that this would translate into a mode of connection, fellowship and socialization created potential harm. Taking for granted that relations would be created based on the juridical situation of the participants potentially re-establishes and perpetuates their marginalized life situation. Overemphasizing the importance of their irregular status might have the opposite effect of healing (Willen, 2014). Participants experience marginalization and stigma (Øien & Sønsterudbråten, 2011), and being invited to be part of an initiative evolving around their status as the main source for connecting with the other participants might further confirm their experiences of stigma. One of the participants from the Middle East who attended a couple of times expressed that the initiative was really good for the other participants who could meet people in the same situation as them. She explicitly excluded herself from the identity of being an irregular migrant, as she never mentioned that she too was there to meet people in the same situation. She did, however, come alone to the activity without knowing anybody, and said that she came because it was nice to be around people from her own culture and to speak her own language. She withdrew herself from the label of irregular migrant and rather found a common ground for relation-building through other similarities, such as language and background.

It seemed clear that the joint ethnic background and same language was what the participants valued, and this became the foundation on which they connected and built the fellowship. Previous research and experiences from the Health Center indicates the same, as the psychoeducational sessions and the development of a cooperation council at the reception center both had elements of challenges associated with different cultures and language. Going back to the previous discussion, finding the balance between providing equal services to all the users of the Health Center and providing adequate quality services to particular groups present among the service users of the Health Center needs to be addressed. The experiences point in the direction of it being quite challenging to mix such a large variety of people when trying to create a “safe space” (The Church City Mission & Red Cross Oslo., 2014b). The Health Center has not actually tested this theory before, and while the initiative was not able to include all the users within a “safe space”, one can question if this was because of the variety of people with different languages and ethnicities or if it was due to the large number of participants from one area. Maybe the initiative would have benefitted all users if the group was smaller, opening up for cross-cultural conversations. But, then the balance between a service user driven initiative and an initiative developed with the rationale of “knowing what is best for others” creates another dimension for reflections and source of potential harm. There is a question of whether the potential harm of implementing activities provide a reason for a professional representative from the Health Center to monitor and be present throughout the period to ensure that the initiative is justifiable and safe.

5.5.3 A social workers job?

Irregular migrants are often in unstable and vulnerable life situations. Because of the exclusion they experience from the welfare system, they are some of the most marginalized and stigmatized people in the Norwegian society. Research shows that they are at high risk of developing mental health problems, as their health can be affected by their previous life experiences, the often long and difficult journey to Europe and their current living situation (Øien & Sønsterudbråten, 2011; Straßmayr et.al., 2012; Khosravi, 2010; Småstuen, 2016). The importance of well-being is universal and can be dependent on common human needs of fitting in, being seen and needed, and being treated with respect and dignity (Nissen & Skræbæk, 2014). The activity initiative was not a mental health treatment offer, and its aim was not to treat participants with poor mental health. It was an offer aiming to give the users the possibility of increased psychosocial health, in which one can imagine that any person with a wish to help and who has an understanding of the situation potentially could be fit to do. In addition to the potential risks discussed in Chapter 5.4.2 “The silent participants” and 5.5.1 “Potential risk”, other situations negatively affecting the potential for fellowship and safety occurred. Avoiding or managing these situations sensitively required a solid insight into the activity initiative, its dynamic and its rationale. One can question whether or not a planning group who had stakes of their own was able to identify or avoid situations like these, and if there was a need for a person with fewer stakes, who could advocate for all the activity participants and the potential fellowship. So, did the initiative need a social worker or a health professional? Was it safe, fair or adequate to leave the initiative and the full responsibility to service users?

Going back to Activity 12 and the story of Helen, one of these situations of potential harm was identified. A service using planning group participant asked if Helen could call a friend; that way she would not have been so alone at the activity. The planning group participant asked in an attempt to help; he wanted Helen to feel comfortable at activity, but at the same time, he wanted to play cards with the group from the Middle East. He wanted to relax and enjoy himself, which again did not include communicating without language or trying to understand someone from a different culture when “his group” was also present playing cards having fun. The stakes for the service using planning group participant were high, as he also used the activity initiative to get a break from his everyday life. His role as organizer, “social worker”, and planning group participant were therefore, understandably, overshadowed in this instance by his role as an activity participant.

Having a joint meeting place for all the participants before going together to an activity also created situations of potential harm because of a lack of joint understandings. While having a meeting place could potentially have created situations in which fellowship and relations between participants were facilitated, this was not fully recognized, understood or explored by the planning group. Having a set meeting point was something the planning group had discussed and agreed on. A set meeting place would make it easier for people to attend the activity, as they would get the chance to meet each other and have time to talk and “break the ice” while waiting for everybody. In addition, this did facilitate not having to figure out how to get to the different locations.

The planning group decided that they wanted to wait at least half an hour at the National Theatre before the group was supposed to jointly walk to the activity destination. As the summer months passed, this need seemed to no longer be necessary for the group from the Middle East. They had become comfortable with each other, and started to view it as excessive to wait for so long before going to the actual activity spot. Since this group knew where the activity was taking place, many started to meet directly at the activity destination. Some of the service using planning group participants also started to meet directly at the activity spot. These were the same service using participants who potentially understood the planning meetings and the activities to be of the same purpose and who rarely showed up to either planning meetings or activities.

The service using planning participants who would also take the lead in organizing and planning started to use the half an hour wait at the National Theatre as a margin for when they needed to show up. This resulted in me often being the only one on time at the National Theatre. The service using planning group participants would sometimes show up after ten minutes and sometimes after 40. This meant that if the participants did not already know me, it would be almost impossible for them to understand that I was the one who waited for them, representing the Health Center`s activity initiative.

Participants from the Middle East meeting up at the activity and not near the National Theatre were not an issue in itself. But, seeing as how the planning group and the Health Center were recruiting other people throughout the period, this became a potential harm for other participants. In the beginning, the activity group would consist of 15 people gathered near the National Theatre, talking loudly, listening to music. Thus, understanding that this was the activity group from the Health Center was easier for other participants. When the planning group participants started to show late at the National Theatre, or even show up at the activity instead, the stability and the safe meeting point did no longer existed. Even though there had been discussions about the importance of showing on time and bringing a sign or a vest so that participants could identify the activity group, this was never implemented in practice. Some of the reasons for this was varied perceptions of time, as well as situations that came up regarding their difficult life situation. It was also a consequence of wanting the activity initiative to be a fellowship among equals rather than standing out as the leader.

What in the beginning worked as a platform for a safe entrance into the activity group, became a place for people to experience insecurity and disappointment through not finding the group (silent participants), not knowing for how long everybody had to wait and sometimes not knowing what the activity entailed.

This was again experienced by Helen, as she attended Activity 13 as well. She had gotten yet another text message from the Health Center inviting her for an activity, and she showed up at the meeting spot near National Theatre. It was during the daytime and one of the service using participants had arranged to get cheaper movie tickets, so we were going to watch an action movie. Helen had brought her baby, not having fully understood what was written in the text message. Because of the baby, she was not allowed in to the movie theatre.

We all felt bad for her and, while she packed her stuff, one of the service using participants bought her a chocolate bar as a consolation prize. Helen left and the rest of us went into the movie theatre. Potential harm because of language barriers and not having an adequate quality service offer was again present. What could have been done differently? Is the harm already done when texting in a language many of the users do not understand, or is this a necessary risk for such service offers at the Health Center to even be feasible? Would a social worker have done anything differently while we were there? Did giving Helen a chocolate bar make her feel the care that the service using participant was trying to show her, or did it make her feel that we pitied her? Helen came for activity a second time, even after having spent most of activity 12 by herself, with her son, on the couch. What made her come back? Helen spent most of her days alone with her son while her husband worked, she seemingly had few other people, and was as the Health Center had rationalized it the ideal participant, both in need and deserving.

There was a joint wish from both the participants and the Health Center to include everybody and, with everybody, create a space for fellowship. But, the activity initiative never truly reached its potential. The lack of a joint platform, language barriers, situated fear or even potential dangers of being caught, a high number of silent participants, exclusion of participants and questioning the need and deservingness of the participants that did attend were all aspects of the activity initiative that potentially caused or could have caused harm. And, while if not being of direct endangerment for an already vulnerable group of people, the factors discussed did at least not contribute to the Health Center´s aim of increasing the service users’ psychosocial health. That being said, participants did indeed express the need, a wish for and benefit from the activity initiative. Laughter, joy, and the creation of new relations was also present, and one can imagine that, by addressing the potential harm, a beneficial psychosocial activity initiative could emerge.

6 CHAPTER SIX – Humanitarianism - The psychosocial shift

The increasing emphasize on existential and social vulnerability as a consequence of difficult life situations, suffering and trauma has led to interventions such as the activity initiative, to be of increased focus within humanitarian aid. As addressed in Chapter 1.3 “Humanitarianism” and touched upon in 4.3.2 “To need it, deserve it and want it – An unspoken moral discourse”, critiques about the practical feasibility of humanitarian aid and psychosocial humanitarian interventions evolve around asymmetrical relations and how the provider needs to be aware. As the asymmetrical relations are seen as almost impossible to avoid, the activity initiative did confirm this to be a challenge. While the intention was to avoid power relations by service using participants being in charge, the actual power dimensions did not disappear.

In the final findings and discussion chapter, I will first discuss how psychosocial humanitarian principles were applied and acted out within the activity initiative. Finally, I will address the question of the positive potential existing in the initiative, and whether increased psychosocial health really was feasible within the frames of the activity initiative.

6.1 The humanitarian rationale for the activity initiative

The psychosocial shift in humanitarianism has, potentially and in part, led NGOs, such as MSF, the Church City Mission and the Red Cross, to identify emotional vulnerability within people in crisis and in difficult situations and to advocate for and provide psychosocial interventions and support. Research does show that irregular migrants in Norway are at a higher risk of poor mental health (Myhrvold & Småstuen, 2016), and experiences from the Health Center have indicated that there is a wish and need for emotional support (The Church City Mission & Red Cross Oslo., 2014b). The core of needing emotional psychosocial support is based on people experiencing emotional vulnerability as a consequence of traumatic and difficult life experiences and living situations. This truth is not universal, as it is a way of thinking situated in cultures of the developed Western society and the humanitarian aid workers’ reactions to the experience of other people’s suffering (Pupavac, 2004). Thus, as Pupavac (2004) emphasizes, there is a danger that psychosocial interventions that emphasize coping are not appropriate, meaning that people who initially have understood their situation as a problem with a concrete solution, rather than as an individual, emotional or psychosocial dysfunction, could end up adapting their mindsets so as to fit in within the socially appropriate way of reacting and receiving care in the Western society. By offering psychosocial programs to people who are perceived as `the suffering and in need`, humanitarian aid can ultimately teach people who saw their problems as based on material and concrete restraints, to identify themselves in this role, thus becoming the suffering, vulnerable people in need of emotional support that the humanitarian workers assume that they are.

The voice of a participant in “Project mental health” demonstrates many of the irregular migrants frustrations over the limited help the Health Center for Undocumented Migrants in Oslo can contribute with: “I come with a headache and you treat my foot (translated)” (The Church City Mission & Red Cross Oslo, 2014b, p. 25), as the `actual problem` is their lack of a residence permit and thus they at least partially view their situation as a problem with a solution. While the activity initiative did not experience participants expressing that the resources were put into the wrong area, it did frame the participants as being in need of emotional support. And, while the initial idea of including all the users at the Health Center resonates with the humanitarian principle of all being equally entitled to health services, it initially also became a perception of all users of the Health Center as being in need of psychosocial support, thus indirectly assuming that all the users were suffering and vulnerable individuals in need of humanitarian emotional aid. Viewing the Health Center as not only in the role of providing its users with primary health care on the same grounds as the entitlements of the rest of the Norwegian population, but expanding it to cover an aspect that people usually have to ensure themselves. The attempt was thus to constantly recruit more people with different ethnic backgrounds, assuming that the initiative was something all the users needed, potentially wanted and deserved.

The matter of deservingness, discussed in chapter 4.3.2 “The ideal participant – Who is the target group?”, manifested covertly in a way that excluded participants from the initiative’s entitlements. This became a paradox, as deservingness was based on perceptions of suffering, vulnerability and disempowerment, at the same time that the activity initiative was designed so that its participant would become just the opposite: empowered in accordance with theories of salutogenesis and empowerment. But, when the participants in the activity initiative seemingly became just that, they also were put in the category of not deserving anymore, as they were no longer viewed, seemingly so, as suffering enough, thus demonstrating how the people receiving humanitarian aid often need to perform the role of helplessness in order for the care providers to assess them as deserving. This again points out another potential challenge within humanitarian aid of this sort, as there often is a power imbalance. While the service using planning group participants and the planning group initially were supposed to address the issue of power imbalance, this seemingly was only implemented at the activities, when the service using participants and the activity participants were the ones in control. Within the planning group, there was a power imbalance between the service using participant who advocated for the participants from the Middle East and the non-service-using participants who advocated for the ideal of the 'suffering and vulnerable' participants. One can say that the service using planning group participants therefore were forced to 'perform', 'act' and advocate to prove the participants from the Middle East´s deservingness, suffering and helplessness, rather than the participant from the Middle East`s wish to be in the role as empowered when service using participants and non-service-using participants were discussing at planning meetings. Principles of humanitarianism and empowerment, although the former was never directly labelled or discussed, thus seem to have informed both the rationale for initiating the activity and a source of potential harm throughout.

6.2 Construction of psychosocial moments

A "breathing space", "safe space" and "a break" are terms used in the previous chapters when illustrating the aim of the initiative. The psychosocial moments that are aimed to be produced have the intention of creating a sense of meaning or purpose in one's life. The activity initiative is thus ideally an arena for people to experience well-being. Through moments experienced and potential relations, a stronger resilience, increased SOC and therefore a better potential for dealing with difficult life situations and everyday challenges could ultimately be created. Reflecting upon what factors need to be present and what factors were present during the initiative will possibly give an idea of the actual potential for the activity initiative. Can a positive psychosocial moment be produced within the frames of the activity initiative? Is the idea just an illusion created based on theory and the perception of what the service users of the Health Center for Undocumented Migrants in Oslo need?

In Brux, C. M. et al.'s (2018, p. 19) study about migration and temporality participants expressed long periods of waiting, having to play cards, watch TV, sleeping in, exercising and going on walks with no specific directions. While some expressed this as just ‘killing’ time, the same activities can be interpreted as the government and state demonstrating their control. The activities are therefore, not just activities. They can be perceived and experienced in different ways. Participants in the activity group would often play cards, and, for some, this activity could represent engaging in a familiar culture from their home country, thus constituting a potentially positive psychosocial moment. For others, the same activity could potentially be associated with meaningless passing of time and potentially even perceived as negative control. The same can be argued for Activity 12 “Ginger bread making”; while some decided not to engage in the activity out of not being interested, others might have seen it as degrading to be offered an activity that could be associated with children’s play. While, for a third part, the same activity was potentially exactly the frames needed for the psychosocial moment, seeing as it became a way for people who did not speak the same language and did not know anybody to more easily connect, having something joint to both do and talk about.

As presented in Chapter 5.2 “Perception of own well-being”, participants identify happy moments experienced often during childhood when being with family and feeling “care-free”. This happy feeling, or these existentially comforting moments of meaning, include feelings of belonging, either as children playing and being with family, or when they themselves become parents. A service using planning group participant explained how he had felt a glimpse of hope and happiness, and a feeling of everything changing, when he became a father, only to later understand that nothing changed. As I asked if he meant that he had hoped for a change in his residence status, he said that that was not all, but that he had moreover hoped it would change his perception of life. Another activity participant expressed how he had experienced a moment of happiness when he thought that he had gotten a residence permit after having been in Norway as an asylum seeker for three years. The permit turned out to only be temporary and his feeling of happiness had quickly disappeared. All the examples of participants experiencing what was for them a feeling of meaning, included the past, when being “care-free”, or when having hope – Hope that their lives would change for the better, and that all their problems would go away.

When the participants’ life situation was described by them as an all-consuming reason for their difficulties, one can question the rationale for putting resources into an activity initiative that, at best, treats the symptom of the disease but not the disease itself. In Brux et al.’s (2018, p. 20) article, the story of a man and his son portrays an example of what is described as an existentially grounding moment. A father sees his son eating ice cream and celebrating the Norwegian national day, seemingly fitting in with the other children and the rest of society. Moments like these are what become important in human lives, as they create the magic of existential value and meaning, providing something to look back on in difficult times and something that strengthens the confirmation of self. This shows that there is a difference between just passing time and experiencing a moment in time that brings purpose to one's life, and how both experiences can be important experiences in the lives of irregular migrants.

Willen (2014) argues that there is an overemphasis on the juridical and sociopolitical situation of irregular migrants when exploring their lives and potentials. They do live in a context in which they find ways to cope and "work around", and they make choices based on the reality of their world just as everybody else makes choices based on their individual realities. The Health Center coordinator pointed out that the users of the Health Center do not exist within the vacuum of the center; their lives are acted out and lived in several arenas other than those of seeking health care, underlining how natural connections are explored through family, friends, ethnic communities and hobbies. Thus, there was indeed a potential for creating psychosocial moments within the activity initiative, but the actual occurrence of these moments was perhaps taken for granted. As demonstrated above, the true moments of meaning are possibly created when experiencing more than just activities to 'pass time'. While some participants might not have felt like they were merely passing time, few means were pre-planned or implemented to actually facilitate the potential, as it was taken for granted that people would automatically connect and be 'reached' by just showing up to an activity, even though, as described in Chapter 4.3.1 "Everybody is welcome – Recruitment and feasibility", 'reaching out' to the same participants through the phone was experienced as close to impossible.

In addition, it was pointed out during a planning meeting that the actual doings of the activities that the participants were invited to should ultimately not be of high importance for participants, as the suggestion was that they should just want to come anyway since they were in such dire 'need' of the activity. Willen's (2014, p. 87) encouragement to avoid over-emphasizing the juridical and sociopolitical aspects of the lives of the participants, and to rather focus on the reality in which the participants live, how they chose to see the world and how they act within it, could potentially be a reminder the initiative could have benefitted from, as it seemed that the perception that the users of the Health Center needed it so much meant that the content, frames and people driving the actual activity suddenly were not of as high importance. Again, Willen (2014) warns of the potential danger of exploring *what* an irregular migrant is, instead of *who* (p. 97), which was maybe overlooked by the Health Center, the non-service-using participant and myself as we constantly aspired to recruit service users who were, in our perception, the most deserving and, in doing so, neglected the process of fellowship already being creating within the ongoing activities. Given that the service using participant who advocated for the group from the Middle East saw the participants and tried to adjust the activities to their wishes, this very likely did create positive psychosocial moments, as several attended again and again, looked forward to activities and created emotionally supportive relations, as demonstrated in Chapter 5.4.1 “The participants from the Middle East – Recreation as Therapy”.

So, going back to the question initially asked, there seemed to be a potential for creating psychosocial moments within the activity initiative. Some participants did experience the aim that the Health Center sought for its service users. But the psychosocial moment and the road to reaching the aim of the Health Center were, in many ways, taken for granted, suggesting that the initiative did not fully enable the existing potential for the participants from the Middle East to blossom. The potential for adjusting the initiative to better accommodate the “silent participants” was also not fully explored.

Concluding remarks

Å flykte
[…]
Det er så tungt å være alene i en liten
leilighet søndag kveld og dine tanker vandrer
som løvetannsporer mange kilometer til
hjemlandet […]

To flee
[…]
It is hard to be alone in a small apartment
Sunday evening, as your thoughts wonder as
dandelion spores miles away to your home
country […] (translated)

Excerpt from poem by Nasim Alimoradi, from «Kunsten å flykte: Fortellinger om flukt og menneskerettigheter» (Dahl, C., 2017, p. 52-53)

Nasim Alimoradi`s poem paints a picture of the challenging situation of being in a unfamiliar place and feeling lost and confronted with the truth of the harsh reality that lives sometimes entail. One should be careful to avoid victimizing people; although my thoughts automatically go to the lonely, isolated and "needing" migrant, the poem also paints a picture of feelings that most of us experience during a lifetime. However, there is a difference between the possibilities and starting points of people. Finding oneself in a foreign country, with dreams of a better life being suppressed by the lack of a residence permit, makes for a tougher starting point than what most people work with. It was on the basis of this and the knowledge of the Health Center´s service users being alone, with little network and limited options, that the organized social activities were conceived of as a means to meet the unmet psychosocial health needs of irregular migrants.

This thesis has explored the process of implementing a service user-driven organized social activity initiative with the use of a planning group consisting mostly of service users. While there seemed to be a potential for creating a platform for participants to feel useful and connect with each other, several challenges were identified. Low attendance because of not identifying with the project together with the prioritization of covering basic needs led to vulnerability in the group´s sustainability. Although the initiative was meant to commence in accordance with the service using participants wishes, the non-service-using participants, including the Health Center, were seemingly steering the direction of the initiative, only truly acknowledging the service-using participants' opinions if they corresponded to the Health Center rationale. This ultimately led to tension in terms of questioning each other's motives, and further to the covert discussion about the deservingness of the activity initiative participants and the Health Center´s users. Questions about the empowering dimension were also brought up. The responsibility shift between the Health Center and the service using planning group participants seemed to mostly be a consequence of the limited resources that the initiative was framed by and not only as a means to empower the service-users, leading the empowering process for the service-users to not fully develop.

This thesis was also aiming to generate insight into the initiative's potential for enhancing psychosocial well-being among service users. The participants in the activity initiative reflected the participants in the planning group; the group from the Middle East was most dominant. This was the group that benefited from the project. They could, however, have potentially benefitted more if they had been recognized as legitimate beneficiaries of the initiative. Instead, the perception among the non-service-using participants was that the participants who had not yet attended were the ones who should be 'reached out' to and prioritized. These people, the ones I address as "the silent participants", became the ones who were thus ultimately targeted but simultaneously also excluded, resulting in potential harm.

There is growing emphasis on user involvement within the service provision context, especially within mental health. And, while psychosocial health initiatives have become more common, the focus is often on mental health treatment with supplementary psychosocial initiatives. This study is a contribution to research regarding both irregular migrants in Norway and psychosocial health and user involvement as a means to empower both service users who contribute to the organizing of services and service users who can benefit from what is organized. Even though some of the findings were, to some extent, particular to the living situation of irregular migrants, I argue that the study can be relevant for other service providers who, for example, seek to develop service offers for asylum seekers who, similar to irregular migrants, often identify with being in limbo. The understanding of the implementation process and the insight into the initiative´s potential can lead to early identification of challenges and can be of potential benefit for service providers, such as the Health Center for Undocumented Migrants, that are looking to implement similar initiatives. Being aware of the challenges and benefits that this initiative experienced could, if not eliminate, at least help to acknowledge factors that should be taken into consideration when addressing the design of a similar initiative in the future.

This study became a study about an activity initiative that in many ways went wrong. Limited resources and challenging conditions implicated in political factors leaves the Health

Center with the difficult task of developing a means to address needs that are often grounded in deeper issues, such as the lack of a residence permit, that are beyond the control of both the service users and the Health Center. These are fundamental dilemmas of humanitarianism. The existence of the Health Center for Undocumented Migrants is based on the unmet need of the service users. There is an unavoidable dilemma for organizations providing humanitarian aid, such as the Health Center, to try out services that can contain massive potential, albeit with similarly high stakes, potential harm and possible failure. The settings in which humanitarian aid is often provided are ones that entail limited resources and vulnerable populations, which renders the potential for failure even more concerning. Assessing risks and benefits before implementing initiatives and while they are underway, and potentially anticipating alternative courses of action as relevant, are therefore of great importance.

As this study contributes to the awareness of some potential ‘dos and don’ts’ when organizing and implementing an activity initiative for irregular migrants living in Oslo. Further research can be of even higher benefit and interest. While the initiative did entail some shortcomings, it also involved a number of potential psychosocial health benefits. The rationale and reasoning behind the activity initiative is still very much relevant with respect to the perceived needs of many of the Health Center’s service users and, potentially, irregular migrants living in Norway. It is suggested that this potential be further explored in future service initiatives and research projects, albeit while thoroughly addressing the risks and benefits both when designing the initiative and throughout its course.

References

Askheim, O.P. (2003). Empowerment as guidance for professional social work: An act of balancing on a slack rope. *European Journal of Social Work*, 6(3), 229–240. doi:10.1080/1369145032000164546

Borg, M., Karlsson, B., & Kim, H. S. (2009). User involvement in community mental health services–principles and practices. *Journal of Psychiatric and Mental Health Nursing*, *16*(3), 285-292. doi: https://doi.org/10.1111/j.1365-2850.2008.01370.x

Brux, C., Hilden, P. K., & Middelthon, A. L. O. (2018). "Klokka tikker, tiden går": Time and irregular migration. *Time & Society*. doi: 10.1177/0961463X18783356

Burchett, N., & Matheson, R. (2010). The need for belonging: The impact of restrictions on working on the well-being of an asylum seeker. *Journal of Occupational Science*, *17*(2), 85-91. doi: https://doi.org/10.1080/14427591.2010.9686679

Buvik, K. & Hansen, M. B. (2017). Sluttrapport for Røde Kors-prosjektet: Samtalegrupper i Mottak (2015-2017). Retrieved from http://www.asylsokereogpsykiskhelse.no/wp-content/uploads/2017/12/Sluttrapport-Samtalegrupper-i-mottak-2017.pdf

Cleaveland, C. (2010). "We are not criminals": Social work advocacy and unauthorized migrants. *Social work*, *55*(1), 74-81. doi: https://doi.org/10.1093/sw/55.1.74

Dahl, C. (2017). *Kunsten å flykte: Fortellinger om flukt og menneskerettigheter*. Oslo: Camilla Dahl Kunst.

Dahl, U. (2014). Et salutogent perspektiv. I Nissen, M. & Skræbæk, E. (Editor.), *Psykossialt arbeid: fortellinger, medvirkning og fellesskap* (p.11-28). Oslo: Gyldendal Akademisk.

Fassin, D. (2007). Humanitarianism as a Politics of Life. *Public culture*, *19*(3), 499-520.

Fassin, D. (2011). Introduction: Humanitarian Government. *Humanitarian reason: a moral history of the present* (p. 4-20). California: University of California Press

Fernandes, A. G. (2015). (Dis) empowering new immigrants and refugees through their participation in introduction programs in Sweden, Denmark, and Norway. *Journal of Immigrant & Refugee Studies*, *13*(3), 245-264. doi:https://doi.org/10.1080/15562948.2015.1045054

Green, J. & Thorogood, N. (2014), *Qualitative Methods for Health Research*. London: SAGE Oublication Ltd.

Huma network. (2009). Access to health care for undocumented migrants and asylum seekers *in 10 EU countries: law and practice*. Retrieved from http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf

Huschke, S. (2014). Performing deservingness. Humanitarian health care provision for migrants in Germany. *Social Science & Medicine*, vol*120*, 352-359. doi: https://doi.org/10.1016/j.socscimed.2014.04.046

Jordan, B. (2004). Emancipatory social work? Opportunity or oxymoron. *British Journal of Social Work*, 34(1), 5–19. doi: 10.1093/bjsw/bch002

JussBuss. (2013). "Sosiale rettigheter for alle i Norge?". *Jussbuss*. Retrieved from http://foreninger.uio.no/jussbuss/aktuelt/studjur---papirlose.pdf.

Khosravi, S. (2010). An ethnography of migrant 'illegality' in Sweden: Included yet excepted?. *Journal of International Political Theory*, 6(1), 95-116. doi: https://doi.org/10.3366/E1755088210000479

Kielmann, K., Cataldo, F. & Seeley, J. (2011). *Introduction to Qualitative Research Methodology*. UK Department for International Development.

Leonardsen, D. (2007). Empowerment in social work: an individual vs. a relational perspective. *International journal of social welfare*, 16(1), 3-11. doi:https//doi.org/10.1111/j.1468-2397.2006.00449.x

Lysaker, O. B., Fangen, K., & Sarin, T. (2011). Inside and outside simultaneously. Recognising the vulnerability of irregular migrants in Europe. POLICY BRIEF, EUMARGINS, On the Margins of the European Community.

Lønne, A. (2018). *Salutogenese*. Retrieved 03.04.2019 from https://sml.snl.no/salutogenese

Malterud, K.(2001). Qualitative Research: Standards, Challenges, and Guidelines. *The Lancet* 358 (2001), 483-488. Doi: https://doi.org/10.1016/S0140-6736(01)05627-6

Marshall, M. N. (1996). Sampling for qualitative research. *Family practice*, *13*(6), 522-526. doi: https://doi.org/10.1093/fampra/13.6.522

Martikainen, Pekka, Mel Bartley, & Eero Lahelma. (2002). Psychosocial determinants of health in social epidemiology. *International Journal of Epidemiology*, 31(6), 1091-1093. doi: https://doi.org/10.1093/ije/31.6.1091

Maxwell, J. (2013). Validity: How Might You be Wrong? I Maxwell, J (editor), *Qualitative Research Design: An Interactive Approach*, 3rd Edition (121-138). Los Angeles: SAGE Publications.

Mburu, C. B., Middelthon, A.L. & Hilden, P.C. (2015). Utvikling av psykiske og psykososiale helsetjenester ved Helsesenteret for papirløse migranter. I Bendixsen, S.K., Jacobsen, C. M. & Søvig, K.H. *Eksepsjonell velferd? Irregulære migranter i det norske velferdssamfunnet*. (s.165-182). Oslo: Gyldendal norsk forlag.

Meyer, S., & Morand, M. B. (2015). Mental health and psychosocial support in humanitarian settings: reflections on a review of UNHCR's approach and activities. *Intervention*, *13*(3), 235-247.

Miller, K. E., Omidian, P., Kulkarni, M., Yaqubi, A., Daudzai, H., & Rasmussen, A. (2009). The validity and clinical utility of post-traumatic stress disorder in Afghanistan. *Transcultural Psychiatry*, *46*(2), 219-237. doi: https://doi.org/10.1177/1363461509105813

Ministry of Health and Care Services. (2017). Innstilling fra helse- og omsorgskomiteen og Representantforslag fra stortingsrepresentantene Olaug V. Bollestad, Rigmor Andersen Eide og Geir Jørgen Bekkevold om helsehjelp til papirløse migranter (8:106 S 2016–2017). Retrieved from https://www.stortinget.no/no/Saker-og-publikasjoner/Publikasjoner/Innstillinger/Stortinget/2016-2017/inns-201617-402s/?all=true

Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews* (Vol. 3). Greenwood Publishing Group.

MSF (2018). Life In Limbo: MSF’s psychosocial support for asylum seekers in Sweden (MSF report 2018). Stocholm: Läkare Utan Gränser. Retrieved from https://lakareutangranser.se/sites/default/files/media/msf_report_life_in_limbo_web_eng.pdf

Moen, K & Middelthon, A. (2016). Qualitative Research Methods. I Laake, P., Benestad, A. B. & Olsen, B. R (editor), *Research in Medical and Biological Sciences: From Planning and Preparation to Grant Application and Publication* (321-378). Amsterdam: Eldevier.

Myhrvold, T. & Småstuen, M. C. (2016). The mental healthcare needs of undocumented migrants: an exploratory analysis of psychological distress and living conditions among undocumented migrants in Norway. *Journal of Clinical Nursing*, *26*: 825–839. doi:10.1111/jocn.13670

Myhrvold, T. & Småstuen, M. C. (2018). Undocumented migrants` life situations: An exploratory analysis of quality of life and living conditions in a sample of undocumented migrants living in Norway. *Journal of Clinical Nursing*. doi: http://doi.org/10.1111/jocn.14743

Nissen, M. & Skræbæk, E. (2014). Hva er psykososialt arbeid? I Nissen, M. & Skræbæk, E. (Editor.), *Psykossialt arbeid: fortellinger, medvirkning og fellesskap* (p.11-28). Oslo: Gyldendal Akademisk.

NOAS. (2017). Rikets tilstand på asylfeltet: Statistikk 2017. Retrieved from https://www.riketstilstand.noas.no/2017/statistikk

NRC. (2018a). Global statistikk over mennesker på flukt (table 2). Retrieved from https://www.flyktninghjelpen.no/global/statistikk/statistikk/#static-main-table

NRC. (2018b). Global statistikk over mennesker på flukt (table 6). Retrieved from https://www.flyktninghjelpen.no/global/statistikk/statistikk/#static-main-table

NRC. (2018c). Global statistikk over mennesker på flukt (table 3). Retrieved from https://www.flyktninghjelpen.no/global/statistikk/statistikk/#static-main-table

Näsholm L. (2014a). *Helping Others and Helping Myself Too": A Study of Irregular Migrants Experience of Doing Volunteer Work*. (Master's thesis). Oslo: Oslo and Akershus University College

Näsholm, L. (2014b). Group activities for undocumented migrants: An alternative approach to mental and psychosocial challenges?. I Overland, G., Guribye, E. & Lie, B.(Ed.), *Nordic Work with Traumatized Refugees: Do We Really Care* (200-2010). Newcastle: Cambridge Scholars Publishing

OED. (2007). Psychosocial, adj. *Oxford English Dictionary*. Third edition. Retrieved 02.15.2019
from http://www.oed.com/view/Entry/153937?redirectedFrom=psychosocial#eid

Ottesen, S. H. (2008). *Papirløse migranter: En undersøkelse av situasjonen for mennesker uten lovlig opphold i Norge, og humanitære tiltak for denne gruppen i europeiske land* (report from Kirkens Bymisjon Oslo, Mangfold & Oppvekst). Oslo: Stiftelsen Kirkens bymisjon Oslo.

Owren, T. (2008). *Noen betraktninger om brukerråd, empowerment og samfunnsarbeid*. *Oslo:* SOR Rapport, 4, 4-12. Retrieved from http://www.samordningsradet.no/sitefiles/4055/Arkiv_Rapport/Artikler/2008/Owren__Noen_betraktninger_om_brukerrad__4_08.pdf

Pupavac, V. (2004). Psychosocial interventions and the demoralization of humanitarianism. *Journal of Biosocial Science*, *36*(4), 491-504. doi: https://doi.org/10.1017/S0021932004006613

Regjeringen. (2019). Politisk platform: For en regjering utgatt av Høyre, Fremskrittspartiet, Venstre og Kristelig Folkeparti. Retrieved from https://www.regjeringen.no/no/dokumenter/politisk-plattform/id2626036/

Richards, H M. & Schwartz, J L. (2002). Ethics of Qualitative Research: Are there Special Issues for Health Services Research? *Family Practice* 19.2 (2002), 135-139. doi: https//doi.org/10.1093/fampra/19.2.135

Slagstad, K. (2017). Den annens lidelse (The suffering of others). *Tidsskriftet for den norske legeforeningen*. doi: 10.4045/tidsskr.17.0764

Slettebø, T. (2000). Empowerment som tilnærming i sosialt arbeid. *Nordisk sosialt arbeid*, *2*(00), 75-85.

The Norwegian Directorate of Health (Sosial- og Helsedirektoratet). (2006*). Plan for brukermedvirkning Mål, anbefalinger og tiltak i Opptrappingsplanen for psykisk helse* (IS-1315). Retrieved from https://helsedirektoratet.no/Lists/Publikasjoner/Attachments/158/Brukermedvirkning-psykisk%20helsefeltet-mal-anbefalinger-og-tiltak-i-opptrappingsplanen-for-psykisk-helse-IS-1315.pdf

Straßmayr, C., Matanov, A., Priebe, S., Barros, H., Canavan, R., Díaz-Olalla, J.M., …Katschnig, H. (2012). Mental health care for irregular migrants in Europe: Barriers and how they are overcome. *Biomedcentral Public Health, Vol 12*(367). doi: https://doi.org/10.1186/1471-2458-12-367

Teodorescu, D. S., Heir, T., Hauff, E., Wentzel-Larsen, T., & Lien, L. (2012). Mental health problems and post-migration stress among multi-traumatized refugees attending outpatient clinics upon resettlement to Norway. *Scandinavian Journal of Psychology, 53*(4), 316-332. doi: https://doi.org/10.1111/j.1467-9450.2012.00954.x

Valenta, M., & Berg, B. (2010). User involvement and empowerment among asylum seekers in Norwegian reception centres: Brukermedvirkning blant beboere i norske asylmottak. *European Journal of Social Work, 13*(4), 483-501. doi: https://doi.org/10.1080/13691451003603406

UDI. (2016). Hvem og hvor mange søkte om beskyttelse i 2016? Retrieved from https://www.udi.no/statistikk-og-analyse/arsrapporter/tall-og-fakta-2016/faktaskriv-2016/hvor-mange-sokte-om-beskyttelse/

UDI. (2017). Asylsøknader etter statsborgerskap, aldersgruppe og kjønn(2017). Retrieved from https://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-aldersgruppe-og-kjonn-2017/

UDI. (2018a). *Dublin-samarbeidet*. Retrieved from https://www.udi.no/nn/ord-og-omgrep/dublin-samarbeidet/

UDI. (2018b). Asylsøknader etter statsborgerskap, aldersgruppe og kjønn(2018). Retrieved from https://www.udi.no/statistikk-og-analyse/statistikk/asylsoknader-etter-statsborgerskap-aldersgruppe-og-kjonn-2018/

UN Committee on Economic, Social and Cultural Rights (CESCR). (2013). *Concluding observations on the fifth periodic report of Norway* (E/C.12/NOR/CO/5). Retrieved from https://www.refworld.org/docid/52d53eb34.html

UNHCR (2018). Refugee Crisis in Europe. Retrieved 04.03.2019 from https://www.unrefugees.org/emergencies/refugee-crisis-in-europe/

Vogel, D., Kovacheva, V., & Prescott, H. (2011). The size of the irregular migrant population in the European Union–counting the uncountable?. *International Migration, Vol 49*(5), 78-96. doi: https://doi.org/10.1111/j.1468-2435.2011.00700.x

Walseth, L. T., & Malterud, K. (2004). Salutogenese og empowerment i allmennmedisinsk perspektiv. Tidsskrift for Den Norske Lægeforening, 124, 65-66.

WHO. (2019). Constitution of WHO: principles. Retrieved 04.04.2018 from: http://www.who.int/about/mission/en/

WHO. (2014). *Mental health: a state of well-being*. Retrieved 04.04.2018 from http://www.who.int/features/factfiles/mental_health/en/

Willen, S. S. (2014). Plotting a Moral Trajectory, *Sans Papiers*: Outlaw Motherhood as Inhabitable Space of Welcome. *Ethos, 42:* 84–100. doi:10.1111/etho.12040

Zhang, L.C. (2008) *Developing methods for determining the number of unauthorized foreigners in Norway* (FoU report 2008). Oslo: Utlendingsdirektoratet. Retrieved from http://www.ssb.no/a/english/publikasjoner/pdf/doc_200811_en/doc_200811_en.pdf

Øien, C. & Sønsterudbråten, S. (2011). *No way in, no way out? A study of living conditions* of *irregular migrants in Norway* (Fafo- report 3/2011). Tøyen: Fafo

Annual- service, and project reports

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2009). *Helsesenteret for papirløse migranter: Årsrapport 2009*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2009.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2010). *Årsmelding 2010: Helsesenteret for papirløse migranter*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2010.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2011). *Årsmelding 2011: Helsesenteret for papirløse migranter*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2011.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2012a). *Årsrapport 2012: om det skjulte helsebehovet.* Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2012.compressed.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2012b). Erfaringsrapport: Stabiliseringsgruppe for etiopiske og eritreiske kvinner ved Helsesenteret for papirløse migranter i Oslo høsten 2012. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/Stabiliseringsgruppe-for-etiopiske-og-eritreiske-kvinner.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2013a). Årsrapport 2013: om det skjulte helsebehovet. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2013.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2013b). *Hverdagsmestring: erfaringsrapport.* Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/Hverdagsmestring.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2014a). *Årsrapport: om det skjulte helsebehovet*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2014.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2014b). *Prosjekt Psykisk Helse: Et prosjekt om mestring*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/10/Prosjekt-psykisk-helse-et-prosjekt-om-mestring-2012-2014.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2014c). *Erfaringsrapport: Stabiliseringsgruppe for arabisktalende menn, Helsesenteret for papirløse migranter i Oslo våren 2014.* Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/Stabiliseringsgruppe-for-arabisktalende-menn.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2015a). *Årsrapport 2015:Om det skjulte helsebehovet*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2015.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2015b). *Erfaringsrapport: Hverdagsmestringsgruppe for persisktalende kvinner og menn.* Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/Hverdagsmestringsgruppe-for-persisktalende-kvinner-og-menn.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2015c). *Erfaringsrapport: kroppsbevissthetsgruppe for somalisktalende kvinner, Vår 2015.* Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/Kroppsbevissthetsgruppe-for-somalisktalende-kvinner.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2016). *Årsrapport 2016: Det skjulte helsebehovet*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2016.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2017). *Årsmelding 2017: Helsesenteret for papirløse migranter*. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/%C3%85rsmelding-Helsesenteret-2017.pdf

The Church City Mission & Red Cross Oslo (Kirkens bymisjon & Røde kors Oslo). (2018).

Årsmelding 2017: Helsesenteret for papirløse migranter: Helsesenteret – Det skjulte helsebehovet 2018. Retrieved from https://kirkensbymisjon.no/content/uploads/2018/06/A%CC%8Arsmelding-Helsesenteret-2018.pdf

Laws, regulations and conventions

Council of Europe. (1950). *The European Convention on Human Rights*. Retrieved from https://www.echr.coe.int/Documents/Convention_ENG.pdf

Council for international organizations of medical science (CIOMS). (2016). *International* Ethical Guidelines for Health-related Research Involving Humans. Fourth Edition. Geneva: CIOMS. doi: http://doi.org/10.5334/ijic.478

Directorate of Labour and Welfare. (2012). *Rundskriv: Sosialtjenesteloven* (35). Retrieved from https://www.nav.no/rettskildene/Rundskriv/hovednr.35-lov-om-sosiale-tjenester-i-nav

Folketrygdloven. (1997). Lov om folketrygd (LOV-1997-02-28-19) Retrieved from https://lovdata.no/lov/1997-02-28-19

Forskrift om tjenester til personer uten fast opphold. (2011) . Forskrift om rett til helse- og omsorgstjenester til personer uten fast opphold i riket (FOR-2011-12-16-1255) Retrieved from https://lovdata.no/forskrift/2011-12-16-1255

Kvamme, E. & Ytrehus, S. (2015). Barriers to health care access among undocumented migrant women in Norway. Society, Health & Vulnerability, Vol. 6(1). doi: https://doi.org/10.3402/shv.v6.28668

Opplæringslova. (1998). The Education Act (in full Act relating to Primary and Secondary Education.)/ Lov om grunnskolen og den vidaregåande opplæringa (LOV-1998-07-17-61). Retrieved from https://lovdata.no/lov/1998-07-17-61

Pasient- og brukerrettighetsloven. (1999). Lov om pasient- og brukerrettigheter (LOV-1999-07-02-63). Retrieved from https://lovdata.no/lov/1999-07-02-63

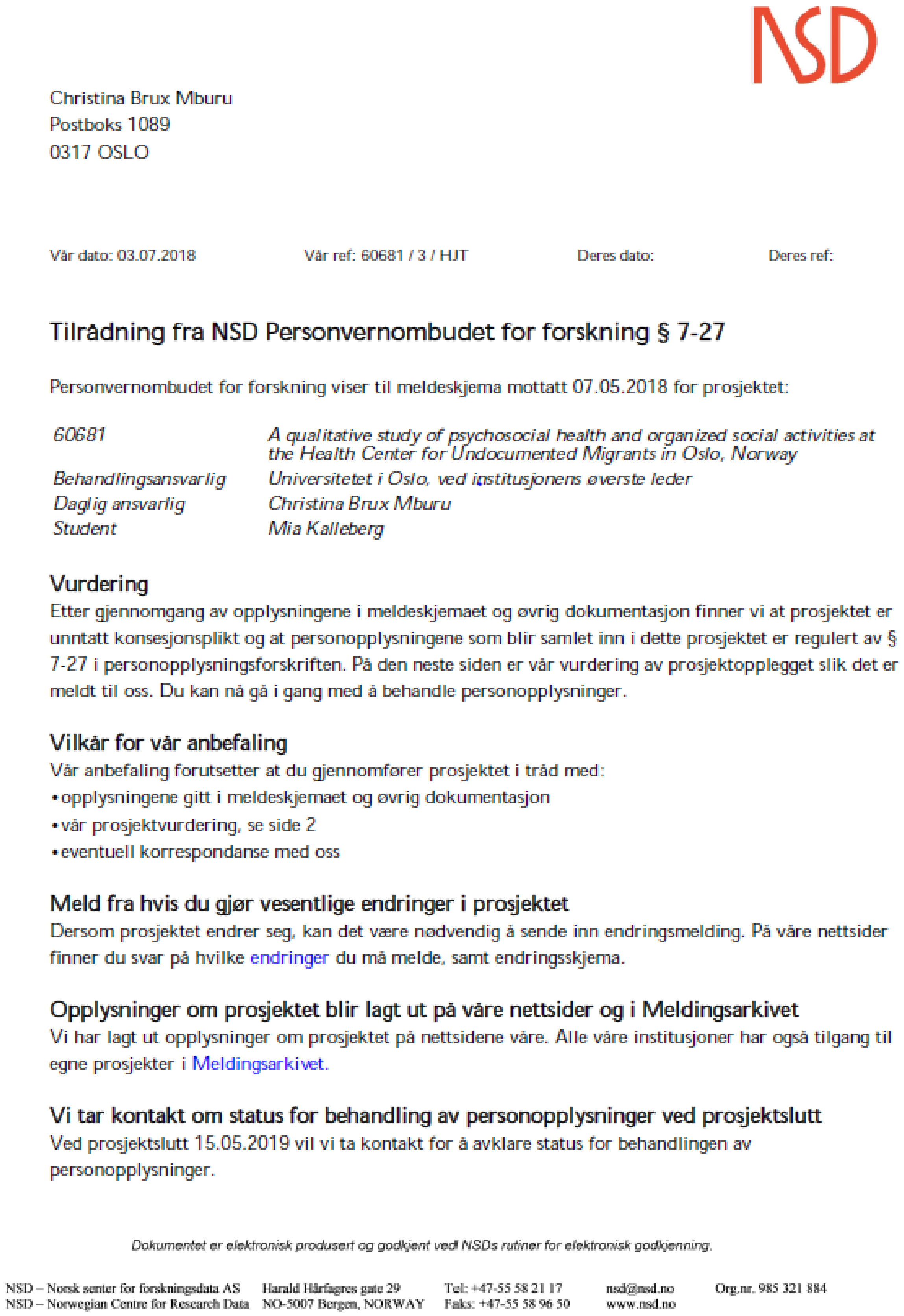
Smittevernloven (1994). Lov om vern mot smittsomme sykdommer (LOV-1994-08-05-55). Retrieved from https://lovdata.no/lov/1994-08-05-55

Sosialtjenesteloven. (2009). Lov om sosiale tjenester i arbeids- og velferdsforvaltningen (LOV-2018-12-20-98). Retrieved from https://lovdata.no/lov/2009-12-18-131

The Law Department. (2017). Tolkningsuttalelse fra lovavdelingen: § 2-1 b - Rett til helsehjelp for personer uten fast opphold i riket - forholdet til internasjonale forpliktelser. Retrieved from https://www.regjeringen.no/no/dokumenter/-2-1-b---rett-til-helsehjelp-for-personer-uten-fast-opphold-i-riket---forholdet-til-internasjonale-forpliktelser/id2565645/

United Nations. (1966). The United Nations International Covenant on Economic, Social and *Cultural Rights*. Retrieved from https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx

Appendix 1: Letter from the Norwegian Social Science Data Service



Christina Brux Mburu
Postboks 1089
0317 OSLO

Vår dato: 03.07.2018	Vår ref: 60681 / 3 / HJT	Deres dato:	Deres ref:

Tilrådning fra NSD Personvernombudet for forskning § 7-27

Personvernombudet for forskning viser til meldeskjema mottatt 07.05.2018 for prosjektet:

60681	*A qualitative study of psychosocial health and organized social activities at the Health Center for Undocumented Migrants in Oslo, Norway*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Christina Brux Mburu*
Student	*Mia Kalleberg*

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er unntatt konsesjonsplikt og at personopplysningene som blir samlet inn i dette prosjektet er regulert av § 7-27 i personopplysningsforskriften. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 15.05.2019 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

NSD – Norsk senter for forskningsdata AS Harald Hårfagres gate 29 Tel: +47-55 58 21 17 nsd@nsd.no Org.nr. 985 321 884
NSD – Norwegian Centre for Research Data NO-5007 Bergen, NORWAY Faks: +47-55 58 96 50 www.nsd.no

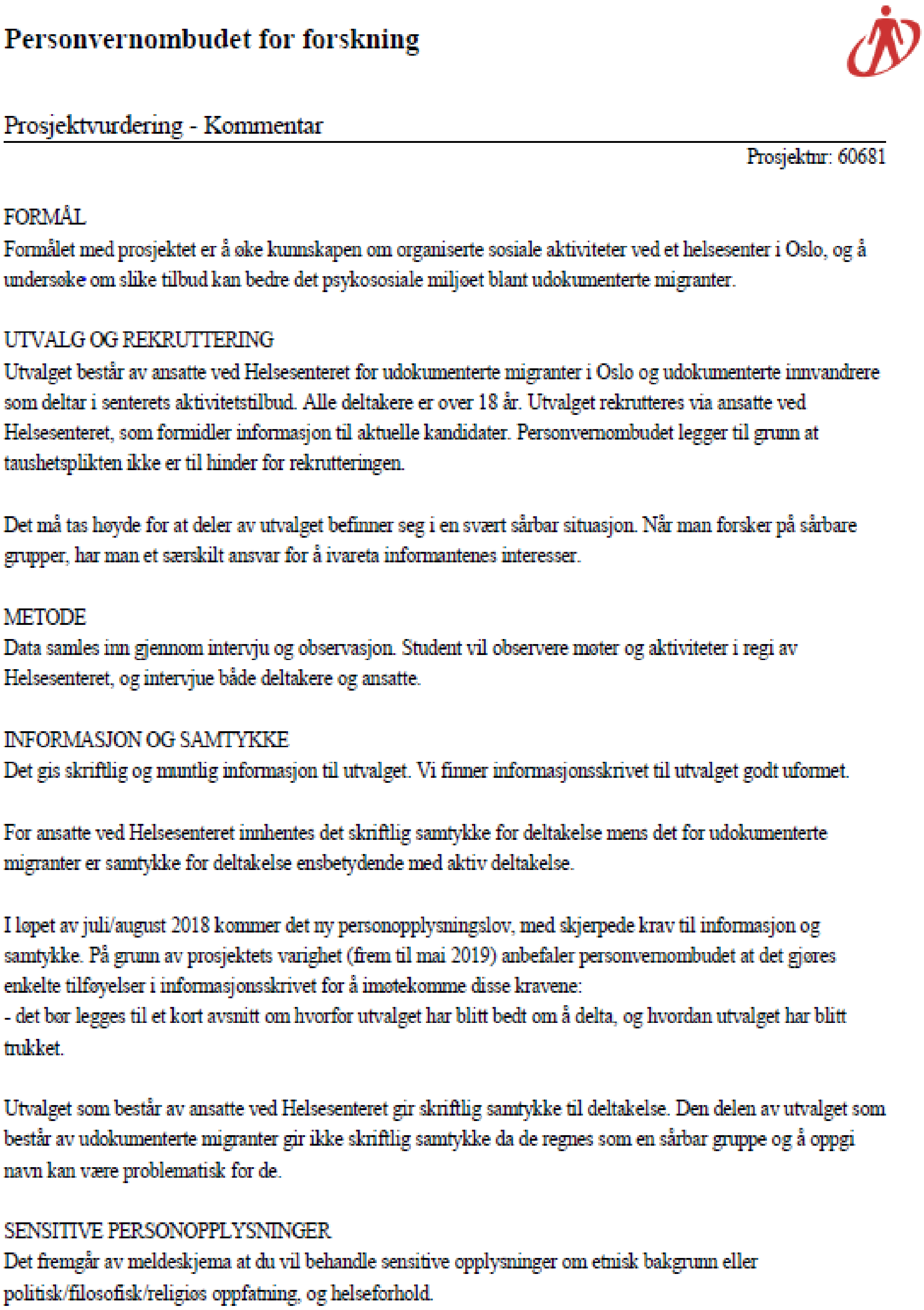
Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Vennlig hilsen

Dag Kiberg

Håkon Jørgen Tranvåg

Kontaktperson: Håkon Jørgen Tranvåg tlf: 55 58 20 43 / Hakon.Tranvag@nsd.no
Vedlegg: Prosjektvurdering
Kopi: Mia Kalleberg, mia.kk@hotmail.com



Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 60681

FORMÅL
Formålet med prosjektet er å øke kunnskapen om organiserte sosiale aktiviteter ved et helsesenter i Oslo, og å undersøke om slike tilbud kan bedre det psykososiale miljøet blant udokumenterte migranter.

UTVALG OG REKRUTTERING
Utvalget består av ansatte ved Helsesenteret for udokumenterte migranter i Oslo og udokumenterte innvandrere som deltar i senterets aktivitetstilbud. Alle deltakere er over 18 år. Utvalget rekrutteres via ansatte ved Helsesenteret, som formidler informasjon til aktuelle kandidater. Personvernombudet legger til grunn at taushetsplikten ikke er til hinder for rekrutteringen.

Det må tas høyde for at deler av utvalget befinner seg i en svært sårbar situasjon. Når man forsker på sårbare grupper, har man et særskilt ansvar for å ivareta informantenes interesser.

METODE
Data samles inn gjennom intervju og observasjon. Student vil observere møter og aktiviteter i regi av Helsesenteret, og intervjue både deltakere og ansatte.

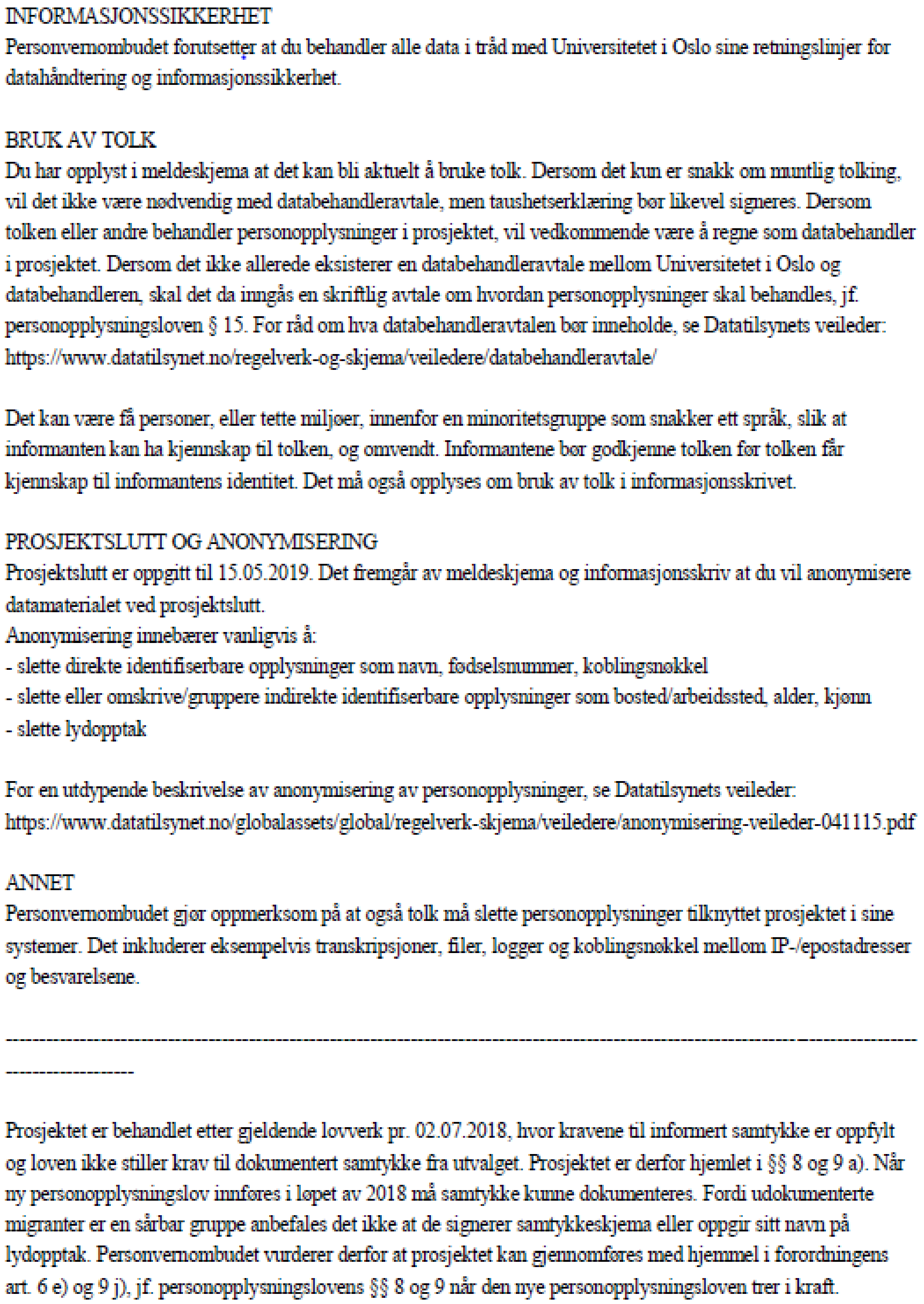
INFORMASJON OG SAMTYKKE
Det gis skriftlig og muntlig informasjon til utvalget. Vi finner informasjonsskrivet til utvalget godt utformet.

For ansatte ved Helsesenteret innhentes det skriftlig samtykke for deltakelse mens det for udokumenterte migranter er samtykke for deltakelse ensbetydende med aktiv deltakelse.

I løpet av juli/august 2018 kommer det ny personopplysningslov, med skjerpede krav til informasjon og samtykke. På grunn av prosjektets varighet (frem til mai 2019) anbefaler personvernombudet at det gjøres enkelte tilføyelser i informasjonsskrivet for å imøtekomme disse kravene:
- det bør legges til et kort avsnitt om hvorfor utvalget har blitt bedt om å delta, og hvordan utvalget har blitt trukket.

Utvalget som består av ansatte ved Helsesenteret gir skriftlig samtykke til deltakelse. Den delen av utvalget som består av udokumenterte migranter gir ikke skriftlig samtykke da de regnes som en sårbar gruppe og å oppgi navn kan være problematisk for de.

SENSITIVE PERSONOPPLYSNINGER
Det fremgår av meldeskjema at du vil behandle sensitive opplysninger om etnisk bakgrunn eller politisk/filosofisk/religiøs oppfatning, og helseforhold.



INFORMASJONSSIKKERHET

Personvernombudet forutsetter at du behandler alle data i tråd med Universitetet i Oslo sine retningslinjer for datahåndtering og informasjonssikkerhet.

BRUK AV TOLK

Du har opplyst i meldeskjema at det kan bli aktuelt å bruke tolk. Dersom det kun er snakk om muntlig tolking, vil det ikke være nødvendig med databehandleravtale, men taushetserklæring bør likevel signeres. Dersom tolken eller andre behandler personopplysninger i prosjektet, vil vedkommende være å regne som databehandler i prosjektet. Dersom det ikke allerede eksisterer en databehandleravtale mellom Universitetet i Oslo og databehandleren, skal det da inngås en skriftlig avtale om hvordan personopplysninger skal behandles, jf. personopplysningsloven § 15. For råd om hva databehandleravtalen bør inneholde, se Datatilsynets veileder: https://www.datatilsynet.no/regelverk-og-skjema/veiledere/databehandleravtale/

Det kan være få personer, eller tette miljøer, innenfor en minoritetsgruppe som snakker ett språk, slik at informanten kan ha kjennskap til tolken, og omvendt. Informantene bør godkjenne tolken før tolken får kjennskap til informantens identitet. Det må også opplyses om bruk av tolk i informasjonsskrivet.

PROSJEKTSLUTT OG ANONYMISERING

Prosjektslutt er oppgitt til 15.05.2019. Det fremgår av meldeskjema og informasjonsskriv at du vil anonymisere datamaterialet ved prosjektslutt.
Anonymisering innebærer vanligvis å:
- slette direkte identifiserbare opplysninger som navn, fødselsnummer, koblingsnøkkel
- slette eller omskrive/gruppere indirekte identifiserbare opplysninger som bosted/arbeidssted, alder, kjønn
- slette lydopptak

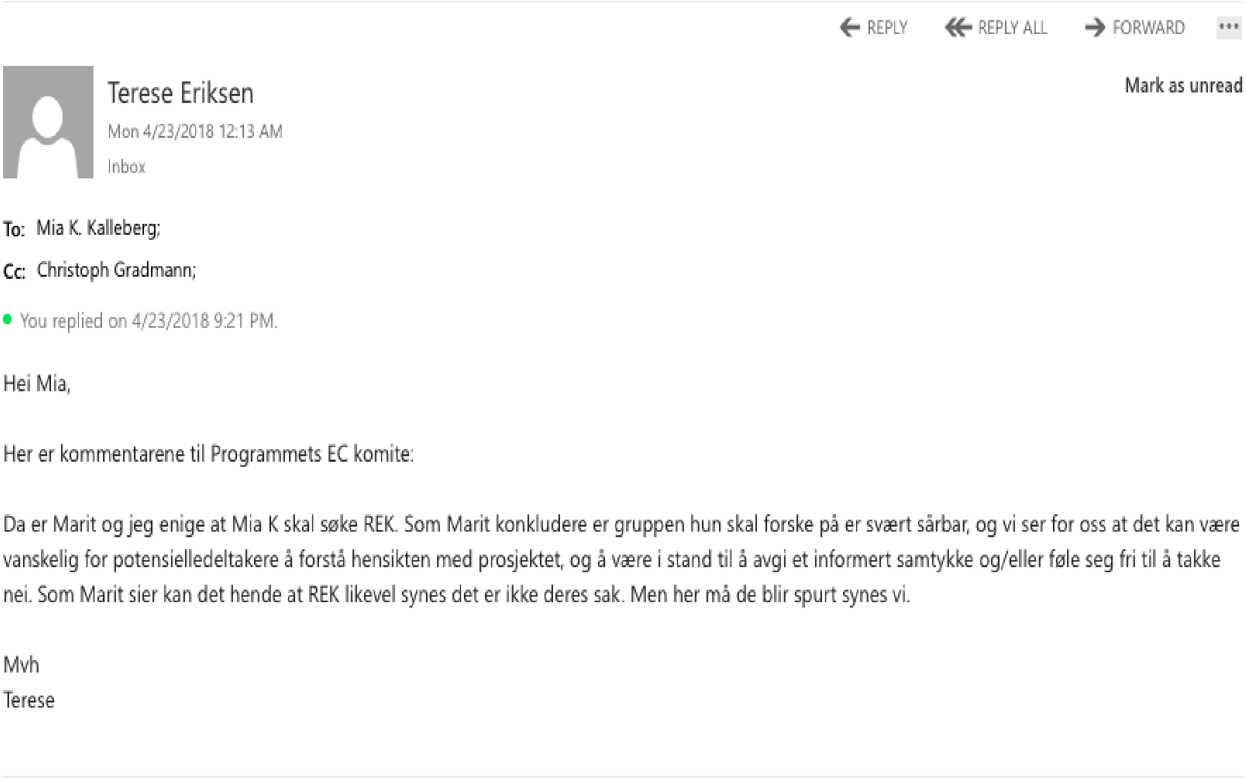
For en utdypende beskrivelse av anonymisering av personopplysninger, se Datatilsynets veileder: https://www.datatilsynet.no/globalassets/global/regelverk-skjema/veiledere/anonymisering-veileder-041115.pdf

ANNET

Personvernombudet gjør oppmerksom på at også tolk må slette personopplysninger tilknyttet prosjektet i sine systemer. Det inkluderer eksempelvis transkripsjoner, filer, logger og koblingsnøkkel mellom IP-/epostadresser og besvarelsene.

Prosjektet er behandlet etter gjeldende lovverk pr. 02.07.2018, hvor kravene til informert samtykke er oppfylt og loven ikke stiller krav til dokumentert samtykke fra utvalget. Prosjektet er derfor hjemlet i §§ 8 og 9 a). Når ny personopplysningslov innføres i løpet av 2018 må samtykke kunne dokumenteres. Fordi udokumenterte migranter er en sårbar gruppe anbefales det ikke at de signerer samtykkeskjema eller oppgir sitt navn på lydopptak. Personvernombudet vurderer derfor at prosjektet kan gjennomføres med hjemmel i forordningens art. 6 e) og 9 j), jf. personopplysningslovens §§ 8 og 9 når den nye personopplysningsloven trer i kraft.

Appendix 2: Letter from the Internal Ethics Committee



Terese Eriksen
Mon 4/23/2018 12:13 AM
Inbox

To: Mia K. Kalleberg;
Cc: Christoph Gradmann;

You replied on 4/23/2018 9:21 PM.

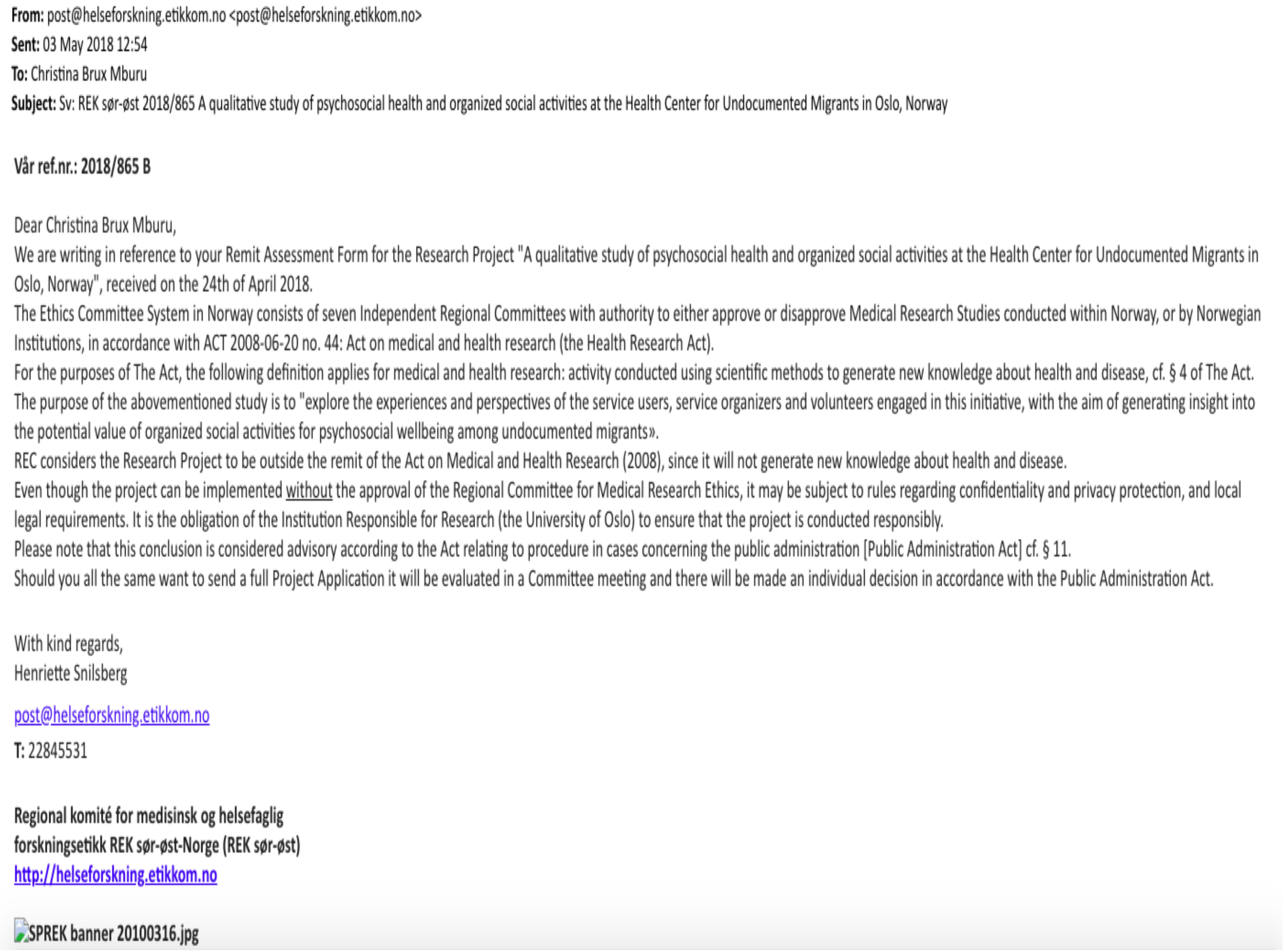
Hei Mia,

Her er kommentarene til Programmets EC komite:

Da er Marit og jeg enige at Mia K skal søke REK. Som Marit konkludere er gruppen hun skal forske på er svært sårbar, og vi ser for oss at det kan være vanskelig for potensielledeltakere å forstå hensikten med prosjektet, og å være i stand til å avgi et informert samtykke og/eller føle seg fri til å takke nei. Som Marit sier kan det hende at REK likevel synes det er ikke deres sak. Men her må de blir spurt synes vi.

Mvh
Terese

Appendix 3: Letter from the Regional Ethics Committee



From: post@helseforskning.etikkom.no <post@helseforskning.etikkom.no>
Sent: 03 May 2018 12:54
To: Christina Brux Mburu
Subject: Sv: REK sør-øst 2018/865 A qualitative study of psychosocial health and organized social activities at the Health Center for Undocumented Migrants in Oslo, Norway

Vår ref.nr.: 2018/865 B

Dear Christina Brux Mburu,
We are writing in reference to your Remit Assessment Form for the Research Project "A qualitative study of psychosocial health and organized social activities at the Health Center for Undocumented Migrants in Oslo, Norway", received on the 24th of April 2018.
The Ethics Committee System in Norway consists of seven Independent Regional Committees with authority to either approve or disapprove Medical Research Studies conducted within Norway, or by Norwegian Institutions, in accordance with ACT 2008-06-20 no. 44: Act on medical and health research (the Health Research Act).
For the purposes of The Act, the following definition applies for medical and health research: activity conducted using scientific methods to generate new knowledge about health and disease, cf. § 4 of The Act.
The purpose of the abovementioned study is to "explore the experiences and perspectives of the service users, service organizers and volunteers engaged in this initiative, with the aim of generating insight into the potential value of organized social activities for psychosocial wellbeing among undocumented migrants».
REC considers the Research Project to be outside the remit of the Act on Medical and Health Research (2008), since it will not generate new knowledge about health and disease.
Even though the project can be implemented without the approval of the Regional Committee for Medical Research Ethics, it may be subject to rules regarding confidentiality and privacy protection, and local legal requirements. It is the obligation of the Institution Responsible for Research (the University of Oslo) to ensure that the project is conducted responsibly.
Please note that this conclusion is considered advisory according to the Act relating to procedure in cases concerning the public administration [Public Administration Act] cf. § 11.
Should you all the same want to send a full Project Application it will be evaluated in a Committee meeting and there will be made an individual decision in accordance with the Public Administration Act.

With kind regards,
Henriette Snilsberg

post@helseforskning.etikkom.no

T: 22845531

Regional komité for medisinsk og helsefaglig
forskningsetikk REK sør-øst-Norge (REK sør-øst)
http://helseforskning.etikkom.no

SPREK banner 20100316.jpg

Appendix 4: Interview guide

Service using participants and activity participants

Psychosocial wellbeing: needs and concerns

- What is wellbeing for you?
- What is important for your wellbeing?
- Can you tell me about a good day that you have recently had? (If it is difficult to recall, can you imagine what a good day might be like and tell me about that?)
- During a week, what is it that gives you a good feeling, (a sense of meaning and/or happiness?)
- Can you tell me about something that gives you a sense of relief or a "break" from the difficulties that you face in your everyday life?

Motivation

- What made you want to be a part of the initiative?
- What is it that makes you continue to participate? Tell me about why you want to or not want to continue participating.

Experience and expectations with the initiative

- What did you think the group activities was going to be like?
- How has it actually been?
- What do you do in the group activities? Tell me about what you do in the group activities, how has participation been for you?
- Can describe one of your favorite moments from the activities or one of the things that you have liked best
- Can you tell me about something that made you feel bad or something that surprised you during the activities?

Perceived benefits and drawbacks/challenges

- Tell me about the relation you have with the participants

- Can you describe what you are feeling or thinking before, during and after the activities.
- Can you tell me what you and the other participants are talking about during the activities?
- Do you talk about what you think about the initiative?
- Is the initiative contributing/impacting (positive or negative) in any way in your life?
- If so, what kind of impact?
- Would you want to keep attending the group activities in the future? Why or why not?

Planing group

Motivation

- Tell me about what made you decide to participate in the initiative.
- Why do you think the undocumented service users are participating?
- Why do you think that some said that they would attend but then didn´t?
- Why do you think those who participated the first time didn´t keep attending?

Experiences

- Can you describe how the first times you participated in the group activities was, how did you experience it?
- Can you tell me about how it is to participate in the activities now? (Maybe something has changed?)
- What kind of changes have been done throughout the initiative?
- How do you think the initiative should be in the future?
- Can you describe your ideal group activity initiative?

Perceived benefits and drawbacks

- Can you tell me about the emotions experienced during the initiative/group activities/period?

- Can you describe the interaction and relationship between participants in the group?
- How is the group dynamic? Has it changed from the beginning of the initiative?
- What kind of feedback are you getting from other participants?

Appendix 5: Consent form for activity initiative participants

English

Request for participation in a research project:

"A qualitative study of psychosocial health and organized social activities at the Health Center for Undocumented Migrants in Oslo, Norway"

Background and Purpose

The Health Center for Undocumented Migrants is expanding their services to include organized social activities. A student from the University of Oslo, Institute of Health and Society, is going to follow the process, with the aim of understanding the organization and implementation of these activities, as well as the experiences and perspectives of those who participate in them. The information collected from this research will be used to write a master's thesis and/or article(s), which can be of help for the Health Center to further develop their offer and useful for other organizations that provide health and social services. The study has been notified to the Data Protection Official for Research, NSD - Norwegian Centre for Research Data.

Your experience with, and perception of the activity group is important knowledge for the research being conducted. Because of your engagement and participation in the activity initiative at the Health Center for Undocumented Migrants you have been invited to participate in the study.

What does participation in the project imply?

By participating in the study, you will contribute to an increased understanding of the ways in which it is experienced and its potential value. If you consent, the researcher will participate in the activities, meetings and arrangements associated with the group activities, observing what is happening and talking with those present. In addition to this, you might be invited to sit down with the researcher for a conversation/interview, in which you can talk about, for example, your motivation for joining the activities, your expectations and your experiences. You are always allowed to say no and you do not have to give a reason for this.

What will happen to the information about you?

All personal data will be treated confidentially. Notes might be taken during the activities and interviews. These notes will be stored in a password protected drive on the University of Oslo´s server, accessible only to the researcher. An audio recorder will be used during the additional conversations/interviews, but only if you are comfortable with it. The audio records will be stored in the same drive as the notes and deleted from the recorder right after the interview. Your real name will not be written down or recorded at any point in the project. The research project is scheduled for completion in May 2019, and all non-anonymous data, notes and records will be deleted by that time. In the finished paper(s), all of the data/information about you will be anonymized, meaning that it will not be possible to identify you when reading it.

Voluntary participation

It is voluntary to participate in the research project, and you can at any time choose to withdraw your consent without stating any reason. If you decide to withdraw, all your personal data will be deleted. Not agreeing to participate or withdrawing at a later date will not have an impact on your participation in the Health Center’s activity initiative. You can participate in the Health Center’s activity initiative and not participate in the research project.

If you have any questions concerning the project, please contact the researcher, Mia Kaels Kalleberg (phone number: 47861833/ email: mia.k.kalleberg@studmed.uio.no) or the supervisor of the research project, Christina Brux Mburu (phone number: 96879017 / email: c.b.mburu@medisin.uio.no).

Consent for participation in the study

Consent is attained verbally to secure participant anonymity. By verbally saying that you have received information about the project and that you are willing to participate, you are agreeing to be a part of the research project. ‘

Norwegian

Forespørsel om deltakelse i forskningsprosjektet

En kvalitativ studie om psykososial helse og organiserte sosiale aktiviteter på Helsesenteret for Udokumenterte Migranter i Oslo, Norge.

Bakgrunn og formål

Helsesenteret for Udokumenterte Migranter i Oslo utvider helsetilbudet sitt og skal nå tilby organiserte sosiale aktiviteter. En student fra Universitetet i Oslo, Institutt for Helse og Samfunn, skal følge prosessen og prøve å forstå organiseringen og implementeringen av aktivitetene samt oppfatninger og erfaringer til deltagerne. Studenten skal bruke informasjonen til å skrive en master oppgave og/eller artikler. Oppgaven vil brukes til å bedre forstå og videre utvikle Helsesenterets sosiale aktivitets tilbud. Studien er meldt til personvernombudet for forskning, NSD – Norsk senter for forskningsdata AS.

Dine erfaringer og refleksjoner rundt Helsesenterets sosiale aktivitets tilbud kan være et viktig bidrag i studien. På grunn av ditt engasjement, oppmøte og deltagelse på de sosiale aktivitetene, utført i regi av Helsesenteret for Udokumenterte Migranter, inviteres du til å ta delta i studien.

Hva innebærer deltakelse i studien?

Ved å delta i studien bidrar du med erfaringer og gjennom dette en økt forståelse for hvilken verdi et sosialt aktivitetstilbud kan ha. Hvis du samtykker vil forskeren delta på møtene, aktivitetene og arrangementene holdt i regi av tilbudet. Forskeren vil observere og prate med deltagerne underveis. I tillegg kan du bli spurt om å møtes for en samtale/intervju med forskeren der du kan prate om blant annet din motivasjon for å delta, forventninger du har og erfaringer du har gjort deg. Du kan når som helst velge å trekke deg fra studien, og du har ingen forpliktelse til å oppgi noen grunn for dette.

Hva skjer med informasjonen om deg?

All personlig data vil bli behandlet konfidensielt. Forskeren vil skrive notater fra aktivitetene og under samtalene. Notatene vil bli lagret på Universitetet i Oslo sin passord beskyttede harddisk, med forskeren som eneste person med tilgang. Hvis deltageren er komfortabel med det vil tilleggs-samtalene/intervjuene bli tatt opp på lydopptak. Lydopptakene vil bli slettet fra opptakeren med en gang etter at de er lagret. De vil bli lagret på samme harddisk som notatene, dette gjøres rett etter intervjuet. Ditt ekte navn vil aldri bli notert eller tatt opp på bånd. Forskningsprosjektet skal være fullført innen mai 2019 og all data, inkludert notater og lydopptak, vil være slettet innen da. All data/informasjon om deg som brukes i selve oppgaven/artiklene vil bli anonymisert, det vil derfor ikke være mulig å identifisere deg gjennom å lese disse.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli slettet. Hvis du ikke ønsker å delta eller senere velger å trekke deg vil ikke dette ha innvirkning på din deltagelse i Helsesenterets aktivitetstilbud. Du kan delta på Helsesenterets aktivitetstilbud uten å delta i forskningsprosjektet.

Dersom du har spørsmål til studien, ta kontakt med forskeren, Mia Kaels Kalleberg (telefonnummer: 47861833/ email: mia.k.kalleberg@studmed.uio.no) eller forskningsprosjektets veileder, Christina Brux Mburu (telefonnummer: 96879017 / email: c.b.mburu@medisin.uio.no).

Samtykke til deltakelse i studien

Fordi du er ansatt på helsesenteret gir du din samtykke om å være en del av forskningsprosjektet skriftlig. Ved å skrive under på samtykke skjemaet bekrefter du at du har fått informasjon om forskningsprosjektet og at du ønsker å delta.

Underskrift: ___________________________