

**Migration, super-diversity, and health: studies on  
immigrants' health care integration in Norway**

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## Summary

This dissertation is about the extra-medical dimensions of immigrants' health and health care integration. The inquiry is guided by two core questions: How do immigrants' cultural norms and values pertaining to family, gender roles, and social organization intertwine with processes of immigrants' health care integration? How do immigrants negotiate health beliefs, behaviors, and health care-seeking practices upon resettlement? These overlapping questions are explored through on qualitative research among Pakistani and Somali immigrants in Oslo, Norway. The concept of super-diversity underscores that processes of immigrants' health care integration increasingly have to be understood not only in light of the continuous diversification of diversity that results from sustained migration over time, but with attention to variations in integration, transnational relations, and culture differences. The four articles comprising the empirical part of the dissertation cover the following topics: The first article explores the link between integration, negotiations of intergenerational reciprocity, and responses to signs and symptoms of cognitive decline among Pakistanis. Article two is about trust, cultural health capital mobilizations, and health care integration among Somali immigrants. The third article takes vantage point in quantitative findings to explore the link between migration, gender role negotiations, and mental illness responses among Somalis in diaspora. The fourth article lends a comparative perspective to the bridge-builder role of Pakistani and Somali immigrant organizations in public health matters and processes of immigrants' health care integration. Building on classical sociological theory, the dissertation contributes to immigrant health research and the social scientific study of migration, processes of diversification, and integration.



# **Part I. The Foundations**



## 1. Introduction

On the 11<sup>th</sup> of March 2020, the General-Director of the World Health Organization (WHO), Tedros Adhanom Ghebreyesus, declared the outbreak of Covid-19 a global pandemic (WHO 2020). The virus was first contracted by humans around November 2019; presumably at a live animal market in Wuhan, China, before migrating between people and to new countries through international travel. Immediately, speculations arose regarding cause and susceptibility. Whereas the 45<sup>th</sup> president of the United States, Donald Trump, persistently referred to the “Chinese virus” (Al Jazeera News 2020), insisting that it would cause minimal harm within the American population, in the Brazilian favelas of Rio de Janeiro, the coronavirus was contrastingly labelled “a rich man’s disease” (BBC 2020). Regardless of perspective, the virus spread silently to new countries and ethnic groups. In Norway, this was confirmed throughout early April, when a range of news outlets featured stories about immigrants who were concerned that limited trust and information attainment placed immigrants at particular risk (NRK 2020a). The basis for concern was a belated increase in corona-cases among immigrants in Norway, even though the national apex for new cases was passed a month earlier (Norwegian Institute of Public Health 2020). The unfolding of this situation is a glaring example that migration and increasing ethno-cultural diversity poses new health related challenges both to immigrants and to the health care systems of their resettlement destinations. Moreover, it points to the need for new sociological insights about the ways that immigrants deal with and think about health and illness in migratory contexts.

Migration underpins the entire human history (Manning 2012). Still, it is reasonable to say that “the age of migration” is now (Castles, de Haas, and Miller 2013). Contemporary migration is faster, more complex, and diverse than ever before because of global market integration and developments in communication- and transportation technologies since the end

of WWII (Weiner 1997). As a result of decades of migration, and despite tightened immigration regimes in the wake of the 9/11 terror attacks and the unsettling effects of the Arab Spring, in sum, ethnic minorities now make up nearly half the population in major European cities like Amsterdam. This is also the situation in Oslo, where minorities currently make up more than half of all residents in several of the city's 15 districts (Høydahl 2015), and where continued immigration and generational procreation has produced grounds for thinking in terms new layers of distinction and difference. The social and ethno-cultural complexities arising from sustained migration and ethno-cultural diversification are here to be conceptualized in terms of “super-diversity” (Vertovec 2007).

A common observation in research on migration and health, is that “migrants are often (at least initially) more healthy than non-migrant populations in their host countries (the so-called healthy immigrant effect), not least because the act of migration usually requires those involved to be in good health” (Rechel et al. 2013:1237). Yet, this does not necessarily mean that immigrants' health statuses will persist over time, as factors like acculturative stress, dietary changes, educational lags, and socio-economic difficulties are associated with negative health implications (Abebe 2014; Levecque and Van Rossem 2015). In this regard, it is perhaps not surprising that duration of residency has been correlated with declining health status (Kjøllestadal et al. 2019). The mortality of immigrant in Norway has similarly been found to increase with duration of residency (Syse and Dzamarija 2016). However, while inconclusive as to the reasons behind the identified patterns, although asserted to be uniquely complex for different immigrant groups, the above studies point to immigrants' social worlds for explanations. Hence, as the introductory recap of immigrants' experiences of the corona pandemic in Norway also indicates, there is a widening knowledge gap pertaining to the extra-medical dimensions of immigrants' health and health care integration.

In this dissertation, I aim to fill part of this knowledge gap through a qualitative exploration of the socio-cultural and relational dimensions of immigrants' health care integration in Norway. The focus of analysis is set to the experience narratives of Pakistani and Somali immigrants in Norway and their encounters with the Norwegian health care culture. While there are examples of allopathic medicine in both Pakistan and Somalia, particularly sale of pharmaceuticals, the infrastructure for large-scale institutionalized health care-provision is largely missing, making access and familiarity with formalized health care a matter largely of social privilege (Shaw 2000; Ali et al. 2014). This relative lack in familiarity with western medicine, combined with ecologically and culturally evolved systems of traditional medicine along with spiritual etiologies and solutions, implies that many immigrants are likely to encounter the health care institutions of their resettlement societies with "discordant beliefs, divergent expectations, and silent worries" (Pavlish, Noor, and Brandt 2010). Therefore, as attested to by the impact of the corona outbreak among immigrants in Norway, enhancing our sociological insights about immigrants' health care integration and its determinants is both pertinent and warranted.

Considering migration implies a broad set of changes in the lives of those who migrate as well as to their societies of resettlement, my approach is to view health care-seeking and integration as processes that are highly intertwined with other life aspects, and integration in general. Integration is here to be conceived of as a relational process of negotiation that takes place between immigrants, juxtaposed to the society of resettlement. In attaining and conveying insights regarding processes of health care integration, I explore how within-group social dynamics and relational structures intertwine with negotiations of health beliefs, practices, and attitudes towards the Norwegian health care system.

The argument running through this dissertation is that processes of immigrants' health care integration, which can be discerned in ways that immigrants negotiate interpretations and responses around signs and symptoms of illness, are intertwined with wider integration

processes. In Norway, like in many other countries, “the political inclusion of minorities has meant the acceptance of groups formed by specific (often conflicting) historical narratives, and the embodied memories, feelings, and desires that the narratives have helped to shape” (Asad 2003:174). Hence, while immigrants in Norway may face pressures to contribute in society and to the welfare state, in the private sphere people can freely associate and uphold culturally imbued ideas and practices. My empirical focus is therefore lent to health care integration as a process that takes place in social settings like the family, religious establishments, and social gathering places like immigrant organizations. Under the umbrella of health care integration, the four articles of the dissertation are about the following topics: negotiations of intergenerational reciprocity and responses to dementia disease among Pakistanis, trust and cultural health capital mobilizations among Somalis, gender roles and mental illness responses among Somalis, and the role of Pakistani and Somali immigrant organizations as bridge-builders in health matters.

### Contributing to the sociology of migration and health

Considerable research exists in Norway on immigrants’ health (e.g. Abebe, Elstad, and Lien 2018; Abebe, Lien, and Elstad 2017; Elstad, Finnvold, and Texmon 2015), yet information on the determinants of immigrants’ pathways to health and care services, as well as how health beliefs and practices become subject to negotiation in the context of migration, remains scattered and incomplete. Moreover, while much attention has been paid to the general characteristics of immigrant health, less attention has been afforded the ways that immigrants negotiate health beliefs, practices and decisions about health care utilization in social settings, such as the family and immigrant social networks. A key aim of this dissertation is therefore to apply a sociological conceptual framework to empirically explore, uncover, and enhance our



understanding of the ways that socio-cultural determinants and process of cultural negotiation around health matters shape immigrants' health care seeking practices, and immigrants' health care integration more broadly. As part of this aim, I identify barriers to immigrants' health care integration and the ways that solutions to these barriers become subject to debate among immigrants themselves. Central to the exploration are health beliefs, socio-cultural factors, and attitudes. In aiming to fill part of the knowledge gap on health care integration as a social and relational process, the dissertation is guided by two overarching questions, namely:

- *How are imported cultural norms and values pertaining to family, gender roles, and social organization intertwined with processes of immigrants' health care integration?*
- *How do immigrants negotiate health beliefs, behaviors, and health care seeking practices upon resettlement in initially unfamiliar socio-cultural and institutional contexts?*

The first question not only asserts that processes of immigrants' health care integration are intertwined not purely with traditional or culturally established understandings of health, sickness, and the body, but relatedly that such processes are heavily informed by cultural ideas about social and relational practices. In this regard, the question speaks to the notion that culture has long been "the missing link" in health research (Singer et al. 2016). The question also recognizes that health matters and the ideas and practices that surround them constitute a window for broadening our understanding of the relationship between immigrants and their societies of resettlement.

The importance of exploring health matters in light of cultural norms for relationships, interactions, and health can be illustrated with reference to the American Sociologist, Irwing

Zola, and an observation about doctors' attitudinal approaches to patients who postponed necessary appointments (Zola 1973). According to Zola, rather than inquiring about why the patient did not show up earlier despite apparent symptoms and presumable worries, he should instead ask the patient what caused him to arrive at this particular moment. From this example, it is clear that the latter question would likely yield more useful information about the health needs and problems of the patient. Hence, bringing it back to migration and sociocultural differences, we can assert that health issues and decisions to seek help often take place in detachment from health care providers and institutions, supposing a social and relational dimension to immigrants' health care integration. Hence, in exploring the ways that Pakistani and Somali immigrants in Norway deal with health matters, I bring attention to the ways that social relationships and networks inform decision making, opportunities for health care seeking, and attitudes towards the Norwegian health care system. In this way, it is, for example possible to ascertain explanations for immigrants' patterns of service utilization.

The second question, which alludes to the problem that migration often involves encounters between people who are mutually unfamiliar with each other's cultural frameworks for thinking about health and illness, overlaps with the first in the sense that social relationships and networks, and the resources contained within them, are central to any consideration of the ways that immigrants negotiate health beliefs, behaviors, and practices.

To illustrate the rationale for approaching immigrants' health care integration as a matter of negotiation around conflicting meanings and rationales pertaining to illness, I here highlight two observations made by the French sociologist, Michel Foucault, in his seminal historical-philosophical work on the *History of Madness* (Foucault 1961). The first is the notion that every society at any given moment defines deviance and madness, as well as other health issues, in a particular fashion, and when ascribed to individuals who meet the relevant criteria, the responses they meet, for example institutionalization, hospitalization, or stigmatization, will

work to affirm the normality of the remainders in society. The second observation is that definitions and responses to deviance change over time, depending on the conditions for what are considered normal and deviant. While important in themselves, both of these observations underscore that dominant frameworks of definition pertaining to health are contextual and temporally relative. In the context of migration, then, there is a question of what happens to people's familiar frameworks of interpretation and responses, which may be dominant in one socio-cultural and historical setting, are contrasted against those of their new surroundings.

In the context of migration, when people bring with them their own health beliefs and practices to encounter a new health care culture and institutional structure, it is possible that dominant health perspectives of the host country might face both competition and resistance from multiple parallel interpretative frameworks. Health care integration is thus a matter of immigrants' ability and willingness to familiarize with and submit to a new framework of norms and expert knowledge to achieve health benefits. This, is not to say that traditional perspectives on and solutions to health and illness in the immigrants' localities of departure are without benefit and value, also to immigrants, but that resort to the familiar can delay receipt of allopathic medicine as well prevent general uptake of health advice and information of relevance to both individual and public health.

The themes and concepts in focus throughout this dissertation were selected and developed on basis of patterns emerging through analysis of the empirical data. My initial idea and broad mandate behind the data collection was to look at health care seeking through an exploration of "third party" involvements. The notion of third parties underscores that particular individuals and organizations may act like filters between immigrants ("first party") and the formal health care system ("second party"). On the one hand, third parties may function as mediators and door-openers in accordance with Norwegian health care, but on the other hand,

they may also filter information and advice through their own health beliefs and myths about Norwegian health care and in this way subvert both official policy objectives pertaining to equitable health care provision and outreach to immigrants in public health matters. The term also denotes that intermediary engagements or sources of influence in immigrant health matters take myriad forms. As I tapped into this intermediary field, however, the following set of core analytical concepts emerged: intergenerational reciprocity, bridge-building, gender roles, familiarity, trust, and cultural health capital. I elaborate on these concepts and their overlaps in chapter three, which outlines the dissertation's theoretical framework.

### The layout of the dissertation

This dissertation is structured as follows. In chapter two, I proceed to describe the contextual background for the dissertation topic. Here, I map out the Pakistani and Somali migration and resettlement experience in Norway, and discuss the health and health care implications of socio-cultural diversification and “super-diversity” (Vertovec 2007). In chapter three, I lay out the theoretical concepts and perspectives foundational to the article collection, as well as the reasons for their present relevance. In chapter four, I outline the study approach and methods applied in data collection, management, and analysis. The chapter is also devoted to reflection around the methodological and ethical issues encountered in the study of difference within one's own society, and their implications for choice of research methods. In chapter five, I present an overview of the four articles. Finally, in chapter six, I highlight the main findings and discuss their implications for the Norwegian health care system, public health, and immigrants' health care integration. Part two of the dissertation consists of the four empirically based articles.

## **2. The context**

In this chapter, I provide an outline of the contextual backdrop for the dissertations' focus on processes of health care integration among Pakistanis and Somalis in Norway. I begin the chapter with a brief outline of the background and characteristics of Pakistani and Somali migration to Norway. This is followed by a related discussion on ethno-cultural diversification and super-diversity. I then outline some of the ways that super-diversity is linked to immigrants' familiarization with the Norwegian health care culture, and what it implies for the Norwegian health care system.

### **Pakistani and Somali migration and resettlement in Norway**

The association between migration and swift demographic changes makes migration one of the most contentious social phenomena of our present (Castles, de Haas, and Miller 2013). In Europe, the tensions associated with immigration and diversity have surfaced in the headscarf- and secularism affaire in France (Asad 2005), debates about religion and freedom of expression spurred by the Danish cartoons featuring the Prophet Muhammad (Lindekilde, Mouritsen, and Zapata-Barrero 2009), terror attacks and resulting fears in several countries (Nesser 2018), revival of right wing extremism (Fangen 1998; Fangen and Classon 2013; Koehler 2016), and in media and political constructions of immigrants as a transformative threat to public solidarity and welfare arrangements (Algan, Bisin, and Verdier 2012; Brochmann and Dølvik 2018). Across national contexts, recurring displays of clashing values, xenophobia, and mistrust have served to symbolically legitimize a social and political "backlash against multiculturalism," the notion that people of different cultures and values can coexist within shared national frameworks (Vertovec and Wessendorf 2010). However, despite restrictive immigration policies and rising concerns about the preservation of culture, identity, and welfare, the

consequences of climate change, combined with globalization, ongoing conflicts, and a North-South divide, suggest the ethno-cultural complexity of European citizenries will continue to rise over the coming decades (Castles 2004; Donato and Massey 2016). From this perspective, it is important to recognize that the health- and health care seeking practices of immigrants may have myriad characteristics, both because it reflects previous lives in different socio-cultural and socio-economic settings, and because the migration and settlement experiences themselves may influence health statuses, perceptions of health, sickness, and the body, as well as attitudes towards society's institutions.

In Norway, migration has been a familiar phenomenon for centuries (Brockmann and Kjelstadli 2008). Yet, it was not before the early 1970s', when the first Pakistanis, Turks, and Moroccans arrived as guest workers that immigration emerged as topic of public discourse and policy concern (Khan 2009). In the case of the Pakistanis, the combination of population growth and a heritage system of dividing landholdings between male heirs that came to constitute the main driver of out-migration, as agricultural properties shrank below subsistence size (Lefevebre 2000). Throughout the 1960's, many young Pakistani men therefore obtained travel permits and arranged for temporary work in the Gulf States, and eventually in Norway. Since this time and up until the present the immigrant population in Norway has increased steadily to a present 15 percent, with most living in the Oslo area (Statistics Norway 2020). Within these statistics, however, an important change is that immigrants have gradually come from new places and for different reasons. This is evident in that the Pakistani population of a present 38 264, was recently surpassed by Somalis in terms of numbers (Statistics Norway 2020). For a fuller picture of the migration and resettlement experiences of Pakistanis and Somalis, I will here describe and contrast the populations in some more detail.

Granted transnational migration and increasing ethno-cultural heterogeneity poses a challenge to health care systems across the globe, it is not a challenge without endemic characteristics, as

every country has its own unique culture, a history of migration, and systems of structural and bureaucratic organization. The importance of considering processes of health care integration with in-depth attention to specific immigrant groups rather than immigrants as a general whole is reflected in the shifting causes and patterns of transnational migration over time. For instance, while we might describe the nature of Pakistani mobility as the product of an expanding “culture of migration” (Kandel and Massey 2002), whereby migration between localities is upheld over time and across generations, the forced nature of Somali migration is perhaps better described as resulting in a “regime of mobility,” underscoring an even greater element of necessity (Glick-Schiller and Salazar 2013). However, while this distinction suggests that attention to the characteristics that define and set different immigrant groups apart is important to any exploration of immigrants’ health care seeking and overall health care integration, it is imperative to consider the within-group differences that already exist and that might develop uniquely within each immigrant group over time.

Among the 38 264 persons with Pakistani heritage in Norway, 21 109 have immigrant background, and the remaining 17 565 can be said to make up the second and third generation (Statistics Norway 2020). However, a peculiar feature of the Pakistani immigrant population in Norway is that the vast majority trace their background to the city of Kharian and its rural environs, located in the Gujarat district in Punjab province. Relatedly, mirroring that an estimated 70 percent of people in the area have family members who have resettled in Norway, the city has become known as “little Norway” (The Express Tribune 2012).

Correspondingly, the city district of Grønland, in Oslo, is sometimes colloquially referred to as “little Pakistan.” The longstanding migration of both Pakistanis from particular localities to particular destinations hints at process of “cumulative causation,” that migration experiences within a community inspires new migration among remaining community members and among new generations (Massey 1990). Clustered migration patterns are thus

likely to have some form of defining influence on immigrants' resettlement experiences and transnational relations.

In the case of both Pakistanis in Britain and in Norway, it is for instance notable that the Pakistani system of brotherhood and kinship affinity, called *biraderi*, continues to have a decisive influence on relationships, preservation of values, and identity (Shaw 2000; Næss and Vabø 2012). Notions about caste add another layer of complexity in terms of status ascription and marriages (Shaw 2002). As I discuss in article I, this system, which pertains most commonly to relations by blood and marriage, but which also extends to presumed kinship affinity, is central for understanding how traditions of intergenerational reciprocity and familial elderly care are negotiated in contrast to public health care, to also shape interpretations and responses to signs and symptoms of cognitive decline. The diversity of concern in this dissertation thus not limited to diversity of cultures, but diversity within immigrant groups, such as in that between men and women and between generations.

In recent years, Grønland, or "little Pakistan," has also been referred to as "little Mogadishu," perhaps because the Somali population has doubled over the past two decades to make them more visible within the cityscape. The first wave of Somalis immigrants arrived in Norway in 1987 and consisted of 290 persons, followed by the arrival of 358 Somalis in 1988 and 587 in 1989 (Statistics Norway 2014). The majority of the first Somali refugees to arrive in Norway had fled Somaliland situated in the northeastern part of the Horn of Africa, eventually transiting in Denmark, Finland, or Russia (Assal 2006), before applying for asylum in Norway. While some of the Somalis who arrived in the first waves moved on to Britain after a short while, as the Somali presence was established already in late nineteenth century through the British colonialization of Somaliland (Hopkins 2006:365), the arrival of an annual average of 500 Somalis throughout the 1990s led to the permanent settlement of Somalis also in Norway (Statistics Norway 2014). Since the mid-2000s, the Somali population in Norway has nearly



doubled, making Somalis as the largest non-western immigrant group in Norway. At present, there are 43 273 Somalis living in Norway, of whom 14 719 are born in Norway, and 28 554 have immigrant background (Statistics Norway 2020). About half of the Somali immigrants are refugees, whereas the remainders have arrived primarily through family reunification. In contrast to the Pakistanis' search for income and opportunity abroad in the face of increasing economic hardships, however, recent Somali migration to Europe is largely associated with the Somali Civil War.

The Somali Civil War erupted in 1991, as a result of lengthy military repression, famines and resource deprivation, uncertainty and insecurity, as well as the cultural setting and the region's colonial past with the British governing Somaliland and the Italians southSomalia until 1960 (Elmi 2006; Menkhaus 2007). Approaching the 1990's, dictator Siad Barre (1969-1991), who seized power nine years after the ending of the colonial presence, was facing increasingly tense scrutiny not only for his repressive rule the conditions in the country, but also for favoring his own clan and thereby ignoring his own restrictions on clanship expressions (Ciisa-Salwe 1996). Barre's project was, after all, to enforce totalitarian rule in Somali and "to stamp out clannism through an ideological mix of Lenin, Marx, the Qur'an, Mao and Mussolini, obliquely known as 'scientific socialism'" (Hesse 2010:251). Consequently, despite Barre's overthrow by a coalition of opposition groups in 1991, after more than two decades as president, there was no unifying force or clan coalition in position to exploit the power-vacuum that emerged behind the dictator (Lewis 2002). However, while the Somali system of patrilineal clanship, individualized democracy, and segmented loyalties was not particularly compatible with scientific socialism, nationalism, and centralized government (Lewis 2002), clan remains a decisive feature of Somali culture and society. It was not until 2004 that Somalia managed to restore central governance, which since this time has been based on a so-called 4.5 formula, ensuring equal representation in parliament by the four largest clans, namely Darod, Dir,

Hawiye, and Digle-Mirifle, along with five minority electorates (Hesse 2010). By contrast, the breakaway state of Somaliland, where the clans of Isaaq and Dir are in majority, declared independence in 1991. It is also for this reason; usually drawing on the anthropological and historical studies that discuss clan dynamics in Somalia (Lewis 2002, 1999, 1994; McGown 1999; Samatar 1991), that clan connections and the nature of kinship networks have been recognized as a facet of Somalis' social lives, wellbeing, and cooperation in diaspora (Assal 2006; El-Sohl 1991; Engebriksen 2007; Fangen 2006; Farah 2000; Griffiths 1997; Hopkins 2006; McGown 1999).

The Somali clan system constitutes a “scheme which explains why the various groups are where and what they are” (Luling 2006: 471), in much the same way as the Pakistani *biraderi* system. According to Somali genealogy, “most Somalis are born into one of six ‘big tent’ clans” (Hesse 2010:249). Hence, although the majority of Somalis today identify as Sunni Muslims, often with ties to the Prophet Muhammad’s Banu Hashim clan of the Quraysh tribe from Hijaz, Saudi Arabia (Lewis 2002), “Somali genealogy presents individuals with a seemingly infinite number of ways to affiliate with, or disassociate from, fellow Somalis – which may be the point” (Hesse 2010:249). Of the six clans, the Darod, Dir, Isaaq, and Hawiye, accounting for about 75 percent of Somalis, are referred to collectively as ‘Samaale,’ after a Yemeni patriarch considered being the founder of the Somali ethnic group (Hesse 2010). In addition, there are the clans of Digil and Rahanwayn in south Somalia, who make up 20 percent of the population and are traditionally pastoralists in the arable lands along the rivers of Juba and Shabelle in south Somalia (Lewis 2002). However, with regard to clan-representation among Somali immigrants in Norway, it is presumable that many of the first Somalis to arrive were Isaaq as the conflict’s early epicenter was Somaliland. Towards the mid-1990s, however, as the conflict spread southwards, the clan-representation became much more diverse (Assal

2006). It is with this backdrop in mind that I draw attention to clan in article II and IV, on trust, cultural health capital, and Somali bridge-building towards Norwegian health care.

In this section, I have described and contrasted the background and characteristics of contemporary migration from Pakistan and Somalia to Norway. The purpose of setting up this backdrop is both to present the cultures and people in focus throughout this dissertation, and to indicate some cultural facets that require consideration when examining processes of immigrants' health care integration in Norway. In this regard, family and kinship traditions are highlighted because they define social relationships, spaces of experience and information exchange, as well as value negotiations. These cultural facets are also central to understanding how processes of immigrants' health care integration intertwine with the gradual "diversification of diversity," the notion that sustained migration, lengthy residency, and integration unsettles stereotypical associations between ethnic background and the maintenance of cultural practices and values (Vertovec 2007:1025).

## Super-Diversity

Migration and ethno-cultural diversification is challenging established ways of thinking about who is integrated and who is not. As hypothesized in a study on the implications of "super-diversity" in Amsterdam, when a clear majority exists, the "minorities are expected to adapt to the opinions and customs of the dominant group," but when there is no clear dominant group, then integration might become more of a collective enterprise where everyone has to adapt to everyone (Crul, Schneider, and Lelie 2013). The question of concern in this dissertation, however, is what demographic changes and within group differences and dynamics mean for immigrants' health care integration. With reference to the above section, we can assert there are

great differences both among and between Somalis and Pakistanis with regard to migration and resettlement experiences, duration of residency, societal participation, and adaptive strategies.

In Oslo, as in the case of Amsterdam, the sum persons with immigrant backgrounds now make up about half of the population in the city districts of Stovner, Søndre Nordstrand, Alna, Grorud, and Gamle Oslo, (Høydahl 2015). In the capital as a whole, immigrants account for well over 33 percent of the total population (Statistics Norway 2020). The outcome of increasing ethno-cultural diversity as it has developed in Oslo over the past decades can suitably be referred to as “super-diversity” (Vertovec 2007). Although the concept is used in myriad ways in migration related research, the purpose of developing the term was rather specific, namely to bring light to complex and changing social formations pertaining to migration-driven diversification over time (Vertovec 2007). Since then, the migration literature has deployed the concept in a variety of ways, ranging from context descriptions to the simple assertion that migration from different places necessarily implies more diversity (Vertovec 2019). Here, I draw on the concept as it was originally intended, namely to denote that ethno-cultural diversification over time produces not simply more ethnicity, but within-group complexities and difference, for example in terms of differences in duration of residency, levels of language acquisition and education, and integration.

Drawing on the original definition and intent behind the concept, it should be noted that it does not amount to a theoretical framework of analysis in itself. Rather it should be seen as a conceptual notion with methodological implications in that it encourages types of analysis that acknowledge variations of ethno-cultural complexity. While relevant in itself, in doing research among Pakistanis and Somalis, who both are inherently complex ethnic groups, by keeping it in mind it served to counter-work any temptation to “medicalize culture,” that is, to

presume that resources, health beliefs, or health related behaviors are defined by ethno-cultural background alone (Lock and Nguyen 2011:8).

## Immigrants and the Norwegian health care system

Immigration from non-Western countries has been identified as a challenge to the universalistic welfare systems of the Nordic countries. Unlike the more conservative welfare models in France and Germany, which largely allocate social responsibilities to the family and various private institutions, and the liberal setup characteristic of the US, where public services are limited to mere survival aid, the Nordic model is founded on principles of equitable redistribution and universal access to welfare services (Esping-Andersen 1990). Within this system, the population receives services based on needs rather than degree of tax contribution. The Scandinavian welfare model is in this sense an inclusionary construction, which works to compensate for a verity of social, economic, and cultural distinctions that otherwise could undermine social solidarity and fragment national unity.

Immigration has been said to put into question the foundational imagery of the Nordic welfare model and the ideas of social equality and unity. It has for instance been asserted about the Danish welfare state that it has worked to integrate society as a whole and that it has come to constitute a central aspect of Danes' ethnic identification (Jöhncke 2011). Also in Norway and Sweden the welfare state has "nearly become an organic part of the national self-understanding in the region after WWII" (Brochmann and Hagelund 2012:18). The challenge of immigration, then, is therefore connected to the desire to maintain the Nordic welfare state, and to the idea that immigrants demand and get from it more than they contribute. Maintaining it also implies that services, such as health care, are reliable and meet public expectations. However, in the context of migration and diversification, also immigrants have a right to their

expectations about being accommodated, as all residents are entitled to equal, tax-financed, health care services, regardless of age, gender, or ethnicity (Ministry of Health and Care Services 2009).

A particular challenge to both immigrants and the Norwegian health care system is in this regard is that the neutrality that makes the system equitable in principle has its roots in the dominant culture. It is for instance notable that adaptation of services to specific ethnic groups within the Nordic countries is restricted by welfare principles of non-differentiation and universalism in public services (Nannestad 2006). However, because the population is fast becoming more diverse, issues of unfamiliarity and cultural and linguistic barriers increasingly challenge the very idea of equal access to equal services (Norwegian Ministry of Health and Care Services 2013). This may partially explain why immigrants' use of specialist health care services in Norway is lower than that of ethnic Norwegians (Elstad, Finnvold, and Texmon 2015). It could moreover explain why immigrants might resort to traditional medicine instead of prescription drugs (Ramzan et al. 2017), as well as why many immigrants, particularly Somali and Pakistani immigrants in Oslo resort to the general emergency clinic significantly more often than Norwegians (Ruud et al. 2015). An important point two be extracted here is that processes of immigrants' health care integration appear to be shaped in large part beyond the healthcare system itself. The framework presented in the following chapter constitutes the conceptual spine of the dissertation.

### **3. Theoretical framework**

In this chapter, I outline the theoretical concepts and considerations that are foundational to the four articles and their focus on interpreting and conveying how processes of health care integration are shaped by immigrants' broader negotiations of cultural norms, relational practices, and differing health care cultures. In the proceeding pages, central concepts discussed are trust/mistrust, social capital and cultural health capital, integration, gender roles, and the notion of health care cultures. By discussing the linkages and overlaps between these concepts and discussing them in relation to the problem of migration and health, I here make visible the red line running through the dissertation. I begin with a discussion on developments in migration research as it relates to this dissertation.

#### **Towards super-diversity: developments in migration research**

Over the past decades, there have been at least five important developments in the domain of migration research. One of these is the incorporation of relational practices and social network approaches to examine the dynamics of both migration and adaptation (Portes 1998; Massey 2009). An important feature of this development is the growing interest in immigrants transnational relations and their implications for future migration, developments in the place of origin, often through remittances (Giuliano and Ruiz-Arranz 2009), as well integration processes (Schiller, Basch, and Blanc-Szanton 1992; Basch, Schiller, and Blanc 2005 ). An underlying condition here is that family and community characteristics, often pertaining to variations in kinship systems, social organization, and generational differences are central to integration processes (Shaw 2009). A second development that has fast gained ground is the recognition that gender and gender roles are a decisive feature of both migration decisions, the migration process itself, and resettlement and reestablishment processes (Willis and Yeoh 2000;

Piper 2005; Fangen 2008). The third advance to be highlighted here overlaps with the two above, namely a concern with the fact that migration over long spans of time to the same destination makes for increasingly complex and inherently diversified immigrant populations (Vertovec 2007). An implication of these overlapping observations is that researchers need to find approaches that can recognize the “traits” that distinguishes immigrants from each other and that constitutes that basis for inter-ethnic relations (Eidheim 1969:39), without reducing diversity. Hence, when exploring the characteristics and determinants behind Pakistani and Somali immigrants’ health care seeking practices and health care integration more broadly, attention must be lent to the possibility that immigrants also of the same ethnic group can draw from multiple frameworks and have differing preferences for thinking about and dealing with health and illness (Shaw 2000).

Several studies have indicated that immigrants’ social networks constitute a decisive influence on perceptions about health issues and attitudes about utilizing different health- and care services in migratory contexts (Rogler and Cortes 1993). Bringing attention to immigrants’ social relationships and network constellations is thus central to understanding how immigrants adapt and live their lives within initially unfamiliar settings, especially because it is here that cultural perceptions, values, and instrumental information is exchanged, negotiated, and acted upon to shape continued migration, transnational connections, and local adaptation (Massey 1987; 1990). Hence, drawing on the Palestinian-American anthropologist, Lila Abu-Lughod, it can be useful to think that “the effects of extra-local and long-term processes are only manifested locally and specifically, produced in the actions of individuals living their particular lives, inscribed in their bodies and in their words” (Abu-Lughod 1991:150). From this perspective, it is through the stories of individual immigrants that we can attain insights about new forms of societal complexity, characteristics of changes, and related implication across various aspects of life.



All of these aspects considered, we might assert that approaches to migration should account for new differences and find ways to circumvent the reduction of complexity. As I have touched open earlier, the notion of super-diversity constitutes one such conceptual example (Arnaut and Spotti 2015). However, while the notion of super-diversity recognizes ethno-cultural complexities, additional theoretical concepts are needed to explore how this complexity comes about, how it might structure or restructure the lives of immigrants, and manifest in patterns of behavior.

### Culture, values, and integration

The aim of sorting out parts of how immigrants deal with health issues necessitates a concern with the desires and strategies immigrants act on to participate and find value in new contexts, and what informs them. Here, I build on Fredrik Barth's typologies of possible adaptive strategies as a vantage point for analyzing processes of resettlement and health care integration among Pakistani and Somali immigrants in Norway (Barth 1969). While developed based on an elaborate fieldwork material on inter-ethnic relations in different localities, the issue of boundaries and boundary maintenance has become increasingly relevant in a time of transnational migration and ethno-cultural diversification. To better understand processes of health care integration, it might be helpful to have a framework for broadly conceptualizing the notion that immigrants often make use of a variety of strategies to negotiate, soften, and maintain ethnic boundaries in contexts of resettlement. Barth distinguishes between three adaptive strategies, often, but not exclusively deployed by resourceful persons, or elites, identified as "agents of change" (Barth 1969:33). This subject is a core concern in article 2 and 4, addressing health care integration through a focus on cultural health capital, trust, and bridge-building among Somalis towards the Norwegian health care system.

The first strategy set forth by Barth (1969), which I here modify somewhat to line up with the conundrums arising from transnational migration and integration, is that the agents of change can attempt to become incorporated in the pre-established structures that they encounter upon resettlement, despite diacritics of noticeable ethnic difference. If this succeeds, then their ethnic group will likely lose part of the basis for internal differentiation and only conservatively express their background in the larger context. At the same time their status position in society might be somewhat weakened. A second strategy is to accept having a minority status in society, and to downplay and place all of their cultural differences within “sectors of non-articulation” (Barth 1969), such as family, to some extent immigrant organizations, and religious institutions, while participating within the larger social structure. When general acceptance for the second type of strategy is found within a group, this can serve to prevent sharp dichotomizations between immigrants and the majority and can perhaps lead to their eventual assimilation, particularly among the second and third generation, whether this is desirable or not for the pioneering immigrants. This, however, is not to say that cultural institutions, identities, and practices will necessarily atrophy over time. The third strategy option is for immigrants to place emphasis on ethnic identity and to exploit it to develop positions for incorporating new activities into their ways of relating and organizing.

While the mentioned strategies appear to play the entire process of integration into the immigrants’ court, as they are making strategic decisions, we can also assert that integration is informed by context. For example, whereas integration in the USA is largely an individual and group matter as one is largely dependent upon one’s own resources for subsistence as well as health care, in the Nordic countries, where welfare entitlements are rather generous, the pressures to conform are undoubtedly greater as work and tax-contributions are necessary to uphold the welfare state. At the same time, in Norway, free education, introductory programs

for refugees, introductory programs for immigrants, and health care entitlements are stepping-stones for immigrants to partake in the collective and define their place in the mix.

Although immigrants' work participation and contributions to the Norwegian welfare state are often the criteria upon which immigrants' integration is evaluated and perceived by politicians and the public mainstream, limited participation and reliance on the welfare state, as in the case of the relatively young Somali population, brings negative light to cultural practices and immigrant backgrounds (Engebrigtsen and Fuglerud 2009). Hence, notwithstanding the majority immigrants excel over time and across generations in terms of education and work participation (Statistics Norway 2020), many immigrants also experience systematic disadvantage (Fangen and Mohn 2016). Such disadvantages, often exacerbated by negative stereotypes, are not only reflected in patterns of labor market discrimination (Midtbøen 2016; Quillian et al. 2017), but also in immigrants' experiences with Norwegian bureaucracy and public institutions (Fangen 2006). Therefore, notwithstanding many Somalis have expressed a sense of exclusion from Norwegian society (Open Society Foundation 2015), to attain a nuanced perspective on the components and determinants of integration, it is important to recognize that within-group differences in desires, adaptation strategies, and resources translate to various forms of incorporation, a process referred to as "segmented assimilation" (Portes and Zhou 1993).

In the case of Pakistani immigrants in Denmark for instance, the economic recession in the 1970s and 80s led some families to prioritize immediate opportunities for earning money whereas other families focused on education (Rytter 2011). This choice of different long-term strategies, and the resulting distinction between uneducated and educated Pakistani families, has had enduring implications in terms of the second generation's marriage patterns, sense of belonging, and identity. The development of professional niches by second generation immigrants in Norway, either through targeted entry into selected employment sectors or as

entrepreneurs, is a similar example of segmented assimilation (Midtbøen and Nadim 2019), and of how the notion of diversity is fast becoming more complex. In terms of understanding immigrants' adaptation strategies and their impact on family, identity, and belonging upon resettlement, both "'family history,' as well as the position of 'the family in history,'" are of central importance (Rytter 2013:3). This is because family and kinship, as exemplified in two studies on Somalis' notions of masculinity in Denmark and Norway, lie at the core of how immigrants' negotiate adaptation and incorporation on the backdrop of clashing values and ideals in diaspora (Markussen 2018; Kleist 2010). It is my perspective, then, that sociological insights into processes of health care integration require exploration with attention how contextual circumstances define cultural negotiations as well as how modes of adaptation intertwine with both imported cultural concerns.

An underlying premise or outset for this research is not only the observation that immigrants, particularly from non-western countries, tend to represent different healthcare cultures as compared to the ones they encounter upon resettlement. Similarly, Barth's example addresses difference in terms of variations in people's familiarity with and reliance upon existing structures. By bringing attention to the ways that values and social capital resources are distributed, evolve, and become mobilized to influence group members, however, my outlined focus on diversity is maintained. In this regard, it is important to recognize that status and resources are unevenly distributed in nearly any given society. In the context of migration, this implies that in order to understand integration, one must take into account that some immigrants are in a better position to adapt and maneuver than others, and that integration is a matter of reliance on and trust in others, such as representatives of health care institutions. Integration is here understood with reference to Richard Alba and Nancy Foner, who define integration as, "the processes that increase the opportunities of immigrants and their descendants to obtain the valued 'stuff' of a society, as well as social acceptance, through

participation in majority institutions such as the educational and political system and the labor and housing markets” (Alba and Foner 2015:5). Relatedly, in Article II and IV, I lend analytical attention to how variations in social capital mobilizations can affect individual and group changes in terms of health beliefs, behaviors, and health care seeking practices.

### Familiarity, trust, and health care integration

Norway is often thought of as a high-trust society because the population relies heavily on the tax-financed welfare state for their security and well-being (Statistics Norway 2016). Trust in the Norwegian health care system is also believed to be high. It is also the country’s largest public employer and the national budget’s largest expense post. However, while most ethnic Norwegians become familiar with and learn to trust the health care system and welfare state from early on, elevating it as central to national identity, immigrants from non-western countries tend to arrive with different sets of experiences and prerequisites for both familiarization and trust investments.

Trust is a fragile attitude and can easily erode under the “right” circumstances. Conversely, trust is not always easily established once it has broken down. Trust in the abstract health care system and the experts that represent it are nevertheless a decisive feature of health care-seeking and health care beneficence, as well as for immigrants’ general integration (NOU 2017). However, when it comes to the implications of transnational migration for the Norwegian welfare model, flag-shipped by the health care system, this will largely be contingent upon the immigrants who come, in terms of the resources they bring with them and their general inclusion and participation in society and working life (NOU 2011). This luggage can be particularly decisive for immigrants’ familiarization with and trust and towards health care institutions.

Here, a suitable way to conceptualize trust sociologically is to imagine it “as a reciprocal orientation and interpretative assumption that is shared, has the social relationship itself as the object, and is symbolized through intentional action” (Lewis and Weigert 1985). Trust is in this respect a social enterprise and important indicator of integration, as it is reflected in decision-making and can work to shape health care encounters in a variety of ways. While this establishes the interpersonal dimension of trust, in this dissertation I also bring attention to institutional trust, viewing both as determined by the mutually entangled relations and interactions taking place among and between individuals and social systems (Meyer et al. 2008). Hence, “trust occurs within a framework of interaction which is influenced by both personality and social system, and cannot be exclusively associated with either” (Luhmann 2000:6). In many cases, however, immigrants lack the familiarity, resources, and experiential basis necessary for evaluating risks and utilizing trust as a solution to counter them (Luhmann 2000), something which in turn can affect the experiences that underpin institutional trust. From this position, one could presume that interpersonal trust within a given segment of immigrants could affect perspectives on health care institutions, which in turn could yield negative experiences that reinforce interpersonal trust while obfuscating a group’s trust in the abstract system. It is notable in this regard that immigrants in Norway have been found to have less trust in other people than their fellowmen, but more trust than ethnic Norwegians in the country’s political institutions (Støren 2019). This underscores that the beliefs, resources, and experiences of different immigrant groups can have decisive implications for immigrant’s health care integration.

In article II and IV, I attempt to cover part of this research gap through a focus on trust and health care integration among Somali immigrants in Norway. To operationalize trust, I both draw on and elaborate on the concept of “cultural health capital” (Shim 2010). However, before elaborating on why this concept has particular application, I will first discuss the some of the

by now classic contributions to social capital theory. This is relevant both for the overarching focus of the dissertation and for understanding the utility of the cultural health capital concept.

## Social capital and migration

Social capital is one of modern sociology's foundational theoretical concepts, and it has been utilized across a range of topics in combination with both qualitative and quantitative methods. Myriad definitions of social capital have been developed to suit different levels of analysis and academic disciplines. However, what most of the definitions have in common is that they tend to focus on social relations and the ways that relationships and networks can provide benefits for individuals and groups in society. However, when it comes to the question of selecting which definition to lean on, my focus was primarily lent to definitions with application in the context of migration. I was in search of a definition that could serve to operationalize trust in a context of diversity.

While finding the definitions by Bourdieu and Wacquant (1992), Portes and Sensenbrenner (1993), Portes (1998), Putnam (2000), and Putnam, Leobardi, and Nanetti (1993) useful because of their attention to the resources and relations, I soon became aware of new concepts derived in large part from their work. As I will discuss under the next heading, with reference to the concept of "cultural health capital" (Shim 2010), I also saw an eye for making a small contribution to expand and specify the operational utility of the cultural health capital concept. Before elaborating further on the cultural health capital concept, I will briefly discuss the present relevance of some of the earliest and most commonly cited social capital definitions.

Social capital has been defined by Bourdieu and Wacquant as "the sum of resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network

of more or less institutionalized relationships of mutual acquaintance and recognition” (Bourdieu and Wacquant 1992: 119). From this definition, social capital emerges as a foundational condition for peoples’ contentment and well-being. The definition also provides, through its focus on the importance of familiarity, recognition, and durability in shaping social relationships, a way to think about both immigrants’ social relationships and how these relationships affect familiarity with and trust towards the institutional structures that surround them.

Portes and Sensenbrenner’s definition of social capital has had great impact in research on migration (Portes and Sensenbrenner 1993). Although concerned with the economic goals of individuals and groups, an important feature of their definition, which holds that social capital is a matter of expectations about action within a collectivity that affect the economic goals and goal seeking behavior, is peoples’ desires to seek forms of beneficence (Portes and Sensenbrenner 1993). In relation to the topic of health and health care integration, and the guiding focus on practices and determinants of health care seeking, a point to be drawn from their study is that immigrants may also be inclined to seek solutions that are not beneficial in terms of health, as long as it suits group expectations. This point ties into the notion that health and health care seeking is heavily influenced by collective and relational concerns. Hence, we can assert that beneficence in a broad sense is a matter not only of membership in social networks, but also of the resources found within them (Portes 1998).

Some of the other scholars to engage with the social capital concept early on did so because they saw a need for strengthening the focus on associational life, particularly the role of civic organizations, and the element of trust in social organization and cooperation in relations to migration and integration (Putnam, Leobardi, and Nanetti 1994). From the perspective of the American Sociologist, Robert D. Putnam, social capital emphasizes the importance of collectivistic and group-level mobilization of, and distribution of social resources



as foundational for understanding the motivations behind and the outcomes of both individual and collective practices (Putnam 2000). According to an analysis by Moore et al. (2005), this communitarian definition has been one of the dominant social capital applications in studies on health matters and migration. This is presumably because the perspective centers on “features of social organization, such as trust, norms, and civic networks” (Putnam 2000:167), which also enables people to stay health and collectively adjust to changing circumstances and produce a stable and just societies (Putnam 2000). It is also for these types of reasons that social capital theory has had such a marked influence on recent migration and integration research. In article IV, I follow in this vein to explore cultural health capital and trust through a focus on implications of immigrants’ associational lives for health care integration.

While social capital, from Putnam’s “communitarian perspective,” is a quality pertaining to the individual, the “social cohesion” perspective on social capital highlights it can also be regarded a group or sub-group attribute or characteristic (Kawachi et al. 2008). The social cohesion perspective on social capital pertains to the structural and contextual qualities of a community, as these conditions influence who might benefit from the resources contained within social networks. From this perspective, considering the Norwegian welfare state is founded on principles of solidarity and redistribution through tax-financed health- and social services, it is fair to assert, as previously touched upon, that the functioning of the welfare state is premised on a high degree of social cohesion. The question, then, becomes one of determining how variations of social cohesion among immigrants influences their attitudes and relationships towards the institutional fabric of a given resettlement society.

The sociological works outlined here, as well as many I have omitted, uncover some of the core components that have made the social capital concept subject to wide application, debates, and continuous modification. The key components of relevance for exploring processes of health care integration, including notions of familiarity and trust, are its focus on

relations, trust, collaboration, and beneficence. The concept of cultural health capital embodies these core components. The main reason for applying it, however, is that it allows for an additional layer of analysis pertaining to the implications of cultural difference in the negotiations that take place among immigrants around health and the core facets of social capital.

### Cultural health capital: operationalizing familiarity, resources, and trust

While trust is a central indicator of integration, it is also an abstract notion as it pertains to feelings and attitudes. Cultural health capital, as found among Mexican immigrants in America, can be mobilized to navigate health care systems and improve access (Madden 2015). Reflecting its roots in social capital theory, the concept is particularly appealing because it allows for considering trust in health related interactions, experiences, and relationships. It pertains to a type of resource that can be mobilized for collective beneficence, although the extent of its efficiency depends upon on distribution within a group, as well as relationship structures and cultural values.

A theoretical contribution derived at on basis of my empirical data is that immigrants who command two health care cultures possess a particular type of cultural health capital. While everyone's opportunities and health decisions are contingent upon cultural health capital, cultural health capital is contextually defined. When people settle in a new cultural and institutional setting, however, the familiarity, resources, and experiences they have had may no longer be of relevance. However, in contrast to the notion of "health literacy," which has been applied extensively to elucidate that immigrants often lack the language, familiarity, and terminological command necessary for uptake of health advice and pursuing services at the right moment (Nutbeam 2008), the cultural health capital concept recognizes immigrants'

health care integration as a matter also of the health care system's familiarity with immigrants' backgrounds, resources, and relationships. A central point in this regard is the notion that immigrants are under pressure to somehow strategize and adapt to the dominant ideas about health and illness in their new context, whereas the majority group, including health care employees who meet immigrants, may have less capacity and incentive to acquire full knowledge about other health care cultures than their own. Hence, while cultural competency has become somewhat of a buzzword in health related policy documents in Norway (e.g. Ministry of Education and Research 2012), largely because immigrants share the same entitlements as ethnic Norwegians to public health care services and because immigrant health is a matter of both individual and public health, simple knowledge about a foreign language and cultural characteristics might be insufficient for interpreting and accommodating the needs of immigrant patients. This is because cultural competency does not imply in-depth knowledge about and command of other health care cultures. The basis for medical advice, conviction, and trust might therefore be missing, sometimes leading immigrants who command two health care cultures and systems of health care to be sought after by both ethnic peers and health care providers.

While cultural knowledge among health care employees is undoubtedly important, I will illustrate some limitations with an example told to me in an interview with a Somali social worker at psychiatric hospital in Oslo, about mental health and illness. The scene narrated proceeded as follows; a Somali woman was sitting in the waiting room, looking at her hands, mumbling, and talking to herself aloud. The young psychologist that first observed the woman was immediately convinced she had to be psychotic as she was unresponsive to her making contact and seemed detached from her surroundings. When my interviewee was asked to talk to her because of his shared Somali background, he discovered she was simply reciting the 99 names of Allah. How was the young psychologist supposed to know that the palm lines inside

the left hand spell 81 in Arabic, and that the lines inside the right spell 18, let alone what she was saying?

This situation illustrates both why cultural health capital is important in relation to immigrants health and illness, as well as why there is a focus on cultural competency within the Norwegian health care system. Moreover, the example hints at the challenges that super-diversity can represent to health care institutions and practitioners, as cultural health capital among immigrants is often an unevenly distributed resource. Here, however, I am referring to a particular type of cultural health capital, namely that of commanding two distinct health care cultures and institutional structures. Yet, while the super-diversity brought about by sustained migration and global linkages over time complicates generalizations on the basis of ethnic background, I contend that bringing attention to the distribution and mobilizations of cultural health capital is one way to attain insights of relevance for analyzing cultural intersections and processes of health care integration. It is also notable in this regard that mistrust among immigrants towards the health care providers and institutions in their resettlement destinations is also matter of the providers' ability to accommodate diversity. In this regard, it is important to stress that while most immigrants might value that health care services are highly accessible and provided free of charge in Norway, there may also be pressures to conform to imported practices as well as convictive forces that limits opportunities for familiarization and, by implication, trust in the health care system. From this perspective, the cultural health capital held by a limited number of immigrants can emerge as a collective resource to counter misconceptions or mistrust, as well as for health care providers to reach the immigrant population. In article 2 and 4, the findings elucidate that persons who possess this resource often engage or are consulted as bridge-builders both in health care settings and in immigrants' social milieus, thus informally extending the reach of the health care system. Still, the convictive

efficiency and reach of this resource can face limitations in the existence of within-group differences in social compartments, dynamics, and organizational forms.



#### **4. Methods and methodology**

The core aim of this Ph.D. project was to conduct empirically based analysis that could enhance our sociological understanding of the extra-medical sides of immigrants' health care seeking practices and health care integration in Norway. To approach the subject of study, given the methodological implications of super-diversity and the unsettling of ethnicity as a finite determinant of traits, my research design can be described as constituting "a reflexive process operating through every stage" of research (Hammersley and Atkinson 1995:24). I begin this chapter with a discussion of methodological concerns encountered at the planning stage and throughout the research process. This is followed by an outline of the data collection methods, analysis process, and my ethical considerations.

##### **Studying ethno-cultural difference within one's own society**

What does the diversification of diversity mean for sociology's concern with understanding, theorizing, and representing patterns of social interactions, practices, and relationships, within diverse cultural contexts? Just as "cultural interpretations of human nature have shifted in tandem with changes of institutional influence, power, and hegemony" (Brante 2009:189), so too have social scientific attitudes towards the interpretation of culture and people. Over the past five decades, the (mis-) presentation and (mis-) re-presentation of cultural otherness has thus been subject to much debate, particularly in relation to the European colonial projects around the globe (e.g. Spivak 1988; Said 1978). Some underlying question of concern in this regard is who one is writing for, how "the other" is portrayed and spoken on behalf of, and whether the observer, often a cultural outsider, can capture and convey the emic perspective.

Today, in line with Taylor's (1985) "intelligibility thesis", which holds that it is not possible to make sound judgments of other cultures on the basis of one's own, the question of

how otherness is interpreted and presented is not just a moral one, but also one that pertains to scientific rigor and reflexivity. One of the most foundational questions in the interpretative branch of the social sciences is how we can attain an understanding of “the meaning that our subjects give to the world” (Benton and Craib 2011:101), and how this meaning can be conveyed and made intelligible through scientific language. This is a complex question, not only because pure social scientific objectivity seems unachievable as understandings of social action is variably intertwined with the subjective meanings of social actors, as well as the subjective standpoint of the researcher (Goddard 1973), but also because “there is no overarching form of life or language which is neutral and into which other languages can be translated” (Benton and Craib 2011:98).

These issues will always be lurking in the background when researchers engage in efforts to understand social change and new forms of diversity, all the more often within one’s own society. However, it is hard to disagree with Knorr-Cetina (1981) and Hastrup (2004) for instance, who assert that purely objective knowledge is merely an ideal because qualitative researchers, through their direct engagement with their subjects of study in attaining data, always influence it and form part of it. Yet, with these unavoidable facts in mind, it is still possible to strive towards this ideal. Given that complex issues of the social world, such as people’s identity claims or personal desires, cannot be understood by the same kind of scientific laws, or simply by quantitative methods, the interpretative branch of the social sciences stands firm. Hence, as some aspects of the social - the relative yet “specific domain of reality” - can only be attained by way of qualitative methods, they are not necessarily “alternative” or secondary to those of the quantitative, including when it comes to attaining objective knowledge (Latour 2005:4).

In order to be able to attain and convey some kind of general insight about the meanings that Somalis and Pakistanis give to their surroundings in the context of health and health care,



how these meanings are shaped and negotiated to influence health behaviors, health care expectations, preconceptions, and experiences, a first step is to adhere to various science norms (Merton 1973), as well as some form of rules of interpretation (Knorr-Cetina 1981:21). In addition, there is a need for reflection and self-awareness with regard to the data collection, the researcher's own placement in the data collection, and in interpretation and presentation of data. I have aimed to align with these principles throughout this dissertation. In this regard, I have drawn thoughtful inspiration from a range of social scientific work, such as Soraya Altorki and Camillia Fawzi El-Sohl's book, *Arab Women in the Field: Studying Your Own Society*, which demonstrates the implications of positionality and interpretation, as well as the advantages and disadvantages of variations of the insider and outsider role (Altorki and El-Sohl 1988).

This book, as in the case of Steven C. Caton's, *Yemen Chronicle: An Anthropology of War and Mediation* and Lila Abu Lughod's book, *Veiled Sentiments: Honor and Poetry in a Bedouin Society*, exemplify the importance of being aware that anthropological and sociological knowledge is inevitably inseparable from the processes of its production (Caton 2005, Abu Lughod 2016). It is, put simply, an indistinguishable part of the knowledge. The objective limits of objectivism are perhaps therefore one of the most intricate challenges for the social scientist studying a culture and social phenomenon as an outsider (Bourdieu 1977). When the researcher enters a landscape unfamiliar to him, he can be said to constitute an object of observation, and he has to compensate for his lack of native perspective by leaving all alternatives open. Hence, because the outsider researcher constitutes an object of observation within the setting of research, special efforts are required to reflect on his position in relation to the place and people unknown to him, and how he is implicated in the data obtained in order to represent the perspectives and reasoning of others around patterns of behavior or thought. In a time of migration and swift diversification, however, the issues of representation and positionality are

more relevant than ever before. Representation and positionality also tie into the process of entering the field and establishing contact with prospective research participants.

## Data collection

Choice of methods, it has been said, defines one's placement within the philosophy of social sciences, the type of scientific challenges that one might encounter in the process of research, and sets the guidelines for how to achieve scientific knowledge (Mjøset 2009). Deciding on methods and approach is in other words the process of realizing the appropriate approach for studying a particular phenomenon in a particular context (Gobo 2011). In this dissertation, to attain insights regarding health beliefs, practices, and health care utilization among Pakistanis and Somalis, I have relied primarily on interviews and observational data, obtained following a preparatory stage of reviewing the relevant literature and constructing interview guides. Considering the intricacies of the topic at hand, these data collection methods appeared the most suitable for an interpretative framework. In addition, data was also collected through policy documents and media reports related to Pakistani and Somali immigrants in Norway and from my attendance in meetings, lectures, and cultural arrangements involving Pakistanis and Somalis. Such events served as sites for informal conversation and observation. Document analysis served to identify how immigrant health features in official ideas and initiatives, thus producing a perspective against which to explore and contrast immigrants' health related experiences, perceptions, and health care seeking practices.

The bulk of the data material utilized in this dissertation was obtained by way of in-depth interviews (individual and focus groups) and observations at various arrangements initiated by immigrant organizations, where the emphasis was on attaining health related narratives and perspectives from a broad set of Pakistani and Somali immigrants in the

Osloarea. These methods were selected because of their suitability for an explorative and interpretative approach to attaining insights that could be aggregated to sociological patterns deemed representative of health related phenomenon and perspectives. Interviewees were recruited through immigrant organizations, established immigrant contacts, mosques, and by approaching local health care providers and community actors working in collaboration with immigrant communities on health related issues.

Conducting research among people of other cultural backgrounds than one's own demands not only preparations in terms of reviewing previous research and attaining some basic historical, linguistic, and cultural insight, but also a strategy for accessing the field. My challenge was that of attaining insights about and stories from the "backstage" of immigrants' social worlds, that is, the social spaces where social performance is prepared by sharing of information, rumors, and experience narratives (Goffmann 1959). However, while the experience of entering the field can vary by context (e.g. Geertz 1973), my experience of establishing contacts with Pakistanis and Somalis was rather similar, perhaps because I used a similar strategy in both cases.

In getting access to the field and recruiting participants for the study, I took vantage point in immigrant organizations, foundations, and networks fronting an engagement in health issues constituted a strategic vantage point. I also relied on some contacts established prior to and early on in the project who acted as informants and door openers. To have names and recommendations to refer to seemed to produce a greater sense of purpose for participating.

Also in the interview situations, having stories and insights to refer to aided in eliciting related experience narratives, thoughts, and opinions, perhaps because it distracted from my outsider position. Recruitment was also facilitated by my intention to recruit persons familiar with the Norwegian or English, and whom I presumed could have engagements and insights about

immigrant health and social matters. This choice was made not only out of linguistic practicality, but also based on my interest in the perspectives of persons familiar with both the Norwegian health care culture and their own, and who therefor could reflect on the contrasts and the socio-cultural determinants shaping process of immigrants' healthcare integration. This double-insight focus was moreover directed by the project's concern with "third parties" and the extra-medical sides of immigrants' health care seeking and integration.

This dissertation's articles builds on three sets of qualitative data. The dissertation's first article draws on two types of data, namely anthropological fieldwork in the homes of four Pakistani families in Oslo, performed by the article's co-author, Dr. Bjørg Moen, and interviews based on a semi-structured interview guide. The central focus was on intergenerational relations, elderly care, and perspectives on cognitive decline among Pakistanis. To supplement the participant observational data and interview with Pakistan, as well as to test the topic from a different viewpoint than Pakistanis' own, we conducted interviews with health care employees. In preparing these data for analysis, we had ongoing conversations about their overlaps and where my co-author provided me supplementary information, experiential reflections from the performance of fieldwork, and cues as to how the extensive field data was to be analyzed and interpret. In total, 22 interviewees participated.

The data collection among Somalis in Oslo began as an open inquiry to map out health concerns and the features of Somalis health beliefs, attitudes towards Norwegian health care and health care seeking practices. While concepts like trust and mistrust, along with bridge-building, emerged early on in the interview process to inform articles II and IV, so did mental health and illness as a central health concern among Somalis in Norway, which is the topic in article III. From this point, aware that mental health features centrally in the literature on Somalis in diaspora, I began inquiring more in-depth about the topic alongside the issues of integration, familiarization, and trust. At the same time, my colleagues were conducting a

registry-based analysis on immigrants' utilization of specialist health care services that I hoped to elaborate on through my growing focus on mental illness. In all, 36 men and women between the ages of 20 and 64 were recruited for in-depth interviews of one-two hours on health and integration. Article III, however, included two additional interviews. The interviewees were Somali representatives of immigrant organizations, health care professionals, including psychiatrists, psychiatric social workers, and nurses, as well as a group of laypersons. However, to account for potential nuances in attitudes and perspectives with the Somali community, it was necessary to account for factors like age, residency duration, language, and education in the interviews. It should also be noted in this regard that my informants played an important role both in directing me to potential participants and in helping me navigate clan divisions. In addition, two focus group discussions, counting four and eight participants, were arranged via two immigrant organizations.

I wrote article IV based on additional interviews, making up a third data set consisting of 16 interviews with leader figures in Pakistani and Somali immigrant organizations. These were supplemented by 6 interviews with organizational affiliates. However, the idea of comparing the role of Pakistani and Somali immigrant organizations in processes of health care integration surfaced during my work on the latter two. In this regard, the task of recruiting participants was rather purposive as I targeted immigrant organizations not just as access points, but also as objects of study in themselves. The aim of this part of my research, beyond empirically elucidating the extra-medical sides of immigrants' health care integration, was to explore the mediating capacity and engagements of immigrant organizations in shaping immigrants' health beliefs, health related decision-making, and attitudes towards the Norwegian health care system.

Finally, it should be noted about article III that it evolved into a type of mixed method article once anticipated results emerged in the quantitative part of the project. Specifically, I saw an opportunity to qualitatively explore why Somali women used specialist mental health services at a much lower rate compared to Somali men, as well as women of all other backgrounds, including Norwegian (Elstad, Finnvold, and Texmon 2015). While there have been various definitions of “mixed methods” and what it entails, in the article, I use what has been termed a “sequential mixed methods design” (Tashakkori and Creswell 2007). In other words, I used qualitative data and analysis to explain quantitative findings (Steckler et al. 1992). Although the topical focus of this article, or in the others, were set in advance, it was established at the planning stage of the project that attempts should be made at bridging the qualitative and quantitative parts of the overall project.

The main rule for determining how many informants are required in a sample to shed light on a social phenomenon is that the number should reflect the variance of the sampling unit (Gobo 2004:414), which in my case were immigrants invested in questions of relevance for immigrants’ relationship to the Norwegian health care system. It is important to note in this respect that I regarded data sufficiency not a matter of data amount, but rather data substance and depth (Gobo2004). Hence, following a process of cumulative identification of similarities and differences within the expanding data, I was able to determine the points when further interviews could be presumed to not provide further insights, or perspectives that would break the emerging patterns within the aggregate data (Strauss and Corbin 1990).

## Data preparation

Following Silverman (2015), my approach to the data-preparation process of transcription was to regard it as part of the analytic process. By listening through the interviews and pausing to

be sure of the accuracy of my transcription, I saw three useful side effects. On the one hand, I was able to attach my images of the participants and the interview situations, making the content a more vivid vantage point for further analysis. Secondly, it allowed me to retrospectively get to know my participants better and to consider how they implicated themselves in their stories. In this regard, listening for the way that participants performed their stories in reference to me was also a chance to think about and evaluate my own involvement in shaping and co-creating the content. A third benefit in this process was that the process of listening through the interview recordings in order to transcription allowed for reviewing my field notes on the interview settings.

Following the transcription of each interview, I coded the data according to themes and cues. These were then used to contrast the narratives and to identify patterns and diversions in the data material, before performing interpretative analysis of the collected narratives. This process was performed with regard to the data presented in articles II, III, and IV. A similar approach was used in article I, although with greater emphasis on observational insights.

## Narrative analysis

To analyse my participants' stories, I utilized a narrative analysis approach (Riessman, 2008). "Narrative analysis" is a cluster-term for various avenues of analysis, and it therefore requires some specification with regard to the present dissertation. I view participants' narratives as entangled with and reflecting of immigrants' wider social negotiations in diaspora. From this perspective, patterns of recurring and related phenomenon, experiences, and viewpoints across subjects can yield insights of transferrable value. In other words, a collection of narratives should make up something greater than the parts that make up each of them (Elliot 2011).

A systematic analysis of narratives can serve to shed light on individual and collective action and meanings. In this sense, it is also telling of the social processes involved in shaping immigrants' health care seeking and integration. I have thus used narratives as a foundation for producing an understanding of how Pakistanis and Somalis negotiate health matters upon resettlement in Norway. In the analysis process, I took vantage point in the thematically- and cue coded data transcripts in order to identify patterns and divergent issues in the overall data. As insights of broader relevance emerged, I highlighted these in the form of particularly representative and telling interview extracts. Many of these snippets worked to illustrate the broader reality and ideas permeating to health care seeking and integration in an increasingly diversified society.

Considering the topic's demand for subjective stories about health matters and perspectives, the present work can be said to fall within the hermeneutic tradition where attention to content trumped attention to narrative form (Reissman 2008). This however, did not mean a disregard for neither narratives as performance, narrative form, or the processes of their production and consumption (Gubrium and Holstein 2009), but rather that a focus on content and interpretation appeared the most suitable analysis for conceptualizing the social and relational determinants and dynamics behind processes of health care integration, or lack thereof.

### Generalization of findings

Generalizing is both possible and a desirable in qualitative research, although it pertains to a particular type of generalization (Williams 2000). The purpose is to arrive at a point of confidence regarding patterns in the data, to allow for theoretical abstractions of transferable value (Guba and Lincoln 1982). "Sociology is," after all, "the art of thinking phenomenally



different things as similar in their structure and form and of transferring that which has been established about a constructed object [...],” to other fields and other objects (Bourdieu 1982:40-41). Hence, some form of general conclusions is simply necessary and desirable in qualitative research (Gobo 2008, 2006).

There has been some debate about whether generalizations in qualitative research should be left to one’s audiences by providing thick description of empirical observations or whether one should always attempt to explicate elements of presumed transferability to further research and policy. However, in an article reviewing how generalizations were undertaken in all qualitative studies in the 2003 volume of *Sociology*, Payne and Williams found that most qualitative researchers actually did engage in some form of generalization, whether intended or not (Payne and Williams 2005). Based on their review, they outlined some considerations and strategies that have been useful to keep in mind throughout the present research. One point is that the data analysis requires a solid and logically structured analysis and a careful conceptual operationalization in order to fence off the space for competing explanations for the same observed patterns. However, the observations should still be open for testing and competing perspectives in subsequent research. Relatedly, by preparing for entering the field by extensive reading, source collection, and reviewing various research literatures related to aspects of immigrants’ health care integration, I have attempted to be cautious about making sweeping statements, and instead make more “modest claims in clearer terms” (Payne and Williams 2005:311). My awareness of considering the extent to which broad generalizations were possible presented itself already at the outset of the project, reflected in the diverse backgrounds and experiences of Pakistani and Somali immigrants in Norway.

## Ethical considerations from the “outsider”

This research was conducted upon ethical approval from the Norwegian Centre for Research Data (NSD). I will briefly mention some of the ethical considerations encountered during the research process. The topic of this study demanded special reflection as to my role as researcher. On the one hand, the study of aspects regarding immigrants’ lives in a Norwegian context makes me, as a representative of the majority culture, an insider. On the other hand, as both Somali and Pakistani immigrants in Norway tend to affiliate based on culture and family networks, in attaining the insiders’ perspective I became the outsider. This position elucidated the importance of gaining a sense of trust among the subjects of study.

One way I did this, was to demonstrate some of my pre-established insights into Pakistani and Somali history and known health concerns, so that “nothing” they would tell me would appear “exotic.” It therefore prepared for the data collection by creating for me a kind of platform of cultural and situational references through which I could pose my questions. At the same time, as Shaw (2000) has noted when studying Pakistani families in Britain, the fact that the researcher will continue to live within the same community as one’s subjects of study encourages sensibility when it comes to which information is conveyed and how this is done.

A precondition for gaining trust among informants, and for their willingness to credibly convey personal stories, is openness about the purpose of study and how data will be used on part of the researcher. Interviews and their recording were therefore carried out upon informed consent. At the same time, participants were made aware of their opportunity to withdraw from the study at any time, upon which all information from and about the participants would be deleted. Anonymization by way of adopting pseudonyms and presenting data on a group level (where vignettes from informant statements are used illustratively) was done to ensure that individual stories were unrecognizable to others. Still, my main concern was the interpretation

of their stories on their terms. In the process of interpretation, I was constantly wary that in order to understand the experiences of the people under study, particular attention had to be lent to “what is at stake” from the perspective of the study participants (Kleinman and Kleinman 1991).

As I recruited informants also from social gathering points such as immigrant organizations, where I was sometimes seen conducting an interview by the participants’ acquaintances, and where suspicions might arise as to what kind of information was exchanged, there was some need for discretion. However, in most cases the participants did not seem to be overly concerned as to whether others listened in. This was also reflected in my focus group interviews, where participants shared rather willingly once the ice was broken, usually by one participant’s willingness to convey their narrative. To eliminate this problem, however, I aimed as far as circumstances allowed conducting individual interviews in private, such as offices at mosques and immigrant organizations.

Moreover, as I identified immigrant organizations as potential “third parties,” as filters of information, bridge-builders, or conservers of tradition, an ethical question concerned the portrayal of these persons. As stated in the *National guidelines on ethics*, “it can be of great public interest to obtain information about how private enterprises and special interest organizations function in society” (NESH 2006:21). However, as official policy directives identify organizations, such as those established and run by immigrants, as potential targets of outreach activities and even integration policy, I have been careful also of revealing these. I have moreover been wary of portraying immigrant organizations in ways that do not resonate with the social functions that the leaders and members themselves attribute to them.



## 5. Article overview

In this chapter, I present an overview of the dissertation’s empirically based articles. Articles II, III, and IV were produced as part of my *stipendiat* position on a project entitled, “Immigrants’ Health Care Utilization in Norway,” headed by Dr. Jon Ivar Elstad (NFR Project No. 222100). Article I was commenced when I was still a research assistant in a project about “Maneuvering in Hybrid Health Care Organizations,” managed by Dr. Mia Vabø (NFR Project No 186516). Both projects were conducted at NOVA. Below, I summarize the empirical and theoretical gist of dissertation’s four articles, as well as their topical characteristics. In the sixth and final chapter, I summarize central findings, discuss their implications for immigrants’ health care integration and future research, and conclude the overarching argument of the dissertation.

Table 1

| No. | Article titles  | Data   | Journal   |
|-----|---|--|---|
| I   | “Dementia and migration: Pakistani immigrants in the Norwegian welfare state”   | Fieldwork / interviews with Pakistani immigrants and Norwegian health care employees | Næss, A. and Moen, B. (2015). <i>Ageing &amp; Society</i> , 35(8): 1713-38. |
| II  | “Trust, Cultural Health Capital, and Immigrants Health Care Integration in Norway”  | Interviews with Somali immigrants  | Næss, A. (2019). <i>Sociology</i> , 53(2): 297-313.                         |
| III | “Migration, Gender Roles, and Mental Illness: The Case of Somali Immigrants in Norway”  | Interviews with Somali immigrants  | Næss, A. (2019). <i>International Migration Review</i> , 54(3): 740-64.     |
| IV  | “Immigrant Organizations and Immigrants’ Health Care Integration in Oslo: A Comparative Study of Pakistani and Somali Immigrant Organizations as Bridge-Builders” | Interviews with leaders and members of Pakistani and Somali immigrant organizations  | Under review at international peer reviewed journal.                        |

## Article I: Dementia and migration: Pakistani immigrants in the Norwegian welfare state

The first article of this dissertation is about dementia disease in the context of Pakistani transnational migration to Norway. Focusing on the example of Pakistani immigrants in Norway, the article explores response processes surrounding signs and symptoms of dementia. Particular attention is lent to understanding how Norwegian-Pakistani families ‘negotiate dementia’ in the space between their own imported, culturally defined system of cure and care, and the Norwegian health-care culture, which is characterized by an inclination towards public care and biomedical intervention. Based on field observations and in-depth interviews with Norwegian-Pakistani families and hospital professionals working with dementia, I show that the centrality of the traditional family in Norwegian-Pakistanis’ identity claims has significant implications for how Norwegian-Pakistanis relate to the Norwegian health-care culture, and for how signs and symptoms of cognitive decline are read and responded to in a migratory context. The central case examples draw attention to the generational dilemmas and concerns that can arise when the “master narrative” of inter-generational reciprocity and familial elderly care is contrasted against a contextual backdrop of mainly public elderly care provision.

## Article II: Trust, Cultural Health Capital, and Immigrants Health Care Integration in Norway

This article examines the role and function of bridge-builders in shaping the convictions that inform health behavior and health care-seeking practices among Somali immigrants in Oslo, Norway. Based on narrative analysis of in-depth interviews with Norwegian-Somali health care personnel and key figures in immigrant organizations, the paper highlights that the relationship between Somali immigrants and the Norwegian healthcare system is characterized by a pervasive, mutual unfamiliarity. This unfamiliarity translates to a mutual reliance on selected Norwegian-Somalis who by virtue of commanding two cultures and systems of health care, can act as bridge-builders and negotiate associated barriers. Particular attention is lent to understanding the ways that Norwegian-Somali bridge-builders act as demystifiers and trust-producers towards the Norwegian health care system, as well as how resourceful Norwegian-Somalis become engaged to enhance the health care systems' outreach capacity and its ability to address ethno-cultural differences within and beyond the clinical sphere. The findings suggest that the combination immigrant background and health care knowledge constitutes a particular, yet largely unacknowledged, kind of bridging social capital, which is crucial for the provision of equitable health care services and for immigrants' health care integration.

### Article III: Migration, Gender Roles, and Mental Illness: The Case of Somali Immigrants in Norway

Gender and gender relations have received limited attention in social scientific research on “mental illness” conceptualizations and responses in the context of transnational migration. Based on narrative analysis of in-depth interviews with Norwegian-Somali health care employees, mosque-representatives, and immigrant organizations, this article explores why Norwegian-Somali women have lower contact rates with psychiatric services compared to Norwegian-Somali men, as well as women of other immigrant backgrounds. This question was derived from the quantitative part of the project, which combined data from National Patient Registry with person data obtained from Statistics Norway to map out immigrants’ utilization of specialist health care services in Norway (Elstad, Finnvold, and Texmon 2015). The article argues that Norwegian-Somalis’ avenues to psychiatric services intersect with imported health beliefs and cultural mechanisms that elicit different responses towards and among men and women in events of mental distress. The article attributes women’s lower contact rates with psychiatric services to their social position as symbolic carriers of clan and family honor. This role accentuates the stigma and presumed social consequences associated with mental illness and diagnosis, leading to various forms of social concealment. Although rumors and mythical constructions around Norwegian health care institutions contribute to service skepticism among both men and women, higher contact rates among Somali men is associated conditions that allow social exposure. In conclusion, the article highlights that because healthcare seeking or avoidance are relationally informed acts, these have to be understood on the backdrop of migration, resettlement and processes of adaptation.



## Article IV: Immigrant Organizations and Immigrants' Health Care Integration in Oslo: A Comparative Study of Pakistani and Somali Immigrant Organizations as Bridge-Builders

There is a vast literature on immigrant organizations and integration, yet few studies have explored immigrant organizations as shapers of health beliefs, attitudes, and practices. Drawing on qualitative interviews with leaders and members of Somali and Pakistani immigrant organizations in Oslo, I provide a comparative analysis of immigrant organizations' engagements as partners in Norwegian public health. The findings show that immigrant organizations often constitute informal extensions of the Norwegian health care system, by promoting health care contacts, dissemination health information, and by countering health care barriers. Comparing the perspectives of Somalis and Pakistanis, the article argues that immigrant organizations serve different health purposes within- and between groups, often reflecting group-specific concerns and needs. The article shows that immigrant organizations can serve as extensions of the health care system by constituting spaces of familiarity in proximity to the Norwegian health care system. However, the outreach potential and health engagements of immigrant organizations is defined by the distribution, interests, and capacity of persons with command of two health care cultures – a resource here conceptualized as cultural health capital. Moreover, in the case of both Pakistani and Somali immigrant organizations, and as reflected in the large number of immigrant organizations in Oslo, organizational outreach and influence might also be defined, and thus limited, by the ways that cultural values pertaining to kinship systems, gender roles, and generational are played out in practice. Future research should pay attention to the implications of within group characteristics and dynamics when considering the integrational capacity and influences of immigrant organizations.



## **6. Conclusion**

This dissertation has been guided by two core questions. The first is the question of how immigrants' cultural norms and values pertaining to family, gender roles, and social organization intertwine with processes of immigrants' health care integration. The second question concerned how immigrants negotiate health beliefs, behaviors, and health care seeking practices upon resettlement in initially unfamiliar socio-cultural and institutional contexts. I have here explored these questions through qualitative research among Pakistani and Somali immigrants in Oslo. In this final chapter, I summarize some of the central findings generated from the overlapping questions and discuss their implications and transferability.

### **Migration, super-diversity, and health**

In this dissertation, I have explored some of the extra-medical dimensions of immigrants' health- and health care integration, particularly the negotiations that take place in the backstage spaces of social interaction. The concept of super-diversity was invoked to underscore that processes of immigrants' health care integration increasingly have to be examined and understood not only with attention to ethno-cultural diversification within a given society, but also with a focus on the diversification of diversity resulting from sustained immigration over time. The empirical part of the dissertation has explored immigrants' health care integration through four overlapping topics, namely; intergenerational reciprocity and responses to signs and symptoms of cognitive decline among Pakistanis, trust, cultural health capital mobilizations, and health care integration among Somalis, gender role negotiations and mental illness responses among Somalis, the bridge-builder role of Pakistani and Somali immigrant organizations. These topics were selected as they emerged as the most express and pressing within the data material. Building on classical sociological theory, the dissertation contributes

to the fields of immigrant health research and the social scientific study of migration, ethno-cultural diversification, and integration.

Zooming out for a birds eye view of the empirical findings, the case examples presented in the four articles all point to the general argument running through this dissertation, namely that processes of immigrants' health care integration, here distinguished by the ways that immigrants negotiate interpretations and responses around signs and symptoms of illness, intertwine with wider integration processes. In article I on dementia and elderly care among Pakistanis, I show that the second generation is increasingly torn between the welfare state's demand for societal participation, pursuit of personal desires, and the first comers' expectations about co-generational living situations and familial elderly care. Based on fieldwork among Pakistani families caring for elderly relatives in the Oslo area, the article suggests that the centrality of the traditional family and intergenerational reciprocity in their identity claims often lead signs and symptoms of cognitive decline to be overlooked as normal aging. This centrality of the family as a source of ontological security at old age was also found to be fueled by contrasting, negative portrayals and presumptions about dementia diagnosis and public elderly care. An important observation here was that some Pakistanis are beginning to realize that familial elderly care may not be a realistic option in all families and illness trajectories, and thus that some forms of public intervention could be both desirable and necessary. In article III, which is a qualitative exploration of why Somali women Norway utilize specialist mental health services at a lower rate than Somali men, I found similar associations between health care integration and imported notions of kinship, family, gender, and generation. A central finding in this regard was that the responsibilities and symbolic position of Somali women within the family, in contrast to the men's public position and responsibilities, worked to accentuate the stigma of mental illness in women. This contributed to both individual and collective forms of illness concealment, as well as use of traditional treatments and resolves rather than immediate

pursuit of formal services. Hence, based on the observation that process of health care integration often play out in extra-medical settings, the two studies underscore that health care integration is a culturally and relationally defined process.

Correspondingly, as I discuss in article II and IV, and as reflected in the mobilization of immigrant organizations to counter the spread of Covid-19 among immigrants in Norway (NRK 2020b), both immigrants and policy makers now acknowledge the need for bridge-building efforts and initiatives between immigrants and the Norwegian health care system. A central reason for this is that sustained immigration over time produces new and increasingly complex social fields of social interaction, cultural negotiations, and information flow (Vertovec 2007). In article II, based on narratives from a birth-clinic, a measles outbreak, and of everyday consultancy, I discuss unfamiliarity and mistrust as critical hindrances to immigrants' health- and health care utilization in Norway. In this regard, while article IV comparatively explores the role and potential of immigrant organizations to serve a bridge-building purpose, a key finding in this dissertation is that increasing ethno-cultural diversity works to both demand and inspire informal and spontaneous capital mobilizations by a variety of third party actors. Hence, in line with research documenting the engagements of immigrant children as health care brokers within their families (Katz 2010), this dissertation brings light to a subtle and partially hidden social field of health related interactions and resource mobilizations between immigrants and the health care system.

The Norwegian health care system is, as I have mentioned, highly aware of the potential advantages of collaborating with immigrant communities around immigrants' health care integration. However, with sustained immigration and increasing ethno-cultural diversity, there is always a risk that presumptions about immigrant communities become overly simplified. For instance, as I discuss in article II and IV, while bridge-building engagements constitute

important links for exploring processes of immigrants' health care integration, depending on the context and problem in question, there are also associated limitations to the efficiency of immigrants' cultural health capital mobilizations. Hence, while the bridge-builders featured in this dissertation worked to mediate ethno-cultural differences that the Norwegian health care system has to resolve in order to ensure equitable services and service access, their efforts also met hindrances in the form of limited resources and capacity. Sustained migration, variations in duration of residency, and differences in choice of adaptation strategies are all determinants likely to both be reflected in and to be accentuated by within-group differences in resources, selective acculturation, and integration.

In major cities all across western-European, there are districts that are characterized in terms of super-diversity. This dissertation has shown that the complexities arising from the combination sustained migration, variations in immigrants' integration and adaptations strategies, as well cultural and experiential backgrounds poses a complex and evolving challenge to the Norwegian health care system. It has simultaneously shown that immigrants' health care integration often relies on the skills and social capital resources possessed and mobilized by immigrants to bridge cultural differences and to resolve issues of mutual unfamiliarity. Hence, aggregating the main findings of the different empirical analyses, I conclude that processes of immigrants' health care integration are relational as they play out in social life across a variety of social arenas. The dissertation's main contribution of transferable importance to future research, as indicated by the socio-cultural and relational dimensions of immigrants' health, is thus that the complexities of immigrants' health care integration demands for its examination with attention to wider social processes and integration in general.

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## **Part II. The Articles**





## **Article I.**

Næss, A. and Moen, B. (2015). Dementia and Migration: Pakistani Immigrants in the Norwegian Welfare State. *Ageing and Society*, 35(8): 1713-38.

## **Article II.**

Næss, A. (2019). Trust, cultural health capital, and immigrants' health care integration in Norway. *Sociology*, 53(2): 297-313.



## Trust, Cultural Health Capital, and Immigrants' Health Care Integration in Norway

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### Abstract

Trust is a decisive feature of social interactions, transactions, and relationships, yet the implications of trust in integration processes has largely escaped sociological inquiry. Based on interviews and focus group discussions with Somali immigrants in Norway, this article examines trust in the context of health care integration. Using empirical examples from a birth-clinic, the MMR-vaccine, and everyday consultancy, the study highlights that the relationship between Somalis and Norwegian health care providers is characterized by a pervasive, mutual unfamiliarity. This unfamiliarity translates to a reliance on selected Norwegian-Somalis who by commanding two health care cultures can engage as bridge-builders to negotiate associated barriers. The article argues that the combination of immigrant background and formal health knowledge constitutes a type of cultural health capital. Although tapping into this capital extends the health care system and enhances Somalis' ability to invest trust and benefit from entitlements, a shared background is not synonymous with trust.

### Keywords

Bridge-builders, cultural health capital, health care integration, Norway, Somali immigrants, trust

### Introduction

The observation that trust is important in the context of health care is far from novel (e.g. Parsons, 1951). This qualitative study explores trust in relation to immigrants' integration into new health care cultures. Across country contexts, a lack of trust has been identified as a prevalent barrier to immigrants and ethnic minorities' health care utilization (Ayazi, 2006; Feldmann et al., 2007; Manderson and Allotey, 2003; Vozikis and Sigano, 2003).

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2015). A lack of trust has been associated with worse self-reported health, reduced willingness to pursue services, lower relationship quality with health care providers, lower treatment adherence, and poorer service satisfaction (Benkert et al., 2006; Halbert et al., 2006; Hsieh et al., 2010; Whetten et al., 2006). Still, the question of how notions of trust and mistrust are informed, manifested, and responded to in the context of immigrants' integration has received limited sociological attention.

Based on interviews and focus group discussions with Norwegian-Somalis in Oslo, this study explores trust as an attitude that facilitates communication, reduces risks, and potentially increases beneficence and satisfaction in health care encounters. Conversely, mistrust has the opposite qualities. Lending attention to expressions of mistrust in health beliefs and practices, the article discusses how selected Somali immigrants become engaged in and take command of the health care integration of other Somalis. The article argues that commanding two cultures and systems of health care constitutes a type of 'cultural health capital' (Shim, 2010). This resourcefulness makes its possessors sought after as intermediaries in clinical settings, public health situations, and in everyday life. The analysis shows that whereas ethnic Norwegian health care employees require the language and cultural insight of selected Norwegian-Somalis, Somalis often rely on their formal knowledge in combination with their command of the Somali language and culture. However, critical contingencies exist regarding the efficacy of cultural health capital mobilizations.

A range of terms have been used to capture the different formations and functions of intermediary roles in the context of health care, such as 'community health workers' or 'natural helpers' (Cherrington et al., 2010), 'navigational assistance' providers (Green et al., 2014), and 'lay health advisers' (Vissman et al., 2009). Although these concepts pertain to variations of intermediary health care engagements, I will here use the concept of 'bridge-building'. This is not only a concept that reflects the immediacies of local context, since Norwegian-Somalis themselves use it to denote a particular kind of work taking place between the Norwegian-Somali community and the health care system, but it also serves as a vehicle for analysing trust/mistrust and cultural health capital as determinants of Norwegian-Somalis' health care integration.

## Trust and Immigrant Health

Within the Norwegian welfare state, equitable redistribution in the form of universal access to tax-financed health- and care services is in many ways the symbolic archetype of public solidarity (Magnussen et al., 2009). In this context, the legitimacy of public institutions, like the bulk of the Norwegian health care system, is a product of its ability to fulfil the entrusted task of providing timely and efficient services to all segments of the population, regardless of age, gender, income, or ethnicity (Norwegian Ministry of Health and Care Services, 2013). Notwithstanding all residents have equal rights, an important indicator of integration is how and whether one's status as immigrant or refugee compromises life opportunities in a new society (Alba and Foner, 2015), including possibilities for benefitting from health care entitlements.

According to the German sociologist Niklas Luhmann (1979: 19), 'familiarity is the precondition for trust as well as distrust, i.e., for every sort of commitment to a particular

attitude towards the future'. When familiarity is in place, however, trust can be a solution to risk and vulnerability, as it can work to enable or guide social action in situations where actors are overwhelmed with ambiguity or fear regarding the future consequences or outcomes of different choices (Di Luzio, 2006; Luhmann, 2000). The instrumental advantage of trust in the context of health care is thus that it allows for calculated risk-taking by making decisions based on expectations and presumptions about the benefits secured in the moral and skilled practice of professionals (Gilson, 2003). Another important function is in this respect that 'trust, by keeping our mind open to all evidence, secures communication and dialogue' (Misztal, 2013: 95), enabling benefit from available health care services.

The centrality of familiarity and trust in the context of health- and health care utilization is underscored by studies that attribute negative health status to a lack of trust. In a Swedish study, limited trust in general, combined with limited trust in institutions has been associated with a higher ratio of low self-reported mental health (Mohseni and Lindstrom, 2007). The same correlation appears in a study involving 22 Chinese villages, where trust and mistrust at both the individual and collective level was associated with better and worse mental health (Wang et al., 2009). It is notable that studies among Somalis in Sweden (Svenberg et al., 2011), and among Somalis in Norway (Ayazi, 2006), have found trust to be a fragile construct beneath differences in culture and communication. Moreover, in the case of Norwegian-Somalis, experiences of 'humiliation' in their contacts with other public institutions (Fangen, 2006), could thus work to compromise familiarity and health care trust. Hence, in examining Somalis' health care integration in Norway, which is also a matter of general integration, both trust and mistrust requires consideration.

Sociologists have proposed distinguishing between different forms of trust, depending on whether a social order is stable, cohesive, or collaborative in nature (Misztal, 2013). According to Giddens, we might also imagine different environments of trust, specifically those of individual networks and relations, and trust in abstract systems fronted by experts (Giddens, 1990). This distinction will here serve to analyse the extra-medical space within which Norwegian-Somalis exchange health care experiences and information to shape the convictions that individuals and families might act upon in health matters. I lend particular attention to counteractive responses to the manifestation of attitudes that might subvert the official policy goal of equal health care access and treatment to all segments of the population.

Whereas ethnic Norwegians rely heavily on institutions beyond the family for help and security, Somalis, who have a limited tradition of trusting in state institutions (Lewis, 2002, 2004), often rely upon the traditional system of patrilineal clanship for structuring social networks and for maintaining a sense of ontological security and identity in diaspora (Engebriksen, 2007; Farah, 2000; Hopkins, 2006; McGown, 1999). Against this backdrop, health care trust/mistrust is not simply the direct outcome of individuals' health care encounters but is also generated or counter-worked in immigrants' interaction and exchange with each other. Immigrants' networks and social interactions and the distribution and mobilization of cultural health capital within them are thus likely to shape health beliefs and practices.

## Cultural Health Capital

Although many Norwegian-Somalis are wary of investing their trust in the bureaucratized health care institutions of a highly individualized society, trust can nevertheless be swayed towards improvement through familiarization, positive experiences, and through the vouching or convincing of presumably trustworthy others. Trust is also a collective enterprise, as group perceptions about social phenomena often inform individuals' sense of trust. This is evident in that trust is a defining attribute of both stable, collaborative, and cohesive social networks and relations (Misztal, 2013). Here, I will examine the dynamics of trust in immigrants' health care integration through the concept of cultural health capital to forefront 'the fluid yet durably structured relationships between health professionals, gatekeepers, and patients' (Shim, 2010: 11).

The concept of cultural health capital was developed as a response to sociocultural changes within the United States to better account for the implications of culture and social status on health care interactions (Shim, 2010). Inspired by the writings of Bourdieu and the idea of 'habitus', which denotes the cultural embeddedness of social action, the concept allows for explaining how the features of health-related interaction, such as trust, empathy, or informational exchange, are accomplished or broken down. Just as social capital is an aggregate of resources that reflect and that can be translated into social action (Bourdieu and Wacquant, 1992), cultural health capital similarly pertains to a 'set of resources critical to the pursuit of social privilege, the maintenance of stratification, and the exercise of power' (Shim, 2010: 11). Depending on circumstances, 'cultural health capital develops in and through the repeated enactment of health-related practices, such as consuming biomedical knowledge, exercising calculative and future oriented approaches to decision-making, and engaging in self-surveillance and risk-reduction practices' (Shim, 2010: 3). In immigrants' health care interactions, however, it is often the compatibility of both the patient's and the provider's cultural health capital that shapes relations and outcomes (Dubbin et al., 2013). Relatedly, cultural health capital can also be regarded a community- or health care resource to overcome differences pertaining to communication, familiarity, and trust.

A central aspect of social capital is its interlinkage with the characteristics of networks, social norms, and trust (Putnam, 2000). Hence, as suggested by Strang and Ager (2010), rather than drawing on concepts of social capital to frame notions of social connections in relation to integration, I will focus on how the dynamics of social bonds and bridges shape Norwegian-Somalis' trust and health care integration. Norwegian-Somalis' outward orientation, processes of familiarization, and the manifestations of trust/mistrust towards public institutions are to be seen in relation to the internal workings of culturally defined social networks (Engebrigtsen, 2007). From this perspective, it is notable that the values and convictions that people act upon, as in the example of vaccine attitudes, are shaped also in contrast to and in detachment from formal health care institutions (Yaqub et al., 2014). Although a lack of cultural health capital is a common explanation for health disparities among immigrants, the underlying focus on shortcomings in immigrants' command of the majority culture, which seems to guide much of this research, might contribute to the overlooking and misrecognition of the skills, contacts, and abilities contained within socially marginalized groups (Yosso, 2005). At the same time,

overemphasizing the positive, collaborative sides of strong networks might lead to the overlooking of within-group hindrances to outward interactions and cooperation.

## Methods and Approach

The Somali Civil War, which escalated into a full-scale clan-based conflict in 1991 has displaced and dispersed more than two million Somalis around the globe. Relatedly, the Norwegian-Somali population has nearly doubled since the mid-2000s, making them the largest non-western immigrant group in Norway. There are currently 35,912 Norwegian-Somalis, of whom 16,108 have arrived as refugees and 8887 by way of family reunification with a refugee, whereas 9750 are born in Norway to Somali parents (Statistics Norway, 2015). In addition, about 1300 are not listed with a reason for immigration. Considering that the first Somalis to seek asylum in Norway arrived in the late 1980s, combined with the fact that the authorities did not discriminate based on clan (Assal, 2006), the Norway-Somali population is highly heterogeneous in terms of both age, duration of residency, clan composition, war, migration, and resettlement experiences, as well as levels of education and integration. To account for this complexity, the aim was to recruit a diverse set of interviewees, particularly in terms of gender and affinity to the main clans of Dir, Isaq, Hawiye, Darod, Digil, and Rahanweyn, as this defines Somali notions of identity and collaboration (Lewis, 2002, 2004).

No statistics exist for the clan- and sub-clan composition of the Norwegian-Somali population, yet we know that most who arrived in the late 1980s were Isaq from Somaliland, whereas the immigrant stream since 1991 has made up a ‘mosaic of clans’ (Assal, 2006: 168). In recent years, however, because of the rise of al-Shabaab in southern Somalia and the capital Mogadishu, many have claimed affinity as Hawiye. In Oslo, this clan-diversity is evident in that 27 out of 276 immigrant organizations are Somali (Unit for Diversity and Integration, 2016). Membership in these organizations, or in the range of informal networks, centres on clan- and sub-clan affinity. Somali organizations, foundations, and networks fronting an engagement in health issues therefore constituted a strategic vantage point for recruiting participants. In this process, considering most organizations are outwardly clan-neutral and that many Somalis are reluctant about engaging with strangers on sensitive topics like clan or their migration (Assal, 2006), three Somalis with whom contact had been established at previous points assisted as door openers and key informants towards different clan-compartments in the Norwegian-Somali community. While the focus on understanding trust and health care integration in light of community relations, resource mobilizations, and information flow both necessitated and allowed for inquiring about clan, the concern here is with the significance of clan for these dynamics, not the details of individuals’ lineage. I merely note that among the 38 participants (20 men and 18 women), 13 identified as Hawiye, 11 as Isaq, and six as Darod, whereas eight claimed neutrality. The data collection commenced upon ethical approval by the Norwegian Centre for Research Data (NSD).

Individual, in-depth interviews of one–two hours were conducted with 26 Norwegian-Somalis between the ages of 20 and 64. The interviewees included eight persons representing the organizational sphere, nine health care professionals (psychiatrists, psychiatric social workers, and nurses), two high-ranking mosque representatives, and seven



laypersons with only informal health knowledge and organizational experience. The interviews took place in various settings, such as cafes, hospitals, and organizations, depending on the participants' convenience. In addition to the individual interviews, assisted by two organizations I arranged two focus group discussions with four and eight participants, respectively. These discussions were moderated to attain insights on conflicting attitudes and perceptions towards the Norwegian health care system, health care experiences, and determinants shaping health beliefs and health care seeking practices. All the interviews were in Norwegian and were recorded upon informed consent for subsequent transcription, coding, and analysis. To assist recollection, I jotted field notes following each interview.

The analysis and data collection constituted an integrated and continuous process as it involved iterative revisions of semi-structured interview guides and testing of emerging themes in the expanding data. In analysing the participants' stories, to identify patterns of actions and meanings related to health care integration, along with the social circumstances and processes that informed them, I applied a narrative analysis approach (Gubrium and Holstein, 2009; Riessman, 2008). Grounded narrative analysis concerns what individuals subjectively convey in storytelling, and how, it was by drawing out and interpreting elements of similarity and difference across several narratives that sociological insights pertaining to the general question of inquiry were attained (Riessman, 1993). The work of 'bridge-building' emerged early on as a central analytical theme in relation to health care integration and recurring stories of unfamiliarity and mistrust between Norwegian-Somalis and the health care system. Although leaders of immigrant organizations were more inclined to refer to themselves as bridge-builders compared to health care employees, I here extend the term to encompass variations of cultural health capital mobilizations. In presenting the central findings regarding the various formations and influences of the Somali bridge-builder role, I focus on case examples from a birth-clinic, a measles outbreak, and everyday consultancy. Pseudonyms are applied to conceal participants' identities.

### **In the Birth-Clinic: Countering Unfamiliarity and Establishing Trust**

According to the participants of this study, Norwegian-Somalis often encounter Norwegian health care providers with negative preconceptions. When mistrust surfaces in clinical settings, however, there might not be a quick fix to it. In such situations, allocating individuals who are not merely interpreters, but who have the presumed ability and mandate to attempt changing convictions and establishing trust, is sometimes the only resolve for ensuring safety and for maintaining patients' integrity.

In an interview with Arif (64), who is one of few Somali psychiatrist and who therefore has a large network, he explained that he was frequently contacted to act as bridge-builder in more or less critical situations. He recalled a recent situation, when he was called in connection with a Somali woman who was refusing a planned caesarean:

I had to have a full consultation over the phone where I tried to explain why the caesarean was necessary for both the woman and her child. Some people think that this is done to sterilize

them, but this is a myth. The problem in this case was that what people had told her still had great influence.

Although Arif managed to convince the woman that the greatest risk was in abstaining from the procedure, in more urgent situations there may not be enough time to turn an established mind-set.

Basma (43), a midwife at a major hospital in Oslo, expressed feeling a special responsibility for patients of Somali backgrounds because of her awareness of risks associated with miscommunication and mistrust during childbirths. Although it was through stories and experiences, rather than research findings, that Somalis seemed to fuel sceptical attitudes, it is notable in this regard that Norwegian-Somali women have been found at higher risk of requiring emergency caesarean sections compared to Norwegian women, even after lengthy residency (Sørbye et al., 2015). It is also notable that Somali immigrant women in different resettlement countries, including Norway, are more likely to experience stillbirths compared to the general populations (Small et al., 2008). Adverse obstetric outcomes in Somali immigrant women have been attributed to both the practice of female genital cutting (Johansen, 2006), and to the broader issues of sociocultural and linguistic unfamiliarity and mistrust in maternity care providers, as these issues might delay antenatal care, limit compliance with advice, and lead to inappropriate decisions (Binder et al., 2012b). A challenge in this respect is the question of who the patient is inclined to rely on for information, and why. Basma explained that the circulation of stories and rumours was often a main cause of scepticism and suspicion among expecting Norwegian-Somali mothers and family members at her hospital. Such attitudes can contribute to produce negative outcome- and experience narratives that in turn fuel rumours and exacerbate dissenting opinions about the health care system.

She recounted a recent situation where she was requested as mediator. Basma was working out when her job called:

They told me, ‘Basma, we have a woman here who is bleeding and who needs a surgery, but she is refusing and screaming furiously.’ The worst thing was that this woman had lived in Norway for only two years, and she was giving birth to her seventh child. She had a Somali friend with her who had lived in Norway for many years, but this woman was more of a burden than a help. She told her: ‘You know what, now they are going to remove your uterus. You are going to be operated because you are giving birth to so many children, it’s nothing else. You have to refuse. Call your husband!’ He also told her not to get operated on, and that he was jumping into the car to come right away. It turned out that he also feared that his wife’s uterus would be taken and given to a Norwegian woman who can’t have children. Hehe... it’s an absurd thought.

Unable to get through to the woman, Basma received another call after the woman was rolled off to the surgical theatre, by force. The doctors needed her to explain once more to the woman that she would be dead in 40 minutes, before her husband would get there, if immediate action abstained. ‘She still refused,’ Basma explained, ‘so they grabbed the phone from her, telling me that they just had to go ahead.’

The next day, before her night shift, Basma made sure to see the woman. The surgery had been successful, and her first utterance was, ‘oh my God, how lovely that narcosis was’.

Although Basma was relieved, her frustration with the woman, the husband, and her friend made her determined to ensure that the woman departed with her previous scepticism. It was here that she learned about the reasoning behind the refusal. According to Basma, and as Arif narrated, this kind of effort was particularly important because of the Somali culture of storytelling, wherein negative health care stories often weigh heavily on the convictions upon which people act. Notwithstanding mistrust is a protective mechanism (Wang et al., 2009), part of the problem is that it can also be a contributor to risk and unequal treatment.

Although trust is often co-produced in interactions between patients and providers, the outlined examples suggest the efficiency of cultural capital mobilizations depend upon both timing and setting. An argument for pre-delivery contacts and familiarization sessions is in this respect that continuity of care improves confidence and trust among immigrants (Bhatia and Wallace, 2007). Moreover, as found in a study among Somali women in London, early contacts can facilitate detection of women likely to require but also resist caesareans (Binder et al., 2012a). These were also the reasons why Basma was in the process of applying to the hospital board to fund maternity courses targeting Somali and African women.

## Responding to a Measles Outbreak in Oslo

Bridge-building efforts also take place beyond health care institutions. In January 2011, there was a rare outbreak of measles in Oslo. The first person to contract the disease, and the subsequent five of 18 persons, were unvaccinated Norwegian-Somali children (Vainio et al., 2011). The outbreak, which was associated with the hosting of relatives living in Ethiopia, occurred in Gamle Oslo, a district with a high concentration of Somali residents and low vaccination coverage (Steen et al., 2012). While there are vaccine-sceptics in every society, avoidance among Norwegian-Somalis has not only been associated with the global myth that the measles, mumps, and rubella vaccination (MMR) causes autism in children (Norwegian Institute of Public Health, 2012), much a reverberation of a fraudulent study retracted in 2010 (Wakefield et al., 1998), but also with a general 'suspiciousness and limited trust towards the Norwegian health care system' (PROBA, 2013: 31). Hence, since the vaccine could not be trusted, neither could the health care providers, nor the health care system proper.

Realizing the barriers to a swift response, local health authorities proceeded to engage Norwegian-Somali health care employees, who by their medical training and community bonds could address Somalis. Arif, the psychiatrist, talked about his involvement in the counter-efforts following the above-mentioned measles outbreak:

I was called in to host meetings, and I talked on two Somali radio stations in Oslo. Autism is something new to many, since it is not something that people have heard much about in Somalia. When the rumour first spread, people got fixated on it. We now know it's only coincidental that the time when signs of autism tend to appear and the age that the vaccine is given coincide. I had to convince people in Somali that there was no proven connection, and that it could be dangerous for children to go unvaccinated.

In this situation, Arif was able to vouch for the vaccine because he could provide explanations for biomedical concepts that have no direct Somali translation. In this sense, he

gained authority through his command of the very system that other Somalis viewed with scepticism. These retrospective preventative efforts led 25 Norwegian-Somali children to receive vaccinations in the subsequent weeks (Steen et al., 2012).

Similarly, in an interview with Mohammed (28), who is a nurse, he explained that:

I have been consulted several times by the head doctor in the city district to provide information to Somalis. There are a lot of false rumours, and they get spread quickly within the Somali community. As a consequence, many Somali parents avoid vaccinating their children. Also, in 2009, when there was a suspected polio case involving a Somali child, I was called in because the vaccination rate among Somalis was low.

In these cases, it was not only necessary for the health care apparatus to address proactively the Somali community in order to prevent further disease, but to appear with trust and credibility there was also a need for involving Somali health care employees. As both Arif and Mohammed were selected as mediators because of their background, combined with their formal competency, this indicates that the health care system's capability and credibility is situationally contingent upon putting informal kinds of competency in motion.

### **Formations of Everyday Consultancy: Strains and Gains**

In everyday life, the distance to the Norwegian health culture and difficulties in communicating directly with health institutions and health professionals might orientate Somali immigrants, as in the case of Norwegian-Pakistanis (Næss and Moen, 2015), towards friends, family, and civil society organizations for related advice and assistance. Imported health beliefs, divergent expectations, and widespread unfamiliarity with both biomedicine and the Norwegian health care system among Norwegian-Somalis was identified in various ways by both health care employees and organization leaders as the motivating force and reason behind their engagements as bridge-builders.

As Mariam (61), a nurse and head of an organization, illustrated regarding divergent health beliefs and expectations:

If my mother comes here from Somalia, and after a couple of days she gets a fever, she will immediately think that it's malaria or typhoid fever. Then, if we take her to the hospital or emergency room, she will expect to get a needle shot because the mentality is that something significant or big needs to happen in order to survive.

According to Mariam, the reason small signs might be exaggerated, and vice versa, is because people from Somalia often have different experiential prerequisites for distinguishing between serious and harmless symptoms. Somalis might therefore adhere to different notions of treatment, but also of giving and receiving help. This was exemplified in the two focus group discussions, where doctor's visits were highlighted as frequently unproductive, because 'nothing happens'. This perceived passivity, exemplified by the advice to 'stay hydrated and rest', was highlighted both as explanation for why some participants reported not going to doctor 'unless one is injured or really ill', and for why Somalis pick up on advice to pursue treatments abroad, a practice common also

among Swedish-Somalis (Svenberg et al., 2011). It could also partially explain why Norwegian-Somalis resort to emergency room services, which do not require appointments or referrals, more often than other immigrant groups (Sandvik et al., 2012).

From Samira's (35) experience as a hospital nurse, another challenge to immigrants' health care integration, besides divergent health beliefs and expectations about action, was differences in language and interactional styles. She explained that:

When Somalis are hurting or feel pain, they are looking for sympathy. In Norway you don't get this sympathy directly, but you get empathy. The Norwegian health care system makes everyone, including me, empathize with everything. If you sympathize too much, you cannot do the job you are supposed to.

This difference can be difficult for Norwegian health care providers to address, not only because of communication barriers, but because sympathizing might conflict with ideas of system neutrality, equality, as well as norms of professional distance. A common complaint among the layperson participants and doctor visitors was thus that impersonal interaction and time-constraints create for a poor environment of trust and nondisclosure of experiences and feelings of relevance for medical assessments.

A third challenge behind the engagement of Norwegian-Somalis in bridge-builder roles was that of comprehension of and compliance with treatments and advice. In an interview with Habiba (52) and Salma (48), two central women in a large Somali organization, they explicated that Somalis have a precarious need for translated information about both biomedicine and available services. Leaning forward to underscore the seriousness of the problem, Habiba said that:

In Norway, it is one's own responsibility to find information, and when people have a sickness, a diagnosis; many Norwegian-Somalis do not take it seriously. They do not take their medications, do not have confidence in health care staff, and they might use own methods or traditional medicine that might not work.

In some cases, this kind of unfamiliarity and mistrust is also the basis for exerting influence on others. This was exemplified by Bilal (52), the leader of a Somali recreational organization, who explained that his friend, in response to him being prescribed blood-pressure medications by his doctor, suggested that he should quit and instead make use of herbal remedies, like him.

Direct involvement within the Norwegian-Somali community was thus identified as crucial to establish first contacts, facilitate communication between patients and providers, but also to counter misconceptions and advice that could restrict utilization and beneficence from available services.

Although the capacity, focus areas, and aims to provide help varied among the organization leaders and the health care employees, they reported being utilized as reference points, or stepping stones both within and beyond the health care system. A notable difference between the different actors, however, was that health care employees tended to engage as bridge-builders upon the request of employers, colleagues, and acquaintances, whereas the formal engagements of representatives of organizations involved personal

initiatives combined with an awareness of pressing health challenges. Occasionally, the organizations would also invite health care professionals to convey health and services information and answer questions.

Different forms of bridge-builder involvements were also accompanied by potential limitations to their impact and outreach capacity. Hala (33), for instance, who was interviewed at the nursing home where she works, said that she rarely saw any Somalis at work, but explained that she would get contacted by family and friends 'when someone is experiencing symptoms or have questions, for example about typical woman's issues like urinary infections'. By contrast, Arif, the psychiatrist's role as bridge-builder, which had attained a transnational character, was limited not in outreach but his capacity and time. He explained that:

People will find out where there is a Somali doctor and seek contact. Since I was one of the first Somali GPs in Norway, many know me, and many Somalis contact me from countries like Denmark, Sweden, and Britain. Everyone who has been in contact with me, convey his or her knowledge of me to others. Also, if someone knows my wife or our children, then they will contact me. Now, I'm stepping down, but even after I changed my phone number...

According to his wife, Amal, who partook in the interview at their home, Arif spent most of his spare time assisting Somali individuals and families. This activity, which can be described as the 'hobbyfication' of his daytime profession, was undoubtedly important for Arif, but he was at the same time overworked because of the persistent demand for his competency and experience. Strenuousness was also described by other health care employees, but in the setting of the work place. Basma and Mohammed for instance, who became engaged in situations involving Somalis in different ways, not only perceived these engagements as sometimes coming on top of their main responsibilities, but they also implied that 'some people might find it tiring to always be recognized based on their ethnic background rather than their skills'. Moreover, as Basma narrated, a shared ethnic background is not always synonymous with trust and convictive force.

The starting point for this study was to establish contact with Somali immigrant organizations to attain further contacts and insights on health issues among Norwegian-Somalis. While many Somali organizations in Oslo exist for social bonding, some are geared towards addressing health issues within their own ethnic group through a focus on the barriers that characterize Somalis' relationship with the public health care system. In addition to addressing community health issues like diabetes, sometimes within the framework of social or cultural arrangements, these organizations, particularly their leaders, also work to raise awareness around health issues and topics that are associated with stigma or that are otherwise controversial. Some of the topics they highlighted were mental illness, tuberculosis, breast cancer screenings, female circumcision, and *khat* chewing. While the organizations are important meeting grounds for exchange and dissemination of health information, two important observations are that some organizations are operated and attended predominately by women or by men, and second, that the membership base is often homogenous in terms of clan and sub-clan affiliation.

Reflecting a community relatively fragmented by clan, as well as gender, there are currently no pan-Somali organizations in Norway. While Norwegian-Somali children

and youth tend to place less emphasis on clan than do their parents (Fangen, 2008), the 'invisible differences' associated with clan affinity continue to define how Somalis relate and who they might trust (Lewis, 2004). This might be both a challenge to and motivation behind some types of organizational work. According to Basma, as well as Hala, they knew women who chose not to attend various health-related meetings arranged by some of the largest Somali organizations because of the leaders' clan background. Hence, as observed among Somalis in London (Hopkins, 2006), even organizations that claim clan neutrality and that are working to achieve this image have possible limitations to their inclusiveness and outreach capacity.

### **Invisible Extensions of the Health Care System**

The three case examples, encompassing a public health issue, a clinical encounter, and everyday consultancy illustrate that unfamiliarity and mistrust are critical barriers to immigrants' health care integration. A central observation in this respect was that Norwegian-Somalis who possess cultural health capital were approached by both ethnic Norwegian health care employees and Somalis with requests for them to act as bridge-builders.

Although not officially organized or institutionalized, the findings show that the bridge-builder role can be filled with various degrees of formality depending on the environment where familiarity and trust is lacking. This was evident in that resourceful Norwegian-Somalis reported to engage as bridge-builders in a variety of circumstances and to various capacities. Whereas ethnic Norwegians often request the language and cultural competency of Somali colleagues when meeting or aiming to reach out to Somalis, Somalis themselves often require the bridge-builders' formal competency and system familiarity to make sense of biomedicine and to manoeuvre within the institutional landscape. The analysed data show that this double competency enables these persons to act as trust-producers within and towards the Norwegian health care system. The importance of these actors for Somali immigrants is that they constitute points of familiarity within or in proximity to an unfamiliar context.

Through the bridge-builders, the unfamiliar can be introduced through the familiar, compensating for that abstract 'expert systems are disembedding mechanisms [...] in that they remove social relations from the immediacies of context' (Giddens, 1990: 28). This was reflected in that several interviewees, particularly among the focus groups who concurred patient–doctor relationships could be experienced as unproductive because they were too impersonal, much because of their mutual unfamiliarity, which was not seen as immediately fixable by involving interpreters. Cramped timeslots and a 'cut-to-the-chase-attitude' among doctors was said to be a poor foundation for trust. Although many Norwegian-Somalis, as exemplified by several of the study participants, are well integrated, system unfamiliarity and the perceived distance to health care providers among Somalis underscores that integration is not only a two-way process, but one that generates mediation in both directions.

However, although the identified bridge-builders were said to for instance have a better understanding of how Somalis conceptualize symptoms and ask for help, a shared background was not synonymous with a foundation for familiarity and trust.

Several of the bridge-builders in this sample explained that they had to prove themselves trustworthy by having a record of and reputation for helping others. In practice, this meant that bridge-builder trust was a precondition for convictive power and facilitation of health care contacts.

## Conclusion

Health care institutions demand both the formal and informal competency of their members. Yet it is becoming increasingly clear in a time of new and perpetual migration flows that the informal is becoming of greater importance for the realization of the overarching ideology of equitable health care. This is because trust, which pertains to a particular attitude towards the future outcome of decisions (Luhmann, 1979), and health beliefs are often shaped indirectly, based on immigrants' exchange of experiences and stories. Notwithstanding that cultural insights and person-centredness among health care staff are important for immigrants' health care integration, the health care system's reputation and trustworthiness, and its ability to address public health matters, this study highlights that the challenges of unfamiliarity and limited trust not only surface in clinical encounters, but also require addressing within realms of social life. Hence, despite the Norwegian policy focus on improving the cultural skills of health care professionals, in practice, current shortcomings are partially compensated by employees of immigrant backgrounds and the activities of different organizations. In this sense, the need for cultural competency can be said to 'fix itself', at least to the extent that resourceful Norwegian-Somalis have successors or the sustained capacity to extend themselves to newcomers. Even though several participants said that they would prefer not to act as bridge-builders, it was difficult for them to decline requests for help, both out of their own conscience and presumably out of concern for their positions and reputations.

The bridge-builders identified in this study are accounting for ethno-cultural differences that the Norwegian health care system must grapple with in order to provide equitable services, but which meets hindrance in unfamiliarity and mistrust. Familiarity requires experience and openness to new information both on the individual and collective level in a community. It is against the backdrop of familiarity that trust is largely determined. Trust cannot simply be imposed to replace individuals' uncertainties, but requires active negotiation of its basis (Giddens, 1991). Although it is presumable that continued immigration could sustain the demand for collaborative partnerships both within and beyond institutional settings, the study identifies significant limitations to the capacity and outreach of this form of intermediation work.

To conclude, three main observations of general relevance for immigrants' health care integration can be drawn from this study. The first is that Norwegian-Somalis possessing the double competency of commanding two health care cultures are filling a recognized need for cultural health capital in immigrants' health care integration. A second finding is that bridge-building activities often require flexibility as cultural health capital is often required and mobilized on an ad hoc basis both within health care institutions and in extra-medical settings. Finally, the study shows that the efficiency of cultural health capital mobilizations is contingent upon timing and setting, as well as the internal social structure and cultural dynamics of immigrant communities. Hence, notwithstanding



partnerships between resourceful immigrants and health care institutions is a policy ideal with apparent potential, the findings underscore the importance of examining immigrants' health care integration with attention to local resettlement contexts, and with a concern for the culture and social organization of different immigrant groups. In this respect, a focus on trust can yield invaluable insights about immigrants' resettlement and integration experiences.

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## **Article III.**

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# Migration, Gender Roles, and Mental Illness: The Case of Somali Immigrants in Norway

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## Abstract

This article explores why Somali immigrant women in Norway have a lower utilization rate of mental-health services compared to Somali men. Based on qualitative research, it argues that the maintenance of traditional gender ideals shapes barriers and opportunities for mental-health utilization. Discussing health beliefs and responses in relation to gender roles and integration, the study identifies different illness implications for Somali men and women. Whereas Somali women's symbolic association with family accentuates perceived stigma, contributing to collective and individual concealments, higher utilization of mental-health services among Somali men is associated with social exposure. The findings suggest that research and outreach measures related to mental health require attention to immigrant women.

## Introduction

Across cultural contexts, notions of masculinity and femininity have a decisive influence on people's health beliefs and behaviors (e.g., Courtenay 2000). However, when people migrate and resettle in societies different from their own, pertinent questions arise regarding both the negotiation and enactment of gender ideals and

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the gendered dimensions of health and health-care utilization (Llácer et al. 2007). This article examines how gender, conceptualized as negotiable cultural frameworks that situationally organize relational thoughts and practices between men and women, shapes the ways that Somali immigrants in Norway think about mental illness and its associated responses.

The Norwegian welfare state builds on the ideal of equitable redistribution through a universal scheme of tax-financed health and social services (Kildal and Kuhnle 2005; Kvist et al. 2012). Within it, every inhabitant is entitled to a wide array of health and care services based on need, irrespective of tax contribution. Yet there are great variations within and between immigrant groups in terms of how they utilize different services in Norway (Diaz et al. 2014; Næss and Vabø 2014; Straiton, Reneflot, and Diaz 2014). Within this landscape, Somali women distinguish themselves by having a significantly lower utilization rate of specialized mental-health services, compared to both Somali men and ethnically Norwegian women (Elstad, Finnvold, and Texmon 2015). More specifically, whereas the utilization rate among ethnic Norwegians between 20 and 69 years of age was 8.0 percent among women and 6.5 percent for men between 2008 and 2011, for Somalis the gendered pattern was reversed, with a mere 4.5 percent for women and 6.9 percent for men (Elstad, Finnvold, and Texmon 2015, 58). Although comparable national statistics are scarce, the fact that Somali women utilize other specialist health services at a similar rate as native Norwegian women indicates that mental illness might be set apart from other health problems (Elstad, Finnvold, and Texmon 2015). In this regard, the disproportionate rates of mental-health utilization between Somali men and women raise critical questions about within-group mental-health disparities and potential gender differences in service access. The aim here is to provide an explanation for the outlined statistical pattern through qualitative exploration of the underlying determinants.

On the surface, disproportionate rates of mental-health service utilization between Somali men and women suggest the hypothesis that Somali women tend to have fewer or less significant mental-health problems, compared to their male counterparts, upon resettlement in Norway. However, this presumption appears questionable, considering the incremental association between war and trauma experiences and mental disorders (Steel et al. 2009). In this regard, it is notable that female gender is a particular risk factor for the development and exacerbation of post-traumatic stress disorders (PTSD) in adult civilian survivors of war trauma and torture (Johnson and Thompson 2008). Somali women, for example, were subjected to violence, loss, and fear during the Somali Civil War (1991–present), in the predominantly Somali refugee camps in Dadaab, Kenya, and as migrants to Europe (Kagwanja 2000; Gardner and el Bushra 2004; Horst 2006; Rivelli 2010; Bokore 2013). In fact, studies among Somali refugees in both Africa and the United States suggest that Somali women have experienced violence and trauma to the same extent as Somali men (Jaranson et al. 2004; Onyut et al. 2009; Cavallera et al. 2016). A prerequisite for the present exploration is, therefore, that Somali women

in theory, because of their war, migration, and resettlement experiences, are equally susceptible to mental illness as are Somali men.

Moreover, although pre-migration trauma experiences can elevate the risk of mental disorders in refugees (Bhui et al. 2003), it is important to note that conditions and events in their resettlement destinations can also have a decisive influence on immigrants' mental health (Miller and Rasmussen 2010; Hynie 2018). Studies among different immigrant groups—Turkish immigrants in Denmark (Mirdal 2006) and Mexican farmworkers in the United States (Finch, Frank, and Vega 2004)—suggest that acculturation and integration stressors have sustained negative impacts on immigrants' mental well-being after resettlement. Conversely, successful social integration, which implies alleviation of stressors such as language barriers and loneliness, might have positive implications for immigrants' mental well-being (Chen et al. 2017). However, while social integration has been found to improve immigrants' mental well-being in general, dominant notions about gender roles might produce different challenges and opportunities for men's and women's socio-cultural adaptation and social participation (Dalgard and Thapa 2007). Hence, the gendered disproportionality in Somalis' mental-health service utilization in Norway must be examined in light of local social practices and processes of adaptation and integration.

Immigrants' healthcare-seeking practices are often complex processes shaped by the interplay of cultural and structural conditions (Rogler and Cortes 1993). In the case of Somalis in Norway, their pursuit of mental-health services is impacted by their previous lives in different sociocultural and socio-economic settings and the migration/resettlement experience itself, both of which influence their health status and perceptions of formalized healthcare. While the cultural and acculturative sides of "mental illness" conceptualizations and responses among Somali immigrants have been subject to much scholarly research in countries like Finland, the United States, and Sweden (e.g., Pavlish, Noor, and Brandt 2010; Johnsdotter et al. 2011; Svenberg, Skott, and Lepp 2011; Wedel 2012), specific attention to gender has been limited. Given the decisive influence that gender roles and social networks can have on immigrants' perspectives on health issues and attitudes about utilizing health and care services (Næss and Moen 2015), the subject merits further critical attention.

In exploring the association between gender roles and mental illness conceptions and responses among Somali immigrants in Norway, this article recognizes that Somalis often face multiple pressures to renegotiate their identity and gender roles in diaspora (Hopkins 2010; Kleist 2010). On the one hand, Somali immigrants face cultural and transnational pressures to maintain religious practices and modes of social organization associated with their home country. On the other hand, there are host-society demands for cultural adaptation and work participation. For this analysis, we can imagine the identities of Somalis in Norway "as 'framed' by two axes or vectors, simultaneously operational: the vector of similarity and contiguity; and the vector of difference and rupture" (Hall 1990, 226). Accordingly, a consideration of

how Somalis negotiate and settle tensions between competing traditions and sources of influence is integral to the present inquiry.

By drawing attention to the association between migration, gender roles, and mental illness, this article aims to contribute a more nuanced perspective on the social dynamics behind immigrants' mental-illness conceptualizations and responses. Insights regarding gender's role in shaping the social sides of mental illness can help shed light on gendered barriers to mental-health services, hidden health needs, and potential areas of intervention. Based on in-depth interviews with Somalis in Oslo, this article argues that whereas the enactment of Somali notions of gender complementarity is associated with conditions permitting the social exposure and targeting of Somali men's mental illness, Somali women's responsibilities and symbolic position within the family contribute to both collective and self-initiated strategies of symptom concealment.

Before presenting the analysis and its methodological basis, I first provide an outline of the Somali, predominately Islamic, conception of mental illness and a description of Somali resettlement experiences in Norway. These sections frame the topic and set the scene for the presentation of findings on the following four themes: differences in Somali men's and women's public visibility and targeting by mental-health outreach initiatives, Somali women's symbolic status and mental-illness responses, the implications of institutional mistrust for mental-health contacts, and gendered nondisclosure of mental-health problems. To conclude, the article highlights the importance of examining immigrants' health-care integration in light of extra-medical concerns and influences.

## **Mental Illness in Somalia and in Diaspora**

The Somali Civil War, which in 1991 erupted into a full-scale, clan-based conflict in the power vacuum that followed the toppling of Siyad Barre's dictatorship by a coalition of opposition groups, not only displaced and dispersed more than two million Somalis but left deep imprints in the population's mental health (Cavallera et al. 2016). A 2010 analysis of the mental-health situation in Somalia showed that more than one third of the population suffered from mental disorders (Rivelli 2010). Relatedly, a growing body of research across disciplines and country contexts has shown that mental illness is a prevalent health problem among Somalis in diaspora across Africa, Asia, Europe, North America, and Oceania (e.g., Whittaker et al. 2005; Mölsä, Hjelde, and Tiilikainen 2010; Kroll, Yusuf, and Fujiwara 2011).

Somalis in diaspora rely on traditional forms of medicine and healing, upheld through transnational connections to Somalia, while at the same time adapting to new health-care cultures (Tiilikainen and Koehn 2011). Although mental illness is an exception in this regard, it is notable that unorthodox beliefs, such as possession by malevolent *zar* spirits as explanations for women's mental illness (Lewis 1998), have been largely abandoned or redefined among Somalis in diaspora for practical reasons, as they have in Somalia because of recent Islamization (Tiilikainen 2010).

At the same time, belief in *jinn*, or spirit possession as a principal cause of “mental illness,” has remained strong among men and women across both Somalia and the diaspora (Abdullahi 2001; Mölsä, Hjelde, and Tiilikainen 2010; Tiilikainen 2011; Lim, Hoek, and Blom 2015). The symptoms associated with *jinn* are sometimes synonymous with what Western medicine defines as depression, stress-related disorders, and psychosis (Al-Issa 2000). However, an important distinction can be made between possession, which is seen as temporary and resolvable, and *waali*, or “craziness,” which is the Somali term for chronic loss of self-control (Carroll 2004). It is when a person’s behavior appears pathological, rather than normal, that *jinn*-possession is ruled out. Hence, considering that the initial responses to suspected *jinn*-possession are the same toward Somali men and women, it is in relation to behavior that falls outside the normative framework of interpretation that we might decipher whether and how gender roles shape barriers and opportunities for utilizing mental-health services.

Broadly speaking, the Somali system of health and healing consists of two main branches of treatments and rationales: (a) viewing and treating illness and injury as naturally caused and (b) viewing and treating illness, and mental illness in particular, as caused by the spirit world (Helander 1995). According to the Qur’an, the spirit world is unquestionable; thus, most Muslims acknowledge the existence of *jinn*, shapeshifting creatures or spirits created by scorching fire that occupy a parallel world to that of humans (Qur’an 2011, 15, 26–27). They can be male or female, appear in different forms, and be provoked to enter and tamper with human subjects. As is the case with humans, some *jinn* are good, and others are evil. The evil ones, related to the *Shaytaan* (the devil), are associated with illness. While illnesses or possession by *jinn* can occur as punishment for presumed wrongdoings (Rothenberg 2004), humans can also call upon *jinn*s by way of *sihr* (black magic) to inflict harm upon others.

A more common explanation for illness and other forms of misfortune, such as failed marriages, miscarriages, or loss of wealth, however, is *al’ayn* (the evil eye), when envious or ill-intended persons wish harm upon others (Utz 2013). Because the source of mental illness is often understood by Somalis to be external to the body and because a number of potential stigmas exist, Somalis are frequently careful of how they ask about others’ health and what they tell about their own health (Helander 1995). A particular characteristic of Somali illness labels and associated remedies is thus that they are often initially assigned “by the household and not by healers or experts,” with persons within and beyond the extended family gradually consulted if conditions worsen (Helander 1995, 83). From this perspective, we can presume that trusting relationships and familial circumstances have a decisive influence on Somali immigrants’ information sharing, help-seeking behavior, and health-related interactions (Næss 2019). Therefore, in efforts to understand the social determinants behind the disproportionate rates of mental-health utilization between Somali men and women in Norway, the ways that Somalis enact traditional family ideals in diaspora is a topic that requires research attention.

The traditional solution to mental disorders, whether symptoms are presumed to be caused by the evil eye, black magic, or direct possession, is performing *Ruqyah*, or exorcism, by reciting the Qur'an, saying prayers (*du'aa*), and consulting religious expertise (Mölsä, Hjelde, and Tiilikainen 2010). Somalis commonly refer to persons recognized for their religious competency as *sheikh* or *wadaad*, the former term indicating superior Islamic competency (Lewis 1998, 59). Exorcists can thus be Imams (Islamic leaders) or persons recognized for their abilities as "traditional" healers. According to Tiilikaninen (2011), there are an increasing number of professional healers and clinics in Somalia, and *jinn* is one of the most common diagnoses, especially for mental disorders. It is also notable that *jinn* often remains the most common explanation for mental problems in the diaspora, as found among elderly Somalis in Finland (Kuittinen et al. 2017). Somali religious healers in the diaspora operate through a familiar cultural framework, as can be seen in the fact that some Somalis pursue reputed experts locally or travel to other countries to consult them (Svenberg, Skott, and Lepp 2011; Wedel 2012). The maintenance of these practices and perspectives has implications for how Somali immigrants understand and relate to biomedical concepts of mental illness.

Perseverance of imported perspectives on and treatments for mental illness among Somali immigrants has been linked to the association between presumed craziness or biomedical diagnosis and ideas of stigma and permanence (Whittaker et al. 2005; Mölsä, Hjelde, and Tiilikainen 2010). In line with a study on dementia perceptions among Norwegian-Pakistanis (Næss and Moen 2015), this link suggests that skepticism toward biomedical diagnosis relates to its unclear purpose and potential social implications, such as shaming the family. Because the Somali language has few words corresponding directly to biomedical concepts, a diagnosis in a context like Sweden can be perceived to affirm that one is mentally ill or "crazy" (Wedel 2012). This point is also exemplified in a study among Somalis in the US state of Minnesota, where a wife's depression was identified as potentially disgraceful to her husband and his position as household head (Pavlish, Noor, and Brandt 2010). As this finding suggests, interpretations and responses to mental-illness symptoms in diaspora might intertwine with symbolic ideas about Somali gender roles to produce different implications for men and women. To contextualize the question of whether the enactment of traditional gender roles can explain the disproportionate rates of mental-health utilization between Somali men and women in Norway, I now provide a brief account of the Somali resettlement experience.

### **Somali Resettlement in an Individualized Society**

Since the mid-2000s, Norway's Somali population has more than doubled to a current 42,802 persons, about half of whom have status as refugees, making them Norway's largest non-Western immigrant and refugee group (Statistics Norway 2019). This rapid population growth is attributable to high birth rates, family reunification, and a continuing stream of asylum seekers, and creates a highly diverse

population in terms of residency duration, migration experiences, education, and acquired familiarity with a Norwegian cultural and institutional context. Recognizing this diversity is central to the present exploration of how gendered social dynamics shape immigrants' mental-illness conceptualizations and responses.

Norwegian integration policy combines the principles of what Nancy Fraser (1995) has called "a politics of redistribution" and "a politics of recognition." This mix implies that immigrants who obtain residency in Norway have unequivocal social rights, including access to public healthcare, alongside the freedom to maintain cultural and religious practices (Brochmann and Hagelund 2012). Ideally, integration in this context implies a situation where immigrant status is not decisive of life opportunities and social participation (Alba and Nee 2009). However, in practice, while social inclusion and nondiscrimination lie at the core of Norwegian integration policy, many Somalis in Norway do not experience a sense of belonging and feel excluded from mainstream society (Open Society Foundations 2013). Continued immigration and high unemployment rates over time (Statistics Norway 2018a) have not only cast Somalis as scapegoats in Norwegian immigration and integration debates but also nourished the mass media's construction of Somalis as a problematic group associated with a culture of violence, masculine domination, *khat* consumption, and female circumcision (Engebriksen and Fuglerud 2009). It is also notable in this respect that Norwegian public employees often perceive Somalis as a difficult group to work with because of their proud and demanding attitude, combined with a presumed unwillingness to adapt, whereas Somalis often report humiliation in these encounters (e.g., Fangen 2006). From immigrants' perspective, negative portrayals by the host society, combined with experiences of exclusion, might exacerbate forms of "bounded solidarity" and inward-looking social orientations (Portes and Sensenbrenner 1993), including a preoccupation with maintaining transnational bonds (Carling, Erdal, and Horst 2012).

Although many Somali refugees who came to Norway and other Western countries in the late 1980s and early 1990s were among the better off and better educated (Gundel 2002, 264), the process of adaptation and integration has not been easy for more recent arrivals (Fangen 2008). One reason for this is that most recent Somali asylum seekers have come from southern Somalia (Norwegian Directorate of Immigration 2016), where the rise of the Islamist group Al-Shabaab, droughts, famines, and continued fighting have restricted everyday life more than in Somaliland (northern Somalia) over the last decade (Moyi 2012). Somali immigrants, therefore, tend to arrive with limited or no familiarity with functioning public or state institutions (Engebriksen and Farstad 2004). An associated integrational hindrance is that educational and linguistic requirements for employment in Norway have increased over the past decades while the demand for unskilled labor has decreased (Norwegian Ministry of Education 2016). The fact that six out of 10 Somali women and two out of 10 Somali men have no formal education upon arrival in Norway underscores why many experience an educational lag that restricts employment opportunities (Vrålstad and Wiggen 2017). Relatedly, adaptive challenges among Somalis are

evident in the employment rates of 48.2 and 28.7 percent for men and women, respectively, the lowest of all immigrant groups in Norway (Statistics Norway 2018a). While low job participation among Somalis could be attributed to limited education and perhaps to discrimination (Midtbøen and Rogstad 2012), the gendered difference in employment is exacerbated by the fact that Somali couples often have many children and a desire to uphold a traditional Somali family system (Fangen 2006; Fuglerud and Engebrigtsen 2006; Engebrigtsen 2007).

Although migration is often associated with newfound opportunities and pressures to renegotiate gender roles (e.g., Jolly and Reeves 2005), the enactment of traditional gender ideals as a source of identity and ontological security in diaspora both reflects and amplifies Somalis' adaptation difficulties (Engebrigtsen 2007; Hopkins 2010). Within the Somali system of gender complementarity, which is becoming of less concern to second-generation Somalis (e.g., Fangen 2008; Maliepaard and Alba 2015), men and women often have relatively separate social networks, with women responsible for the domestic sphere and men responsible for earning income and outward authority (Lewis 2002). Despite challenges experienced by many Somali men in fulfilling the breadwinner role in Norway, the provision of public welfare support has enabled Somali couples to have many children and Somali women to remain the locus of identity production and cultural perseverance through child-rearing (Engebrigtsen 2007). Yet, welfare support, particularly to mothers, can also have an unsettling effect on gender relations in that it works to "empower" women by elevating their financial status and limiting their reliance on men (Kleist 2010). While this empowerment has the advantage of facilitating the termination of troubled marriages for both Somali men and women, it also works to increase Somali women's vulnerability and workloads as they usually maintain custody of children upon divorce (Engebrigtsen 2007). Hence, because Somali men and women often have different roles and separate social networks and spaces and because Somalis in diaspora are often principally concerned with their appearance and status in the eyes of fellow Somalis (Kleist 2010), we can presume a gendered dimension to the barriers and opportunities experienced by Somali men and women for utilizing mental-health services.

## Methods

This article is based on in-depth interviews with Somalis in Oslo and its environs throughout 2015 and early 2016. At the outset, three key informants representing organizations interested in immigrant health facilitated my entry into the different clan compartments of Oslo's Somali community. Although beyond this article's focus, clan affinity is a defining aspect of Somalis' familial and social lives in Somalia (e.g., Lewis 1994) and diaspora (e.g., Assal 2006; Næss 2019). According to informants, who themselves represented different clans, for many Somalis in Oslo clan affinity is decisive of the choice of which café to visit, which mosque to attend, and which Somali immigrant organizations to join. Hence, conscious of this

community's compartmentalization, the three key informants expedited links to other actors within their networks, allowing further snowball sampling of persons known or presumed to have insights or experiences regarding Somalis' health situation. Reflecting the centrality of oral communication and face-to-face interaction within Somali culture, having a shared reference point in previous interviewees seemed to motivate participation and information sharing.

In total, 38 persons (20 men and 18 women) between the ages of 20 and 64 years participated in the study. In-depth individual interviews of 1 to 2 hours were conducted with 26 participants, including two high-ranking mosque representatives, eight persons representing Somali immigrant organizations, nine health-care professionals (psychiatrists, psychiatric social workers, and nurses), and seven lay persons. The 12 remaining persons participated in focus groups. The sample included persons who had seen instances of mental illness in their families, who had worked with or encountered mentally ill persons regularly, and who possessed only indirect knowledge of mental illness. Two considerations dictated my decision to recruit this diverse set of participants. On the one hand, because mental illness is a sensitive topic, arranging interviews with Somalis known to have mental-health problems was both practically and ethically restricted. Whereas Somali participants working with psychiatry were concerned that a potential diagnosis, language difficulties, and mistrust could obstruct informed consent and sound data, other participants were reluctant to convey contact information for fear it would reveal persons in vulnerable situations. On the other hand, to capture the potential nuances in attitudes and perspectives within Oslo's Somali community, it was necessary to account for factors such as age, residency duration, language, and education among interviewees.

To supplement individual interviews, with the assistance of the leaders of two immigrant organizations, I arranged two focus groups, involving four and eight participants, respectively. I moderated these discussions to attain further insights into conflicting perceptions of, experiences with, and attitudes toward Norwegian healthcare and mental-health services. The focus groups and individual interviews took place in a variety of settings, including hospitals, cafés, informants' homes, mosques, and organizations' headquarters. I conducted all data gathering in Norwegian. Recruitment primarily of Somalis with command of the Norwegian language was informed both by the aim to interview persons with experience and insight regarding the convergence between Somali and Norwegian health-care cultures and by considerations voiced by the three initial informants regarding trust, terminology, system familiarity, and inclusion of both men and women.

While recruiting primarily Somalis familiar with two health-care cultures eased communication, reflexivity was still necessary regarding my social position as an ethnically Norwegian, male researcher during research planning, data collection, and analysis (e.g., Berger 2015). The question of positionality was clearest when some interviewees, upon my introducing the research topic, positioned me as an "outsider." One measure that helped establish a sense of trust in these situations was



my demonstrated awareness of an insider's perspectives and dilemmas regarding mental illness by drawing on issues mentioned in prior interviews. Demonstrating awareness regarding stigma, rumors, and spirit possession also facilitated inquiry into the link between gender and mental illness. However, a notable disadvantage with recruiting Somalis familiar with two health-care cultures was their inclination to discuss mental illness and Somalis' encounter with the Norwegian health-care culture based on general cultural insights and professional experiences, rather than personal or familial illness narratives. I recorded all interviews, upon informed consent, for subsequent transcription. To account for how interview situations played out, I also jotted field notes shortly after each interview (Emerson, Fretz, and Shaw 2011).

Data collection and analysis constituted an integrated and continuous process whereby emergent patterns and voids in the empirical material served as the basis for iterative revisions of the interview guides. When conducting new interviews, being able to draw on information that surfaced in prior ones proved fruitful for both testing statements and constructing questions that stimulated storytelling. For instance, hearing from one interviewee that he had witnessed mentally ill Somali women locked in apartments in Oslo, I had a specific example or way to probe about gender and differences in symptom interpretations and responses in subsequent interviews.

To analyze informants' stories, I applied a narrative analysis approach (Riessman 2008). By identifying thematic lines within interview data, I aimed to bring forth "meaning and reason to reported events through contextual and processual presentations" (Hammersley and Atkinson 2007, 199). During data attainment and analysis, I, thus, lent special consideration to what words and concepts participants used in their stories about mental illness, how interviewees implicated themselves in what they conveyed, and how my position as researcher informed the storytelling of men and women. This process involved reviewing notes from specific interview situations and listening for grammatical turns and shifting modes of speech in recorded interviews, for example, when there was a shift in talk between a personal story and a cultural perspective. Throughout the presentation of findings, I use pseudonyms when quoting and referring to participants' stories.

## Findings

### *Social Exposure and Targeting: Somali Men in the Limelight*

This section addresses how differences in Somali men and women's visibility in spaces such as cafés, immigrant organizations, or neighborhoods might affect men's and women's targeting in mental-health outreach. Participants in this study not only emphasized mental illness as a principal health concern in Norway but also tended to relate it to Somali men because of its association with unemployment, loneliness, *khat* chewing, and the idea that Somali men were more dangerous to others than

were Somali women. Moreover, participants frequently linked Somalis' perceptions about mental illness to the Somali, or Islamic, master narrative of mental illness, while also underscoring distinctions between instances of *jinn*-possession and cases of mental illness. As data accumulated, it gradually became clear that mental illness carried different social implications for Somali men and women, a fact that in turn shaped both collective and individual responses to symptoms of mental illness. Because Somali men more frequently had the freedom to socialize and spend time in public settings like cafés or in the street, their problematic mental-health behavior was more often visible to others. Because of Somali women's symbolic position within and responsibilities for the family, however, Somali women experienced both collective and individual forms of problem concealment.

A recurring notion among all interviewees was that "Somalis go to the mosque in events of mental distress." According to both Marwa (47) and Amal (44), for instance, two leaders of Somali organizations centered on women, this practice arose because people's beliefs had a great influence on where they sought help. As Marwa explained, and as Amal had similarly mentioned in an interview, "many people therefore go to the mosque, so we see that the mosque is a social helper." Abdi-Saleh (37), however, a central figure in one of Oslo's largest mosques, believed that the mosque's role was both varied and changing. In his experience, mosque communities had become increasingly hesitant about being associated with religious healing, following a 2013 incident at Oslo's Rabita mosque where a 21-year-old woman, allegedly undergoing an exorcism, died from heart failure. While not denying that exorcisms still took place at mosques, he stressed that many mosques had developed restrictive guidelines, including an age limit and the requirement of accompaniment by family members or other entrusted persons during treatments. This restrictiveness on the part of mosques, he felt, might increase the pursuit of Islamic solutions within the private sphere, rather than push Somalis to seek public mental-health services.

Besides individual prayer and Qur'an recitations at home, Abdi-Saleh explained that Somalis sometimes paid religious experts to come on home visits or traveled far to see them. Knowledge about these experts and their whereabouts traveled by word of mouth. From Abdi-Saleh's viewpoint, these solutions and the fact that the mosque was more an arena for advice, consultancy, and worship than a place of treatment could partially explain why suspected mental-health problems among Somalis, particularly among women, remained out of sight from both other Somali families and health-care providers. This perspective was rooted in Abdi-Saleh's experience with his mosque's partnership with a mental-health institution, where most referrals of mentally distressed persons to mental-health services concerned Somali men. However, while admitting the mosque's leadership knew little about the mental-health situation of Somali women in Norway, Abdi-Saleh emphasized that fewer contacts with Somali women did not necessarily mean that Somali women had better mental health than Somali men. Considering that both lay participants and mosque representatives identified Somali women as the typical victim of *jinn*-possession, we

might deduce that gender is associated with differences in symptom interpretations and responses, but not necessarily in the distribution of mental illness.

In an interview, Ahmed (59), a psychiatric social worker engaged in what he called “bridge-building” between Somalis and Norwegian mental-health services through a major organization, said, “We have made few contacts with women, but with many men.” He had become engaged in his current work following the so-called tram-murder in 2004, when a Somali man, equipped with a knife, killed one person and seriously injured four others on a tram in Oslo shortly after his discharge from an acute mental ward. This event, along with previous incidents involving Somali immigrants, not only spurred debates about Norwegian mental-health services’ ability to assess and accommodate the needs of an increasingly ethnoculturally diverse citizenry but, as Ahmed’s role attests, also raised concerns about Somalis’ perspectives on mental illness and mental-health services in general.

When asked why his organization had reached few Somali women, Ahmed explained that their experience mostly with men was not intentional:

Because Somali men are out in the streets or in cafés, we have been able to approach them. The women, we rarely see like this because of their families. For the women, it has to do with family honor, so families protect them; they send them back to Somalia. They protect the honor of the whole clan and family. But the men . . . nobody cares . . . They are not so protected.

From both Ahmed’s and Abdi-Saleh’s viewpoints, the lack of social restrictions regarding Somali men’s presence in public spaces and, thus, their displays of unconventional behaviors and resulting visibility had contributed to men rather than women being targeted in existing outreach initiatives. At the same time, while asserting that the outreach to primarily Somali men was not intentional, they also admitted that both spotting and establishing contact with unacquainted Somali women were difficult. According to Ahmed and Abdi-Saleh, reaching Somali women with potential health needs was especially problematic because of the combination of closed family networks, the relatively separate social networks of Somali men and women, and the stigma associated with mental-health problems. From their narratives, women’s domestic roles and responsibilities not only restricted their visibility in public but also elevated the presumed social risks of displaying symptoms, admitting illness, or seeking help. From this perspective, disclosure of Somali women’s mental illness, particularly to Somali acquaintances or persons beyond the immediate family, might question their fulfillment of feminine ideals, which in turn could reflect poorly on Somali men’s positions as household heads. Relatedly, both Ahmed and Abdi-Saleh hinted that mental illness in Somali men and women could trigger different responses. The missing women in both Ahmed and Abdi-Saleh’s narratives, therefore, spurred the question, “Where were the women?”

### *Somali Men's Problem with Women's Mental Illness*

This section discusses Somali men's and familial responses toward mental illness in Somali women. If a person becomes *waali*, which translates to "crazy," Somali tradition says that he/she will never get well (Mölsä, Hjelde, and Tiilikainen 2010). Descriptions of the ways that people in this state are treated in Somalia echo this attitude. For instance, the practice of "chaining" persons whose behavior is unpredictable, aggressive, or self-destructive is widespread in Somalia, including in the country's mental-health facilities (Rivelli 2010; Johnsdotter et al. 2011; Tiilikainen 2011). While used to contain individuals in the face of unavailable medications and treatments, the practice can be a "permanent trauma" in itself, as communities sometimes regard mentally ill persons as eternally dangerous and unpredictable (Rivelli 2010, 23), with sometimes-fatal consequences for such individuals. Despite the availability of psychiatric treatments in Norway, similar practices are sometimes reenacted in diaspora.

Arif (64), who is a psychiatrist, explained in an interview at his home that he had witnessed such containment practices in Somali homes in Norway:

Also in Oslo, that there are people contained inside apartments. This is mostly women. Some of them have mental retardations or psychological disorders, and some have become psychotic at a young age. Their families keep them hidden. When they manage to, they will return them to Somalia, but as long as they do not have a place to send them, they keep them locked up at home. If you can pay, send a hundred dollars per month, then you can get an aunt or someone to watch over them in Somalia, but depending on their behavior, they will often stay chained. This is because, in Norway, it is more stigmatizing to take women for treatment than a man.

When asked about the reason for this containment practice, several interviewees pointed to the connection between Somali women's symbolic status and the family's honor, as well as to vague references to the potential danger posed by mentally ill Somali men. Because forced containment violates Norwegian law, all interviewees, except participants who had seen the practice in Norway or Somalia, clearly disassociated themselves from it as they spoke. Although both Somali men and women were subject to containment, the underlying attitude among men and women interviewees was that women's bodies became subject to collective, especially men's, social control upon displaying unconventional behavior, whereas men's bodies typically did not.

According to a number of interviewees, maintenance of containment practices in diaspora was symptomatic of imported health beliefs and a limited familiarity with and trust in psychiatric services. In an interview, for instance, with Mido (43), the leader of a Somali organization, he stated that "mental illness is untraditional, so we do not talk about it." According to him, an implication of this attitude was that mental illness, in cases where possession was unlikely, often remained seen as stigmatizing, untreatable, and something to conceal. Sometimes, only the immediate

family knew about mental problems. In this regard, while transnational connections and local bonding capital can be advantageous for adaptation and belonging upon resettlement, there can also be a backside to strong transnational network relations in diaspora (Ryan et al. 2008). Mido explained that strong network relations not only limited contacts, familiarity, and trust toward Norwegian mental-health services but also encouraged alternatives to professional help and potential stigma. Besides local containment and spiritual healing, one such alternative, as mentioned by Arif, was to return severely ill persons to Somalia in the hope of improvement.

Several interviewees brought up the utilization of transnational ties to Somalia as a way to return persons with mental problems. Hala, for instance, who worked at a nursing home, was familiar with one case where “a husband sent his wife and children back to Somalia where her family could take care of them.” This return, she explained, was driven by the husband’s wish to relieve himself of both child-rearing responsibilities and stigma. Other informants had also heard about such cases, although none involving persons close to them. Hala, however, expressed doubt as to whether returning to Somalia would yield efficient help or improvement. According to her, this was because family members in Somalia were often unable to provide much care. A study on mentally ill returnees to Somaliland from Finland underscores the limited potential for appropriate help (Tiilikainen 2011). The limited potential for efficient help upon returning to Somalia was also Ahmed’s contention when describing his recent travel to Hargeisa, Somaliland, accompanying a psychiatrist:

He showed me the situation in the area that I come from. People were standing in one position facing walls, they ate little food...like dogs...they died. There are few medications available. They did this, trapped them inside a room, because if the person does something wrong, it is the family’s responsibility to reimburse or settle things. Sometimes there is no family either.

Muhammad, a nurse and cofounder of a Somali organization, who had also observed the situation in Somaliland, attested to the hopelessness. In a less figurative way, he stressed, “the family has a big responsibility, but they are often unable to provide any proper care for mentally ill family members.” In other words, although relatives might attempt to provide care and involve religious experts, the result is often containment, and the idea of improvement is often faint.

Although determining the extent to which practices of containment and returns occur among Somalis in Norway is beyond this study, most interviewees were familiar with the phenomenon. The main lessons to be drawn from these examples, however, are not only that severe mental-health problems in Somali women are seen as potentially more damaging to the family than are men’s but also, and more importantly, that mentally ill Somali women are particularly vulnerable to male control and to Somali men’s priority of reputational preservation. The use of

containment and returns is symptomatic of imported health beliefs, traditional gender roles, and limited health-care integration in Norway.

### *Fear of Child Welfare Services as a Barrier to Mental-Health Utilization*

Institutional trust/mistrust can have decisive implications for people's health behaviors and decisions to utilize available health-care services (Mohseni and Lindstrom 2007; Schout, de Jong, and Zeelen 2011). In Norway, non-Western children are twice as likely as ethnic Norwegian children to be taken by child welfare services (Staer and Bjørknes 2015), and many Somalis see this institution as problematic (Open Society Foundations 2013). A recent study shows that 86 in 1,000 Somali immigrant children and 45 in 1,000 children born in Norway to Somali parents were clients of childcare services, compared to 31 in 1,000 nonimmigrant children (Dyrhaug and Sky 2015). Regardless of the background and nature of these client relationships, many Somalis struggle to see the benefits of such contacts because stories of mistakes and invasive conduct circulate widely among Somali immigrants. In both focus groups and many individual interviews, participants brought attention to child welfare services when asked about gender and barriers to mental-health services utilization. Both Somali men and women attributed the gendering of such barriers to women's family position and to fear of involvement by child welfare services.

Adil (24), a student interviewed following the Friday prayer (salāt al-jum'ah) at a large mosque, for example, explained, "Somalis call each other and meet all the time. In a very short time, Somalis all across Norway will have heard rumors or stories about critical situations involving Somalis." This information, although potentially distorted in the flow of exchange, is particularly impactful, considering Somali culture's oral foundation and lack of trust in state institutions (Lewis 2002). A central observation here was that both Somali men and women attributed great risk to utilizing mental-health services, not simply because of social stigma and community exclusion, but also because of a perceived link between contact with mental-health services and targeting by child welfare services.

According to Marwa and Amal, "many Norwegian-Somali women think that if I explain my situation to a psychologist or a doctor, they will take my child"—a point raised in other interviews as well. As Hira (31), who worked as a nurse, shared, there were even Somalis who moved between municipalities to protect their families from child-welfare services. Mohammed (28), who was also a nurse, held that a central reason for this skepticism was that "child welfare services do not recognize that controlled forms of violence is something that all Somali children experience during their upbringing." While in stark contrast to Norwegian nontolerance of corporal punishment and disciplining of children (Stang 2011), in interviews, the negative view of child-welfare services was associated with the low threshold for action and correspondingly high risk of mistakes.

Both Somali men and women of different ages expressed concerns about the trustworthiness and intentions of child welfare services. Mido exemplified this risk,

saying that “child welfare services sometimes make judgements about the situation of children simply based on the standard of the apartments where families live.” From Mido’s viewpoint, the fact that Somalis were in economically disadvantaged positions not only increased the presumed risk of misjudgments but also obfuscated recognition of child welfare services’ mission to ensure the well-being of children and families. Involvements by child welfare services in general typically occur based on reports by police, schools, kindergartens, parents, medical practitioners, private citizens, and to a much less extent mental-health providers (Statistics Norway 2018b). Nonetheless, Somali interviewees highlighted fear of child welfare services as reason for avoiding mental-health services in Norway.

Because most Somalis regarded family and kinship as prerequisites for stability, mental well-being, and communal recognition (Lewis 1994), the imagined familial consequences of child-welfare involvement appeared to overshadow the idea that Somali individuals and families could benefit from such contacts. Although such involvements typically affected the whole family, participants recurrently identified women as particularly vulnerable because they became the targets of blame, and self-blame, if their family was affected. Therefore, coupled with an awareness of the above-mentioned repertoire of measures taken to conceal pathological behavior, Somali women themselves sometimes strove to conceal internal struggles.

### *Gendered Nondisclosure: Self-Protection and Mental Health Barrier*

A common source of relief for Somali women suffering mental distress was to share their problems with other women, but depending on circumstances, they might also fear disclosure and value concealment (Whittaker et al. 2005). While participants in this study acknowledged that Somali women often offer support toward other women within their social networks, with reference to mental illness, they placed particular emphasis on the issue of women who suffered in silence through the “hidden sacrifice of constant, on-going, self-giving” (Mayblin 2014, 361). Several interviewees, both men and women, brought up the topic of nondisclosure and memory suppression, suggesting that mental illness was perceived as having greater social consequences for Somali women than for Somali men. Although four interviewees suggested that Somali women were “mentally stronger” or more resilient than men when it came to mental distress, interviews also revealed that Somali women faced a different set of pressures to conceal problems and suppress memories. These pressures shaped both treatment situations and pathways to services.

According to Mariam (56), the leader of an organization concerned with Somali women and children’s health, both female circumcision and exposure to torture and sexual violence were part of many Somali women’s background, something that impeded their mental well-being in various ways. These experiences were associated with a lingering sense of shame and stigma, making them socially dangerous to share openly. Nondisclosure of experiences and suppression of memories were, therefore, both forms of self-protection in Somali women’s relationships with men or

psychiatric consultations and intricate reasons for avoiding mental-health services altogether. Arif, an experienced psychiatrist, recalled a related patient consultation:

I can tell you about the case of a Somali woman who had four children close after one another. When her husband came to Norway through family reunification, she got pregnant again right away. She got morning sickness but also got depressed and psychotic. She related everything to the pregnancy, although she had experienced other trauma. Even after undergoing treatment, she still would say that her conditions were purely because of her pregnancy.

From Arif's perspective, this type of trauma-denial, or self-protection, was a barrier to both mental-health contacts and treatments. The benefit of receiving professional help in this case would be to identify trauma experiences and receive help with reprocessing memories.

In Arif's consultation example, the downplaying and denial of potential mental-illness triggers indicated self-stigma. That is, by not conveying the details of her situation, the woman avoided both the consequences of a potential diagnostic label and the social dangers of an information leak. For similar reasons, as found in a study of Canadian-Somali women, "in group counselling, women often talk about sexual violence in the third person to avoid implicating themselves" (Bokore 2013, 99). As this example shows, unfamiliar settings and people can accentuate pressures to disguise symptoms of trauma experiences by upholding a façade of resilience (Beauboeuf-Lafontant 2007). However, while such efforts are forms of self-protection, they are also obstacles for pursuing and accepting professional help.

Marwa and Amal, who frequently consulted Somali women experiencing post-partum depressions and other mental difficulties, found it challenging and time consuming to convince women to pursue available services. As they explained,

We say we can come with you. We can go and have a conversation with them. You are not alone. In Norway, you have many rights. Even if you have received treatment, nobody can take your child from you. This information takes time, patience, good communication, and a shared language. It might be that Somalis who are integrated accept help, but for newcomers, it is very difficult.

There were also great differences among Somali participants in terms of integration and their ability to trust in and negotiate the Norwegian health-care apparatus. Interviewees with little or no direct familiarity with biomedicine and mental illness, for example, were often inclined to talk about it primarily with reference to the Islamic narrative. By contrast, interviewees representing the health-care system or immigrant organizations, like Marwa and Amal, recognized conflicting mental-health perspectives as a community health challenge. Perhaps most importantly, they were conscious of the need for information in Somali, patience, and trust-building in health relations.



Madinah, a 33-year-old teacher, illustrated the need for familiarization and trust with reference to her mentally ill aunt. She explained, “Although we believed she was mentally disturbed, because of rumors about the system and her concern with her appearance, for years she convinced us of the dangers of seeking professional help.” From Madinah’s perspective, aware that her aunt aimed at safeguarding herself and her family from stigma, her aunt’s desire to conceal her symptoms was problematic because it strained the family internally and obfuscated professional help as a possibility. Yet, her aunt was not solely responsible for avoiding mental-health contacts. According to Madinah, her aunt’s husband had been especially adamant about waiting out the situation within the household rather than placing his wife’s health and the family’s reputation at risk. However, Madinah went on to explain that she had not given up and that she and her brother were beginning to change the husband’s views because of the stagnant situation. This example further underscores the point made by Marwa and Amal that there is a general need for information and service familiarization that can counter stigma presumptions in Somali families. Madinah’s story also hinted that the complementary division of social responsibilities between Somali men and women, particularly women’s symbolic role as carriers of family honor, works to gender perceptions of barriers and opportunities for utilizing mental-health services.

In an eight-person focus group, Ismael, an 18-year-old student, reflected on his mother’s mental health and its implications on the family. Because participants were familiar with one another, as they met regularly for social activities like music and sports, there seemed to be little reluctance about sharing information. Saying that his mother rarely spoke about her experiences from Somalia and that he therefore knew little about them, Ismael explained that he sometimes felt the consequences of her silence. In particular, he felt that his mother sometimes acted nervous and temperamental. According to Ismael, his mother, as far as he knew, had never sought any help, although he felt “she could need to talk to someone.” Moreover, Ismael, as the oldest sibling, never confronted her with how he and his younger siblings experienced living with her, largely because they managed as a family, but also because he did not see his mother as mentally ill. Nevertheless, during the same discussion, participants voiced many of the concerns presented earlier, suggesting that risk perceptions sometimes outweighed ideas about potential benefits or health gains from consulting health professionals and investing trust in public mental-health services. Provided Somali women can fulfill communal, familial, and self-instigated expectations regarding the feminine role, the threshold can be high for tending to their own mental health in the face of potential social consequences.

## **Conclusion**

Exploring how gender roles shape patterns of mental-health service utilization among Somali immigrants in Norway, the analysis presented here shows that normative gender expectations, often upheld as a source of identity and ontological

security in diaspora (Kleist 2010), can moderate conceptions of mental illness to shape gendered differences in presumed barriers and opportunities for seeking and accepting mental-health services. Whereas the traditional notion of gender complementarity permits Somali men's exposure of illness symptoms in public spaces, making them potential targets of formal intervention, Somali women's responsibilities and symbolic positions as wives and mothers encourage both collective and self-initiated forms of problem concealment. The collective form of concealment, which involves containment and returns to Somalia, is thus a measure to protect individual and family reputations, whereas women's own strategies of internalization aim to safeguard themselves against both social consequences and familial actions. In this respect, this study not only calls for incorporating gender as a relational concept in studies of immigrant health and health-care adaptation but also illuminates a potential for exploring gender, adaptation, and integration through a focus on health and illness.

Although there are many Somali women who do utilize mental-health services in Norway, this study suggests that there is a general need for information about mental illness and mental-health services in the Somali language and for outreach measures or contact points that are discrete and focus on women. It is notable in this respect, as indicated in a study among elderly Somalis in Finland (Mölsä, Tiilikainen, and Punamäki 2017), that there is a preference for culturally appropriate services. Although the enactment of normative gender expectations partially explains why a mere 4.5 percent of Somali women, compared to 6.9 percent of Somali men, utilize specialist mental-health services in Norway (Elstad, Finnfold, and Texmon 2015), both outreach measures and culturally sensitive services appear contingent upon Somalis' general familiarization with the Norwegian health-care culture. Familiarization with a new health-care culture among both men and women is particularly central to countering mistrust and negative presumptions, stigma, and associated gender disparities in barriers and opportunities for utilizing mental-health services. Hence, while culturally adapted services could contribute positively toward immigrants' cultural and institutional familiarization, this study underscores, in line with previous research (e.g., Rogler and Cortes 1993), the pertinence of addressing and understanding immigrants' health-care integration as entwined with extra-medical processes and concerns, particularly dominant understandings and practices of gender.

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## **Article IV.**

Næss, A. (2020). Immigrant Organizations and Immigrants' Health Care Integration in Oslo: A Comparative Study of Pakistani and Somali Immigrant Organizations as Bridge-Builders (Under review in international peer reviewed journal)

## **Part III. Appendices**





Anders Næss  
Norsk institutt for forskning om oppvekst, velferd og aldring (NOVA)  
Postboks 3223 Elisenberg  
0208 OSLO

Vår dato: 30.08.2013

Vår ref: 35195 / 3 / MSS

Deres dato:

Deres ref:

## TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 22.08.2013. Meldingen gjelder prosjektet:

|                      |  |
|----------------------|--|
| 35195                | <i>Immigrants' Health Care Seeking: The Role of Third Parties</i>                                      |
| Behandlingsansvarlig | Norsk institutt for forskning om oppvekst, velferd og aldring (NOVA), ved institusjonens øverste leder |
| Daglig ansvarlig     | Anders Næss  |

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 28.02.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

A handwritten signature in blue ink, which appears to read 'Vigdis Namtvedt Kvalheim'.

Vigdis Namtvedt Kvalheim

A handwritten signature in blue ink, which appears to read 'Marie Strand Schildmann'.

Marie Strand Schildmann

Kontaktperson: Marie Strand Schildmann tlf: 55 58 31 52  
Vedlegg: Prosjektvurdering



Datamaterialet innhentes gjennom personlig intervju, gruppeintervju og observasjon.

Utvalgene rekrutteres delvis via eget nettverk, gjennom somalske og pakistanske organisasjoner/miljø og gjennom helseforetak. Ved bruk av snøballmetoden anbefaler vi at den som formidler kontakt med respondenten innhenter samtykke til at prosjektleder tar kontakt eller at respondenten selv kontakter prosjektleder. Dersom forespørsel om deltakelse skjer via helseforetak, anbefales det at den som forespørres tar direkte kontakt med forsker, ikke samtykker via helsepersonell. Dette for å sikre en størst mulig grad av personvern i forbindelse med deltakelsen.

Ifølge prosjektmeldingen skal det innhentes muntlig og skriftlig samtykke basert på muntlig og skriftlig informasjon om prosjektet og behandling av personopplysninger. Personvernombudet finner informasjonsskrivet tilfredsstillende utformet i henhold til personopplysningslovens vilkår, forutsatt at det påføres dato for prosjektslutt og anonymisering (28.02.2017). Det bør utformes informasjonsskriv som er tilpasset språkkunnskapene til utvalget, eventuelt på annet språk enn norsk.

Det vil i prosjektet bli registrert sensitive personopplysninger om rasemessig eller etnisk bakgrunn, eller politisk, filosofisk eller religiøs oppfatning jf. personopplysningsloven § 2 nr. 8 a), samt om helseforhold, jf. personopplysningsloven § 2 nr. 8 c).

Ombudet forutsetter at det ikke innhentes opplysninger om 3. person (brukere av helsetjenestene) og at taushetsplikten ikke er til hinder for den behandlingen som finner sted. Ombudet anbefaler at forsker gjør informanten tydelig oppmerksom på dette i forkant av intervju.

Prosjektet skal avsluttes 28.02.2017 og innsamlede opplysninger skal da anonymiseres og lydopptak slettes. Anonymisering innebærer at direkte personidentifiserende opplysninger som navn/koblingsnøkkel slettes, og at indirekte personidentifiserende opplysninger (sammenstilling av bakgrunnsopplysninger som f.eks. yrke, alder, kjønn) fjernes eller grovkategoriseres slik at ingen enkeltpersoner kan gjenkjennes i materialet.

## Forskningsprosjekt om tredjepartsroller i innvandreres forbindelse til helsetjenester



Norsk institutt for forskning om oppvekst, velferd og aldring (NOVA) har fått økonomiske midler fra Norges forskningsråd (NFR) til å gjennomføre doktorgradsprosjektet: «The Immigrants' Health Care-Seeking Study: The Role of Third Parties». Prosjektet tar sikte på å innhente kunnskap om hvor innvandrere henvender seg for å få svar på helse- og sykdomsrelaterte spørsmål og for å innhente informasjon og råd om ulike offentlige helsetjenester og andre behandlingsalternativ. Hvordan fungerer ulike informasjons- og rådgivningskanaler og hvordan påvirker informasjonskanalene innvandreres helse- og sykdomsoppfatninger og deres helsetjenesteoppsøkende adferd?

Dersom du ønsker å være med betyr dette at du deltar i en undersøkelse der vi gjennom et intervju spør deg om forhold knyttet til tredjepartsrollen som vi tror kan ha betydning for personer med innvandrerbakgrunn. Spørsmålene retter seg mot innvandreres kanaler for informasjon om behandlingsalternativ og tjenestetilbud, kilder for helseråd, bruk- og tilbud av helsetjenester samt dine erfaringer fra kontakten med disse. Intervjuet vil ta om lag en time.

Under alle omstendigheter er det du som velger om du vil delta og vi vil først vite hvem du er når du skriver under samtykkeerklæringen nederst på denne siden. Vi som jobber på prosjektet har taushetsplikt. Alle opplysninger du oppgir vil bli anonymisert og vil ikke kunne føres tilbake til deg. Du kan trekke deg når som helst uten å gi en begrunnelse. Dersom du trekker deg vil opplysninger som er innsamlet bli makulert.

Resultatene fra undersøkelsen blir publisert anonymisert og som gruppedata slik at du er sikret fullstendig anonymitet. Prosjektet er tilrådd av personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste a/s (NSD).

Til sammen rundt 35-40 personer med innvandrerbakgrunn (somaliere og pakistanere), 10-20 personer i tredjepartsroller (f.eks. ledere av innvandrerorganisasjoner), og 10-15 representanter for helse- og omsorgstjenesten som har erfaring med å møte innvandrerbefolkningen skal delta i undersøkelsen. De tre gruppene vil bli intervjuet om samme tema.

Er det noe du lurer på angående studien kan du ta kontakt med oss. Du kan nå meg, Anders Næss, på mobil: 480 27 532, eller epost: [anders.nass@nova.hioa.no](mailto:anders.nass@nova.hioa.no). Du kan også ta kontakt med prosjektleder, Jon Ivar Elstad, på mobil: 465 06 294, eller epost: [jon.i.elstad@nova.hioa.no](mailto:jon.i.elstad@nova.hioa.no).

Du må skrive under samtykkeerklæringen nedenfor, om du ønsker å delta undersøkelsen.

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### Samtykkeerklæring:

Jeg har mottatt informasjon om prosjektet: "The Immigrants' Health Care-Seeking Study: The Role of Third Parties" og er villig til å delta i studien.

Signatur:..... Dato/ sted:.....

# Intervjuguide om tredjepartsroller og integrering

Introduksjon: presentasjon av prosjektet og informasjon om hva deltagelse innebærer.

Bakgrunn:

- 1) Hva er det som er annerledes her i Norge med tanke på bruk og tilbud av helsetjenester? Hva tenker du om hvordan somaliere opplever og forholder seg forskjellene?
- 2) Har somaliere spesielle utfordringer/ barrierer når det gjelder å ta kontakt med og komme i kontakt med ulike deler av helsetjenesteapparatet?
- 3) Helseutfordringer?
- 4) Hvordan tror du helseerfaringer fra Somalia innvirker på somalieres forhold til det norske helsetjenesteapparatet?
- 5) Er terskelen høy blant somaliere for å ta kontakt med lege eller andre helseaktører?
- 6) Har somaliere tiltro til norske helseinstitusjoner med tanke på mangelen på helsetjenester i Somalia? Situasjonen som flyktning? Utfordringer? Den somaliske hjelperollen.
- 7) Forskjeller mellom kvinner og menn?

Kulturelle aspekter:

- 8) Er helse- og helsetjenestespørsmål noe som diskuteres blant somaliere i Norge? Hva er det som er viktige diskusjonsområder? Hvorfor tror du dette diskuteres mye?
- 9) Stigma i forhold til enkelte helseproblem og tjenester? Mentale lidelser? Andre ting?
- 10) Kan du fortelle litt om det somaliske helsesystemet, og om hvordan sykdom blir forklart og håndtert i ditt opprinnelsesland? Finnes disse praksisene i Norge? Er dette problematisk?
- 11) Bruker norsk-somaliere egne løsninger/ medisiner/ eller lignende? Kan du fortelle litt om disse? Hvor utbredt er dette? Påvirker det bruken av offentlige helsetjenester?
- 12) Et tema som kanskje er sensitivt, og som det snakkes lite om: Sykdommer pga. besettelse av ånder, eksorsisme.
- 13) Religion og helse.



Tredjepartsroller:

- 14) Hvilken rolle har organisasjoner og ulike møtesteder i å forme somalieres helsetjenesteoppsøkende adferd med tanke på utveksling av informasjon og erfaringer?
- 15) Vet du om det henvises til folkemedisin også?
- 16) Betydningen av ressurspersoner i det somaliske miljøet? Somaliske leger, offentlig ansatte?
- 17) Har du erfaringer med å bli kontaktet i forbindelse med helse- og helsetjenestespørsmål?
- 18) Et annet tema som det snakkes lite om er: Betydningen av klan og slektskap i Norge for hvilke ressurser og kontakter enkeltpersoner har tilgang til? Har dette noe å si?
- 19) Er det noen spesielle tiltak som det er behov for i forhold til norsk-somaliers tilgang til og forhold til helsetjenesteapparatet?
- 20) Kan organisasjoner, foreninger, møtesteder eller nøkkelpersoner i større grad spille en rolle som samarbeidspartnere i forhold til myndighetenes mål om å nå ut til alle, oppfylle alles rettigheter? Hvordan?

## **Intervjuguide: Representanter for innvandrersorganisasjoner**

- 1) Kan du fortelle litt om organisasjonen? Hva gjør dere og hvordan jobber dere?
- 2) Hvor mange medlemmer har dere?
- 3) Hva er organisasjonens målgruppe? Kvinner, menn, ulike bakgrunner?
- 4) Hvem kommer hit? Hvem er deres mest aktive medlemmer?
- 5) Hvilke typer helserelaterte aktiviteter tilbyr dere? Diskuterer dere og personene som kommer hit ofte helse- og helsetjenesterelaterte spørsmål?
- 6) Hva er grunnene til at dere har/ikke har dette fokuset?
- 7) Samarbeider dere med bydelen/kommunen eller andre offentlige eller private aktører? Hva består samarbeidet i?
- 8) Hvordan fungerer organisasjonen som forum for utveksling av helse- og helsetjenesteerfaringer?
- 9) Hvilke typer helse- eller helsetjenesterelaterte spørsmål er det som ofte diskuteres?
- 10) Hvorfor tror du at nettopp denne typen spørsmål og problemstillinger tas opp?
- 11) Opplever dere at personer kommer hit med tanke på å innhente råd eller informasjon i forbindelse med sykdoms- og helsespørsmål?
- 12) Gjøres deres henvendelser på eget eller andres initiativ? Tar dere initiativ?
- 13) I slike situasjoner, hva slags råd og informasjon er det som vanligvis etterspørres? Norske helsetjenester eller tradisjonell medisin/ behandling? Hva slags råd og informasjon får de? Hvem gir denne informasjonen?
- 14) Har personene som tar opp spørsmål og etterspør råd eller informasjon vært i kontakt med aktører i det offentlige helsevesenet forut for kontakten med dere?
- 15) Hender det at organisasjonen for enkelte er det første stedet de henvender seg i forbindelse med personlig sykdom eller sykdom i familien?
- 16) Hvorfor tror du at enkelte kommer hit for å diskutere eller innhente råd og informasjon? Hva karakteriserer situasjonen til personene som henvender seg hos dere?
- 17) Hva tror du denne typen organisasjoner betyr for helseatferden til de som kommer hit og deres familier?

**The end.**