Master's thesis

NTNU
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"If the doctor can't help, you start reading the Quran!"

- A qualitative study of perceptions and experience of health and well-being among Somali women in Norway

Master's thesis in Global Health Master program
Supervisor: Laila Tingvold
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SAMMENDRAG

INTRODUKSJON: Denne masteroppgaven utforsker det tilsynelatende paradokset mellom forskning på helserisiko og substandard levekår for somaliske kvinner som er bosatt i Norge, og deres selvrapporterte evalueringer av personlig helse og velvære. Denne studien undersøker de emiske perspektivene for helse og velvære blant somaliske kvinner bosatt i Norge. Spesielt har studien som mål å utforske innvirkningen av religiøse overbevisninger og kulturelle verdier på deres oppfatninger og opplevelser av helse og velvære.

METODE: Totalt ble det gjennomført seks semistrukturerte dybdeintervjuer med somaliske kvinner bosatt i Norge. Lydopptakene av intervjuene ble transkribert i sin helhet og en tematisk tilnærming ble benyttet for dataanalysen.

RESULTAT: Analysen av intervjuene identifiserte et mangfold av religiøse, relasjonelle og individuelle determinanter som påvirker deres oppfatninger og erfaringer med velvære og helse. Determinantene omfatter religiøs tro, praksis og verdier, sammen med familiære og fellesskapspåvirkninger, i tillegg til individuelle egenskaper som motstandskraft og effekten av en optimistisk tankegang.

DISKUSJON: Deltakernes islamske tro har en dyp innvirkning på deres oppfatning og opplevelse av helse og velvære, og fungerer som et grunnleggende aspekt av deres liv. De somaliske kvinnenes oppfatninger og verdier angående helse og velvære skiller seg fra det sekulære vestlige perspektivet. Denne forskjellen kan bidra til det evidente paradokset mellom forskning på helserisiko og dårlige levekår blant somaliske kvinner og deres egne evalueringer av personlig helse og velvære.

KONKLUSJON: Resultatene av denne studien kan ha praktiske fordeler for beslutningstakere, helsepersonell og utdanningsinstitusjoner. Konkret kan disse funnene bidra til å øke forståelsen av den religiøse og kulturelle konteksten til somaliske kvinner som bor i Norge, noe som kan legge til rette for utvikling av mer skreddersydde helsetjenester.

ABSTRACT

INTRODUCTION: The present thesis explores the apparent paradox between the research on health risk and substandard living conditions of Somali women who are residing in Norway, and their self-reported evaluations of personal health and well-being. This research endeavors to examine the emic perspectives of health and well-being among Somali women residing in Norway. Specifically, the study aims to explore the impact of religious convictions and cultural values on their perceptions and experiences.

METHOD: In total, six semi-structured in-depth interviews were carried out with Somali women residing in Norway. The audio recordings of the interviews were transcribed in their entirety and a thematic approach was utilized for the data analysis.

FINDINGS: The analysis of interviews conducted with participants identified a diverse range of religious, relational, and individual determinants that impact their perceptions and experiences with well-being and health. The determinants encompass religious belief, practices, and values, along with familial and community impacts, in addition to individual qualities of resilience and the impact of an optimistic mindset.

DISCUSSION: The Islamic belief of participants has a profound impact on their perception and experience of health and well-being, serving as a fundamental aspect of their overall life. The Somali women's perceptions and values regarding health and well-being differ from the secular western perspective. This disparity may contribute to the noticeable paradox between the research on health risks and substandard living conditions among Somali women and their own evaluations of personal health and well-being.

CONCLUSION: The results of this study may have practical benefits for policymakers, healthcare professionals, and educational institutions. Specifically, these findings can contribute to enhancing their comprehension of the religious and cultural contexts of Somali women living in Norway, which can facilitate the development of more tailored health support.

KEYWORDS: Somali women, health literacy, spiritual health, well-being, religion, culture, migration

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ABBREVIATIONS AND ACRONYMS

SSB - Statistics Norway

HSB – Health Seeking Behavior

SIKT- Norwegian Agency for Shared Services in Education and Research

HOD – The Norwegian Ministry of Health and Care Services

FGM - Female Genital Mutilation

WHO – World Health Organization

RTA - Reflexive Thematic analysis

COREQ - Consolidated criteria for reporting qualitative research

OPERATIONAL DEFINITIONS

Migrant: “An umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons” (1 p.123)

Culture: “Culture is defined as the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding that are learned through a process of socialization. These shared patterns identify the members of a culture group while also distinguishing those of another group” (2 p.367)

Health literacy: “Ability of an individual to obtain and translate knowledge and information in order to maintain and improve health in a way that is appropriate to the individual and system contexts” (3 p.7)

Clan system: In many traditional societies, the kinship group functions as an organizational technique. Clan membership is traditionally determined by descent from a common ancestor. Typically, this descent is unilineal, or derived solely from the male (patriclan) or female (matriclan) line (4).

Health: - “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (5 p.1)

Well-being: The experience of pleasant emotions, including joy and fulfillment, as well as the realization of one's potential, having a degree of control over one's life, feeling of a sense of purpose, and the enjoyment of meaningful connections (6).

Spiritual health: Is defined in three dimensions: religious, individualistic, and material world-oriented, composing of the human connection with God, himself, others and the nature (7).

Resilience: Is utilized to elucidate why certain individuals exhibit superior coping mechanisms in the presence of challenging circumstances. Resilience, within the present context, pertains to an individual's capacity to effectively adjust and recover from adversities and unfavorable encounters, with the aim of preserving optimal mental well-being (8).

Acculturation: Refers to the cultural and psychological transformation that occurs when different cultural groups and their respective members come into contact with one another. The process of acculturation occurs subsequent to migration and persists within culturally diverse societies among various ethnocultural groups (9).

Western Countries: Is utilized to denote nations that possess developed economies, as per the United Nations' World Economic Situation and Prospects 2018 report (10). Therefore, this term encompasses the subsequent countries: Canada, Japan, United States, New Zealand, Iceland, Norway Switzerland, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, United Kingdom, Bulgaria, Croatia Cyprus, Czech Republic, Estonia Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia (10).

1 INTRODUCTION

The present chapter provides an overview of the research study, explains its rationale and objectives, and presents a review of the current research and theoretical frameworks to the area being studied.

1.1 RATIONALE FOR CONDUCTING THIS STUDY

This section presents the rationale for undertaking the study and the justification for selecting the research focus and topic.

1.1.1 Migration, health, and well-being among Somali women in Norway

The general health condition of the Norwegian population is favorable, although evident health disparities are present between ethnic Norwegians and the immigrant populace (11). The period before migration, as well as each phase of the migration process, can have a noticeable influence on an individual's health, with consequences that persist into the post-migration period within the new nation of residence (12-14). Previous research implies that immigrants tend to adopt less healthy dietary patterns and engage in more sedentary behaviors (13-15). It is observed across various immigrant populations globally that the phenomenon of transition, combined with social marginalization and reduced socioeconomic status can have adverse health consequences for both individuals and communities (13).

The Somali community represents one of the largest ethnic immigrant groups in Norway. A significant number of individuals from Somalia migrated after 2002, primarily as refugees, due to the long-lasting civil war (15). The portrayal of the Somali population in Norway in media stories has often been characterized by unfavorable depictions, leading to the stigmatization of this community. The portrayal of this particular ethnic group has often shown them as being the most challenging to adapt into society (16-18). Empirical data indicates that Somalis exhibit lower performance on various indicators of quality of life, including elevated rates of unemployment, inadequate financial resources, and reduced educational attainment (19). Furthermore, various health studies conducted on the Somali population, with an emphasis on Somali women, indicate an increased risk for physical and mental health hazards (15, 17, 18, 20-29). Additionally, some research findings suggest a poor level of health literacy within this population (30). Several studies have indicated that culturally appropriate interventions, enhanced knowledge and understanding among

healthcare professionals, and customized health information for the Somali community are crucial future strategies for tackling health issues faced by Somali women (15, 20-22, 29-34).

The existing research on health risk in relation to the self-reported health and life satisfaction of Somalis yields paradoxical results. According to a 2017 public study conducted by Statistics Norway (SSB), a significant proportion of Somalis residing in Norway, specifically 80 percent, reported their individual health status as either good or very good. This percentage is notably higher than several other immigrant populations (19, 35). Similarly, the statistical agency evaluated the level of life satisfaction and discovered that the Somali participants exhibited the greatest mean score on the quality of life metric in comparison to all other cohorts examined, encompassing the ethnic Norwegian population (36). The discovery caused astonishment and garnered media attention, triggering questions into the underlying reasons for this occurrence, given the disadvantaged financial circumstances and below-average living conditions experienced by the Somali population in Norway (37, 38).

The aforementioned research highlights a paradoxical relationship between the health risks encountered by Somali women residing in Norway and their subjective evaluations of health and well-being. The lack of clarity regarding the paradox necessitates further investigation, which might provide valuable insights and enhance the understanding of a more effective approach against health disparities and more tailored health support.

1.2 PURPOSE OF THE STUDY

This section presents the rationale for undertaking the study and the justification for selecting the research focus and topic.

1.2.1 Study aim, objectives and key research question

The master's thesis project aim was to explore how there is a paradox between the knowledge on health risks among Somali women in Norway, and the emic views on health and well-being. In the long term the knowledge from this study could help awareness-raising and educational initiatives for healthcare policy makers or practitioners to better understand and support Somali women in Norway in health and life choices.

The specific objectives of the study were to:
(1) Gain insight on which practices and behaviors promote and guide health and well-being among Somali women in Norway.
(2) Increase knowledge on where, and how Somali women acquire, understand, and act up on health information.

The key research question was: How are cultural values and religious beliefs influencing the perception and experience of well-being and health for Somali women living in Norway?

1.3 BACKGROUND

This section provides an overview of the research context and presents an overview of relevant literature on the research topics.

1.3.1 Somalian history, culture and religion

Located in the eastern region of the African continent, Somalia shares borders with the Gulf of Aden and the Indian Ocean. In contrast to numerous African nations, Somalia is comprised of a predominantly homogeneous ethnic group that possesses a shared language, religion, and culture, and can trace their lineage to a common progenitor (39). The Somali people commonly identify themselves as an ethnic group with ancestral ties to Arab origins, tracing their lineage through patrilineal clans that can be traced back to the era of the Prophet Muhammad (18, 40-42). Historically, Somalians have been a migratory population that has occupied extensive regions of the Horn of Africa, encompassing present-day Somalia, Djibouti, Kenya, and eastern Ethiopia (18). During the 1880-90s, Somalia was subjected to colonization by the British in the northern region and the Italians in the southern region. The colonial powers introduced various institutions, such as health systems and education for health professions, which led to disparities within the country, particularly between the North and the South. Somalia attained its independence in 1960, and subsequently underwent a transition to a socialist republic under the leadership of Siyad Barre after a military coup in 1969. In 1972, during the socialist era in Somalia, the first written language with Latin letters was introduced. In addition, the clan system was in principle abolished yet local clan-based organizations persisted (43, 44). In 1991, Somalia experienced the onset of a Civil War, which resulted in the removal of Siyad Barre from power. This was formed by the consolidation of various clan-based factions, which united to seize control of the country. The

conflict initially erupted in the northern region before spreading to the southern part of Somalia. The successful factions were unable to establish a unified government, leading to politico-military control by distinct leaders of various territories, unsettled boundaries, and ongoing sporadic conflict and political maneuvering, particularly in the southern region (45) Somaliland, situated in the northern region, has proclaimed itself as a sovereign state in 1991; however, it has yet to receive global acknowledgement (46) The historical and contemporary occurrences have compelled the Somali populace to undertake migration to neighboring sub-Saharan African and Western nations (47).

The Somali population is primarily characterized by a nomadic pastoralist culture, although certain ancient cities within their territory have maintained a longstanding tradition of maritime activity (48). Somalis are distinctive within the African context due to their singular ethnic group (Somali), exclusive language (Somali), and sole religion (Sunni Islam) (49). The Somali population has historically been characterized by the presence of multiple clans and confederations. These groupings have emerged as a result of political alliances, whereby smaller clans have joined forces with larger ones for practical purposes. The merging of clans and confederations resulted in a collective effort towards safeguarding, acquiring access to fertile land and water resources, political dominance, and strong unity. However, it also led to conflict and significant inequalities (48). Within the Somali diaspora community, it is uncommon to observe tribal distinctions as Somali individuals tend to suppress their clan affiliations in adherence to a communication prohibition (42). Despite a protracted history of civil strife, economic deprivation, and political turmoil, the Somali populace exhibits a strong sense of national pride, even among those residing outside their homeland (50). However, a study suggested that the crisis of Somali cultural integrity is a result of the devastating impact of the civil war and the challenges faced by the diaspora, which has put the pride in Somali culture under immense pressure (49).

As noted earlier, the Somali narrative revolves around a creational myth, wherein two clans establish a genealogical link to one of the early followers of Prophet Muhammad (43). This genealogical descent clarifies the manner in which Somalis assert their Arabic ancestry as a means of separating themselves from non-Muslim Africans (49). The is a lack of historical verification for this genealogy, and scholars from various disciplines, including anthropology, linguistics, and history, have expressed doubts regarding the claimed Arab origins. Nonetheless, the significance of the shared sense of ancestry should not be underestimated

(40). Some Somalis identify themselves as Arabs rather than Africans, and their way of life and culture are heavily influenced by the Islamic religion (42). In Somali, an overwhelming majority of 99.9 percent of the populace residing in Somalia self-identify as adherents of Sunni Islam (39). Islam is a monotheistic religion that belongs to the Abrahamic tradition. Its teachings were founded by Muhammad in the 7th century. Muslims hold the belief that Muhammad is the ultimate religious prophet and that the Quran, which is the Islamic scripture, was divinely revealed to him by God. The central focus of Islam is the adherence to the commands of God. Adhering to the five fundamental pillars of Islam is essential for leading a life in accordance with Islamic teachings. These principles include the declaration of faith (shahada), performing daily prayers (salat), giving alms (zakat), fasting during Ramadan (sawm), and completing the pilgrimage to Mecca (hajj) (51). The findings of a study that examined Somali students on the relationship between their Muslim faith and Somali national identity demonstrated that the majority of respondents placed great importance on the role of Islam in Somali culture, and the interdependent nature of religion and culture (49). Studies have demonstrated that the Islamic religion and its value system deeply penetrate all facets of Somali society, making it arduous to comprehend the term Somali without simultaneously inferring an Islamic identity (42). The Somali society's ethical principles, cultural standards, and values are grounded in the Islamic faith. Key principles include the significance of the family, utmost respect for the elderly, social responsibilities, generosity, and modesty (52).

1.3.2 Migration as a health determinant

Approximately one-seventh of the global population currently resides in a location other than their place of birth (12). A migrant is an individual who has moved from their customary place of residence across a national border or within their own nation (13). The process of migration is not a recent development, throughout the course of human history, there has been a consistent pattern of human migration. The movement of populations has proven to be advantageous for numerous individuals and communities, resulting in a significant contribution to global social and economic development (12). Despite the extensive historical record of human migration, there is just recently an attention on the topic in the international debate, and the impact of migration on health has been largely overlooked (13).

The act of migration exposes individuals to novel circumstances and health risks. Abubakar et al. (2018) have demonstrated that a multitude of factors, including an individual's health prior to departure, socioeconomic and environmental circumstances, local disease prevalence and

risk behaviors, cultural customs and traditions, and availability of preventive or therapeutic interventions during the migration journey, can significantly impact the morbidity trends observed among migrant populations. Research has revealed the presence of health hazards and risks among migrants, which may result in health disparities for the demographic (12). In the last half-century, Norway has undergone substantial immigration of individuals from diverse countries and cultures (53). A significant number of individuals migrated to Norway either as refugees, asylum seekers, or in search of employment opportunities (54). Over time, an increasing number of individuals have converged via the process of family reunification, in addition to the emergence of subsequent generations. A prevalent experience immigrants face upon arrival in a foreign country is the presence of obstacles related to learning a new language, employment, cultural adaptation, residential arrangements, understanding of societal systems, rules, and norms (53). Research has indicated that a considerable number of immigrants who migrate to Norway experience health issues upon their arrival, and these conditions could worsen as time progresses.

The Ministry of Health and Care Services (HOD) strategy for equal health and care services, *"Good health for all 2013-2017*", reflected concerns regarding the health of immigrants and health-related difficulties in Norway (11). The proposed strategy aimed to enhance competence in addressing the distinct health concerns of immigrant populations, as well as the cultural and linguistic barriers that may arise during interactions between healthcare providers and patients with immigrant backgrounds. The suggested strategy expected to establish a fundamental basis for new initiatives, such as research and knowledge advancement within the relevant field (1).

1.3.3 Health status of Somali migrants internationally

Somalia is regarded as a nation that has undergone globalization, as evidenced by the fact that over one million Somalis presently reside beyond its borders. The Somali population is primarily concentrated in three regions, namely the Horn of Africa, Yemen, and the Gulf States, as well as Western Europe and North America. Approximately 66 percent of the Somali diaspora population resides in neighboring nations, including Kenya, Ethiopia, Djibouti, and Yemen (55). According to research conducted in North America and Europe, individuals belonging to the Somali diaspora have encountered numerous challenges and obstacles during the resettlement process. The challenges faced by Somali refugees extend beyond the primary traumas of war and displacement and encompass systemic obstacles

during the resettlement process, such as social marginalization, prejudicial treatment, racial discrimination, joblessness, financial difficulties, and general frustration with health care systems that fails to recognize and respect Somali customs and traditions (8, 56-58). Studies indicate that Somali immigrants residing in Europe, North America, and Australia are susceptible to heightened risks of mental and physical health issues. The healthcare systems in these regions have yet to devise effective strategies for attending to the healthcare needs of this demographic (47, 58-68).

1.3.4 Health risks among Somali women in Norway

Several health studies have been conducted on the Somali community residing in Norway, revealing an elevated vulnerability, particularly among females, to various physical and mental health risks (15, 17, 18, 20-29). The available research indicates that individuals of Somali origin exhibit a greater prevalence of obesity and reduced levels of physical activity. Their dietary habits are characterized by insufficient intake of fruits, vegetables, hydration, and iodine. Evidenced by various studies, these factors contribute to an elevated susceptibility to noncommunicable diseases and multimorbidity (14, 15, 20, 21, 24-27). Research on mental health indicates that Somali immigrants are at a heightened risk of developing post-traumatic stress disorder and schizophrenia. However, they exhibit a lower propensity to avail themselves of mental health services (17, 18, 28, 29). Somali women exhibit a lower likelihood of undergoing cancer screening, potentially resulting in delayed diagnosis and unfavorable rehabilitation outcomes (23, 31, 69). Moreover, a considerable proportion of Somali women are impacted by female genital mutilation (FGM). Research indicates that women who have undergone FGM frequently experience physical discomfort and health complications, yet they often lack access to adequate medical attention. Insufficient knowledge and awareness among Norwegian healthcare professionals may be a contributing factor, as indicated by sources (32, 70, 71). According to the findings, Somali women have reported that the Norwegian healthcare system does not address their sexual and reproductive health needs in a culturally sensitive manner. This lack of sensitivity may have negative implications for these women as they seek necessary help and support (22, 33, 34). The aforementioned variables are positively associated with an increased likelihood of adverse health outcomes among Somali women residing in Norway and therefore needs to be addressed.

1.3.5 Well-being and self-reported health among Somalians in Norway

The World Health Organization provided a definition of health in 1946, which states that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (5 p.1) Additionally, the phenomenon of well-being has been classified as the experience of pleasant emotions, including joy and fulfillment, as well as the realization of one's potential, having a degree of control over one's life, feeling a sense of purpose, and the enjoyment of meaningful connections (6). Furthermore, scholarly research has demonstrated that the definitions of health and well-being are subject to variability across diverse populations, including individuals, families, ethnic groups, and socioeconomic classes. The understanding and evaluation of health and wellness are notably impacted by contextual elements, including cultural values and religious convictions (6, 71, 72).

As mentioned above, the public study carried out by Statistics Norway (SSB) in 2017, displayed that a significant proportion of Somalis residing in Norway, specifically 80 percent, reported their personal health status as either good or very good. This percentage is notably higher than that of several other immigrant groups in Norway (19, 35). The statistical agency also assessed life satisfaction and found that the Somali population had the highest average score on the quality-of-life scale compared to other ethnic groups included in the study. The majority of the populace, ethnic Norwegians, obtained an average score of 8.1 on a 10-point scale. In contrast, Somalis achieved an average score of 8.8, despite facing challenges such as low employment rates and high poverty indicators (36). The inclination to evaluate their level of life contentment in a positive manner is consistent with the results of a research conducted on Somali females residing in Norway who have undergone female genital mutilation. The evaluation conducted by Somali women regarding their present circumstances and future outlooks indicates a noteworthy level of satisfaction and positive anticipation, as evidenced by their high scores on a happiness and future expectations metric. This phenomenon was also observed among individuals who had undergone multiple traumatic experiences due to female genital mutilation (71). What are the elements contributing to the community's observed resilience and adoption of a positive lifestyle? Research suggests that cultural and religious factors play a big part (8, 71, 73).

1.4 THEORETICAL PERSPECTIVES

This part presents theoretical perspectives and terms that are of significance for the research topics.

1.4.1 Health literacy

According to a qualitative synthesis by Liu et.al, health literacy can be defined as the, "Ability of an individual to obtain and translate knowledge and information in order to maintain and improve health in a way that is appropriate to the individual and system contexts"(3 p.7). As previously mentioned, a cross-sectional study with 302 participants was conducted in 2016 to investigate the health literacy of Somali women residing in Norway. The research indicates that Somali women exhibit low levels of health literacy, which may represent a crucial factor for improving their overall health outcomes. According to the researchers, a significant proportion of Somali women residing in Norway, specifically 71 percent, demonstrate inadequate health literacy skills, which hinders their ability to obtain, understand, and utilize health-related information and services. The authors emphasized that the health literacy level of their participants was significantly lower when compared to the results of a comparative study on the health literacy within eight European nations (30). It is here essential to acknowledge that the outcomes of the comparative investigation represented the average score of the entire population in each nation, without accounting for demographic variations within the populace (74). In the conclusion of the Norwegian health literacy study, the authors expressed concern regarding the health literacy status of Somali women residing in Oslo. The researchers suggested that this could potentially be a crucial factor in the health outcomes of Somali immigrants (30). Contrary to this, an American study provided opposing findings to the aforementioned Norwegian research suggestion, and based on their results subsequently concluded that there was no apparent correlation between health literacy and health outcomes (75).

A more recent survey conducted in Norway, *"Health Literacy in Five Immigrant Populations in Norway: Pakistan, Poland, Somalia, Turkey, and Vietnam"*, describes health literacy in five immigrant populations in Norway (54). The survey is part of a large World Health Organization (WHO) Europe-led data collection initiative involving approximately 20 European nations. The study's findings indicate that individuals with a Somali background exhibited a greater degree of health literacy compared to both the general populace and other immigrant groups. The researchers noted this as a remarkable finding, particularly considering the participants' shorter length of stay in Norway, lower percentage of individuals with advanced education, and relatively disadvantaged socioeconomic circumstances. The

researchers found it challenging to establish a cause for this phenomenon, but they believe that circumstances in their country of origin may have affected their responses (54).

Medical anthropologists have posited that health, illness, and medical care are influenced by cultural and social factors, which shape the perceptions and actions of individuals and communities. Cecil Helman emphasizes in his publication "Culture, Health and Illness" (72), the crucial importance of acknowledging the extensive cultural diversity across the globe in the context of health and medical procedures. Additionally, the author offers a critique of contemporary medicine, asserting that the medical paradigm is primarily focused on quantifying physiochemical data pertaining to patients, while comparatively less emphasis is placed on the more elusive emotional and social factors. According to Helman, acknowledging the extensive diversity of perspectives is crucial for enhancing medical care and treatment. He contends that by valuing alternative worldviews instead of disregarding them, clinical communication can be improved, leading to better health outcomes (72).

A systematic review from 2022 expressed criticism towards the term of health literacy as well as the assessment tools employed, citing a significant level of inconsistency between the definitions of health literacy and the instruments utilized in contemporary health literacy research (76). Attitudes and beliefs related to health literacy are influenced by cultural, social, and familial factors. Cultural diversity plays a crucial role in shaping the interpretation and relevance of health information and messages, transcending linguistic barriers. Culture produces a significant influence on views and definitions regarding sickness and health, habits, linguistic and cultural obstacles, and medical procedures, which can significantly impact health literacy and health outcome (77). A definition of health literacy that fails to acknowledge the potential impact of cultural disparities on the dissemination and comprehension of health-related information would overlook a significant aspect of the fundamental significance and objective of literacy for individuals (78).

1.4.2 Traditional Somali perspectives of illness and treatment

In 1990, Slikkerveer, an anthropologist, authored a publication on the medical system, as well as the viewpoints on health and illness in the Horn of Africa (79). The author posited a theoretical framework in which the medical system is classified into three primary categories: the traditional medical system, the modern medical system, and the transitional medical system. As per Slikkerveer's findings, the "Traditional medical system" comprises two

distinct sub-systems, namely personalistic and naturalistic medicine. Due to the aim presented in this thesis, it will solely present personalistic medicine further. The concept of personalist medicine pertains to a form of relational medicine that encompasses the individual's connections with God, spiritual entities, particularly the Jinn, and other human beings. The association between the Somali cultural identity and Islam must be understood when examining the relationship with God. Illness is believed to be a test or punishment from God for failing to adhere to the divine commandments, treatment therefore consist of reciting the Quran or by prayer. In the realm of interpersonal relationships, neglecting the proper care of others can result in psychological disorders typified by intense affective states that remain unaddressed (79). Even though Slikkerveer's theories were published in 1990, contemporary research has also underscored the noteworthy influence of Islamic faith and cultural practices on the Somalis perceptions of health and illness (71, 73, 80).

1.4.3 Spiritual health

As per the widely recognized definition by the WHO, health is a "complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity" (5 p.1) The present definition delineates three distinct facets of health, namely the physical, mental, and social dimensions. Many people and organizations have for a long time emphasized the need to rephrase the definition in order to explore the fourth dimension of health—people's spiritual well-being. The definition of health by the WHO has therefore been subject to criticism for over six decades. Several countries have proposed the inclusion of spiritual health as the fourth dimension of the definition, but adaptation has never been made. The concept of spirituality is a subject of debate due to its problematic nature, and there is a lack of consensus regarding its definition on a universal level (81, 82).

A qualitative study in Iran made an exploratory definition of the of the concept of spiritual health and found three dimensions to explain the connection in the definition. The three dimensions encompassed in this framework include the human connection with God, *Religious dimension*; the human connection to oneself, *Individualistic dimension*; and human connection with fellow human beings and the natural world, *World orientated dimension*. The majority of the participating experts in the study acknowledged that the human connection with God represents the most significant component of the conceptualization of spiritual well-being. The study also suggests that there are two types of spiritual health: religious health,

which is influenced by one's connection to God or a higher power, and existential health, which is shaped by a person's relationship to himself, others, nature, and purpose of life (7).

According to Islamic theology, the soul or spirit is the inner dimension of our being. It is also related to the body and consciousness, but it possesses a distinct being and existence, presumably within or close to the heart. The significance of spiritual health is equivalent, if not superior, to that of physical and mental health. The spiritual well-being of an individual is closely linked to their attainment of success and salvation in both the present life and the afterlife (83). The primary purpose of the soul or the spiritual heart is to attain knowledge of its Creator, exhibit affection towards Him, and endeavor to achieve closeness to Him (84, 85). It has been suggested that if the heart fails to perform this function, the individual must be aware of their illness (83). The significance of spiritual well-being is commensurate with, if not surpassing, that of physical and mental well-being. The spiritual well-being of an individual is closely linked to their success and salvation in both the present life and the afterlife. The primary purpose of the soul or the spiritual heart is to attain knowledge of its Creator, exhibit affection towards Him, and strive towards achieving proximity with Him (84). It is widely postulated that in the event of the heart's inability to perform its function, the affected individual would become cognizant of its ailment. Heart illness can lead to a decrease in the desire and capacity to perform virtuous and moral deeds. This impacts an individual's ethical and social conduct, as well as their overall manners (86). The primary diseases that impact the heart include arrogance, ostentation, enviousness, hate and fraud, suspicion, rage, greed, and an obsession with power, wealth, status, and prestige. These conditions are commonly referred to as "diseases of the heart" and are believed to result in significant sins if left unchecked and not managed with due care. The attainment of spiritual well-being is based upon one's genuine commitment to Allah through the practice of prayers, engagement in the study of the Qur'an, and connection with good-hearted individuals (83).

Although there is a lack of consensus regarding the definition of spiritual health, scholarly research has demonstrated that both spirituality and religion can have a positive impact on overall well-being, as well as on the management of illness and health (87, 88). Spiritual practices and beliefs also have an impact on people's understanding of health, coping mechanisms for disease, resilience, access to resources, feeling of community, and overall health outcomes (81). Scholarly literature suggests that acknowledging the spiritual aspect is

crucial in delivering healthcare to individuals, and healthcare practitioners need to possess cultural and religious competence (87, 88).

1.4.4 Health seeking behavior

According to Ward et.al (1997), “Health seeking behavior can be defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (89 p.21). The process of health seeking behavior (HSB) is influenced by a decision-making process that is influenced by individual and/or family behavior, community norms, and standards, as well as characteristics and conduct of healthcare providers (90). The homogeneity of care seeking behavior is not evident, since research has demonstrated the intricate array of factors that impact an individual's behavior in a particular context. HSB is significantly impacted by contextual elements, including cognition or awareness, societal influences, religious beliefs, and economic considerations (89). In order to comprehend the intricate nature of health seeking behavior, there are several theories available, one of which is known as "The Health Belief Model." The theory posits that an individual's engagement in a specific health behavior is dependent upon two primary determinants: the perceived level of threat associated with the disease or negative outcome, and the perceived efficacy of the health behavior in mitigating the risk of said negative health outcome (91). Another model is the “Health Locus of Control" (HLC), which is derived from social learning theory. This notion is grounded on the assumption that individuals who perceive themselves as having control over their health are more inclined to adopt activities that promote their overall health (92). Despite the different explanatory models, it is argued that health-seeking behavior is a multifaceted phenomenon that lacks a singular approach for explanation or pattern formation. Consequently, it is important to comprehend the determinants that influence health-seeking behavior in order to effectively deliver client-centered services (91).

1.5 THESIS STRUCTURE

The introductory section of the research study presents the purpose, rationale, and scientific background for conducting the research. The forthcoming methodology section describes the approach utilized for this study, including the study design, data collection and analysis techniques, and ethical aspects. The chapter on findings provides an overview of the demographic characteristics of the study participants and presents the results that were

identified during the analysis of the interview responses. The study findings are analyzed within the scientific context and supported by evidence in the discussion. The concluding section serves to provide a comprehensive summary of the research study.

2 METHODOLOGY

The research design, data collecting and analysis procedures, and project ethics are all covered in this chapter.

2.1 STUDY DESIGN

In order to systematically produce scientific knowledge based on people's experiences, behaviors, interactions, communication, or text, we engage in qualitative research (93). Numerous designs are available in qualitative research, including grounded theory, phenomenology, ethnography, and a descriptive qualitative method (94). Qualitative descriptive research is a method that produces subjective data that characterizes events or experiences in terms of their "who, what, and where" aspects (95). This approach does not necessitate a highly theoretical framework, because the primary objective of qualitative descriptive research is to remain close to portray the experiences of the participants in its unique context (94). This kind of investigation demands flexible, inductive, dynamic research methods that do not significantly alter the data from the phenomena being examined (96).

A qualitative descriptive design has been argued as the most appropriate design in areas where little is known about the investigated topic, this because it acknowledges the subjective character of the issue, the variety of participant experiences, and will provide the results in a form that directly reflects or nearly matches the terminology used in the original research question (94). The principal researcher did not find much research on the health perspectives of Somali women in general; consequently, a qualitative descriptive approach was chosen to address the study's research objective.

2.2 DATA COLLECTION

This section describes the various phases of the data collection process.

2.2.1 Study population, recruitment processes and sample

Women born in Somalia or Somaliland who had resided in Norway for at least five years were eligible to participate in the study. The additional inclusion criterion of five years was debated with the project supervisor to ensure that the participating women had an adequate understanding of the Norwegian society, as the project concerned Somali women in Norway. The participants were required to provide their consent for audio-recorded interviews, which was communicated to them during the recruitment process. The utilization of audio recording facilitates a more accurate understanding and analysis of the information. Audio recording is a more practical option, particularly in situations where there may be potential language challenges. In cases where notable linguistic barriers were present, a female interpreter was brought in to facilitate communication. The participant was given notice of this arrangement and their consent was sought prior to the interview.

A purposeful sampling method was used to recruit women. Purposeful sampling is a non-probability sampling strategy that refers to the selection of research participants who can speak to the study's objectives and who have direct experience with the phenomenon under investigation (97). One of the approaches in purposeful sampling is snowballing which is a technique that relies solely on referrals to generate a sample. Therefore, this approach is commonly referred to as the chain-referral sampling technique. The snowball sampling method is often used when it is tough to assemble participants for research (98). The principal researcher utilized a private network to refer prospective participants, who were contacted only after expressing an interest in participating in the study. Eight women chose not to participate in the study upon being asked by referents and were never directly contacted by the main researcher. The most commonly spoken reasons for non-attendance were hectic schedules and discomfort with the interview process. It was more difficult than anticipated to recruit participants necessitating the use of two strategies. As stated, the primary approach employed was the utilization of referrals from a private network, while the secondary method involved distributing information about the project through a Facebook page dedicated to Somali women residing in Norway. The study included a total of six women, five of whom were recruited through referrals and the sixth through the Facebook invitation. None of the subjects recruited rejected to participate after receiving information verbally and in writing about the study's details, nor dropped out of the study at a later point. The sample and participants are described at the beginning of the chapter on findings.

After making contact with a potential participant and determining that the inclusion criteria were met, the researcher and the participants initiated communication via various online messenger applications and phone calls. The primary researcher contacted four participants via telephone subsequent to obtaining their consent and provided them with details relating to the research project, its purpose, storage of data, and various aspects of involvement, as well as the nature of the questions that would be asked. All four of participants were also provided with a written invitation letter in the Norwegian language, which contained identical information as outlined in Appendix A. The main researcher was unable to provide the necessary information to two participants via phone call or the Norwegian invitation letter due to their inadequate ability in the Norwegian language. Consequently, the identical information was given verbally through their respective representative who recommended their participation in the research. A professional interpreter was employed during the interview with the two women. The interpreter declared the informational letter into Somali before starting the interview to ensure comprehensive transmission of all relevant information. The necessity of utilizing audio recording was questioned by the two participants. However, upon receiving an explanation that it aids in achieving a more precise understanding and evaluation of the data, both parties provided their consent without any additional inquiries. The impact of employing an Audio-recorder on the interview environment was minimal, as participants quickly adjusted to its presence and were able to maintain a level of relaxation. All participants were interviewed once, and before starting all six interviews, information was repeated, and any questions concerning the study were answered and discussed. Furthermore, the participants were duly informed that they retained the right to terminate the interview at their discretion, revoke their consent during or after the interview, acquire access to and documentation of their data, demand correction or deletion of their data, and be informed of the research project's future utilization of their data by communicating with the researcher at their convenience.

2.2.2 Conducting the interviews

Before conducting the interviews, the primary researcher set up two semi-structured interviews with Somali women from a private network. Both women hold health-related positions in Norway and possess extensive health knowledge in addition to cultural and religious knowledge of Somalia. The purpose of the two trial interviews was to increase vocabulary and understanding in preparation for the collection of data; they additionally assisted in assessing the interview guide. After conducting trial interviews and making minor

adjustments to the interview guide, the main data-gathering process began. Six semi-structured in-depth interviews were conducted with Somali women residing in Norway to explore how culture and religion influence their experience of health and well-being. Between October 2022 and January 2023, the principal researcher conducted all six interviews. Five in-person interviews were conducted, three in the participant's residence and two in the researcher's home, all at the participant's request of location and time. The sixth interview was conducted remotely through the university's Zoom account. The duration of the interviews ranged from 33 minutes to 2 hours and 23 minutes. The mean duration of the six interviews was 1 hour and 28 minutes. The researcher obtained the participants' consent prior to audio recording all six interviews using a digital audio recording device. As stated, four of the interviews were conducted in Norwegian, and a proficient female Somali interpreter was present during the final two. Both participants were duly informed and gave consent to this during scheduling of the meeting. Conducting an interview with the assistance of an interpreter may pose difficulties, thus it is crucial to exercise caution when choosing an interpreter. The interpreter should possess cultural competence and linguistic experience, and it is also advantageous to match the participant with the interpreter, taking into consideration factors such as age, gender, and ethnicity, which can significantly influence the interaction. During the course of an interview, it is important to consider certain practical aspects in order to enhance the overall interview conditions. These include ensuring appropriate seating arrangements, familiarizing the interpreter with the interview guide, emphasizing the significance of maintaining eye contact with the interviewee, and responding to verbal communication through appropriate body language cues (93, 99). A study revealed the importance for researchers to acknowledge the impact of interpreters during interviews (99). The findings indicated that interpreters play an active role and exert influence in various ways, such as assuming the interviewer's communicative role, editing information, initiating information-seeking, assuming control of the interview, and even assuming the respondent's role. Although the presence of an interpreter provided assistance to the interviewer, it also introduced potential hazards that may compromise the overall quality of the interview (99). The primary investigator's awareness of the potential hazards and the previous proficiency in utilizing an interpreter through prior employment enabled a successful execution of the two interviews.

The written informed consent form (Appendix A) was utilized to obtain written consent for the in-person interviews. During the online interview, the participant's oral consent was

obtained through a recorded statement of her name and voluntary agreement to participate in the study. The contextual data, including the date and time, was also documented.

Before the interview began, the primary researcher engaged in unstructured conversations in which the origins of the interviewee's interest in the topic also were discussed. The interview stage environment should encourage interviewees to characterize their perspectives on their lives and worlds. The first few moments of an interview are crucial. Prior to engaging in open and candid communication regarding their personal experiences and emotions with an unfamiliar individual, the interviewees will likely desire to establish a level of familiarity with the interviewer (93). Once a satisfactory connection had been formed between the main researcher and the participant, the interviews commenced with gathering demographic information such as age and duration of residency in Norway. Subsequently, the participants were questioned on their perceptions of the concept of health and the factors that contribute to their overall feeling of well-being. At the conclusion of the interview, the main researcher shifted focus to the influence of cultural values and religious beliefs on the interviewees' perceptions of health and wellbeing.

2.2.3 The interview guide

The interview guide (Appendix B) was created with the support of the project manager and two Somali women who participated in trial interviews. The interview guide was semi-structured and included open-ended questions, which encouraged participants to elaborate and share more of their perceptions and experiences. The manner in which the questions were asked were tailored to each individual interview situation, with an emphasis on creating a secure and peaceful environment in which the participants would feel at ease sharing their perceptions. The interview guide was also modified as new information or knowledge became available. In the context of exploratory research, the process of questioning may undergo continuous refinement as the researcher gains a deeper understanding of the subject matter. This iterative approach ideally leads to the development of a nuanced and sophisticated interviewing technique that is attuned to the intricacies and complexities of the topic under investigation (93).

2.2.4 Saturation of data

This study utilized the concept of data saturation as described by Saunders et al. (100) to determine when to end gathering data. Data saturation focuses on informational redundancy during data collection, where the number of interviews required is determined based on when the researcher becomes aware of repetition in the interview topics (100). After the sixth interview, the principal researcher observed a recurrence of themes, and an adequate level of data saturation was determined based on the insights obtained from a comprehensive data analysis.

2.2.5 Data management and storage

The audio recordings obtained from the interviews were transferred to the primary researcher's institutional Microsoft Office 365 account for temporary storage after being erased from the digital audio recorder. The anonymity of the participants was maintained in the audio recordings as their personal information such as names and other identifiable characteristics was not disclosed. The primary investigator transcribed the interviews' audio recordings in their entirety. During this procedure, all confidential information was anonymized in the written transcripts, including geographical locations, dates, and names. Upon having finished a comprehensive review of the transcripts, the audio recordings were immediately removed. This was done to ensure the precision of the transcripts. Subsequently, the transcripts were assigned numerical identifiers, which had no connection to the specific participants.

The consent forms will be retained five years subsequent to the conclusion of the study, specifically until September 2027, after which they will be securely disposed of through confidential shredding. The recordings of oral consent and the transcripts that have been anonymized will be encrypted and stored electronically in separate locations for a duration of five years. These records will be erased from the system in September of 2027. The documents containing written consent were stored in a cabinet with restricted access solely granted to the project manager.

2.3 DATA ANALYSIS

This section describes the steps involved in data analysis, such as how the data collected was transcribed, coded, classified, and explained.

2.3.1 The analytic approach and process

Braun and Clarke's guidelines for using a reflexive thematic analysis (RTA) served as the basis for the coding and analysis. According to Braun and Clarke, RTA is a method wherein a researcher explores and creates an understanding of patterned meaning in the data with the goal of producing a solid and persuasive interpretation of the data, based on the data (101). The RTA differs from other thematic approaches such as "coding reliability" and "codebook approach" by its organic and flexible manner throughout the process (102) . One of the key principles of RTA analysis is that the researcher's position and contribution are essential, unavoidable, and fundamental to the procedure. The reflexivity is a process that utilizes the researchers' experiences, pre-existing knowledge, and social position to critically examine how these factors impact and contribute to the research process and findings in qualitative data. The researcher and their personal perspective are instruments that should be utilized consciously and actively. It is not something to eliminate, diminish, evade, or minimize, but rather a valuable resource to be utilized (103). The reflexive approach to research therefore necessitates an understanding of knowledge as being situated, wherein it is always a result of the interaction between the researcher and the data.

According to Braun and Clarke, the RTA process involves six phases including familiarizing with the dataset, coding, generating initial themes, developing and reviewing themes, refining, defining and naming themes and writing the report (103). An outline of the research process for each of these are presented below, and an example of the table follows in the next section.

Phase 1, familiarization: The first step in the analytical process involved composing a reflective summary after each interview, in addition to the notes taken during the interviews. Upon conducting six interviews, each of them was transcribed verbatim. Transcribing the interviews necessitated attentive and repetitive listening to the audio recordings, with a focus on the words, sentences, intonation, emphasis and pauses, in order to accurately capture the nuances of both the content and delivery. After completing the transcriptions, each interview was read in its entirety and identified statements, expressions, concepts, and views among the participants, as well as those that were unique and divergent were written in the notes. According to Braun and Clarke, in the phase of familiarization, the data should be carefully read through with multiple readings to gain a comprehensive understanding of the content,

and detailed notes on initial analytical observations and insights, relating to both individual data items and the dataset as a whole, should be written (103).

Phase 2, coding: The coding procedures were executed in two stages. The initial phase of coding involved the usage of hard copies and colored markers. The complete dataset then underwent a systematic coding process, in an inductive manner with open codes. This means that the process of coding development was not predetermined, and the codes were directed by the content of the data (10). The labeled text was subsequently transferred to a Word table within the institutional Microsoft Word account of the university as initial codes. A second round of coding was then carried out to investigate how the initial codes corresponded to or related to the research aim.

Phase 3, constructing themes: Following the completion of the initial coding process, a comprehensive search was conducted to identify underlying patterns within the dataset, and the codes were subsequently categorized into sub-themes. As recommended from Braun and Clarke, effort was made to avoid letting concepts, categories, and definitions from earlier research influence my coding and themes in order to promote a more inductive, data-driven approach while still acknowledging my role as a researcher in the creation of themes (103). After the identification of sub-themes, they were eventually categorized into broad candidate themes that communicated a distinct view regarding the research aim. Ultimately, all coded data for each candidate theme was gathered through clustering.

Phases 4 and 5, revising and defining themes: After the dataset in its entirety had been coded and candidate themes had been labeled, the primary researcher and project manager revised the themes. Upon reviewing the analyzed data, it became necessary to modify certain candidate themes and sub-themes in order to properly highlight the most significant patterns within the dataset that align with the research goal. According to Braun and Clarke (10), the process of revising themes is both frequent and essential, involving the merging, splitting, and discarding of themes. Upon reviewing the codes associated with each candidate theme and sub-theme, the analysis was refined resulting in a comprehensive thematic analysis for the writing phase. The main researcher also extracted expressive, vivid, and significant statements to be included in the research results.

Phase 6, writing the report: Due to personal considerations, there was a delay between phase five of the analysis and the stage where the final report was to be composed. Consequently, a subsequent examination of the themes took place, resulting in the merging of four sub-themes. The statements obtained during phase five were subjected to further review, resulting in the removal of certain statements and the inclusion of others. The selected statements were subsequently translated from Norwegian to English by the main researcher, and the accuracy of the translations was verified by a fellow student who is proficient in both Norwegian and English. During the interview, the interpreter provided translations for Somali phrases and metaphors, and afterwards verified her comprehension of them with the participant. The principal researcher was also provided with accurate spelling of them in Somali. The chosen statements were then categorized into one of the main themes, namely religious determinants, relational determinants, and individual determinants, and further subcategorized under their respective sub-themes. The arrangement of statements and their order helped establish the framework for the results and facilitated the ultimate writing procedure with greater efficiency.

2.3.2 Example table

Phase 1, familiarization	Phase 2, coding	Phase 3, constructing themes	Phases 4 and 5, revising and defining themes
"It might be called therapy. When I'm in my room, late at night or early in the morning, whenever I feel like it, I pray for myself. I'll go into the room and pray. I speak from my heart, and I let it all out."	Prayer as a source of therapy	RELIGIOUS PRACTICE AND BELIEF	RELIGIOUS DETERMINANTS
"Religion tells us about life, and how we are meant to live, so everything has a meaning."	Religion creates meaning and purpose in life	RELIGIOUS VALUES	RELIGIOUS DETERMINANTS
"We believe anything and everything can happen, because of destiny. So, we must always have gratitude, patience, and trust in Allah."	Belief in destiny, and the importance of gratitude, patience and trust	DESTINY	RELIGIOUS DETERMINANTS
"Somali people are very proud of their identity, and it is important to communicate that you are Somali even if you're not born there."	Somalis are a proud people	CULTURAL IDENTITY, BEHAVIOR, AND COMMUNITY	RELATIONAL DETERMINANTS
"Praying to God and having close relationships with other people will make you feel good. For Somalis, staying close to family is very important. In a way, family is like your best friends."	Closeness to family is essential for well-being	FAMILY CLAN AND CLOSE RELATIONS	RELATIONAL DETERMINANTS
"It is important to me that I am healthy to be able to take care of my children and also to be able to take care of myself."	Having good health is important to be able to take care of the children and yourself	GENDER ROLES AND FAMILY PATTERNS	RELATIONAL DETERMINANTS
"I think everything is fine as long as you feel good about yourself and have a strong mind."	Positive attitudes and self-esteem	THE POWER OF POSITIVE THINKING	INDIVIDUAL DETERMINANTS
"Dhaxda xirdho is a Somali expression, and my mother also used it often. It means that even if you're going through a lot of bad things and life is heavy, you use a hijab, tighten it around your hip, and swallow the pain! The expression is meant to give strength, "It made me stronger,". "Tie your waist and keep going!" Don't let bad things stop you from moving forward. So, that is what the saying means."	"Dhaxada xirdho" is a Somali expression meant to provide strength	RESILIENCE	INDIVIDUAL DETERMINANTS

2.4 ETHICAL CONSIDERATIONS

This section describes the ethical evaluations, considerations, and reflections made during the course of this research.

2.4.1 Study evaluation and approval

The Norwegian Agency for Shared Services in Education and Research (SIKT) evaluated this study's obedience to research data management guidelines (ID: 854085) and approved it for interviews on August 1, 2022 (Appendix C).

2.4.2 Participant information and consent

The participants were recruited through a snowballing approach and a Facebook post, wherein they were requested to contact the primary researcher if they were interested in participating in the study. The primary researcher refrained from initiating communication with the prospective participant until obtaining their explicit consent to be contacted. This particular approach ensured that the individuals involved were motivated to share their perspectives on health and well-being. Upon establishing contact via phone call, the primary investigator or an interpreter communicated information regarding the study, its objectives, the participants' anonymity, and their right to provide or revoke consent. Additionally, the potential participants were offered a written information letter. Prior to the interview, the participants were provided with comprehensive information regarding their entitlement to refuse to respond to questions, end the interview, or withdraw their agreement to participate at any point during or subsequent to the interview.

2.4.3 Risk assessment

The main researcher and supervisor of the project engaged in a discussion and concluded that the likelihood of any legal or health-related consequences for both the participants and researchers involved in the study was minimal. As a result, a risk assessment was considered unnecessary.

3 FINDINGS

The current chapter provides a comprehensive summary of the characteristics of the participants and the overarching themes that were identified through the process of thematic

data analysis which include the religious, relational, and individual determinants of health and well-being.

3.1 DESCRIPTION OF PARTICIPANTS

The study's cohort comprised six individuals who were born in Somalia and had been residing in Norway for a period exceeding a decade. The study included six participants, with two individuals falling within the age range of their twenties, two in their thirties, one in her forties, and one in her fifties. Two of the individuals immigrated to Norway during their adulthood, while the remaining four migrated to the country during their childhood. Out of the total number of participants, an excellent level of the Norwegian language was demonstrated by four individuals, while the remaining two required the assistance of an interpreter during the interviews. The educational attainment of the female group spans from primary education to attainment of a master's degree at the university level. The names mentioned in the research results are pseudonymous, and to protect the women's anonymity further there will not be given any specific age, educational background, employment, or information on the duration of residency in Norway for each participant.

3.2 THREE DETERMINANTS OF HEALTH AND WELL-BEING

Three themes will be described and portrayed with statements from the participants: "Religious determinants", "Relational determinants", and "Individual determinants", and an explanation of each theme and its sub-theme will be given prior to presenting the associated findings. As it was found through the interviews, all participants characterized their experiences and perceptions of health and well-being in a holistic manner. They explained how health and well-being are interdependent and have an equal impact on one another. The participants discussed the value of maintaining good health through exercise, rest, and diet, as well as how these factors have a favorable impact on both physical and mental health. They also described how stress, particularly stress related to migration, has a detrimental effect on overall health and well-being. Despite the inclusion of the aforementioned factors, the thematic analysis revealed that religious and cultural factors exert a substantial influence on all the participants' perceptions of health and well-being regardless of educational background, age or acculturation. Additionally, the participants expressed that the Somali perspective on health and well-being differs from that of Norwegians, as evidenced by the following citations.

"There is a huge difference in how Norwegians and Somali people think about health. For ethnic Norwegians are concerned with the national health advice and such things, and they believe that it is the most correct way to live. We think of health holistically, what is within us, belonging to God, and those who are closer to us. That's how we think about health. I feel Norwegians live in their own family bubble, they have their husband or wife, and children, or it's just a lady and her children. We on the other hand, have a whole bunch of aunts, uncles, and the big family, who also plays a part for our health." (Najma)

"We don't see health, well-being and religion divided, there is a red thread through them all. And the key is finding a balance, and for Somalis religion comes first, then family, and after that comes whatever, you may wish to focus on." (Bilan)

3.3 RELIGIOUS DETERMINANTS

The religious dimension encompasses various elements such as the spiritual connection between humans and Allah, the expression of gratitude, obedience to Allah's commands and reliance on Him, devotion to religious rituals such as prayer, recognition of the significance of Allah's power and will, and the God-centered mindset, attitude, and manners. The religious dimension comprises three distinct sub-themes, which are "religious belief and practice", "religious values", and "destiny".

3.3.1 Religious belief and practice

Based on the insights shared by the participants, it became evident that everyone possessed a deep praise for Allah and a spiritual connection with Him, regardless of their age or the duration of their residency in Norway. According to the participants, Islamic teachings serve as a set of principles for leading a life in the most appropriate manner, encompassing various aspects including health.

"It is clearly written that we need to take care of ourselves. In the Qur'an it is written specifically that one should take care of his physical and mental health, but then one forgets it sometimes." (Ladan)

The principle of self-care regarding one's health and well-being is described fundamental in the Islamic faith. Furthermore, a religious explanation is also present for the occurrence of illnesses. The general agreement among the participants is that illnesses and difficulties experienced in life are due to God´s intervention and serve as a means of testing individuals. The manner that an individual approaches the test is of considerable significance.

> *"All truly religious Muslims believe that it´s* [disease and difficulties] *a test from God. Hard times don't happen because God won't help us, but because it is a test, so you just have to smile and go on with your life."* (Bilan)

> *"It is as if Allah sees that we are on the wrong path, and He is trying to drag you back to Him. He's testing you to see if you've forgotten him, and he wants you back on the right path. So, it's* [illness and hardship] *a test, because just as he's given us everything, he can take it away."* (Astur)

The study participants explicitly characterize disease as a test rather than a punishment and emphasize that illness can occur for all people despite their relation to Allah.

> *"Illness is not a punishment, it's just a test that you need to have patience to get through. God doesn't like anyone more or less if someone dies from an illness, it's just a test."* (Axado)

According to the women, the phenomenon of djinn possession is known to impact human beings, and while it is not classified as a disease, it can significantly influence an individual's cognitive and behavioral patterns. The phenomenon reportedly falls within the wisdom domain of the participants, who claim to possess the necessary knowledge to prevent, diagnose, and treat it. The participants perceive this as an understanding within the Somali community, however, this viewpoint is not recognized nor accepted within Norwegian society. They describe a belief that there are a number of individuals from Somalia who receive an incorrect diagnosis of mental illness, whereas they are actually suspected to be possessed by a djinn. The study's participants reported an absence of recognition and validation of the phenomenon by healthcare professionals in Norway, leading to an unwillingness among many Somalis to discuss their condition to their physicians. Instead, they choose traditional treatments administered by Sheikhs or Imams who recite the Quran.

According to a participant, the insufficient proficiency in this domain among healthcare professionals in Norway has served as a motivating factor for four of her acquaintances to pursue a career in medicine. Additionally, another participant advocates for an increase in awareness within the healthcare sector.

> *"No Way. If I had a djinn, I would never have gone to a Norwegian doctor. Many people have it, but they don't tell their doctors because then they'd label them "mentally ill" and give them a diagnosis like "Bipolar" or something like that... Especially bipolar.... Because The djinn give you a different personality, you can become very angry, very happy, or something else.... Some people have been diagnosed with schizophrenia, but they aren't! I've seen someone who had been diagnosed with it, sent to Somalia for treatment, and then came back completely healthy!"* (Najma)

> *"I've never met anyone who has a djinn, so I don't know. But you* [the researcher] *have to teach them* [health personnel] *that it exists!"* (Astur)

As previously stated, illnesses and difficulties are regarded as a test from Allah, and the manner in which an individual copes with such challenges holds great importance. Maintaining or improving one's Iman during times of hardship is a crucial element in properly handling the situation. One of the study's participants referred to the narrative of the Prophet Ayub and his management of the divine struggles. According to the participants, the Iman refers to their connection with Allah and their acknowledgement of their religious beliefs and deeds. The solid reliance on Allah and his divine plan is considered a crucial component of possessing a strong Iman, and questioning the reasons for occurrences or expressing dissatisfaction with the circumstances are not considered beneficial.

> "[During illness] *You must take care of yourself so you can make good decisions and also work on your relationship with God, having a strong Iman! It is important that you don't enter a vicious circle and ask yourself "Why did this* [disease] *happen to me", but rather think that there is light at the end of the tunnel and rely on God."* (Astur)

The religious faith is described by the participants to provide solace and fill their existence and life events with purpose. During times of difficulties, seeking comfort in religion eases the process of accepting life's challenges, and ultimately leads to a sense of peace within. The utilization of religion as a source of solace was an ingrained practice among the study's participants, thus providing it a natural mechanism for managing stress.

> *"I feel that when I seek to religion, it gives me inner peace, and this is also something I was brought up to do, so it comes naturally to me. I can pray or read, for example, and then I feel that I get inner peace. I also feel like I'm better able to accept things as they are when I do things this way* [use religious practice]. *Everything has a meaning, and everything makes sense."* (Sagal)

> *"Religion is a great source of comfort. People's wrong ideas about religion make me a bit sad, but I know what the religion does for me."* (Bilan)

The participants employed prayer as a religious practice, which they perceived as a therapeutic technique. Prayer was described as a possible approach to manage emotional distress and release negative feelings.

> *"It might be called therapy. When I'm in my room, late at night or early in the morning, whenever I feel like it, I pray for myself. I´ll go into the room and pray. I speak from my heart, and I let it all out."* (Najma)

One of the study's participants provides additional insight into the impact of prayer, highlighting that the act of praying provides her with a sense of comfort that exceeds what could be offered by another individual.

> *"When I'm having a hard time, I can look at my sister and think, "She's useless!" before I even start talking to her about it. Do you understand? I don't need to talk to her because I have God, so why would I? But I don't keep things a secret either."* (Bilan)

The participant provided further elaboration on the dynamics of a supportive dialogue among Somali women of religious identity, particularly in the context of offering guidance to an individual experiencing difficulty. The participant places significant emphasis on the utilization of Islamic narratives, as well as the importance of recalling one's ultimate purpose and placing trust in the will of Allah, even in the face of seemingly hard and pointless circumstances.

> *"So, if a mother lost her three-year-old child, we would tell her that the Prophet Muhammed lost more children, because we try to follow him, and be copies of him. So, if someone is struggling, you try to remind them of his* [Prophet Muhammed] *life and how he dealt with hardship. So, it's a psychological talk only shaped by the religion. So, you take your time with the person and listen, but you also remind them that it´s a part of God´s plan. So, the person can feel like their Iman is weak, but you try to boost it. At least we try to tell the person "Don't bury yourself, this is God´s plan and know that God is with you even if it doesn't feel that way right now, he is still with you!" So, we talk about the mental health, but with a religious language."* (Bilan)

The respondents not only identify their religious beliefs as a means of comfort, but also as a vital part of the healing process. They report that the Quran possesses healing qualities and that its recitation may offer benefits in circumstances of illness. The women also describe various narratives, extracted from either their personal experiences or those of acquaintances who have undergone recovery through their sacred book. The study participants highlight that the Quran is utilized in addition to help from healthcare providers and treatments, and particularly in cases of deadly and complex medical conditions.

> *"Yes, if someone get seriously ill, there is verses from the Quran we recite. We invite people in and recite the Quran for the sick. And we firmly believe that God and the Quran is a cure, but if there are less seriously illness, we use the doctor and such."* (Bilan)

> *"I experienced paralysis in my legs and could not walk short distances alone. I did not see a doctor, but the Quran was read to me all the time, and after three months my legs were completely fine again. So, the Quran is very powerful, and God can heal through it."* (Astur)

"No, you not only read the Quran, but you also go to the doctor as well. But if the doctor can't help, you start reading the Quran." (Axado)

Pilgrimage is another religious practice that is being emphasized as a potential healing approach.

"I've heard of many people who were diagnosed with cancer who then went on Umrah [Small Pilgrimage] *or Hajj* [Pilgrimage], *prayed more, and had a strong Iman. And when they are checked again later, it can't even be proven that they had cancer."* (Axado)

According to the participants, the development and healing of an individual's illness are ultimately determined upon the will and power of Allah, and this trust serves as a source of solace and satisfaction.

"Religion makes it possible for us to be happy despite illness or difficult things that may arise in life, because we have faith that everything will be fine in the end, and in the same way that the illness first appeared, God can also take it away. So, no matter what condition you have, it is religion that allows us to relax and have faith that everything will go well." (Axado)

According to the participants, an illness may be perceived as a blessing if the individual demonstrates patience, gratitude, and a strong Iman. The condition may serve as an incentive for Allah to forgive an individual's misdeeds.

"You can have your sins cleansed through illness, but then it depends on how close you stay to God." (Astur)

"A disease can be a blessing if you have patience. Because if you get an illness, it can cause all your sins to be forgotten, it can be a way that God erases your sins." (Axado)

3.3.2 Religious values

The participants express perspectives that describe the influence of religious beliefs on their overall well-being and provide them with a sense of life purpose. One of the participants utilized the Arabic term "Alaq" and clarified its origins in Islamic theology. The term is employed to characterize an individual's mindset, morals, attitude, and actions. The participant states that possessing a strong religious morality is crucial for achieving a sense of well-being. An additional term that is discussed is "Niyad," which refers to an individual's heartfelt intentions prior to taking any action. It is commonly believed that possessing virtuous intentions serves as a preventative measure against the spiritual illnesses known as the "diseases of the heart" and promotes a sense of well-being.

> *"Religion tells us about life, and how we are meant to live, so everything has a meaning."* (Sagal)

> *"Niyad, how can I explain it, like... It is something inside you in a way.*
> *Many people believe, "I feel good inside, so therefore my health is good."*
> *If you feel good inside of you, then everything will be fine. It all works out." (Najma)*

One of the ethical considerations being discussed relates to the significance of displaying kindness, politeness, and friendliness regardless of the circumstances. Such behavior is believed to be beneficial to God's satisfaction and the closeness of angels.

> *"Yes, for example, spiritually speaking, if someone says or does something bad to you, you shouldn't get back at them. Instead, you should let go and forgive. "Have trust in God, that he will do your deed for you."* (Najma)

> *"You also need to be open and friendly. If you are angry and closed off, the angels will leave you."* (Astur)

One additional moral value of a religious nature that the participants have identified as significant is the authentic expression of gratitude, regardless of the circumstances. The women claim that individuals should refrain from comparing themselves to those who are in more favorable circumstances, but rather to those who endure greater struggles, as this approach fosters a heightened sense of gratitude.

"You should not complain. Be grateful for what you have instead of being jealous of others." (Najma)

"Although I am sometimes very ill, I am very grateful for my situation, because there are many people out there who, for example, do not have the opportunity for treatment that I have now. So, I say "Alhamdulilah" for everything, because gratitude is important." (Astur)

3.3.3 Destiny

The study participants' perceptions of health and well-being were found to be significantly influenced by the trust in destiny. The importance of this aspect was apparent as all female participants expressed that misinterpretation had the potential to result in negative health effects.

"If you follow the religion in a concrete manner, it plays a positive role for your health. But if you interpret it as many people do, then it can have a negative effect." (Najma)

According to the participants, placing trust in destiny and accepting the possibility of unforeseen events leads to decreased stress levels and a more relaxed outlook on life.

"We believe anything and everything can happen, because of destiny. So, we must always have gratitude, patience, and trust in Allah." (Axado)

"Our laid-back approach to life is because of our faith in God and destiny, and that is connected to our well-being because we always go with the flow. If we plan something we always say, "In Sha Allah", by God´s will." (Bilan)

On the contrary, all participants claim that an incorrect understanding of destiny may result in unfavorable health consequences. They declare that a significant number of individuals may overlook their individual obligation to engage in self-care and uphold their well-being due to the perception that they lack influence over their personal life and health outcomes.

"Someone might not care about their own health because they think that everything in life is set in stone. And yes, Allah has the last word, but our faith also says that everyone should try their best." (Bilan)

"So, there are of course things that we can do to look after our health and quality of life, live healthier, cut sugar and not eat Halva, because you are responsible for your own health, even if in the end only God is in control." (Axado)

"For example, if you see a Somali woman in her 40s and 50s and you tell her that she should perhaps have a medical check-up, she often replies that she doesn't need it because she trusts God. Because everything to come is decided by God, so they think that you cannot stop a disease that is meant for them. And if they are meant to die, they die." (Sagal)

"Allah has not said to just lie down and relax and get everything served, but you should do your best and then Allah says he will support you along the way." (Astur)

One of the participants has reflected on the positive role of destiny, describing it as an element that contributes to reduced stress and increased happiness in the lives of Somalis. She observes that there exist varying approaches to the pursuit of control in life between Somalis and Norwegians and suggests that the act of planning and trying to control life may ultimately lead to significant hardship.

"I believe that Norwegians feel like they need more structure in their lives to be healthy and happy. I also think that they need to be in control of things to feel good, but we [Somalis] *need to let go of control to feel good. Let go of control, give that to Allah, and then you feel fine!"* (Bilan)

"I believe they think that all the planning and control gives them a feeling of well-being, but I believe that's the reason so many struggles as well, because it's demanding and can be extremely stressful to make plans and try to follow them. We don't care too much of plans because Allah always have the ultimate plan." (Bilan)

3.4 RELATIONAL DETERMINANTS

The present dimension is linked to the connection between human beings and their social environment, and its impact on their perceptions and experience of health and well-being. This part explains the cultural identity and the impact of social connections and community on personal values, patterns, and behaviors. The theme encompasses three separate sub-themes, including "Cultural identity, behavior, and community", "Family, clan, and close relations", and "Gender roles and family patterns".

3.4.1 Cultural identity, behavior, and community

The findings from the interviews revealed a common understanding among the participants that the Somali culture is deeply rooted in the Islamic faith and retains a significant influence on the populace in current times. All participants identified as being religious, however, not all of them reported feeling a sense of connection to every cultural aspect.

> *"Yes, Somalians are very religious, and our culture comes from the religion. They are very connected. If you think about how the Somali culture works, then you can look back to religion."* (Najma)

> *"I'm not really into culture, for me it's more about the religion than culture."* (Bilan)

> *"No, culture is not my business. Culture is not my thing."* (Sagal)

The study participants described cultural characteristics that they perceive as being inherent to the Somali population, which hold significance for their sense of self. A prevalent characteristic among participants was the feeling of pride associated with the Somali identity, which also holds great importance for individuals of Somali origin who reside outside their country of origin.

> *"Somali people are very proud of their identity, and it is important to communicate that you are Somali even if you're not born there."* (Najma)

> *"Somalis are a proud and stubborn people, maybe the most stubborn people in the world. People have been saying negative things about Somalis for years, but no one cares, and everyone think highly of themselves."* (Bilan)

The women also emphasized their opinion that Somalis are a cheerful, vibrant, open-minded, and social people. The women addressed the value of humor and sarcasm among Somalis as well as how being optimistic matters.

> *"Somalians are generally happy. You must have seen that they are very lively!"* (Najma)

> *"We Somalis are a very happy people who cherish each other a lot."* (Astur)

> *"Yes, you never sit down in Somalia. You are constant on the move. And it's also a very open and social society, so when you're out you are sort of taken all around by people you meet"* (Axado)

According to the participants, the Somali people also place significant importance on the provision of care to one another, as well as exhibiting kindness and politeness.

> *"We are happy and open people who take care of each other."* (Astur)

> *"I also want to treat people well. People will be nice to you if you are nice to them. So, it's important to be kind to old people, kids, and adults of all ages. Respect the old people and the young ones. And everyone* [all Somalis] *agrees that it´s important to be kind and polite, and when everyone shares that view, I think everyone feels good."* (Ladan)

As previously noted, the participants characterize the Somali populace as possessing a sense of pride. One participant speculated that this attribute may contribute to the challenges that Somalis encounter when attempting to display vulnerability outside their own family.

> *"You know, it can be really tough for us to open up and show our vulnerable side. Well, expressing your vulnerability can be perceived as revealing your weakness. It's important not to reveal your vulnerabilities to others, as they may use them against you. In Norway, people tend to be more expressive when going through tough times. They have specific words to describe their feelings, such as "I'm in a difficult phase, I*

feel life is heavy." Unfortunately, we are unable to do so as we have not yet learned how to." (Najma)

Other participants also displayed the hardship many Somalis feel about being vulnerable and open about illness and difficulties. They reflected over the reasons for this phenomenon and suggested that it can be linked to the wish to display a perfect façade, or the lack of knowledge on how to express emotions.

"I don't know why health is a private matter, for example, you can see another Somali taking medication and if you ask, she flatly refuses and says that she is healthy despite taking a lot of medication. The doctor is up to date on our health, but not people." (Axado)

"There is a lot of "hush, hush!" going on. Maybe they don't want anyone to know that they or someone they know are struggling, because everything should be perfect. It looks like a perfect facade, like everything is fine, but there are many who struggle." (Ladan)

"I'm jealous that we can't do it. We are not good at seeking care if there is something we need support for, ethnic Norwegian are much better to do so than we are. We didn't learn how to talk about feelings." (Najma)

One of the participants held a contrasting view regarding the topic of vulnerability and portrays Somalis as generally open. They openly discussed their personal challenges as a means of relief and coping with emotional distress. Upon further reflection, the individual asserted that the degree of openness is contingent upon one's familial background as well as their customs.

"We talk a lot about health, so if you are sick in Somalia, everyone in your neighborhood knows. Many people bring you food and other things, and everyone knows how sick you are. But this depends on which family you were raised in and how they think about it." (Astur)

As per the descriptions of all respondents, the Somali populace, despite their supposed lack of openness, exhibits a robust sense of solidarity and consistently provides care and assistance to one another during times of hardship. According to the participants, the presence of a strong sense of unity, social responsibility, and altruism is an important factor of their overall well-being and health.

> *"I believe it´s the strong community that creates the happiness, and the faith in God.* (Ladan)

> *"Unity is important. If, for example, a neighbor has experienced a death, you go there even if you didn't know the person very well. But you go there to show your support and love. You stick together through thick and thin, and even if you don't have a family, for example, others will look after you."* (Astur)

3.4.2 Family, clan, and close relations

As per the accounts of all the respondents, the presence of close relationships is considered essential for the maintenance of the condition of one's body and mind, as well as overall sense of satisfaction. The presence of a dependable support system during challenging circumstances may relieve the burden of such situations. Additionally, solid relationships can facilitate the achievement of personal desires and capabilities.

> *"It's very important to be around good people. People who will stand by you and help you when you need it. Everyone has their own goals and wants to move forward in life. You need people who can help you reach your goals and support you as you go. When you just want to give up, it's very important to have someone pushing you forward."* (Najma)

The study's participants reported that their primary source of close relationships is their family, who serve as both a support system and friends with whom they spend the majority of their time.

> *"Praying to God and having close relationships with other people will make you feel good. For Somalis, staying close to family is very important. In a way, family is like your best friends."* (Najma)

> *"Not because I don't trust other people* [spends most time with her family], *but because it's the people home who got your back! You can fight with a friend, and then there's a chance that the friendship will end. But with siblings, you always stick together, even when you're mad at each other you stay together."* (Bilan)

One of the participants elaborated upon the manner in which Somalis construct their life in accordance with religious principles and in closeness with the people they cherish the most. She describes how the phenomenon of creating a personal bubble can lead to increased resilience in the face of societal challenges.

> *"Somalis design their own life and surroundings like they want. Family and religion come first, so they design an environment that consist of the things most important. So, when it's time to pray, you stay at home and pray, and then you spend time with your kids. The household is where it all happens, whatever happens out in the world comes second. And that is 100 percent connected to mental health, because you never get affected by bad things people may say, you don't even notice it. So, you can walk around in the store, and people may give you a bad look, but your attention is not on that person, it's on your home."* (Bilan)

According to some participants, the family interactions are often unstructured and lack a focus on planned activities or obedience to a strict schedule. Rather, such time is often described as chaotic, yet this very lack of structure fills it with even more value.

> *"Us Somali feel that "family-time" is in the chaos we spend together; those people are your herd! I believe that's the biggest difference between Norwegians and Somalis, is that were not that serious about life, we are more chaotic and just go with the flow. Prayer time is the only thing that gives our days any kind of structure, and it makes sure we don't stay up all night. So, I guess you could say that we have what Norwegians would call "unproductive" weekends, but we don't feel like we must do something all the time, we just spend time with our family."* (Bilan)

According to the participants, clan membership displays a substantial influence on the lives of individuals in Somalia. However, the importance of such ties diminishes upon resettlement in Norway.

> "*The clan is very important. Here in Europe, there is a completely different system for Somalians, but in Somalia, clan and family are very important. The higher the clan you come from, the more support you get."* (Najma)

3.4.3 Gender roles and family patterns

The participants have expressed that Islam has an impact on both family life and the upbringing of children. Religious values seem to play a significant role in shaping both family patterns and gender roles.

> *"Our religious beliefs says that it's not just our job to have kids, but also to teach them about Islam. And when you've taught them and they've grown up, you've done your job. Then It's up to them whether or not they want to follow it."* (Najma)

A participant discussed the significant influence of parents, particularly fathers, in the decision-making process within a household. The participant elucidated that while individual autonomy is acknowledged, the parental blessing holds significant worth.

> *"Those who make the decisions are the parents, mom and dad. In some Somali families it is the father who has the greatest determination. You have a lot to say, too. You can make your own decisions, but your family must back you up too. That is important! We say you´ll reach furthest with the blessing of your parents. It will make you go far. So, they are those who decide, but of course you have your own choice, there is no one who can force you……And here* [Norway] *you have much more determination, but in Somalia it´s your family and clan that decide what you can do."* (Najma)

The study's participants expressed that mothers hold a distinctive value within Somali culture, which is deeply ingrained in both religious and cultural beliefs. Somali children possess a distinct cultural significance as well, and Somali mothers strive to provide optimal support

and upbringing for their offspring. This task is frequently challenging due to the fact that a significant number of Somali women in Norway are single mothers who have undergone divorce and are raising their children without substantial support.

> *"Many Somalis I've grown up with say that their moms have had it hard their whole lives, but they weren't aware of it because their moms always put on a smile".* (Najma)

> *"Because we Somalians, we do things for our children, not for ourselves. This is not good for our own health."* (Najma)

> *"But the older women don't think too much about it* [self-care], *they are more focused on their children."* (Ladan)

> *"It is important to me that I am healthy to be able to take care of my children and also to be able to take care of myself."* (Sabal)

The study participants reported observing generational disparities among the Somali population in Norway. Additionally, it was noted that Somali mothers frequently conform to their children's health practices.

> *"The younger generation of Somalis have much better diet and health habits than us in the older generation."* (Axado)

A participant highlighted the necessity of establishing health facilities exclusively for women. She highlights the significance of providing separate workout spaces for women, where men are not allowed to be present, due to religious beliefs.

> *"Yes, it is important to us that we have an area where there are no men present, and this is a relatively new concept that there is an activity center only for women."* (Axado)

3.5 INDIVIDUAL DETERMINANTS

The theme "individual determinants" pertains to the relationship between an individual and their own self. The individual determinants comprise of “The power of positive thinking” and “Resilience”.

3.5.1 The power of positive thinking

The study participants emphasized the significance of maintaining a positive mindset regardless of the circumstances, and they portrayed Somalis as a generally optimistic populace. As per the narratives provided, it is suggested that negative emotions could worsen an already unfavorable circumstance, whereas maintaining a sense of hope and displaying positive emotions can have a beneficial impact not only on the individual but also on their environment.

> *“They think it's* [pain and difficulties] *just a part of life. I believe in the same. If I have problems, it´s just a part of life, and it will pass.”* (Najma)

> *“As long as you aren't dying, it will pass.”* (Ladan)

> *“I think everything is fine as long as you feel good about yourself and have a strong mind.”* (Ladan)

One of the participants emphasized the significance of maintaining a positive outlook while dealing with illness. They suggested that effectively managing one's thoughts is an essential aspect of life skills.

> *“Some people are lucky to experience good health throughout their lives, others may experience more challenges with age, that their health slowly get worse. But all this depends on how you deal with it.”* (Astur)

> *“You can experience good health in your own way. Even if you have diabetes, you can do well in life.”* (Najma)

3.5.2 Resilience

All participants agreed that the psychological resilience and ability to adapt in the Somali population have significant implications for their overall health and well-being. The study's participants collectively employed a Somali expression, "*Dhaxda xirdho*," which translates to "to tie one's waist". The phrase expresses the idea that in the face of adversity and challenges, individuals ought to stay strong and keep on making progress. The phrase was widely recognized among all individuals involved and was perceived as a means of instilling confidence and motivation.

> *"'Dhaxda xirdho" is a Somali expression, and my mother also used it often. It means that even if you're going through a lot of bad things and life is heavy, you use a hijab, tighten it around your hip, and swallow the pain! The expression is meant to give strength, "It made me stronger,". "Tie your waist and keep going!" Don't let bad things stop you from moving forward. So, that is what the saying means."* (Najma)

The study participants further expounded that employing the aforementioned phrase to an individual experiencing adversity may potentially induce stress and fail to provide adequate solace, as the affected individual may require additional emotional support and time to come to terms with their situation.

> *"I think many cultures often forget that we are only human, if someone has been hit very with difficulties and it are feeling down, it is not always easy for the person to pull themselves together and move on. Maybe they need more time and ease to heal and come to acceptance of what's going on."* (Sagal)

The younger participants noted that resilience was a prominent trait observed in the older generation of Somali women, and they held these women in high regard and idealized them for possessing this quality.

> *"At least for the people who raised us* [She believe they have strong minds]. *They might be a little upset about the social welfare system, an interpreter, childcare, or other small things, but they always have a strong mindset. They're extremely stable. I see it in my own mother, too, because she keeps going no matter what happens. I'm like, "Wow!" How?"* (Bilan)

The study participants engage in reflection regarding the origins of resilience, positing a correlation with the hardship endured by many during the period of war and conflict in Somalia, as well as the experience of migration. The contrast generated by their prior experiences of trauma serves to diminish the perceived magnitude of other challenges in life. In addition, they have persevered through distressing experiences and now experience peace and security, which may have contributed to their personal development and strength.

> *"I think it's* [resilience] *because us Somalis who have come here, we came from a country at war and with few resources, and then we came here and experience peace, security and that our children can get an education and so on, and this calms us down. And what can calm you down is thinking about the life you had there, which could be filled with terrible things, and then you look at the life you have here and now."* (Axado)

> *"Many people are not used to it, they may have lived a life that was okay, but not as good as here in Norway. And when they came here and everything is in order, they think that they lack absolutely nothing. They have fled their country, but they are better off here."* (Sagal)

4 DISCUSSION

The current chapter provides a thorough discussion of the research findings, an evaluation of the quality of the findings, and an assessment of the study's strengths and limitations.

4.1 DISCUSSION OF THE FINDINGS

The purpose of this research was to investigate the perspectives and experiences of Somali women residing in Norway related to health and well-being. The analysis of the interviews resulted in the identification of various factors related to religion, interpersonal connections, and personal characteristics that influence an individual's health and overall sense of well-being. The present section of the chapter will discuss various factors identified through data collection and analysis and compare these findings to existing literature.

4.1.1 Religious determinants

This study aligns with prior research that states a noteworthy impact of religious beliefs, practices, and values on the health and well-being of Somali women (8, 71, 73, 79, 80). According to the participants' perspective, illness and hardship are due to God's creation and are perceived as a test that will impact their afterlife. As a result, it is essential to confront these challenges appropriately. The Quran contains narratives of the prophets, describing the adversity they encountered and how they overcame these challenges. These accounts can serve as a model for human behavior and cognition during times of difficulty. The experience of illness and adversity is viewed as a test of human beings, and it is crucial to uphold or nurture a strong Iman by engaging in practices such as prayer, reciting the Quran, good deeds, Quranic study, or undertaking a pilgrimage to Mecca for those who possess the necessary resources. The religious beliefs and values held by the participants in this study influence their Health Seeking Behavior (HSB), shaping their approaches to coping with illness and adversity in ways that differ from Western medical practices. These findings align with two prior studies on HSB among Somali migrants residing in the United States (104, 105). The findings of a comprehensive literature analysis on HSB indicate a prevalent inclination among researchers to primarily investigate the process of seeking formal "health care" services. However, a limited amount of data was also collected pertaining to self-care practices, consultations with traditional healers, and utilization of unauthorized medical channels (106). The literature analysis describes that informal healthcare has often been viewed as something to be avoided, with a focus on promoting the utilization of formal healthcare channels as the primary choice. The prevailing perspective frequently posits that the preferred course of action for an individual in response to an episode of disease is to primarily seek assistance from a certified allopathic physician within an officially recognized healthcare facility. The researchers argue further that despite the accumulating evidence indicating that individuals often opt for traditional remedies or practitioners in various settings, there is a lack of studies proposing strategies to establish connections that would facilitate the integration of individual preferences into a more adaptable healthcare system (106).

The participants of this study emphasized their perception that illness is not viewed as a form of punishment, but rather as God´s trial that aims to encourage a stronger connection with God and to facilitate a return to religious practices in the event of spiritual detachment. There exists a divergence of perspectives in the scholarly literature regarding the perception of illness among Muslims. While some studies argue that participants view illness either as a

trial or as a form of punishment from God, others emphasize that participants regard illness solely as one of the tests that humans must face in the worldly life. Irrespective of whether disease and adversities are perceived as a trial or penalty, the approach to confronting these challenges remains consistent in the research, which involves fortifying one's Iman, performing virtuous deeds, and adhering to Islamic values. These values entail that individuals ought to confront adversity and illness with endurance, patience, trust, and gratitude, irrespective of the severity of the circumstances. Rather than expressing discontent, one should exhibit confidence in God´s decisions and maintain hope and optimism for improved circumstances, as for every illness, God created a treatment (47, 79, 107-109).

The perception of illness is not limited to being a test from God, but also an opportunity for spiritual purification from earthly sins. This, in turn, offers positive prospects in the afterlife, provided that the hardship or illness is endured with patience and gratitude. Thus, the situation may serve as a blessing for those who have been adversely affected. These perspectives are consistent with prior research that demonstrates the significance of enduring illness and suffering with patience. Because suffering promotes spiritual and moral development and allows for the forgiveness of sins to be accomplished only through patience and endurance, it is said to be beneficial to humanity (107). In Somali culture, it is considered inappropriate to express complaints about one's health. Consequently, individuals tend to suppress any feelings of dissatisfaction and strive to maintain a sense of contentment. This is achieved through positive thinking, endurance, and a belief in trusting God, with the hope of being rewarded on Judgment Day (71). The act of exhibiting patience and perseverance in the face of adversity, is originating from the fundamental principles and ethical standards of Islam and have gradually become an integral part of the overarching Somali cultural values. The fact that 99 percent of the Somali population identifies as Muslim implies that the values in question are not exclusively regarded as Muslim values, but rather as values that are intrinsic to the Somali culture (8).

As previously mentioned, the participants believe that illness and hardship are caused by God, and it is a part of His plan. The path of an individual's life is predetermined and limited. Factors such as illness, recovery, and mortality are exclusively determined by God and him alone. The women in this study reported that their reliance on destiny creates a positive outlook and a sense of well-being, as they maintain a belief in the limitless possibilities that are under the control of God. This enables individuals to surrender their desire for control and

premeditation of life events, fostering a greater capacity for embracing and accepting adversities. This finding is consistent with a prior study that posited that the conviction in infinite possibilities fosters a perspective in which surrendering to hopelessness during adversities appears to be nearly inconceivable for Somalis (8). In contrast, the participants assert that the notion of destiny could potentially engender a sense of passivity among individuals with regard to health promotion, disease prevention, and treatment, as they may subscribe to the belief that all outcomes are predetermined by God thereby beyond human influence. The assumptions of the participants align with both "The Health Belief Model" and "Health Locus of Control" (HLC) (91, 92). As a result, the belief in and interpretation of destiny might have a significant influence on individuals' HSB. According to the women, the aforementioned interpretation of destiny is both incorrect and harmful. They contend that the Quran explicitly asserts that each person bears the obligation of maintaining their own health, and that neglecting to do so constitute a lack of respect for God. Hence, it is essential that health promotion and illness prevention are addressed in an active manner. The aforementioned assertions are consistent with prior research (107). The participants describe further that in times of hardship they feel their religious belief and practices give peace, comfort, and a sense of purpose, and therefore also function as a coping mechanism for them. The Quran is also described by the women as having healing powers and are therefore a vital in treatment and care. This is aligned with previous studies that also state the importance for healthcare workers of inhabiting this knowledge but also supporting their religious resources that aid them in coping with their disease and crisis (73, 80, 87, 110, 111).

One of the religious phenomena discussed by the participants pertained to the potential for an individual to be possessed by djinn. It was noted by the women that this occurrence is frequently mistaken by healthcare professionals in Norway as a mental disorder. This finding is consistent with prior studies that have identified variations in the Western and Somali viewpoints regarding mental health conditions (47, 58, 73, 112). This study revealed that Somali women emphasize the importance of healthcare workers possessing an understanding of djinn and its potential impact on an individual's cognition and behavior. Additionally, the participants emphasized the significance of acknowledging and respecting their belief in this phenomenon and the religious interventions associated with it. Prior research has indicated the significance of healthcare professionals recognizing customary treatments and convictions. The act of reciting the Quran, for instance, has been posited as a source of

optimism for recovery and a means of reinforcing cultural, religious, and familial ties (47, 58, 112).

The aforementioned religious viewpoints of the participants about health and well-being differ with the prevailing Norwegian health system, which predominantly relies on Western medicine. Moreover, Norway has been assessed as one of the least religious nations globally, characterized by its secular principles (113). The existing religious and cultural divide between the broader Norwegian populace and the Somali population residing in Norway has the potential to create significant challenges in terms of collaboration, unless addressed in a suitable manner. The findings of a research examining health perspectives among the Somali community residing in the United States have also highlighted the significant impact of Islam on the Somalis' perceptions of health, sickness, and treatment. This effect has been shown to potentially lead to miscommunication and misunderstandings between Somali patients in their healthcare system, which also is predominantly based on Western models. The study's authors contend that there exists a necessity to acquire knowledge and comprehension within the healthcare system regarding Somali perspectives. Additionally, they advocate for healthcare professionals to demonstrate respect for Somali beliefs, rather than engaging in attempts to persuade patients to make decisions that align solely with the healthcare worker's personal belief system (80).

According to the findings of this study, the participants hold the belief that there are barriers hindering Somalis from accessing professional psychological support during periods of emotional trouble. The challenges are attributed to the divergent health and life views between the Somali and ethnic Norwegian populations. According to the participants, the aforementioned disparities pose a significant challenge for a mental health practitioner in Norway to provide adequate assistance to a patient of Somali origin who is experiencing psychological distress. Furthermore, the participants emphasize the importance of communal solidarity through therapeutic dialogues that are rooted in religious tenets when facing sickness and hardship. The individuals assert that these conversations often revolve around reflecting about the narratives of the prophets and promoting the increase of one's Iman. The Somali Reconciliation Institute and the Abu-Bakr Islamic Center in Seattle have collaborated to devise an intervention called "Islamic Trauma Healing" that is consistent with their respective religious convictions. The Islamic Trauma Healing is a group-based intervention that is facilitated by laypersons and integrates concepts from trauma-focused cognitive-

behavioral therapy that are verified by empirical research, in combination with cultural and religious customs. The motivation for the creation of the program stemmed from the recognition that religious beliefs exert a notable influence on the way in which psychological wellness, emotional distress, and help-seeking behaviors are perceived by Muslim individuals. Consequently, a need was recognized to develop a therapeutic methodology that is based on empirical data and aligns with the religious and cultural values of the Muslim community. The program encompasses a number of crucial components, such as the incorporation of prophetic narratives, supplication of Allah for managing trauma, tackling trauma-related cognitions, and avoidance of traumatic memories. Initial findings pertaining to the program have indicated positive outcomes. Nevertheless, a randomized controlled trial is presently underway to furnish more substantial evidence (111). Despite the results of the randomized trial, several studies have highlighted the importance of implementing religious and culturally appropriate community-based interventions to offer enhanced support to Muslim populations (17, 47, 57, 64, 71, 73).

4.1.2 Relational determinants

The study's participants provided insights regarding the impact of their cultural identity, family, and community on their overall health and well-being. According to the women's account, Somalis exhibit a remarkable sense of pride in their national identity, even among those residing in the diaspora. Somalis are also portrayed by the women as being stubborn, joyful, and social. The aforementioned generalizations are consistent with prior research that exhibits similar traits. Additionally, these findings suggest that such characteristics contribute to the resilience of Somalis, enabling them to endure events of racism, stigma, and marginalization (49, 50). On the contrary, scholarly studies have indicated that the manifestation of pride among Somalis may make them vulnerable to experiences of humiliation, thereby impacting their sense of well-being (114).

The Somali culture is founded on Islamic principles, which significantly influence their community and familial structures, as evidenced by prior research and confirmed by the study participants (8, 73, 114). The extended family plays a significant role in an individual's life, serving as both a social network and a source of support. The heightened sense of familial loyalty fosters trust and comfort, leading to a greater reliance on and allocation of time towards one's closest relatives. The significance of family relationships and their positive

impact on individuals' well-being was a shared opinion among all participants. The aforementioned statement aligns with the Grant Study of Adult Development, which has consistently found over the course of 85 years that positive relationships are a key factor in promoting human happiness, health, and life expectancy (115). The respondents in this study have indicated that family members are involved in the decision-making process, not only in matters pertaining to general life, but also with regard to healthcare-related decisions. In accordance with previous research, family structures have traditionally been characterized by a hierarchical arrangement in which elder members and male individuals hold greater decision-making power. Somali parents exhibit a strong emphasis on family and children, with a particular focus on motherhood and childcare as integral components of women's social status and self-conception (49). In contrast to the findings drawn from the present study regarding the favorable influence exerted by familial ties on the health and general well-being of the individuals involved, there exists research highlighting the adverse impacts experienced by several Somali families residing in Norway as a consequence of the migration process (113, 116). The process of migrating to Norway results in Somali families experiencing a cultural disorientation, leading to shifts in familial responsibilities and roles. Additionally, they encounter a loss of the traditional support provided by the extended family in child-rearing, and their previous familial and social networks become disconnected (117).

The migratory process, characterized by several transformations and challenges, appears to be contributing to parental conflict and elevated divorce rates within the Somali community residing in Norway. Consequently, a significant number of children of Somali descent find themselves residing primarily with a single parent, typically the mother (113, 116). Moreover, the significance of modernizing migrant families is regarded as a noteworthy public issue due to the Norwegian state's foundation on principles of autonomy and personal freedom, which are deemed vital to democracy and essential for active involvement in Norwegian society. The Somali migrant family, characterized by obvious gender and age hierarchies, presents a challenge to the democratic and egalitarian principles of the family structure (118-120). The potential challenges faced by Somali women and families due to the cultural differences between traditional Somali family norms and Norwegian egalitarian and democratic ideals are worth considering. Although the current study does not give specific data on this matter, it is realistic to suggest that these differences might potentially have a detrimental impact on the general health and well-being of Somali women.

Historically, the clans in Somalia have exerted significant influence on the well-being and health of individuals. Previous findings indicate that members of the Somali diaspora exhibit a tendency to downplay their clan associations and do not consider them to be of significant importance (42). This observation is consistent with the descriptions provided by the study participants in this research. As per the women's perspective, the Somali community, irrespective of clan affiliation, exerts a significant impact on the overall condition of well-being and health. As previously stated, Somali values are rooted in Islamic principles that emphasize the significance of mutual care, courteousness, generosity, inclusiveness and altruism (8). The World Happiness Report suggests that these values and actions have a significant impact on the promotion of happiness and well-being (121). The Somali diaspora community has been identified in prior research as a cohesive community, with members exhibiting a strong sense of solidarity and mutual aid during times of hardship. Studies have indicated that the Somali network fosters a sense of affiliation and greater meaning, thereby protecting against emotions of exclusion and isolation. The concept of a communal sense of unity has developed a robust obligation to assist others (8). According to a study in the United States, the Somali community places a high value on their support network and homelessness is perceived as a less pressing issue for Somalis compared to the general population, owing to their strong communal support systems (49). The provision of community support, fostering of a sense of belonging, and cultivation of a shared identity have been posited to promote community resilience, which in turn may positively impact individuals' health and well-being (8).

4.1.3 Individual determinants

The female participants in this research also expressed their belief that Somali women possess a favorable outlook towards life, which they consider to be crucial for their overall well-being. According to their report, minimal requirements are necessary for them to experience happiness, and they perceive themselves as healthy as long as they effectively navigate their daily routine. This aligns with prior scholarly studies which have suggested that Somalis conceptualize well-being as encompassing physical health and the capacity to engage in activities necessary for daily functioning (73).

As previously stated, research has argued that there is a resilience present within the Somali community, which is also described at an individual level. The present study involved the characterization of Somali women, with a particular emphasis on the elderly population, as

possessing a high degree of resilience. The origin of this belief is attributed to cultural values, as evidenced by the phrase "Dhaxda xirdho," which denotes the act of tying one's waist. According to the women, possessing the ability to endure adversity and keep going is highly valued in Somali culture. The study's participants reported that their capacity for resilience was augmented through the process of surviving and triumphing over adverse experiences. Their current life in Norway with a sense of tranquility and safety also enhances the feeling of survival and therefore also leads to more gratitude. The aforementioned statement is consistent with a scholarly investigation on the concept of resilience within the Somali population. The study posits that the resilience exhibited by Somalis originates from three overarching domains, namely: their shared historical experiences and common identity as survivors, their adherence to the Islamic belief, and the cultural values of the Somali people that prioritize social unity through a sense of collective oneness (8)

4.1.4 Further directions

The participants of the research exhibit contrasting perspectives towards health and well-being when compared to the principles of Western medicine. These statements align with existing theoretical concepts arguing that cultural, religious, social, and familial factors substantially impact the perceptions of an individual's health and well-being, and by extension, their health literacy. Research on health literacy among Somalis in Norway have shown differences within the demographic because of factors such as education and acculturation, and the researchers have therefore suggested that the health literacy among the highest educated participants with increased integration to the Norwegian society have the highest health competency (30, 54). The interviews and analysis revealed variations among the participants regarding feedback on health promotion and disease prevention in relation to nutrition and physical activity. However, there was a unanimous agreement among all participants that the perceptions and experiences of health and well-being are significantly impacted by individual, relational, and religious determinants, regardless of age, education, or acculturation. The women shared perceptions and personal experiences of how health and well-being are influenced by prayer, the narratives of the prophets, faith in destiny, and the significance of Islamic values such as exhibiting patience and gratitude in all circumstances. In addition, the significance of the family unit is essential not only for an individual's well-being but also in the context of decision-making. Moreover, the importance of the ability to withstand adversity and be resilient when facing challenges. The profound influence of these factors implies that the emic perspectives on health and well-being play a significant role in

the apparent paradox between the findings on risks among Somali women in Norway and their self-reported experience of personal health and well-being. The participants' perspectives on health and well-being appear to align more closely with the notion of spiritual health. As such, it is noteworthy that women prioritize the cultivation of not only their physical and mental health but also their spiritual well-being, both for the present life and the afterlife. The perceptions, experiences, and actions of Somali women regarding health and well-being appear to be influenced by the role of spiritual health and well-being, which is regarded as just as vital as physical and mental health. Further investigation should be conducted to determine the compatibility between the definition, concept, and questionnaires of health literacy and the notion of spiritual health. Do the metrics utilized to assess health literacy accurately capture the health-related proficiency of individuals who prioritize, perceive, and respond to their spiritual well-being to the same extent as their physical and mental health? Moreover, how can a secular nation such as Norway, with its current healthcare infrastructure, deliver proficient and beneficial healthcare services that also tend to the cultural and religious beliefs and requirements of Somali women?

The present study focused only on exploring the perceptions and experiences of Somali women residing in Norway, as this demographic has been significantly addressed in existing literature about health risks and hazards (15, 20-23, 25, 26, 30-34, 69, 71). As previously discussed, migration has significant implications for family structure and gender roles (116-118, 122). Extensive research has demonstrated that men and fathers face various challenges in terms of their involvement in the labor market, decline in social status, engagement in the consumption of the narcotic substance Khat, and the loss of their traditional role as decision-makers and providers within numerous families (16, 114, 116, 117, 123). A significant number of children of Somali heritage residing in Norway are also raised in single-parent families characterized by limited financial resources. These individuals often find themselves navigating the complexities of balancing the demands placed upon them by both their familial and Norwegian cultural contexts. Some studies have demonstrated that a significant proportion of Somali kids become involved in criminal trajectories (113, 116-118). Hence, it is recommended that more investigation be conducted to explore the perspectives of health and well-being among Somali men and youth. This is necessary due to the contextual elements at play, in order to ascertain whether there exist variations within the Somali community residing in Norway.

4.2 QUALITY, STRENGTHS, AND LIMITATIONS

The following section presents an evaluation of the research study's quality, utilizing the consolidated criteria for reporting qualitative research (COREQ). The COREQ checklist is specifically designed to assist researchers in providing a thorough and comprehensive report of qualitative studies (124).

4.2.1 Reflections on study design and data collection

The research's expressed purpose and goals are in alignment with the qualitative descriptive methodology. The research employed a purposeful sampling approach, which involved the implementation of a snowballing method. The utilization of purposive sampling facilitated the gathering of data from female individuals with varying ages, durations of residency in Norway, and educational backgrounds. The diversity of the participants resulted in the obtaining of comprehensive data that applied to the primary focus of the investigation. The sample size of the study may be viewed as a potential limitation. However, the incorporation of two trial interviews and obtaining of comprehensive information from participants resulted in redundancy of information during data collection, and data saturation was later determined during the analysis phase. Hence, it is widely regarded that the conducted study has facilitated a comprehensive understanding of the phenomena being explored.

The data collection setting had variation, as interviews were conducted through face-to-face interactions either at the participants' or researchers' houses, as well as online, and with or without the assistance of an interpreter. The prioritization of women's comfort, simplicity and practicalities of participation was the main priority for the choice of location and setting. The environment in which an interview takes place has the potential to impact various aspects of the interview, including its overall flow, the connection established between the researcher and participants, and other related factors (93). Given that the interviews in this study were conducted in various settings, it is challenging to ascertain the precise influence of the setting on the data collection.

Since the main researcher met the participants solely on the day of the interview, approximately 30 to 60 minutes were invested in building connection with the participants to create a pleasant and secure interview setting. The interviewer observed that the participants exhibited a willingness to disclose their experiences and perceptions. Therefore, it can be inferred that the interview setting, and the connection established with the participants were

adequate in gathering their narratives. However, it is difficult to estimate the full range of perceptions and experiences that the participants may have chosen not to disclose. The implementation of multiple interviews with each female participant could have potentially resulted in greater insight of the phenomenon being explored. The primary investigator chose not to request feedback from the participant regarding the interview transcripts due to practical issues and the project's limited time as underlying reasons. The absence of participant collaboration in verifying the accuracy and authenticity of the findings, as well as the failure to conduct multiple interviews with the same participant, may potentially interfere with the reliability and validity of the outcomes in the present research.

In order to ensure the accuracy of the study, the interviews with participants were conducted thoroughly, transcribed in great detail, and subsequently reviewed to ensure the precision of the transcripts. Additionally, the quotations were cross-checked with a bilingual interpreter to ensure their fidelity. Finally, the data analysis process was conducted transparently to ensure the validity of the findings. Nevertheless, it is uncertain whether the researcher provided an adequate amount of time to gather data. As a result of the difficulties encountered in participant recruitment, there was limited capacity to implement alternative approaches that could have potentially expanded the outreach to a greater number of individuals. A more extensive range of interviews and a larger study sample could have potentially yielded a more comprehensive and nuanced understanding of perspectives on well-being and health.

This research study's primary strengths lie in its conceptualization of the perceptions of health and well-being among a sample of Somali women residing in Norway. The findings of this study may have broader implications and applicability beyond the study's specific context. The study provides novel perspectives on the viewpoints of Somali women, which could potentially shed light on opportunities for structural alterations and pragmatic changes in accordance with the research investigation. The semi-structured interview guide was implemented with flexibility, facilitating unrestricted participant responses which had an impact on the credibility of the research outcomes. This study sheds light on the nuanced aspects of the topic that may have been overlooked, highlighting their significance and relevance.

4.2.2 Reflections on data analysis and findings

The primary researcher carried out the thematic analysis in an inductive manner in accordance with the methodological approach outlined by Braun and Clarke, where the data is analyzed for underlying patterns that are subsequently condensed into themes (103). Thematic analysis is a fundamental and adaptable method that may offer a rich, intricate, and sophisticated explanation of data and is consistent with various scientific perspectives. When conducting a thematic analysis, it is crucial that the researcher understands and considers their role within the research generally and the data analysis particularly as they actively participate in detecting, choosing, and reporting patterns (103). As mentioned above, participant input on the results was not requested, yet it may have improved the research's credibility.

The interviews were carried out in the Norwegian language, either with or without the assistance of an interpreter. During the report composition process, the main researcher translated the Norwegian quotations into English. To enhance the credibility of the results, a bilingual interpreter cross-checked the translations. The final report deliberately refrained from providing a detailed exposition of the participant's demographic information, such as their age, educational background, employment, or information on the duration of residency in Norway, as a measure to safeguard their anonymity.

4.2.3 Ethical considerations

As stated earlier, the research study incorporated ethical issues throughout its design phase. The data collection and analysis were governed by ethical directives, including the principles of not being harmful, obtaining informed consent from participants, and preserving privacy and confidentiality (93). Ethics has a situational nature, necessitating scholars to engage in ongoing introspection and critically evaluate the ethical judgments they make. Furthermore, it is imperative to acknowledge the importance of self-reflection and mindfulness regarding one's own position in relation to other individuals engaged in the research process. This recognition is essential for fostering a research environment characterized by mutual trust, respect, and a meaningful connection with both the participants and the broader community (125). The qualitative researcher should proactively anticipate the possibility of a misrepresentation of the study findings and take measures to address this concern. This is particularly important in situations where there are cultural, social, and language barriers, as

well as other obstacles that may hinder effective communication between the main researcher and the participants (88).

In order to address and alleviate any obstacles in this study, the participants were provided with comprehensive verbal and written instructions, and an interpreter was employed when necessary. The researchers provided explanations on the procedures employed for data collection, including a detailed description of the audio recording process during the interviews. Additionally, participants were requested to provide their informed consent for the utilization of audio recordings. The participants were further requested to provide their informed consent by signing a consent form during the in-person interviews or by giving verbal consent during the online interview in order to participate in the study. The participants were provided with the information that they had the autonomy to discontinue their involvement in the study at any point, without being required to provide a justification for their decision.

4.2.4 Role of the main researcher

The principal investigator is wedded to a Swedish man of Somali origin and possesses professional background in assisting unaccompanied minor refugees in Norway, including youth from Somalia. The researcher's personal life and work experience may have facilitated building trust with interviewees, thereby promoting more openness among the participants. On the contrary, it is plausible that the main researcher's personal experiences could have influenced her outlook and hindered her capacity to undertake neutral data gathering and analysis, thereby potentially introducing bias.

5 CONCLUSION

The current study has examined the apparent paradox between research on health risks among Somali women residing in Norway and their self-disclosed experience of health and wellness. This study has conducted an analysis of emic perceptions and experiences concerning health and well-being, with a particular focus on the impact of religious beliefs and cultural values on these phenomena. The study's data collection and analysis resulted in findings indicating that three determinants, namely religious, relational, and individual factors, appear to exert significant influence. Consequently, this study suggests that these determinants may be the primary factors shaping the health and well-being perceptions and experiences of Somali

women. Additionally, a comprehensive analysis of existing literature has indicated that the determinants mentioned above are more closely associated with the notion of spiritual health and could therefore deviate from conventional Western perspectives on health, well-being as well as health literacy. The impact of prioritizing, perceiving, and responding to spiritual well-being on health literacy metrics is unclear. This may have implications for health literacy research within certain demographics, as it is uncertain whether these metrics accurately capture the health-related proficiency of individuals who place equal importance on their spiritual, physical, and mental health. Within the context of a system, it is crucial for policymakers and educational institutions to have an awareness of the varying perceptions among different demographics. This understanding can aid in the development of policies and educational initiatives aimed at reducing national health disparities. Moreover, familiarity with patients' perceptions is crucial for healthcare professionals to comprehend the stakes, and moral and emotional codes that govern in Somali women's lives. This knowledge would provide healthcare professionals with not only a compassionate comprehension but also a foundation upon which to construct and provide treatments that can consider their motivational factors. Healthcare professionals must comprehend the religious and cultural backgrounds of Somali women to provide treatment that is effective and appropriate. This treatment should be based on scientific evidence while also considering their personal beliefs and values.

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APPENDICES

A. PARTICIPANT INFORMATION LETTER AND WRITTEN CONSENT FORM

Vil du delta i forskningsprosjektet

"Betraktninger av helse og velvære blant somaliske kvinner i Norge"

Formål
I dette prosjektet vil jeg undersøke hvordan Somaliske kvinner i Norge betrakter og opplever helse og velvære. Jeg ønsker også å finne ut hvis, og hvordan kulturelle verdier og religiøs tro påvirker helse og velvære.

Jeg har lyst å snakke med Somaliske kvinner bosatt i Norge, og jeg håper du vil være med!

Jeg vil for eksempel stille deg spørsmål som:

- *Hva betyr helse og velvære for deg?*

-*Hva tror du er viktig å gjøre for å ivareta god helse og føle velvære?*

-*Hvordan kan religion og kulturelle verdier påvirke din helse og velvære?*

Hvem leder forskningsprosjektet?
Jeg heter Cristina Halvorsen og er master student i Global Helse ved NTNU i Trondheim, og dette prosjektet er en del av masteroppgaven min.

Cristina Halvorsen

Veilederen min og ansvarlig for prosjektet heter Laila Tingvold. Hun er ansatt ved Senter for Omsorgsforskning som er en del av NTNU Gjøvik.

Laila Tingvold

Hvorfor får du spørsmål om å delta?
Vi spør deg om å være med, fordi du er du er en Somalisk kvinne bosatt i Norge.

Vi vet enda ikke hvem du er eller hva du heter, men din kontaktperson gir deg dette brevet fra oss.

Hvis du har lyst å være med i forskningsprosjektet, må du skrive under på siste ark i dette brevet, og da vil vi ta kontakt med deg.

Hvis du ikke har lyst å være med, tar vi ikke kontakt med deg.

Hva betyr det for deg å delta?
Hvis du har lyst å delta i forskningsprosjektet, vil vi ha et intervju med deg. Et intervju er en samtale der vi stiller deg forskjellige spørsmål. Spørsmålene vil handle om helse og velvære.

Cristina Halvorsen vil gjennomføre intervjuet, og hun vil gjøre lydopptak av intervjuet. Intervjuet vil ta ca. 45 minutter.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Det betyr at du kan velge selv om du har lyst å være med eller ikke. Ingen andre kan velge dette for deg. Det er bare du som kan samtykke. Samtykke betyr at du sier at du synes noe er greit.

Hvis du vil delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Det betyr at det er lov å ombestemme seg, og det er helt i orden. All informasjon om deg vil da bli slettet.

Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller om du først sier «ja» og så «nei». Ingen vil bli sur eller lei seg, og det vil ikke ha noe å si for jobben din.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke informasjonen om deg til å finne ut betraktninger av helse og velvære blant somaliske kvinner i Norge
Vi vil ikke dele din informasjon med andre. Det er bare forsker Cristina Halvorsen og prosjektleder Laila Tingvold som har tilgang til informasjonen.
Vi passer på at ingen kan få tak i informasjonen som vi samler inn om deg.
Vi lagrer all informasjon på en sikker datamaskin.

Vi sletter lydopptak fra intervjuet når vi har skrevet ned alt som vi har snakket om. Vi passer på at ingen kan kjenne deg igjen når vi skriver forskningsartikler. Vi vil for eksempel finne opp et annet navn når vi skriver om deg.
Vi følger loven om personvern.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Vi er ferdig med forskningsprosjektet 15.06-2023.
Da vil vi passe på at all informasjon om deg er slettet.

Dine rettigheter
Hvis det kommer frem opplysninger om deg i det som vi skriver, eller har i dokumentene våre, har du rett til å få se hvilken informasjon om deg som vi samler inn. Du kan også be om at informasjonen slettes slik at den ikke finnes lenger. Det som det er noen opplysninger som er feil kan du si ifra og be forskeren rette dem. Du kan også spørre om å få en kopi av få informasjonen av oss. Du kan også klage til Datatilsynet dersom du synes at vi har behandlet opplysningene om deg på en uforsiktig måte eller på en måte som ikke er riktig.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler informasjon om deg bare hvis du sier at det er greit og du skriver under på samtykkeskjemaet.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål om studien, kan du ta kontakt med:

- Cristina Halvorsen, Forskningsansvarlig og Master student ved NTNU Trondheim.
  Mail: cristih@stud.ntnu.no
  Tlf: 92479602

- Laila Tingvold, veileder og prosjektansvarlig. Mail: laila.tingvold@ntnu.no

- Vårt personvernombud: Thomas Helgesen, Personvernombud ved NTNU tel:93079038
  Mail: thomas.helgesen@ntnu.no

NTNU har bedt Personverntjenester se om prosjektet følger loven om personvern. Personverntjenester har gjort dette, og mener at vi følger loven.

Hvis du lurer på hvorfor Personverntjenester mener dette, kan du ta kontakt med:

- Personverntjenester på epost (personverntjenester@sikt.no) eller på telefon: 53 21 15 00.

Med vennlig hilsen Cristina Halvorsen

B. INTERVIEW GUIDE

Intervjuguide for individuelle dybde intervjuer

1. Hvor gammel er du?

2. Hvor lenge har du bodd i Norge?

3. Hva er viktig i ditt liv for at du skal oppleve velvære?

4. Hvordan vil du beskrive hva helse er?

5. Hva er viktig for at et menneske skal ha god helse?

6. Hvis mennesker kan påvirke sin egen helse, hvordan kan dette gjøres?

7. Hvordan tenker du helse og velvære påvirker hverandre?

8. Er din helse viktig for deg?
   -Hva gjør du for å ivareta egen helse?

9. Hvem gir deg informasjon og råd om helse, og hvordan får du denne informasjonen?

10. Hvordan opplever etniske nordmenn tenke om helse?
    - Opplever du forskjeller på hvordan somaliske og norske kvinner snakker og fokuserer på helse?

11. Er religion viktig for deg?
    - Hvilke kulturelle verdier er viktig for deg?
    - Familie/venner

12. Hvordan påvirker religion og kulturelle verdier din velvære?

13. Hvilken betydning har religion og kulturelle verdier for din helse?

C. SIKT APPROVAL

Sikt

Meldeskjema / Perceptions of health and well-being among Somali women in Nor... / Vurdering

Vurdering av behandling av personopplysninger

Referansenummer	Vurderingstype	Dato
854085	Standard	01.08.2022

Prosjekttittel
Perceptions of health and well-being among Somali women in Norway

Behandlingsansvarlig institusjon
Norges teknisk-naturvitenskapelige universitet / Fakultet for medisin og helsevitenskap (MH) / Institutt for samfunnsmedisin og sykepleie

Prosjektansvarlig
Laila Tingvold

Student
Cristina Halvorsen

Prosjektperiode
01.09.2022 - 01.06.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 01.06.2023.

Meldeskjema

Kommentar
OM VURDERINGEN
Personverntjenester har en avtale med institusjonen du forsker eller studerer ved. Denne avtalen innebærer at vi skal gi deg råd slik at behandlingen av personopplysninger i prosjektet ditt er lovlig etter personvernregelverket.

Personverntjenester har nå vurdert den planlagte behandlingen av personopplysninger. Vår vurdering er at behandlingen er lovlig, hvis den gjennomføres slik den er beskrevet i meldeskjemaet med dialog og vedlegg.

VIKTIG INFORMASJON TIL DEG
Du må lagre, sende og sikre dataene i tråd med retningslinjene til din institusjon. Dette betyr at du må bruke leverandører for spørreskjema, skylagring, videosamtale o.l. som institusjonen din har avtale med. Vi gir generelle råd rundt dette, men det er institusjonens egne retningslinjer for informasjonssikkerhet som gjelder.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige personopplysninger og særlige kategorier av personopplysninger om etnisk opprinnelse, helse og religion frem til 01.06.2023.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

For alminnelige personopplysninger vil lovlig grunnlag for behandlingen være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 a.

Behandlingen av særlige kategorier av personopplysninger er basert på uttrykkelig samtykke fra den registrerte, jf. personvernforordningen art. 6 nr. 1 a og art. 9 nr. 2 a.

PERSONVERNPRINSIPPER
Personverntjenester vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen:

- om lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet.

DE REGISTRERTES RETTIGHETER
Vi vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18) og dataportabilitet (art. 20).

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
Personverntjenester legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Ved bruk av databehandler (spørreskjemaleverandør, skylagring, videosamtale o.l.) må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29. Bruk leverandører som din institusjon har avtale med.

For å forsikre dere om at kravene oppfylles, må prosjektansvarlig følge interne retningslinjer/rådføre dere med behandlingsansvarlig institusjon.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til oss ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilken type endringer det er nødvendig å melde:
https://www.nsd.no/personverntjenester/fylle-ut-meldeskjema-for-personopplysninger/melde-endringer-i-meldeskjema

Du må vente på svar fra oss før endringen gjennomføres.

OPPFØLGING AV PROSJEKTET
Vi vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Kontaktperson hos oss: Markus Celiussen

Lykke til med prosjektet!

Sikt

Vurdering av behandling av personopplysninger

Referansenummer
854085

Vurderingstype
Standard

Dato
20.06.2023

Prosjekttittel
Perceptions of health and well-being among Somali women in Norway

Behandlingsansvarlig institusjon
Norges teknisk-naturvitenskapelige universitet / Fakultet for medisin og helsevitenskap (MH) / Institutt for samfunnsmedisin og sykepleie

Prosjektansvarlig
Laila Tingvold

Student
Cristina Halvorsen

Prosjektperiode
01.09.2022 - 15.08.2023

Kategorier personopplysninger
Alminnelige
Særlige

Lovlig grunnlag
Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)
Uttrykkelig samtykke (Personvernforordningen art. 9 nr. 2 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 01.09.2027.

Meldeskjema

Kommentar
Personverntjenester har vurdert endringen i prosjektsluttdato.

Vi har nå registrert 01.09.2027 som ny sluttdato for behandling av personopplysninger.

Vi vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til videre med prosjektet!

NTNU

Norwegian University of
Science and Technology