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European Master in Health and Physical Activity

(Laurea Magistrale Internazionale in Attività Fisica e Salute)
LM 67- I

"Good health and physical activity as understood by immigrant women in Norway – a qualitative study"

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Academic Year 2014-2016

ABSTRACT

Background: The increased migration flow creates changing social situations as well as new challenges within European societies. The health sector is one of several sectors that are affected by the increased number of immigrants. In Norway, little research has been conducted on how health is understood and experienced by immigrants themselves, as well as the role of physical activity to good health, especially within a health promotion context.

Objective: To examine how good health is understood by a group of immigrant women in Norway. Thereby put attention on the concept of health among immigrants with a non-European background. Further look into the role of physical activity in relation to the women's understandings of good health. With that build knowledge of how physical activity possibly leads to subjective understandings and experiences of good health among immigrant women. Lastly, contextualize the findings within a specific health promotion theory by applying the theory of salutogenesis and the asset model.

Method: A qualitative study within the theory of hermeneutic phenomenology was undertaken spring 2016. The sample consisted of 36 women. Data was produced through the use of participant observation, walking interviews and in-depth interviews.

Results: Six themes are identified to describe how the informants understand good health: a positive mindset/attitude, social interaction, meaningful days, family, self-image and identity, a sense of safety and belonging in a local environment. Further, health is understood to be an individual experience, a social phenomenon, multidimensional, holistic, and a process. Physical activity is found to create an arena where the women can build and experience good health. Five themes are highlighted. By applying the findings to the theory of salutogenesis and the asset model, the factors identified to describe good health are understood to be GRRs, and physical activity is understood to increase the immigrant women's SOC.

PREFACE

This paper is my finalizing work as a student of the Master's degree *European Master in Health and Physical Activity*. It is also the concluding part of seven years as a student within first social sciences and then health and physical activity. The focus in this thesis unites interests developed within each of the fields.

The chosen topic is related to a social situation in Europe that is of high relevance politically, socially as well as in academia. With an increased number of immigrants in European countries, the health sector faces new challenges. I believe that scientific studies examining immigrant health can contribute to important knowledge in the process of finding ways to handle these challenges.

I am grateful to all the women who took part in this study, who included me in their groups, shared stories and opinions, and allowed me to explore and learn. It has been of great value, not only for this thesis, but also to me personally. I am also thankful for the positive attitude I was met with by the main tour leader, allowing me to take part in the activities and showing interest in my thesis. I also want to thank my supervisor Dr. polit Gunn Engelsrud for helping me in the process of this research. Through critical questions and comments, she has guided my focus and work. Additional gratitude goes to all those that have supported and helped me in this process. Especially my close family and friends who have been patient with me and been a source of inspiration for me through this work.

Conducting this research has been a process of learning, exploring and experiencing. I have gained valuable insights and knowledge on a topic that is of high significance to our societies today. I believe that this thesis can provide insights useful and meaningful also to other, hopefully stimulate more research in this space and possibly provide knowledge that enables us to handle the changes in our societies in a good way.

Oslo, September 2016

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1. INTRODUCTION

1.1 Background

The choice of study topic and sample in this research is related to a social situation in Europe that is of high relevance politically and socially, as well as in academia. The increased migration flow in the world creates changing social situations, as well as new challenges within European countries and societies. Norway is no exception, and it is likely that the migration situation will continue to be a topic of high relevance within the Norwegian society as it converts from having been a very homogenous society to becoming more heterogeneous. The health sector is one of several sectors in Norway that is affected by the increased number of immigrants. With this in mind, I consider the field of migration health within Norway to be of special significance and interest for my thesis.

A number of studies in Norway have been conducted within the topic of health and immigration (Ahlberg, 2006; Garnweidner, 2013; Gele, Torheim, Pettersen & Kumar, 2015; Straiton, Oppedal, Blystad, Rabanal & Reneflot, 2014), but little research within health has examined the subjective understandings and experiences of health among the immigrant population through the use of qualitative methods. At the same time, clarifying understandings of the concept of health has been argued to be of importance within the health sector, related to a view that health is understood and experienced differently based on our backgrounds and health experiences (Naidoo & Wills, 2000).

Within health research, a majority of studies focus on pathogenic aspects of health (Fugelli & Ingstad, 2014). However, it seems like growing attention is given to health promotion and salutogenic approaches to health within research, health policies and health programs. Within a health promotion perspective, physical activity (from now on PA) is often highlighted as a significant factor, and it is well documented that PA has positive effects on our health (Seippel, Strandbu & Sletten, 2011).

Studies have shown that immigrants in Norway report poorer health (Straiton et al., 2014), and at the same time are less active (Abebe, 2010), compared to ethnic Norwegians. Thus, national reports have highlighted the importance of increasing PA among the immigrant population (Det Kongelige Klima- og miljødepartement, 2016;

Helse- og Omsorgsdepartementet, 2004). While studies in Norway have been conducted on topics related to the immigrant population and sport/PA (Strandbu, 2005; Walseth, 2016; Walseth & Strandbu, 2014), few have examined subjective experiences of PA in relation to understandings and experiences of good health.

With this, I have identified areas within health, health promotion and PA that I consider of importance to examine in my thesis work.

1.2 Objectives and research questions

The aim of this research is to explore understandings of the concept of health within a group of immigrant women. Focus is on good health, and emphasis is on the women's own understandings. My aim is to put attention on the concept of health, understood as a relative concept, as well as immigrant women's subjective understandings and experiences connected to this.

A further aim is to study the role of PA in relation to how the immigrant women understand and experience good health. Thus look into which aspects of PA that is important for good health, according to the women themselves.

An additional aim is to look into how two health promotion theories – the theory of salutogenesis and the asset model – can be applied to the immigrant women's subjective understandings and experiences of good health and PA, and how well their understandings align with the health understandings emphasized in the theories.

With this in mind, I have defined three research questions. The first is the main question, while the two others are sub-questions.

> Research question 1 (RQ1): How is good health understood by a group of immigrant women in Norway?
>
> Research question 2 (RQ2): What is, according to the immigrant women, the role of physical activity (PA) in relation to their understandings and experiences of good health?
>
> Research question 3 (RQ3): How do the immigrant women's understandings of good health and the role of physical activity (PA) align with the theory of salutogenesis and the asset model?

1.3 Content preview

The thesis contains eight chapters, with associated sub-chapters. This introductory chapter, *Chapter 1*, sets the agenda for the thesis as a whole and introduces the reader to the topic and objectives. In the following *Chapter 2*, a further and more thorough introduction to the background and topic of the research is presented. This is relevant for understanding the context of the study, and the content of the report. *Chapter 3* provides a description of the salutogenic theory and the asset model, both being health theories relevant in this study. *Chapter 4* lays out the methodology and method of the current study. This chapter will provide the reader with an insight into the research process, with related choices that I have made. In the following chapter, *Chapter 5*, the field and its participants are described in detail. This gives relevant information on the setting of the study, and prepares the reader for the empirical findings, which is presented in *Chapter 6*. Reflections and discussions of the empirical findings are covered in *Chapter* 7, and as part of this other literature and theory is connected to what has been found through the analysis. This chapter also contains limitations and challenges, as well as strengths, of the study. In the last and final chapter, *Chapter 8*, I will provide some concluding remarks.

2. RESEARCH TOPIC AND BACKGROUND

The aim of this chapter is to provide information on the overall framework that has guided the research process, and provide insights into aspects that have played a central role in forming the study. The chapter starts with information on the immigrant population in Norway, as well as a presentation of research that has been conducted on the field of immigration and health, and immigrants and PA, within Norway. It continues with a presentation of the point of departure in regard to my own background and influence. The following subchapter includes a presentation of the key concepts, while the last sub-chapter provides an introduction of the philosophical approach and framework of this thesis.

2.1 Immigrants in Norway – basic knowledge

The term immigrant refers to people that are born outside of Norway by non-Norwegian parents and with non-Norwegian grandparents (Statistisk Sentralbyrå, 2016). This thesis focuses on immigrants of non-EU/EEA- and non-North American background. The total number of immigrants living in Norway today is 700 000. This represents 13,4% of the Norwegian population, and the number is expected to increase (Statistisk Sentralbyrå, 2016). Norway is a country that has gone from being a more or less homogenous society to become a multicultural society in only 50 years.

The migration flow creates opportunities, but also challenges. Research can in this situation play a central role, as it can lead to crucial understandings and findings relevant for policies and programs. There has been a growing amount of research on immigrants in Norway. In relation to health and immigration specifically, it seems like research has especially concentrated around health challenges and diseases, with a so called Western medicine approach. Based on studies, some general trends among immigrants of non-EU/EEA- and non-North American background have been found. This specific immigrant population is more prone to a number of lifestyle related health challenges than ethnic Norwegians (Ahlberg, 2006; Den norske legeforening, 2008; Straiton et al., 2014), and overall, immigrants in Norway report poorer health compared to the majority population in Norway (Straiton et al., 2014). Immigrant women have reported to have more health related challenges than immigrant men (Blom, 2011). We know little about psychological health among immigrants, but numbers from 2002

(Straiton et al., 2014) showed that more immigrant women than immigrant men reported to have psychological health problems.

Despite these findings, it has been argued that the knowledge we have of immigrant health in Norway is relatively poor (Ahlberg, 2006). With rapid changes in the immigrant situation, the studies are outdated in addition to reporting low participation rates, and data collection has mainly relied on self-reported questionnaires (Abebe, 2010; Ahlberg, 2006; Straiton et al., 2014). A majority of the health related studies are of quantitative form, with some exceptions like the work by Goth and Berg (2010), Garnweidner (2013), and Gele, Torheim, Pettersen and Kumar (2015).

When it comes to PA among immigrants in Norway, one can see that the area of study has received growing attention within academia. Quantitative studies show that immigrants take less part in PA compared to ethnic Norwegians (Abebe, 2010). Studies have also found that immigrant women are less physical active than immigrant men (Abebe, 2010; Helse- og Omsorgsdepartementet, 2013). Within the field there has also been a growing amount of qualitative studies, seen through the increased number of studies of this type that have been published in the last 15 years. Among them are studies by Walseth (2006, 2008, 2016), Walseth and Fasting (2004), Strandbu (2005), Walseth and Strandbu (2014), and Seippel, Starndbu and Sletten (2011). A majority of these studies look into sport and/or exercise, focus is often on young people, and topics have included focus on integration and participation, among others. Only some research has been conducted on outdoor recreation activities, and while national policies and papers emphasize PA and outdoor recreation activities to be central for health (Det Kongelige Klima- og miljødepartement, 2016; Miljøverndepartementet, 2009), this is seldom backed with references to research (Dervo et al., 2014; Kurtze, Eikmo & Hem, 2009).

Despite a growing number of studies on the immigrant population in Norway, there is still a lack of qualitative studies within migration health, and it is relevant to broaden the focus so that not only pathogenic approaches are used in health research. Within PA, there is still a need for more qualitative research, especially studies that look into low threshold PA and the use of outdoor recreation activities as compared to sport and exercise. These should further focus on how PA is experienced by the immigrants,

particularly in relation to health and wellbeing, and in addition include participants of different ages. I have not identified any Norwegian studies that explore subjective definitions and understandings of health among the immigrant population with a qualitative approach, nor have I identified studies that research the role PA might play for immigrant women's good health. These are therefore areas of research that is relevant to look further into.

2.2 My point of departure – background and influential literature

In addition to considering the chosen study areas as highly relevant within the Norwegian political, social and academic context, I also chose my focus and approach based on personal interest and the influence of one book in particular. I considered it relevant to present this briefly, as it has played a central role in the development and conduction of the research.

My educational background is from social sciences and from studies within PA and health. Through my years as a student I have developed a special interest in public health among special groups. It is especially immigrants that have become a focus area, and my interest has led to projects and work in relation to immigration and integration in the Norwegian society. Through this, I have experienced a group of people that faces challenges and obstacles concerned with health and wellbeing in the Norwegian society, but on the other hand that find ways to cope and create new lives despite these challenges. Additionally, I have observed how immigrants are introduced to "Norwegian" health promotion thoughts in different health promotion settings. These observations and experiences have made me curious about how the immigrants themselves define good health, what role PA might have in this, and also the relationship between understandings of good health and the salutogenic approach to health, which plays a role in most health promotion policies and projects (WHO, 1986). I consider knowledge of these aspects within health research relevant for development and implementation of health promotion projects.

What really sparked the idea for my research project and thesis was the book "Helse på norsk. God helse slik folk ser det" (directly translated: "Health in Norwegian. Good health as people see it") published in 2014 by Per Fugelli and Benedicte Ingstad. The

book is based on a qualitative study including 80 in-depth interviews, and the authors discuss how good health is defined and understood by common people in Norway. In contrast to earlier research on this topic, where focus often was on how health is defined by experts within the health sector (Fugelli & Ingstad, 2014), the authors highlights the relevance of instead asking the so-called "man in the street". The book introduced me to an approach within health research that I had not seen before, exploring health definitions in light of subjective experiences and perceptions, and outside of the traditional pathogenic approach that is seen in much of the health research that is conducted. I consider Fugelli and Ingstad's (2014) approach to be both relevant and interesting.

There are three factors, highlighted by Fugelli and Ingstad (2014) as important for further research, that has played a special role in this study. First, the two authors state that there has been, and is, too much focus on quantitative studies within health. They find (good) health to be primarily an individual phenomenon and therefore see the need to incorporate more qualitative studies in this field of research. Second, Fugelli and Ingstad argues that there is too little focus on salutogenic approaches to health within health research. This is a limitation that needs to be confronted, according to them, as it influences both academic focus and practical health promotion work. Third, the authors highlight an important limitation of their own research: their work only included ethnic Norwegians, and further studies should therefore look at other groups in the Norwegian society.

This study replies to these recommendations, as I consider these three factors as relevant and important for research on the chosen topic. I do this by conducting a qualitative study, within a health promotion context, and by exploring health understandings among immigrant women and a possible relation between the understandings of good health and the theory of salutogenesis. (I additionally include focus on PA).

2.3 Presentation of key terms, with special focus on the concept of health

Defining which concepts that are key in a study, and be clear on their meanings within the specific context of the study, is considered relevant when conducting a research. In this section, four concepts are highlighted. These are considered the main concepts of

the research and are central terms in the research questions or related to the specific setting in the study. Three of the concepts – PA, outdoor recreation activities, and health promotion – are only briefly described, while the concept of health is presented and discussed in more detail. This because the concept of health plays a central role in this study, and additionally is a complex concept to define.

2.3.1 The mysteries of the concept of health

It is relevant to first look into *why* health is interesting, but also challenging, to define, and then *how* I understand health, as this influences the perspective on health throughout the study.

Health has been described as one of the greatest mysteries in life (Antonovsky, 1979). Gadamer has pointed out that as opposed to a focus on illness, "…we must address the fact that the real mystery lies in the hidden character of health" (Gadamer, 1996, p. 107). There is no way of measuring health objectively (Gadamer, 1996), and we do not have one globally agreed definition of health (Naidoo & Wills, 2000). At the same time, health is a concept that concerns everyone (Gadamer, 1996). It is also a concept that is widely used (Fugelli & Ingstad, 2014). Despite this, it is a concept that the majority of us just take for granted in our communication without further reflection (Engelstad, 2003), and we use the term health without giving much thought to its meanings (Mæland, 2010). Considering this, health is a term that is relevant to give attention and study in relation to how it might be defined by different people and in different settings. However, there are several challenges connected with a search for a definition of health.

Health is a term that can be understood in several ways depending on the context and aim of the definition. For example, it is likely to be defined differently within different sectors in the society, as described by Kleinman (as cited in Fugelli & Ingstad, 2014); among people (the popular sector), in the expert sector (or professional sector), and in the folk sector. It is also likely to be defined differently at the individual level, the interpersonal level, organizational level, community level, and public policy level (Naidoo & Wills, 2000). Further, the health concept can be understood either in theoretical terms or in practical terms, as an active or passive definition, and as subjective or objective (Hugaas, 2004). It can be seen as a state of being or as a process,

a diagnosis, a goal, or a task (Hugaas, 2004). This implies that health is a relative and diverse term that can be understood very differently depending on the context.

There is one further, and central, challenge that should be mentioned: Health is first and foremost an experience (Fugelli & Ingstad, 2014). Transforming a bodily experience into a written term is impossible without loss of meaning (Fugelli & Ingstad, 2014). While our lives, and bodily experiences, are unambiguous, always in movement, and a mixture of feelings and experiences, a term is clear, solid and defined by an either-or perception (Fugelli & Ingstad, 2014). This should be kept in mind when studying experiences and perceptions of health, and when searching for understandings and definitions of the term health. As a researcher one needs to be humble to the complexities of the concept, and in the process of recreating bodily experiences into solid definitions. I nevertheless consider it as relevant, and possible, to search for understandings of good health. A prerequisite for this is that a defined understanding is conceived as only one possible way of understanding the concept, and further considered a tool that can help us structure and organize the complex concept (Engelstad, 2003). The importance of searching for understandings and definitions of (good) health are related to how this is, by me, considered helpful when communicating about (good) health in a health promotion context.

2.3.2 My (pre-)understandings of health

Health in this research is understood as a cultural and social phenomenon. I believe that health and understandings of health are influenced by socialization into the culture(s) and society we are part of (Horntvedt, 1996; Hugaas, 2004; Magelssen, 2002; Naidoo & Wills, 2000). This is one of the reasons why I find it relevant to examine what kinds of perceptions and definitions of health a specific group of immigrants within the Norwegian society have.

Furthermore, I understand health as a subjective experience that is felt and experienced differently by each individual (Fugelli & Ingstad, 2014). I understand the concept of health as developed in a specific context, and it should not be considered value-free (Mæland, 2010). The meaning(s) of health are therefore not universal, but relative (Fugelli & Ingstad, 2014). This has made it important for me to do a qualitative study focusing on each participant as a unique individual.

Influenced by a salutogenic approach (which is described in more detail in the next chapter), health is considered by me as a process (Hugaas, 2004), and it should not (or cannot) be defined by dichotomies (Fugelli & Ingstad, 2014). Further, I believe that health should be perceived in wide terms (Naidoo & Wills, 2000): it is multidimensional, diverse and complex, and builds on a series of different experiences and feelings. With this, it is important for me to let the participants themselves share their own understandings of health.

2.3.3 Physical activity and outdoor recreation activities

PA (physical activity) is a term that is central in RQ2 and plays an important role in the setting of the study. It is commonly defined as: "any bodily movement produced by skeletal muscles that requires energy expenditure" (Caspersen, Powell & Christenson, 1985), and will in this study include walking/hiking and cross-country skiing. While PA is understood as a bodily movement, it is in this study relevant to look into how PA within a specific context is experienced by the sample, and how these experiences influence understandings of good health. With this, PA (bodily movements) will be studied within a broader context than solely the physiological aspects.

Walking/hiking and cross-country skiing are activities that are defined as *outdoor recreation activities*, and part of this research's context. The term refers to activities in the outdoors that take place during leisure time (Det Kongelige Klima- og miljødepartement, 2016). This type of activity plays an important role to many Norwegians (Dervo et al., 2014). First, it is widely recognized to be good for both physical and mental health (Dervo et al., 2014; Det Kongelige Klima- og miljødepartement, 2016), and it is promoted as part of the government's public health promotion work (Det Kongelige Klima- og miljødepartement, 2016). Its positive effects on health is for most Norwegians taken for granted and not questioned, although it is seldom backed by research (Dervo et al., 2014; Kurtze et al., 2009). Second, outdoor recreation activities play a central role in the Norwegian culture and Norwegian identity (Tordsson, 2010).

2.3.4 Health promotion

Health promotion plays a central role in the study's context as a whole and is therefore considered a key term. It is within a health promotion perspective that the research

questions are asked and the study takes place within health promotion activities. Health promotion as a descriptive term implies a positive view on health, focusing on people's resources and capacities (WHO, 1986). It is characterized by an ecological approach, meaning that health is considered to be part of, developed or influenced by several levels and sectors in society (WHO, 1986). Based on this, it is relevant to study health also in contexts that do not belong to the "traditional" health sector. In this study, health is studied within a health promotion context where focus is on PA in an outdoor recreation setting. The theory of salutogenesis is central within health promotion. This theory is described in detail in the next chapter.

Through this section, information on key constructs of the research has been presented and described. By doing this, I have highlighted aspects in the research that are significant for understanding the study process and thesis. In the final section of this chapter, an introduction to the overall and philosophical approach to the study is presented. This will further contribute to contextualize the research and thesis.

2.4 Philosophical perspective and framework

This section includes some of my overall understandings and perspectives that are central to how the aims were developed and how the study topic has been approached throughout the thesis project. The understandings that are presented below are highly influenced by a theory of hermeneutic phenomenology. While this theory has both philosophical and more methodological aspects to it, merely the most central philosophical aspects are described below. Work by van Manen (1990) has been of special influence in connection to the philosophical approach. The aspects closer related to the methodological process are presented in chapter 4.

As described earlier in this thesis, an overall aim of this study is to explore a human phenomenon (health) and through this develop a better understanding of the concept of health. This is in line with a hermeneutic phenomenological approach, which highlights the relevance of coming to deeper understandings of human phenomena (van Manen, 1990), and thus come to a fuller grasp of the lives people live. Central in this is to seek (hidden) meanings behind activities, experiences, opinions and symbols; to look for the deeper meanings behind the obvious (van Manen, 1990). Health is, as described, a term that is widely used but seldom reflected on and defined (Mæland, 2010). PA, on the

other hand, is by me seen as a concept that is often described in terms of measures, visible physiological aspects or in connection to factors taken for granted (like that PA is good for your health). I therefore consider it significant and interesting to seek meanings behind the obvious in these specific study topics.

Within hermeneutic phenomenological studies, it is often the everyday setting, or everyday experiences and life world, that is in focus (van Manen, 1990). The point of departure in this study is activities that are central in the everyday life of the sample. Additionally, good health is explored as a phenomenon that is part of the participants' everyday life – not as a phenomenon that is only relevant in times of illness. Within this perspective, the focus is on the uniqueness of the specific setting of this study and the uniqueness of the opinions and experiences of the individuals that participate (Kafle, 2011). This is in line with a hermeneutic phenomenological approach which highlights the relevance of exploring people's subjective experiences as well as taking into account the specific setting of these experiences (Kafle, 2011; Magelssen, 2002). Based on this, I have put an emphasis on describing the setting of the field as this will contextualize the findings. This is done in chapter 5.

Pre-understanding is a concept within hermeneutic phenomenology that is worth mentioning. This refers to the understandings one has and which is based on one's background and experiences (van Manen, 1990). It is believed that one cannot put these aside, but rather that they are part of who you are and will influence the study (Wilcke, 2002). Based on this it is argued that it is important to openly reflect on, and explicitly state, my prejudices, as well as describe the point of departure for my research (Wilcke, 2002). With this in mind, it has been important in this thesis to put emphasis on being open about and describing the overall framework and context of the research, as well as my own pre-understandings. Through this chapter, I have introduced my point of departure and background, and described my own understandings of health (my pre-understandings). This contextualizes the study and gives a framework to anchor the presentations, descriptions and discussions in the following chapters of this thesis. The context of the field is presented in chapter 5, and the methodological framework is described in chapter 4.

3. THEORETICAL PERSPECTIVES - HEALTH PROMOTION THEORIES

The aim with this chapter is to present the salutogenic theory and the asset model. An insight in, and understanding of, these are of importance in relation to the health approach in this thesis, and further the interpretations conducted in relation to RQ3. The chapter starts with a presentation of the theory of salutogenesis, before the asset model is described. Concluding the chapter, I explain how these two theories are combined in this study.

3.1 The salutogenic theory

The theory of salutogenesis was developed by Aaron Antonovsky in the late 1970's. Since then it has become an established and well known theory within health promotion and public health (Foot & Hopkins, 2010). It set the stage for a different view on health, seeing health in positive terms rather than within the traditional pathogenic approach (Antonovsky, 1979). Two key questions within the theory of salutogenesis is: "what generates health?" and "what makes us move in the direction of health?" (Lindström, n.d.).

According to Antonovsky, we should move away from the ill/healthy-dichotomy, and rather see health as a movement between two axis; ill health (dis-ease) and total health (ease) (1979). Health is therefore, according to Antonovsky, not an either/or concept, but a dynamic process and movement on a continuum (as cited in Bonmatí-Tomás et al., 2016). The emphasis is put on how one can move towards ease (total health), instead of preventing to get closer to dis-ease (ill health) (Lindström & Eriksson, 2005). Two key constructs were identified by Antonovsky: sense of coherence (SOC) and general resistance resources (GRRs) (1979).

3.1.1 Constructs of the salutogenic theory

Lindström and Eriksson (2005, p. 440) define SOC as the "ability to comprehend" your life situation and the "capacity to use the resources available" to move towards good health. SOC can further be understood as a feeling or confidence of being in control of one's own environment and being capable of tackling the demands one meets in life (Lindström & Eriksson, 2005). It is made up by three elements: comprehensibility,

manageability, and meaningfulness (Lindström & Eriksson, 2005). Comprehensibility refers to a perception of the world (one's external and internal environment) as ordered and consistent, and is the cognitive component of SOC. Manageability is the behavioral component, and refers to a feeling of having the needed resources to meet demands posed in life. The last element, meaningfulness, describes the emotional or motivational aspect of SOC and is related to a sense of meaning in life (Antonovsky, 1979).

SOC is not culture-bound (Antonovsky, 1996), but developed through life experiences, and influenced by the environment one is part of (Naidoo & Wills, 2000). Factors like being part of a social network, and experiencing one's everyday life as meaningful are examples of aspects of life that will strengthen the person's SOC (Lindström, n.d.).

The second construct, GRRs, describes the resources that are available for moving towards ease at the health continuum, but importantly also what resources a person is able to identify and take use of (Lindström & Eriksson, 2005). It encompasses biological, material and psychosocial factors, such as social support, religion and knowledge, among others (Lindström & Eriksson, 2005). A person's SOC influences the ability to identify and take use of the available resources, while the use of resources influences the person's movement on the health continuum (Antonovsky, 1979).

3.2 The asset model

The salutogenic approach to health has influenced a series of other health theories and health concepts (Lindström, n.d.), one being the asset model (Morgan & Ziglio, 2007). The asset model was developed by Antony Morgan and Erio Ziglio, based on a salutogenic and health promotion approach to health (Bonmatí-Tomás et al., 2016; Morgan & Ziglio, 2007). According to Morgan and Ziglio (2007), the model seeks to build "a more systematic approach to collecting and synthesizing evidence based on the theory of salutogenesis". The basic principles of this model is shared with that of the theory of salutogeniesis (Bonmatí-Tomás et al., 2016; Foot & Hopkins, 2010).

Assets are at the core of the model, and are defined as "any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being" (Foot & Hopkins, 2010, p. 7). Assets can be identified at an individual level, a community level and on an institutional level (Bonmatí-Tomás et

al., 2016). An asset is closely related to the GRRs of the salutogenic theory (Bonmatí-Tomás et al., 2016).

The theory of salutogenesis and the asset model are two theories both within health promotion. They are closely related, linked and in great accordance with each other. In this research, the asset model are incorporated into the salutogenic approach, and GRRs and assets are looked at as a combined concept, as has also been done by others (Bonmatí-Tomás et al., 2016).

4. METHODOLOGY

The purpose of this chapter is to provide information on the methods chosen for the study, including the methodological circumstances, considerations and decisions. The aim is to be open and transparent about the process, which has earlier in this thesis been highlighted as important, and through that provide necessary information for a good understanding of the research process and further for a critical evaluation of the study. Seven topics are presented in this chapter: 1) research strategy and scientific theoretical framework, 2) literature search and main literature, 3) selection of field and sample, 4) data production methods, 5) transcription and analysis, 6) the quality of the study, and lastly 7) ethical considerations.

4.1 Research strategy and related scientific theoretical framework

The research strategy explains the overall approach to the research process, and provides the background for the methodological choices. In this study I considered a qualitative approach to be the most relevant. The background for this consideration is described in this sub-chapter.

Ontology is concerned with the study of reality and existence (Kafle, 2011). From my perspective, reality is not external to individuals, but instead context-bound and constructed by individuals. This further implies a view on realities as multiple; according to my own views, there is no *one* and universal reality and truth for all (Kafle, 2011). Epistemology is concerned with the theory of knowledge and the methods of getting to this knowledge (Laverty, 2003). My position is that knowledge can be created through subjective experiences, and not only through what is considered objective methods. With this, knowledge is seen as value-laden, and developed through human activity. For this research, it also means that production of knowledge is influenced by my own position as a researcher. My ontological and epistemological perspectives (part of my pre-understandings) were reflected on previously to the research, and this was part of the process of choosing the research strategy as well as the scientific theoretical framework of this study.

In the current study, the hermeneutic phenomenological theory was considered to be the scientific theory most in line with my own beliefs and values, as well as my ontological and epistemological perspectives. Hermeneutic phenomenology is an interdisciplinary theory (Wilcke, 2002) where hermeneutic refers to interpreting (Holroyd, 2007) and phenomenology refers to studying and describing a phenomenon (van Manen, 1990). In this study, both descriptions and interpretations interchangeably play a central role. They are part of, and influence, each other, which in this study means that all my descriptions are also partly interpretations, and further that all interpretations also entail describing. As mentioned in chapter 2, a main focus within the theory – and in this study – is to search for the hidden or deeper meanings of human phenomena (Kafle, 2011).

Through the research questions, I seek knowledge developed by human beings, and on a topic concerning realities of a specific group within the society. Further I am interested in personal experiences, opinions, attitudes and thoughts. With this, it was clear to me that a qualitative approach would define the research strategy and methods chosen for the study. With a qualitative design, it is possible to study human experiences, produce knowledge based on subjective opinions, and take use of both description and interpretation in the process of coming to scientific understandings of a phenomenon (Grimen & Ingstad, 2006; Malterud, 2003; Meadows, Thurston & Melton, 2001).

My methodological choices, presented in the following sub-chapters, should be seen in light of those aspects of the research strategy described in this section.

4.2 Literature search and main literature

A literature search and, further, use of relevant literature is central for developing and conducting a research. A description of the literature research process is considered part of the methodological process and is described in this chapter. With this, a brief introduction to the main literature is also provided.

4.2.1 Literature search

In the present study, the search was not structured, but still thorough. I started with reading literature I already knew of, searching further by looking into literature referenced in these studies, and in addition searching recommended literature databases.

I mainly used Web of Science as the main database. In addition, I used Oria, a Norwegian searching tool for students, and PubMed. Literature search was conducted as part of the preparation for the research, but also throughout the research process. I searched for literature on immigration and health (use of different combinations of these words: migration, health, immigrant, immigrant women, health promotion, definitions of health, understandings of health), on PA and outdoor recreation activities (physical activity, low-threshold physical activity, hiking, walking, cross-country skiing, outdoor recreation activity, immigrant, immigrant women, immigration, integration, health), and on the theory of salutogenesis (salutogenesis, salutogenic, assets, health promotion, immigration, immigrant, immigrant women, health).

4.2.2 Main literature

A central source for information on understandings of health in Norway has been the book "Helse på norsk. God helse slik folk ser det" by Fugelli and Ingstad (2014). This book was known to me before the research. As it was presented in chapter 2, it will not be further described in this part of the thesis. However, the findings of the study are presented and discussed in chapter 7, as part of the discussion of the findings of this study.

The literature searches that were conducted gave few results directly linked to the topic and approach of this study, and of recent date. Nevertheless, three studies were identified as of special relevance. These included one from Sweden (Lundberg, 1999), one from Spain (Bonmatí-Tomás et al., 2016) and one from Canada (Meadows et al., 2001). All of qualitative design, including only immigrant women, and studying health perceptions and experiences within a health promotion framework or approach.

The searches did however result in a number of articles within the topics of immigration and health, and immigration and PA/sport more generally, which had other focus areas and/or approaches than my study. Among these, I chose to look into those studying the Norwegian situation in particular. The studies mentioned in chapter 2.1 are among these. These articles were mainly used in the preparation of the study and fieldwork, and are therefore not specifically mentioned in the discussion of this thesis. I considered it more relevant to look at the findings of this study in comparison to those three articles identified with similar focuses.

In addition to articles found through literature search on databases, I have also taken use of different Norwegian reports on the theme of health, PA and outdoor recreation that I know of (Dervo et al., 2014; Det Kongelige Klima- og miljødepartement, 2016; Krange & Strandbu, 2004; Miljøverndepartementet, 2009), both in my preparation and in the discussion.

When it comes to literature on the philosophical approach, work by van Manen (1990) has been central. In addition, other articles discussing the theory of hermeneutic phenomenology, especially one by Kafle (2011), another by Wilcke (2002), and a third by Laverty (2003) have also been used. These authors refer to Heidegger and Gadamer as central for the development of the hermeneutic phenomenological theory. For the health related theories of salutogenesis and the asset model, work by Antonovsky (1979) and Morgan and Ziglio (2007) respectively have been used. Work by Fangen (2010) and Brinkmann and Kvale (2014) have been important for the methodological process. These two have together influenced me and provided useful and necessary steps and structures to follow. Fangen (2010) has especially been central for the observation process and for structuring the overall analysis through the whole research process, while Brinkmann and Kvale (2014) have been used for interviews and for providing stages to follow for conducting the interpretations of the produced data material after the field work.

4.3 Selection of the field and sample

4.3.1 Selection process

I chose the field based on three criteria: 1) possible access to the wanted sample, 2) inclusion of activities defined as health promotion activities, and 3) inclusion of outdoor recreation activities. The specific field was found and chosen after active outreach to a set of organizations in my network. The chosen field consisted of three different activities: cross-country skiing, hiking and walking. I participated weekly in one or two of these activities over a period of one and a half month.

Considering the selection of participants, my initial aim was to include four to eight informants in the study based on a strategic choice and the chosen inclusion criteria. This meant that all informants had to be: 1) woman, 2) defined as an immigrant according to the definition of Statistics Norway (Statistisk Sentralbyrå, 2016) and in

addition be born in a non-EU/EEA and non-North American country, 3) be between the ages of 20 and 65, and 4) take part in the relevant activities of the research.

As the observations started, I found it difficult to only include four to eight of the women taking part in the activities. This was part of an acknowledgment that all the women in the activities contributed to, influenced and shaped the research. Based on this, I decided to include all the women as informants in the study. All women fulfilled the inclusion criteria.

This decision led to 36 informants in total. All 36 were part of the observations, but only 15 were interviewed. All the 15 women were interviewed through the use of so-called walking interviews. In addition, three were interviewed in depth. The three women that were interviewed in depth are considered to be the study's key informants.

My selection of the 15 women was not structured, but based on possibilities within the activities. However, the three key informants were strategically selected out of the 15 women that were interviewed. The selection was done after four weeks in the field, which made it possible to select women that represented different ages, life situations and cultural background. With 15 walking interviews and three in-depth interviews, I experienced that similar information was revealed. I therefore considered saturation to have been reached.

4.3.2 Presentation of the sample

Looking at the group of participants as a whole, a majority of the women came from the Middle East and Asia – mainly from Turkey, Iran, Kurdistan, Pakistan and India. Eastern Europe, Africa and South America were also represented. The women had left their countries for very different reasons and time in Norway also varied greatly. Ages ranged from 26 to approximately 60, but a majority was between 30 and 50 years old. Of the key informants, age varied between late 20's, mid 30's and early 50's. One lived with her parents and siblings, had no husband and no kids. Another lived with her husband and two school-age children. The third lived on her own, had no husband, and had grown up children. None were at the moment in permanent work.

4.3.3 Access to the field and informants

Access to the field and informants was attained through an employee (later in the thesis referred to as tour leader) at the outdoor organization selected for the study. She became a "door opener" to the field and informants (Johannessen, Tufte & Christoffersen, 2010). It was through this woman that all agreements about my participation were decided. The employee was positive to the study, and gave me full access to take part in all activities that I found relevant. As this woman (an immigrant herself) was respected and trusted by the other immigrant women, her acceptance of the study and the research method also made the participants positive to my presence and work. All women said yes to take part in the research.

My gender was another factor central for access to the field. As a woman, I could take part in all activities and act as a member of the group in the same way as the participants. A man would most likely not have been allowed to take part in all the activities. In addition, I was trusted with information that the women would possibly not have shared with a man.

4.4 Data production methods

In this study, my focus has been on *producing* data together with the informants in the specific context of the study. Two different methods that would make this possible was chosen: observation and interview.

4.4.1 Observation

Participant observation is a research method often used in qualitative studies. There are several advantages to this technique. The first of two aspects considered to be of most importance in this study was the possibility to get an insight into the natural setting of the studied field (Johannessen et al., 2010; Lundberg, 1999), and through that achieve an enhanced understanding of the setting, the participants, and the complexities and depth of the studied field and topic (Johannessen et al., 2010; Lundberg, 1999). The second advantage of significance was related to how participant observation gave opportunities for building a relation with, as well as trust from, the informants (Fangen, 2010). This gave me access to personal opinions, feelings and stories that would otherwise possibly not have been shared by the women. As a central aim in this research was to produce data together with the women, and rely on personal and subjective

opinions, feelings and experiences for further interpretations, my access to the women's own stories were crucial.

Writing field notes is an important part of the production of data material when using observation as a method (Fangen, 2010). I saw it as useful to create routines for note taking, to ensure the quality of the notes (Fangen, 2010). As part of the routine, I took notes straight after each activity using keywords and short sentences. Descriptions, thoughts, impressions – everything was included in these notes. The routines further included a more thorough note taking on the same activity maximum two days after it had taken place. This was based on the first notes, as well as my memory.

4.4.2 Interview

Interview is another much-used technique for collecting and producing qualitative data (Johannessen et al., 2010). It is the only method that can bring forward the participants' own personal experiences, opinions and feelings (Brinkmann & Kvale, 2014). Based on this, interview was crucial in this study and my main method for producing data, as a central aim has been to examine the informant's own understandings, definitions, perceptions and experiences. Two forms of interviews were conducted: walking interviews and in-depth interviews.

In conjunction with the observation, I took use of what has been called *walking interviews* (Clark & Emmel, 2010). This method both complement, and draw from, observations and traditional interviews (Carpiano, 2009). In short, it is an interview that takes place while walking. An important reason for deciding to use this method, was that it would be possible for me to place the experiences and narratives told by the immigrant women in the context where it was experienced (Clark & Emmel, 2010). An additional advantage was that the method is flexible and can be tailored to fit the need of the study (Carpiano, 2009).

The walking interviews took form as semi-structured interviews. The participants more than willingly talked, only led by follow-up questions from me. The topics often developed around the physical context or the activity we were part of, which confirmed the relevance of using walking interviews.

While the walking interviews resulted in important and relevant data, a limitation to the method was the lack of opportunity to go in-depth. Therefore, I selected three key participants and asked them to meet for separate in-depth interviews. Beforehand, a generic interview guide (appendix F) with topics and key questions was prepared to support me during the interviews. I saw it as important to create informal, semi-structured interviews where the informants were given the opportunity to lead the conversation.

I asked open-ended questions and encouraged the women to tell about their own experiences and perspectives. At times I followed up with concrete questions to clarify or verify that I had understood correctly (Brinkmann & Kvale, 2014). Based on the wishes of the informants, the interviews took place on a café in the city center.

All interviews were recorded, and notes were taken straight after the interviews finished (for the in-depth interviews). The recording was in agreement with the participants.

4.5 Transcription and analysis

After the data production phase, I continued with transcription and analysis. Through this work, I was able to create an analytical distance to the field and the informants, which enabled me to go in depth in the material that had been produced.

4.5.1 Transcription

Limited time and resources led to a decision of transcribing all three in-depth interviews verbatim, as well as those parts of the other material that I considered directly relevant to the research questions. This included most of the walking interviews, as well as conversations between the women directly related to health and/or PA. Those parts I did not transcribe verbatim were instead taken notes from. This included general conversations during the activities not related to health/PA.

While the compromise might have led me to miss relevant data, the work on the raw data was considered thorough and strong, and I therefore believe that this did not cause a problem for the quality of the analysis and findings.

4.5.2 Analysis

Analysis refers in this thesis to both the process of ordering and structuring the produced data material, and to the process of interpreting which involves attaching meaning(s) to the analysis (Brekke, 2006; Grimen & Ingstad, 2008). In this study, my process has been characterized by being dynamic, continuous and circular. This is within hermeneutic phenomenology referred to as the hermeneutic circle (van Manen, 1990). It has meant that the analysis has been part of the whole study process, that it has included working on different levels, and further that it has evolved by me going back and forth between looking at the wider picture and the smaller details. Within the theory of hermeneutic phenomenology there is not one standard method for how the analysis should be conducted, but instead different structures or paths that can be used (van Manen, 1990). Paths chosen for this specific study include a combination of a three-degree interpretation process (Fangen, 2010) and a five-stage interpretation procedure (Brinkmann & Kvale, 2014). The three-degree interpretation process has its basis from work by Fangen (2010), and has in this research been used for structuring and describing the overall process of analyzing. The five-stage procedure has been used as recommended by Brinkmann and Kvale (2014), and it has guided the process of attaching meaning to the produced data within one of Fangen's (2010) three levels. In the following sections, these different parts of the analysis are described in more detail.

4.5.3 Fangen's three degrees of analysis

The analysis of this study can be divided into three different "degrees", as according to Fangen (Fangen, 2010). First-degree interpretation involves describing what is being observed. I mainly relied on my field notes in this first stage of the analysis, and focused on describing as true to the experiences of the participants as possible. Chapter 5 is a presentation of the context of the field, and is considered to be the main part of the first-degree interpretation. Second-degree interpretations involve interpreting what the produced data (possibly) mean. In this level I have interpreted the observed (mainly the transcribed texts) and attached meanings to the data. How this was conducted is described in the next section, while the results of this process is presented in chapter 6 (empirical findings). Through the last interpreting-level, the third-degree interpretation, I have applied theory to the findings and further critically reflected on the results. This is presented in chapter 7 (discussion).

4.5.4 Brinkmann and Kvale's five-stage analyze procedure

I consider it necessary to describe in more detail the second-degree interpretation, which involved examining and attaching meaning to the produced data. I followed a procedure recommended by Brinkmann and Kvale (2014), including five stages of structuring and interpreting produced data material.

In this specific part of the analysis, my focus was on data produced through the interviews. I considered this data to be the most relevant in relation to the research questions, as it was through the interviews that information on the participants' own subjective experiences, perceptions, opinions, definitions and understandings was received. Data from both interview methods were gathered and analyzed together.

My first step of the second-degree interpretation, as in line with the recommended stages by Brinkmann and Kvale (2014), was to read through all the material (transcription and notes), and get a general overview and understanding of the whole. While doing this, I also wrote down key words and thoughts that came to my mind. The second stage included identifying meaning units; key words/sentences categorized and grouped into sub-categories (Brinkmann & Kvale, 2014). In stage three I took a wider perspective to define overall themes based on the more detailed meaning units (Brinkmann & Kvale, 2014), a process of relating the sub-categories to broader categories. This stage led to six themes for RQ1 and five themes for RQ2. The fourth step included looking at the meaning units and themes specifically in relation to the overall aim of the research (Brinkmann & Kvale, 2014). In this part of the interpretation I identified five themes for RQ1, and two overall concluding remarks for RQ2. The fifth and last stage included a process of bringing together the findings with the theory, and with that conduct the interpretation specifically related to RQ3. It further included reflecting on the findings in relation to other literature as well as with an overall perspective. This stage is connected to the last degree of interpretation (third-degree interpretation) according to Fangen (2010).

The process of analyzing produced data has been thorough. It is nevertheless important to have in mind that all analysis leads to simplifications of the reality (Brekke, 2006). The presentation of the study setting (first-level interpretation), the attachment of meanings to the produced data and through that categorization of data into themes

(second-level interpretation), and lastly a critical reflection of the findings (third-level interpretation) reflect my priorities and focuses, as well as understandings and interpretations. I nevertheless consider the results of the analysis to represent the informants' own experiences and perceptions.

4.6 Quality of the research

Validity, reliability and generalization are criteria used to evaluate the different processes and findings of a research project (Johannessen et al., 2010). The traditional meanings of the terms are difficult (or arguably impossible) to apply to a qualitative research (Fangen, 2010), and it has been argued that other concepts should be used instead. I nevertheless follow the example of Fangen (2010) and use the three terms, however understood in a broader context than traditionally done.

4.6.1 Validity

There are different types of validity within qualitative research. In this thesis three aspects, based within epistemological validity (Fangen, 2010), are briefly discussed. These can be understood as steps taken I have taken to strengthen validity of this research.

Correspondence is the first key aspect (Fangen, 2010). Through the use of both interviews and observation, I have been able to double check and validate my own understandings of what the women have told me. As described earlier, I experienced it to be of special importance to get to know the context as this created a better understanding of information shared during the interviews. Further, I have been able to look for correspondence (or discrepancies) between what the women say and do, and between the opinions of the different women. I experienced a high correspondence between the observations and the interviews and informal conversations, as well as a high correspondence between the different women. I consider this to strengthen the validity of the data.

Secondly, according to Geertz (as cited in Fangen, 2010), validation of interpretations are strengthened with thorough description of the context and explanations of how the author (I) has come to his/her specific interpretations. It is not up to me to evaluate the process, but, as according to Geertz (as cited in Fangen, 2010), by emphasizing

thorough descriptions of the overall context of the study (specifically in chapter 2) and of the specific study setting (chapter 5), describing the study process in detail (specifically through this chapter), as well as reflecting on the influence of the context on the findings (chapter 7), I have done my best to strengthen the validity of the study.

A third aspect important for strengthening the validation of this research is to examine the findings in relation to other literature on the same topic(s) (Fangen, 2010). In chapter 7, I look into how my interpretations and findings are supported by, or contrasting to, other studies and their results. By doing this, I openly reflect on the validation of my own study, and through that also strengthens it.

4.6.2 Reliability

The findings of this study are, for several reasons, not possible to reproduce or replicate. Firstly, production of data has not followed one specific and predetermined strategy. Instead, different methods and structures (as described in this chapter) has been tailored for use within this specific research. Secondly, the production of data has been influenced by the context and my background and pre-understandings. Thirdly, the production of data has been value-laden. With this in mind, it is, as according to Fangen (2010), relevant to understand reliability in terms of the trustworthiness of the process and how the findings can be strengthened, and not by how reproducible the findings are.

An important part of this is to be open about my own positioning (Fugelli & Ingstad, 2014) as well as the study process and the context of the study (Johannessen et al., 2010), which are factors I emphasize through this thesis. In addition, I have aimed to strengthen the trustworthiness of the results by 1) keeping a self-critical and reflective mind throughout the process (Fangen, 2010), and 2) double-check my understandings and impressions in both interview forms (Brinkmann & Kvale, 2014) (by asking the participants) and observations (Fangen, 2010) (comparing verbal and non-verbal messages from the participants, and observations from different settings).

4.6.3 Generalization

Generalization of empirical findings is not possible within phenomenological research (van Manen, 1990). Within hermeneutic phenomenology, and in this study, it is the uniqueness of the context and the human experiences and perceptions that are in focus,

and findings can therefore not be directly transferred and used in other contexts and with other individuals (van Manen, 1990). In my view it is not possible, nor an aim, to come to *one* "truth". Focus is instead on examining realities as understood and experienced by a specific group of immigrant women within a specific context.

It is nevertheless relevant to emphasize that while generalization of the findings of this study is considered not possible, this does not imply that my research and related findings are irrelevant outside the specific context it has taken place. This is explained in the conclusion.

4.7 Ethical considerations

Ethical concerns arise as soon as the research directly affects individuals (Johannessen et al., 2010). This becomes especially relevant when research contains production, storing and reporting of data directly from and about people (Johannessen et al., 2010), as in this study. It is of great importance to protect the people involved in the study, and I have seen this as a continuous process throughout the whole project. Issues of special importance are presented and discussed in this section.

4.7.1 Norwegian Centre for Research Data (NSD)

As the study included collecting, storing and processing personal and potential sensitive data, it was necessary to submit a request form (appendix A) to the Norwegian Data Protection Official for Research (Norwegian Centre for Research Data, NSD). The NSD approved the study (appendix B). As I was unsure if the study also had to be approved by The Regional Committee for Medical and Health Research Ethics (REK), an inquiry was sent also to this instance (appendix C). It was confirmed that no approval from REK was required (appendix D).

4.7.2 Informed consent

All participants were given information about the study in the first meeting with me. In addition to information about the study, I highlighted their rights as informants. This included the relevant aspects of anonymity, confidentiality and the right to withdraw at any time without giving reasons (Holm & Olsen, 2008). Information was given orally in plenum, with help from the tour leader. After the study was presented orally, a sheet (appendix E) was handed out to all the women, providing the same information in

writing. This sheet also contained a written consent at the end. The women were given the chance to ask any questions they had about the study at any point of time. All women signed, and none withdrew during the project.

4.7.3 Confidentiality and anonymity

Confidentiality refers to agreed conditions between the informants and the researcher (me) on what may be done with collected and produced data (Brinkmann & Kvale, 2014). This implies that I, as a researcher, must take care of the participants' right to privacy throughout the study and after (Holm & Olsen, 2008).

Doing the observations, the walking interviews and also the in-depth interviews in public spaces raised special ethical concern connected to each informant's privacy. The activities and associated methods chosen made it difficult to promise the informants 100% confidentiality. The women were aware of this, but none seemed to experience this as problematic.

In all notes, I chose to rename all of the participants to make sure of anonymity. Storage was in accordance to what was already agreed upon with the informants (see the informed consent, appendix E): Data was only available to me and my supervisor, it was kept on a password secured computer in my home, and as soon as this project is completed all personal data will be securely deleted.

Anonymity in the written report is often the main concern within confidentiality (Fangen, 2010). In this report, no information that can directly be linked to individuals is mentioned. By only providing general information, the aim is that anonymity of the persons involved has been protected.

4.7.4 Other ethical concerns

Apart from ethical considerations described above, I particularly considered three concerns to be of special relevance to this specific research. Firstly, health is a topic that might bring up memories, feelings and thoughts that the participants experience as challenging or difficult. Secondly, the sample consisted of immigrant women. These women have all gone through big changes in life. They have had different reasons for migrating and also different experiences of integrating into a new culture. Additionally,

they are part of a minority group, while I represent the majority group as a native Norwegian. This potentially influenced the power relations between the informants and me. Thirdly, none of the women had Norwegian as their native tongue, and while all spoke relatively well, none were fluent. Possibly, this had an effect on how the participants and I understood each other, as well as being a concern in relation to power relations.

These concerns made me take extra care when planning and preparing my communication with the participants, when conducting the observations and interviews, and when analyzing and writing the report. Among the main considerations were to build trust, participate as an equal, show interest, and when not fully sure ask twice to clarify and validate understandings. Further, it was also to focus on good health and the activities we took part in instead of specifically challenging topics related to home country and integration, be true to the participant's stories, translate into English in the best possible way to keep the meaning of the material, and be careful in the use of value-laden words (as immigrants).

5. PRESENTATION OF THE STUDY SETTING

The aim through this chapter is to introduce the setting of the fieldwork. The importance of describing the context is three-folded. First, within hermeneutic phenomenology the context is considered to play a central role by influencing me as a researcher, the participants, the research process and the following results (Brekke, 2006; Fangen, 2010; Postholm, 2005). Thus, describing the setting in detail is considered important. Second, it is the first step in the process of analyzing (first-degree interpretation (Fangen, 2010)) and with this the chapter plays a role in creating the first understandings and interpretations of the field of study. Third, a description of the setting is considered relevant in relation to validity and reliability, as described in chapter 4.6. Three aspects of the setting are in focus: the activities, the role of the main tour leader, and the participants. In this thesis, *context* and *setting* are used interchangeably.

5.1 The activities

During April and parts of May 2016 I took part in three different types of organized outdoor activities. The activities were arranged and lead by an outdoor organization based in one of Norway's major cities. While the organization offers different activities for different groups, the activities I took part in was specifically for immigrant women.

The first activity was a so-called "hyttetur" (a Norwegian term for a weekend trip to a cabin, often up in the mountains). Ten immigrant women, three tour leaders and I, traveled up to a mountain cabin. This trip was a form of reward at the end of a cross-country skiing course. It was therefore not open for whoever to join. The group stayed at the cabin for three days, went cross-country skiing during the day, as well as doing other social activities in and around the cabin. The women were very excited about the trip, and motivated to get the most out of the experience. They were eager to learn and all had a very positive attitude, which influenced the atmosphere.

The second activity was a weekly hike in the forest, very close to the city center. This activity was open to all women who wanted to participate. Time and meeting place was the same throughout the year, there was no fee, it was a low-threshold activity, and the hike usually lasted for approximately two hours. This activity was popular and

participants of different ages, backgrounds and with different aims as well as with very different physical fitness and health participated.

The last activity was more a walk than a hike. It was weekly, lasted an hour and was situated in the city (by water, and in a park-like setting). The walk was part of a job-seeking course for immigrant women. It was mandatory for the women to go for the walk. Overall, the women seemed to be less motivated for the activities. Nevertheless, all the women communicated that they were positive to the walks.

5.2 The main tour leader

Central to the described activities was the main tour leader. Herself an immigrant woman, she played an important part of the context of the activities. She was an employee of the organization and was responsible for all the administration and for organizing the activities. She also took part herself in (most of) the activities.

The tour leader played an important role in recruiting women to the activities, following up on any issue, motivating and educating the women and providing information. She was very engaged on the topic of immigrant women, health and PA, and strongly believed immigrant women would improve their health as well as become better integrated if they took part in PA and outdoor activities. Her strong and personal engagement and positive attitude towards this affected the participants; they almost "had" to have the same view as her, or were at least strongly influenced. The participants seemed to trust this woman, and she was also aware of her role as a role model for other immigrant women.

5.3 The participants

I consider the women that took part in this study as participants actively involved in the research process, and not as passive subjects. This means that the participants played a central role in forming and influencing the study, as well as in producing the data (Brinkmann & Kvale, 2014; Fangen, 2010).

I got to know a group of women that came from very different backgrounds and lived very different lives in Norway. This heterogeneity is easy to forget when, in most of the report, the participants are referred to as a group. But the heterogeneity is an important

part of the context, as it influenced communication and topics in the group; the women were eager to learn about each other's cultures and also share from their own. Despite heterogeneity and diversity, the women shared the experiences and feelings of being immigrants and minorities in Norway. Based on this, it is my view that the women felt that they had more in common with each other than with ethnic Norwegians. I understood this to be a reason for a strong and inclusive group feeling, especially in the weekend-trip group and the hiking group.

I experienced the participants to be resourceful women. This was an impression from early on in the project, which was kept despite learning that several of the participants had no job, lived on few economic resources, had varying levels of education, and experienced different health challenges in their new lives in Norway. My impression might be explained by the fact that a focus during the activities were on other aspects of life and were influenced by a positive atmosphere during the activities (very much influenced by the main tour leader).

I was met with a very open and positive attitude, and was soon accepted and included in the group. I experienced, both through my own participation and through observation, that inclusion, openness and respect were cherished values among the women. Despite being a native Norwegian, being a student and researcher, coming from another socioeconomic background, and being younger than most participants – factors that could have made relation building difficult – I felt that I was included as one of the women. It is possible that this inclusion also was influenced by the role that was taken by myself; participating fully as one of the participants and showing interest in the women's lives and experiences. It seemed to me that this made the women feel comfortable with my presence, and in addition created trust in me. The women talked freely and I was able to get to know the informants well in relatively short time. All of these described factors made it possible to produce data together with the immigrant women.

Getting to know the informants on a personal level challenged my role of being both a participant and a reflective observant (Fangen, 2010). In this study it was seen as valuable to build ties to the women, both for ethical reasons (Johannessen et al., 2010), and for building trust needed to get access to data (Brinkmann & Kvale, 2014; Grimen

& Ingstad, 2008). This made it possible to create an atmosphere where the women felt they could share their own personal understandings and thoughts on good health, and share experiences from their lives. Some of these are presented as citations or shorter descriptions in the next chapter, as part of the presentation of the study's empirical findings.

6. EMPIRICAL FINDINGS

In this chapter, the empirical findings of the research are presented. These are the results of the second-degree interpretation (Fangen, 2010) and the analysis conducted through the use of Brinkmann and Kvale's (2014) five stage procedure. As described by Fangen (2010), the second-degree interpretation involves interpreting what the produced data might mean and attach meanings to this data. The first subchapter is a brief introduction to the framework of the findings, as well as a further description on how this particular part of the analysis was conducted. The next two subchapters are a presentation of the themes identified for RQ1 and RQ2 respectively. (Interpretations related to RQ3 are presented in the next chapter as this is part of the third-degree interpretation).

6.1 Introduction to the findings

The second-degree interpretation has in this study been divided in two according to the first two research questions. So, firstly an interpretation with RQ1 in focus was conducted, then with RQ2 in mind. The same procedure was conducted for the two RQs: All data material was considered in the process, and the analyses followed the procedure as recommended by Brinkmann and Kvale (2014). This procedure is described step by step in chapter 4.5.4.

The themes are my attempt at capturing the meanings behind the information that the informants shared on the topics of health and PA. As in accordance with van Manen's description of phenomenological themes, the themes can be understood as "structures of experience" (van Manen, 1990, p. 79).

The themes provide structures to the findings, and are based on what I have identified and interpreted as the most important, valued or repeated understandings, definitions and experiences of the immigrant women. It should be kept in mind that the themes do not represent a complete description of the women's understandings, opinions and experiences, and that the themes are simplifications of their lived experiences (van Manen, 1990). The identified themes for RQ1 and RQ2 are divided in two, dependent on being identified through stage three or through stage four in the five stage procedure recommended by Brinkmann and Kvale's (2014).

6.2 The immigrant women's understandings of good health (RQ1)

The first RQ is *how is good health understood by a group of immigrant women in Norway?* During the interpretations conducted as part of the third stage in the interpretation procedure recommended by Brinkmann and Kvale (2014), I identified six themes. These six themes are understood to represent factors considered by the informants as important for good health. These factors are: a positive mindset and attitude, social interaction, meaningful days, family, self-image, and local environment. During the fourth stage of the procedure, I identified five themes. These represent what I understand to be the women's broader understandings of how good health is defined, and good health is then seen as: an individual experience and feeling, an interchangeably personal and social phenomenon, a multidimensional phenomenon, as wholeness, and a dynamic process. Altogether, 11 themes were identified in relation to RQ1, and these are described in the following sections.

6.2.1 Interpretations from the third stage of Brinkmann and Kvale's interpretation procedure

"To think positively is what keeps me up and going" – A positive mindset and attitude in life

From the very beginning of the fieldwork, and through the whole study, the positive mindset of the women, and their positive attitude to life experiences, was central to how I experienced and interpreted the group of women and their involvement in the activities. What I found is that 1) the positive mindset was a result of a conscious decision taken by the women to have a positive look on, and attitude towards, their life situation or specific challenges, and 2) the general look on life was linked to how they understood, perceived and experienced good health. By *a positive mindset and attitude,* I refer to a way of thinking and approaching situations that is explicitly positive.

Several of the women explained to me a belief that each of us has the power over our own mind, and that how this is used affects health. One of the women told me: "It is the brain that tells us 'yes, this is good, this is not good', right. So when I see something or do something, I think 'no, I will not say negative things'. If I say negative things, then I also think negative. And then it turns....it feels wrong. And it affects the body". Another also highlighted the link between one's mindset and one's health: "One has to learn to think properly and positively. That's it!! It is very important! To think positively is what

keeps me up and going." Other women also described the importance of the mindset, simply by stating: "All power is in the brain", and more indirectly, through reflecting on a question about what a good day is: "…So, a perfect day…It is you that decide to have such a day. Because it is you that have the attitude that will make the day perfect, no matter how you are."

Most women showed a gratefulness to life that I understood to be important for how they perceived life, and in terms, good health. Talking about life in Norway, after more than twenty years in this country, one said: "It was, of course, much better [to come to Norway]. I chose to come, right. I am still very happy for that, and I do not regret. Not at all. It feels like I have been given a gift in life, actually. I have been very lucky." Despite challenges and difficulties, they value the bigger things in life: "I am so grateful for being here, that I have come to Norway and had the chance to experience freedom. And meet so many good people." It seemed to me that the positive mindset also opened up for opportunities and created an overall wellbeing.

"One get positive energy by being together with other people" – Social interaction

Social interaction is the second theme. It is a broad theme, and is used to refer to different forms of social interactions (family relations excluded as this is a theme in itself). The women highlighted this aspect several times through the interviews and talk in general. I interpreted social interaction to be conceived by the women as an important part of life, a resource for a good life, and a resource for good health.

Through the observations, I saw how much it meant to some of the women to share experiences, no matter how "everyday" and small, or big and important, to talk, describe, listen, ask, tell. "I feel better when I am together with friends. Then I feel, yes, I feel joy. I like to be with friends. And, eh, telling about my life, just everyday stuff, like what I have been up to. And also listen to them."

Social interaction is also a source for energy and happiness. One said: "One get positive energy by being together with other people." Another told, with eagerness and joy, about a girls' night. She said: "It was such a fun night. We stayed together until 2 am in the morning. I like it if I have my own group that I can talk with, even though my

Norwegian is not very good. But I can talk freely, right. And feel like, feel secure and part of a group. And it creates a feeling of knowing that I know someone. So it gives me energy." A third woman described it like this: "A perfect day for me is being together with wonderful people. Oh, just being together with good people! That is a great day. Good people…you just have that feeling, sitting there and appreciate and enjoy being there together with them. Those people. That is a good day. Really!"

Many of these women have lost their social network in the process of moving to Norway, and several have also left their families. One woman said: "When I am very very sad, then I miss my family. But I know it is not possible [to get support from them]. So then I have to turn to my friends. Build a network. That is very important to me. When I am here [in Norway], then I need to focus on network in Norway." Another woman explained to me: "If I am a lot on my own, then I can feel very alone, or lonely. Sometimes it makes me cry. One needs someone to talk to." Support, gained through social interaction, is understood to be important for the women's health.

"When you have good health you can work" – Meaningful days

Meaningful days is the third theme. It refers to experiencing life as meaningful, as having an everyday life that includes activities or tasks or other content that in some way is felt to be of meaning, either for themselves or for others. Within this are for instance working, volunteering, going for walks, learning new things, and practicing Norwegian.

Most of the women wish to work, but for some it is not possible and for others it is difficult to get into the job marked. This situation, in connection to loss of roles and tasks in the home country, makes meaningful days an important aspect for how the women feel in their everyday life: "If I am busy with things, I do not notice that I am struggling with different things. But if I am sitting home or, yes, do nothing, then I feel tired, not only in my body, but also psychologically". The link between being active and health is also seen in this quote: "When you have good health, then you can work, go for walks and do many things. If you have ill health you do nothing." One woman that worked before, but is now on a sick leave, talks about her early years in Norway:

> *I got a job, luckily …Then I started on a degree. At the university college. I have very good memories from that. It was a good period. I worked on the side, and*

> *when I finished the studies I got a job at once. I worked in a 100% position, and also worked during holidays and the like. It was a lot, but I liked it. I was, I really appreciated the job…I felt active and healthy and happy all the time.*

Several of the women work as volunteers, and a commonality among their stories is how important it is to feel useful: "I feel much better. That I can do something which is good." "It is important to me to contribute, yes, very important. If not I feel totally…maybe I can help, work, you know?"

Learning is another key in creating meaningful days for these women. They seek opportunities to learn and develop, seen for example through one woman who take part in the activities so that she can practice Norwegian while searching for a job, or by those who took part in the skiing course and spent a weekend at a cabin in the Norwegian mountain – for most a completely new experience.

I interpret it to be important for the women to build a sense of being useful, of being part of something, and developing personally, and that they experience this to be important for their overall wellbeing and, further, health.

"It gives me a sense of security and happiness, right" – Family

Most of the women come from collectivist cultures, and the family-unit is a central part of life for many. I also understood *family* to be an important factor within the immigrant women's understandings and perceptions of good health.

One of the women talks about her family relation: "It gives me a sense of security and happiness, right. It is good to be together with them. Even though sometimes I can also get tired." Another describes a normal day to me: "I cook every day, and my son [a teenager] eats at home every day. It becomes a time together. It is very nice." A quote, about contact with grandchildren, is also very telling: "[The contact] is important for the children. Or, actually mostly for the grownups, I believe. To get, you know, to see the children love you. That is special."

For some it seems of special relevance to have ties within the female family members. One describes how much she looks forward to a weekend, as all the women in the family are going on a trip. And how these women often call each other or do things

together. This, she says, makes her do more things, get out of the house, and enjoy herself. It is important for how she feels.

"To have found myself" – Self-image and identity

I found that several of the women perceived health in terms of their *self-image.* It seemed to me that feeling confident in one's own *identity* was important for general wellbeing and good health. In addition, linked to the first theme (positive mindset and attitude), for many it was important to build, or maintain, a positive self-image.

One of the women described how happy she was to "have found myself" here in Norway, and not in her home country, as in Norway she was free to develop her own identity without culturally imposed limitations. On the other hand, others were concerned with taking care of their identity either as a Turk, an Indian, an Iranian, or whichever culture, and felt this to be important for their own good health. Most, though, would (probably) agree to a quotation by one of the women: "I choose the nice things from each of the cultures. That is how I do it. Right? So I don't see this [being part of two cultures] as a big problem. The good things, I take." Even though these descriptions/quotes represent three different aspects of the same issue, all show the relevance of identity as a resource for health.

"I felt safe. It was very nice" – Local environment

The last theme identified to be important for how the women understand good health is *local environment.* This includes perceptions of the physical setting that the women are part of in their everyday life, but also a broader atmosphere of these surroundings.

The nature is a key in this study, and is by the women seen as an important resource for wellbeing and health. "Being in the nature, it gives me so much!" is a quote that several agreed to. It seems like the nature give the women a free-space, away from everyday tasks, and provide opportunities for new experiences that have become important to them in their life in Norway.

The local areas where the women live were also considered as sources of good health. Several of the women focused especially on a feeling of security and safety. Not being

scared, or fearing anything such as theft or rape, makes them freer and creates a sense of wellbeing. One described moving to the city as: “I liked it. I felt safe. It was very nice.”

It was also important for the women to feel at home, or create a sense of belonging, in their area or city. One described a walk she had done through the city center and how she had thought about all the places she passed where she had memories from. She further explained how the city had developed, from being not well planned and now having parks and green areas, public art and the like. For one of the women this was longed for: “I don’t like white [many of the houses in the city are white]. I like to see the green color, flowers, colorful…When I moved here I thought ‘why do everyone paint their houses white? Because, during the winter, everything turns white…But if you have colors that your eyes can see…”

The women describe how their local environment is part of their life in different ways, providing arenas for experiences (like the nature), providing a sense of belonging or identity related to their home city, and how surroundings also affect general moods and wellbeing. This again, is related to good health.

6.2.2 Interpretations from the fourth stage of Brinkmann and Kvale’s interpretation procedure

“Everyone has their own thoughts” – Health as an individual experience and feeling

From both the interviews and observations, it became clear to me that the women perceive health as *a personal feeling* and *experience*. One woman says clearly “everyone has their own thoughts - this is for me, I don’t know about other’s [opinions]”, when talking about experiences of health in Norway. In most cases, though, it is a more implicit thought. The women seem to take for granted that health is subjective. And they also experience the difficulties of explaining this deeper feeling: “It feels so good!! I am not really able to explain it.” Good health for them is an inner feeling and experience, and health is understood as individual, not universal.

"Being able to live your own life fully, but at the same time care about others…It is so important" – Health as interchangeably an individual and a social phenomenon

While good health is a personal feeling, according to the women, it is also in their view a *social phenomenon*. Health can, based on this, be understood at two different levels; the individual and the social. However, these two levels are not separate. In addition, more than simply being connected by influencing each other, they are simultaneously playing a role in the women's understandings and experiences of good health. As described, the study found that health perceptions and health experiences are subjective, private and personal, and part of the women's self-image and identity. Nevertheless, it is at the same time defined, shared, and created in relation to, and together with, other people. This is a dynamic process where the personal and the social health understandings simultaneously interact in shaping understandings and experiences of good health.

This is not explicitly communicated by the women, but can nevertheless be understood from some of their quotes: "Being able to live your own life fully, but at the same time care about others…It is so important. It is very different from where I come from." And: "Each of us follow their own path in life, and find their own 'thing'. But at the same time we need to be open for others' thoughts and opinions." The women understand and experience good health as part of a social group or a society, but at the same time as individuals with their own unique feelings and understandings.

"So health for me is many things" – Health as a multidimensional phenomenon

Good health is a *multidimensional phenomenon*, and it is the totality of the experiences in life that – together – creates good health. Each of the themes presented in relation to the third stage of Brinkmann and Kvale's procedure (2014) should therefore not be seen in isolation – they are connected and influence each other in different ways, and the sum of these is what creates good health. This is how I interpret the informants' definitions and understandings of good health. As one of the women said: "So health for me is many things." It can also be understood through a quote from a woman who wanted to explain good health, and as she spoke, thought of more and more factors:

> *So, good health…it is the thing with the nature. Because it makes you feel good on the inside. And are you feeling good on the inside, then you also feel good on the outside. That is good health. That is the source of good health. And then you need to take care of your body. Of course. And how do you do that? You go out and do activities. Use your body as much as you can. Not too much, though. But take advantage of the opportunities as long as you can. Or if you don't like going out, do something which you like. If there is something you love, do a lot of that. Because that gives you good health both on the inside and on the outside….*

She goes on. The quote gives an example of the complexity and the multidimensionality of the concept, even within one person. Good health is, as interpreted by me, understood by the women to be a mix of different aspects, combined and intertwined.

"There are many things that makes me feel good, and one experience might lead to the other" – Health as wholeness

While good health is understood by the women as being multidimensional, it is also understood in terms of *wholeness*. According to my interpretations, it is the sum of all factors that matters for the women, and they see the interconnectedness of these factors. The holistic view on health is seen through how the women talk about and experiences the connections between the soul and the body, the personal and the social, the surroundings (especially the nature) and themselves. One of the women describes how being mentally down is felt in her whole body, both psychologically and physically. Another woman explains, while skiing in the mountains, that she has a feeling of being part of the nature, a feeling of wholeness with the world. A third replies to a question on what makes her feel good like this: "It is getting out of the house, being social, moving the body, and well, that makes you happy, I get in a good mood. There are many things that makes me feel good, and one experience might lead to the other."

"We are people. It [life] goes up and down" – Health as a dynamic process

The women understand health as *dynamic* and as part of life. From their own experiences, they know that life, and health, is changing. One woman said, in relation to describing her health experiences through life: "We are people. It [life] goes up and down". Part of this *process* is also a health understanding that includes a process of adaptation. This might be of special concern to these women, who have experienced big changes in life. I observed it through almost all activities, for instance in how they tried to adopt to the weather, to the Norwegian language, to cultural customs, to their new social settings. It included a process of redefining, recreating and compromising

between the new and the old. Finding ways of adopting and comprehending was interpreted as something that the women conceived as a process that was part of life and part of health. By that, it was also part of how good health was understood, according to my interpretations.

6.3 The role of physical activity in relation to the women's understandings and experiences of good health (RQ2)

After completing the second-degree interpretations related specifically to RQ1, I continued with a focus on RQ2 (*what is, according to the immigrant women, the role of physical activity (PA) in relation to their understandings and experiences of good health?*).

6.3.1 Interpretations from the third stage of Brinkmann and Kvale's interpretation procedure

Five themes were identified through the interpretations on the third stage of Brinkmann and Kvale's interpretation procedure (2014): psychological health, social wellbeing, learning and mastering, re-establishing identity in a new culture, and the nature. While these themes are broad, they reflect the women's conceptions of the role of PA, and my interpretations of this.

"I get so happy. Because I do something I love" – Psychological health

Through the research I found that the women were more concerned about *psychological health* than physical health. The women focus on how the activity, and how the physical movement in itself, makes them feel good: "I get so happy. Because I do something I love. I get really satisfied [with myself]. And if I can do something and master it, then I get really proud." Another woman talks about a hike she did: "It was very challenging. A lot of uphill. When I got home…I was very happy I did the hike, because it was a challenge, and I used my body a lot. However, at the same time I got really tired. But, psychologically, especially, I felt so much better!" One of the older women who regularly takes part in the hikes said: "I say 'cut out all depression pills and get out in the forests'. One get 'happiness hormones' when one is out hiking."

This shows how PA plays a role for the women's health, as the women experience it to be an activity that build or maintain good psychological health.

"Feeling that one belongs, being part of. It is very very important" – Social wellbeing

As already mentioned, social interaction plays a central role in the women's understandings of good health. It seemed to also be a central factor within the context of PA. I observed how the women enjoyed talking to their friends, met new people and built network, shared experiences and opinions, laughed, asked and explained. The social atmosphere of the groups was characterized by inclusion, openness, respect and tolerance. This made it possible for the women to relax, dare to ask those "stupid questions", share funny experiences and laugh at each other and oneself. One said: "It is a good feeling, when one is taking part in the activities together, and are allowed to just be yourself". The activities provided an arena for building friendships. After the weekend trip, for example, several of the women met also for get-togethers and girls' nights.

Despite cultural and language differences in the groups, the women easily got in touch with each other while they did the activity. One said: "We just chat, and then we almost forget that we are walking".

It seemed to me that the social aspects of the physical activities were a main motivation for taking part: "It [the activities] is social. That is the most important. Feeling that one belongs, being part of. It is very very important." It was also a factor that made PA possible: "It feels safer to be in a group [when going for walks]", and "I don't like to be on my own when I am outside, but in a group it is ok."

The analysis highlight that the social aspects of the PA was central, and that it lead to *social wellbeing*, which again was seen by the women as an important resource for good health.

"It is important to me to keep my identity, but also learn and develop." – Re-establishing identity in a new country

Outdoor activities are by most of the women perceived as an important part of the Norwegian culture and the Norwegian identity. Taking part in this is therefore, for many, a step into the "Norwegian life". For some of the women PA and outdoor activities are not new in itself, but the aim of the activity is different for most. They are not accustomed to go for walks just for the sake of it, without a specific aim. Others

have never had the opportunity to do activities outside of their home, as they have not been allowed. *Identity* connected to doing PA and being outdoors was understood to develop through participation in the walking/hiking/skiing-activities.

It seemed to me that the participation in the activities improved the women's self-esteem and confidence in their (new) identity in Norway. The activities and groups provided an environment for mixing and compromising, "trying and failing". I observed this for example through how some of the women chose to wear regular hats or buffs, instead of a hijab as they normally wore. As they said, as long as they covered the hair, it didn't matter how it was done. By this, these women had found a way of dressing both according to their religion and Norwegian custom for outdoor activities.

Several of the women said they were happy to be part of two (or more) cultures as they could pick the best from both of them. One example was the experience of going for a hike and eat out in the forests, but instead of bringing the traditional Norwegian sandwich, bring couscous and share. "It is important to me to keep my identity, but also learn and develop."

I understood the physical activities to give the women a strengthened self-image in their new life situation and within the Norwegian culture. This again was important for the women's experiences of good health, and something they themselves perceived as important as part of a definition of good health.

"I have learned to go cross-country skiing! It is a lot of fun, yes…a feeling of mastering" – Learning and mastering

This theme is closely linked to re-establishing identity. The women had all gone through big changes in life and were experiencing a socialization process into a new culture and society as grown-ups. All women, no matter how long they had been in Norway, seemed to be in a process of *learning* and *adopting*. I understood the outdoor physical activities to provide an arena for learning in a safe environment.

Many Norwegians possibly forget that it is much more to a walk/hike and most winter activities than we (Norwegians) think of: Where are one allowed to walk? Or where is it possible to ski? What should I wear? What is safe and not safe? Do I need any equipment? How do I use the equipment? In addition to learning about these practical

aspects, many of the women also learned to enjoy going for a walk, enjoy the winter season and snow, enjoy being outside. With the activities, the women experience what is possible in their life in Norway.

One example is from a woman who had never been outside a cold winter day: "First I thought 'eh, this is not….', but then I told myself 'it will be ok!!!' It was minus 18 Celsius degrees. So, yeah, we did it! Two and a half hour. And I thought 'it is actually ok'. I did not feel cold. Because we walked and got warm, and had good clothes." Another example is from a mother: "I had never tried cross-country skiing before, but I decided to join [cross-country ski lessons]. It has opened up opportunities for me and my children", further explaining how she can now take more part in the children's after-school activities. The activities therefore open up for opportunities and possibilities in their everyday lives, which is experienced by the women to be important for creating meaningful days in their lives in Norway.

It seemed to me that the women connected learning to self-esteem, and that they got a sense of mastering through learning new things in a safe environment. One said proudly: "I have learned to go cross-country skiing! It is a lot of fun, yes…a feeling of mastering…it is very good. I like to learn new things. I really like it!"

Based on my interpretations, it seemed that the women, through participation in the activities, learned how PA could be part of meaningful days in Norway. The women also experienced better self-esteem as they mastered new activities. This was further related to good health.

"Wow! It is so beautiful!" – Nature experiences

The outdoor context of the study was central to what role PA had for the women's experiences of good health. Based on both observations and interviews, it seemed like a majority of the women experienced the nature in itself, and *nature experiences*, as a source for good health. Several quotes support this: "I feel well and fit after I have been outside", "So, good health is…it has to do with the nature. The nature gives me a better mental health", "The nature gives me so much", and "A good day for me is getting out and be in the nature". More indirectly: "I want to experience the nature, all of it. See

new trees, paths, flowers, and...make a map of it all in my head so that I can bring it [with me]. Yes, I really want that."

Most of the women also mentioned several times how beautiful the scenery was. A woman from Southern Asia said: "During the summer it is easier and beautiful. Nevertheless, during the winter it is like in movies and pictures I have dreamed of. I feel lucky to have the opportunity to come and see this.". Another said: "Things made by humans doesn't amaze me much, but the nature…Wow! It is so beautiful!"

As presented earlier, I understand the local environment of the women to be an important resource for good health, and nature is for many of these women the most important aspect in this, experienced through PA. As one of the women explained: "I have been going for walks for more than 20 years. Where? In the forests. Sometimes in town as well, but preferably in the forests, and at least once a week in that surrounding".

Another, but very important, aspect is that the women conceived experiences in the nature as important to understand and learn the Norwegian culture, and become more integrated in the Norwegian society. Norwegians are proud of the Norwegian nature, with mountains, fjords and forests, and doing outdoor recreation activities are central to the Norwegian identity (Dervo et al., 2014; Tordsson, 2010). Several of the women explained how learning to be outside, hike or do cross-country skiing, "opened up doors" also in other aspects of life. Emphasis was therefore also on the importance of this in relation to being role models for, and better understand, their children who grow up in the Norwegian culture and with use of the nature as a central part of school education or kindergarten-years.

The nature was, in itself and as part of the context of the PA, understood by me to be important for the women's health in Norway. They experienced the nature to be a resource for good health and a door opener for other possible resources.

6.3.2 Interpretations from the fourth stage of Brinkmann and Kvale's interpretation procedure

The presented themes show that PA plays a role for how the women perceive and experience their own health in Norway. However, it seems like it is not the PA (as the movement of the body) in itself that is of importance, but the factors the women

experience through doing the activity. Through the fourth stage of interpretations within Brinkmann and Kvale's interpretation procedure, I identified two overall understandings of PA.

Physical activity – a broad concept and the importance of the totality

My interpretations are that the immigrant women understand PA to be a *broad concept* that entails much more than the physical movement of the body itself. According to the women it is the *totality* of the experience of being in the nature and walking, hiking or cross-country skiing that is of importance. As one of the women said when being asked about what made her feel good after a hike: "Everything, maybe. The nature, the social, the physical…everything. I feel much better." This broad perspective on PA is also in line with how PA is defined in this study (see chapter 2.3).

Physical activity – an arena for building and experiencing good health

My interpretations show that PA is understood by the immigrant women to be *an arena* or an environment where the women can *build and experience good health*. PA provides an arena where the factors identified as important for good health can be fulfilled. I found a close link between the themes identified in RQ1 and in RQ2: psychological wellbeing is related to positive mindset; social wellbeing is directly linked with social interaction; re-establishing identity is connected with self-image; learning and mastering is related to meaningful days; and nature is connected with local environment and surrounding. This implies, in my interpretations, that PA provides access to important health resources for the women, and through this it plays a role for the women's understandings and experiences of good health.

Through this chapter, I have presented the empirical findings of the study; my interpretations and understandings that are the results of the second-degree analysis. An overall interpretation and impression based on the empirical findings is that the immigrant women focus on aspects of health related to psychological health and wellbeing rather than physical aspects. This is a red thread through the different themes. The same is seen in relation to the role of PA; physical and bodily aspects receive little or no attention from the women.

In the next chapter, the findings presented in this chapter are related to theory, reflected on and discussed. With that the last stage of the analysis (the third degree interpretation) is conducted.

7. DISCUSSION

This chapter describes the last stage of the analysis; the third-degree interpretation (Fangen, 2010). The interpretation is conducted through 1) examining the findings in relation to the relevant health promotion theories of this study and with this reply to RQ3, 2) examining and discussing the findings in relation to the identified main literature, 3) reflecting on central aspects of this study that has influenced the study process and the findings, and 4) looking into challenges, limitations and strengths of this study. The aim through this chapter is to critically reflect on the empirical findings, as well as the process of coming to these.

7.1 The theory of salutogenesis and the asset model

In my interpretations related specifically to RQ3 (*how do the immigrant women's understandings of good health and the role of physical activity (PA) align with the theory of salutogenesis and the asset model?*), I first looked into how the women's overall definitions of good health align with the perspectives of health described within the theories. Secondly, I looked at how the key constructs of the theories can be related to the findings of this study.

7.1.1 Examining the women's understandings of health in comparison to the health perspectives emphasized in the theory of salutogenesis and the asset model

As presented in the previous chapter, good health was by the women understood in terms of being an individual experience and feeling, at the same time being a social, multidimensional and holistic phenomenon, and further a dynamic process. Looking at this in relation to key understandings of health within the salutogenic theory and the asset model, I see several similarities. Within the theories, health is argued to be a process as one moves on a health continuum (connected to *dynamic process*), it is perceived as a phenomenon that entails several aspects (*multidimensional*) that again influence each other for the overall health experience (*holistic*). Through the definitions of SOC, GRRs and assets, one can also see that health is both an *individual experience* and a *social experience*. My interpretation is, based on this, that the overall definitions and understandings of health of the informants are very similar to the perspectives on health as presented in the salutogenic theory and asset model. I consider it relevant to

have knowledge on this when planning or conducting health promotion programs involving participation of immigrant women. The impact of this finding is low within the given context, as the informants have a similar perspective on (good) health as is emphasized in the theories. The impact would, on the other hand, have been highly relevant to examine further if the immigrant women's understandings of health had been in great contrast to perspectives highlighted in the theories, as these perspectives are the base for health promotion work (WHO, 1986).

7.1.2 Examining the identified themes of RQ1 and RQ2 in relation to key constructs of the theory of salutogenesis and the asset model

Based on the first findings related to RQ3, I considered it of interest to further examine how the key constructs of the salutogenic theory and the asset model can be applied to the empirical findings of this research. I saw this as a way of both structuring and contextualizing the findings within a specific health promotion context.

The analysis specifically related to this part, started with looking at the first six themes identified in relation to RQ1 (a positive mindset and attitude, social interaction, meaningful days, family, self-image and identity, and local environment). I understand these six factors to be GRRs and assets that the women either make, or can make, use of for bettering their health and moving towards ease at the health continuum. In addition, I interpret these GRRs and assets to not only be resources that (might) lead to good health, but also factors that themselves are part of experiencing good health. The resources identified were either at the individual level (like self-esteem and positive values) or the community level (like social support and volunteer association), according to the asset model. The women in this study did not mention resources at the institutional level.

I further examined the themes identified within RQ2. Based on my interpretations, PA is understood to provide an arena that positively influence the women's SOC. According to my understandings it seemed like participation in PA increased the immigrant women's feelings of comprehensibility, manageability and meaningfulness (aspects within SOC) in their new life situation in Norway, and thereby increased their SOC.

According to the salutogenic theory, an increased or well-developed SOC influences the ability to identify and take use of GRRs. During the field work, I observed how the women that took part in PA through this participation identified GRRs and assets, and were further able to take use of these resources to experience an improvement in health.

To sum up, my interpretations are that the empirical findings related to RQ1 and RQ2 can be related to, and understood and contextualized within, the theory of salutogenesis and the asset model. This is based on examining the immigrant women's understandings of health in comparison to health understandings emphasized within the two health promotion theories. Further, examining the empirical findings in relation to the key constructs of the theories I see similarities between the health understandings of the women and those understandings highlighted in the theories. Continuing, I understand the first six identified perceptions and experiences of good health (see 6.2) to be related to an identification and use of resources (GRRs and assets), and the identified role of PA to be related to an increase in the women's SOC.

7.2 Discussion related to the main literature

In this section, the findings are compared and discussed in relation to literature on 1) immigrant women and health, focusing on three articles in particular, 2) on Norwegians and health, focusing on the qualitative study by Fugelli and Ingstad (2014), and 3) PA and health. This is done with an aim of examining the findings of this study in light of others' findings, and thereby look for similarities or contrasts that might be important to highlight.

7.2.1 Literature on immigrant women and understandings of health

Through the literature search I identified three studies similar to this one, and considered these to be of special relevance within this research as other articles I identified had other focuses or approaches to the topic of health and immigration.

Anna Bonmatí-Tomás et al. (2016) recently did a study on resources and assets of immigrant women in Spain. Similar to the present study, they identified personal motivation, optimism, a sense of being useful, and centrality of children, family ties and social relationships as main GRRs of the women. They further found religious belief, capability of managing difficult situations, initiative, and support from institutions

and/or organizations as main resources, which was not found in the present study. Another study (Meadows et al., 2001) has looked at perceived health of immigrant women in Canada and found that health is defined as a holistic phenomenon, it is experienced in a setting of redefining personal identity, and social relations are important. In contrast to the findings of this study, they find that the women do not talk about psychological health, and that physical health and function is the focus of the immigrant women. Further, it finds that spirituality is important, and that health of the family unit is more important than individual health. The third and last study is from Sweden (Lundberg, 1999). Looking at immigrant women's perceptions and practices of health, they find health to be "(a) well-being, (b) absence of illness, (c) ability to perform daily role activities, and (d) adaptation to new life situations" (Lundberg, 1999, p. 33). Wellbeing and adaptation is similar to the findings of the present study, while performing role activities and absence of illness is not.

Based on this, I see some similarities or trends across the mentioned studies and the current study that are worth noting: Social ties are in all studies found to be central to the immigrant women's experiences of good health. Further, the socialization process into new cultures plays an important role in the women's health experiences in their new country. Meaningful days, though worded differently in the different studies, are also identified across the studies as central for the immigrant women's health and health perceptions. One last important factor is that health is found to be understood by the participants as a holistic and multidimensional phenomenon. On the other hand, it is important to note that other central findings in the three discussed studies either contrast to findings in the present study, or is not found at all in this study. Three factors are considered of special relevance.

Firstly, it is interesting to note that the women in the present study do not define their own health firstly in relation to their family unit, as is found by Meadows et al. (2001), and also discussed in the two other articles (Bonmatí-Tomás et al., 2016; Lundberg, 1999). As most of the women in this current study comes from so-called collectivistic cultures, this could have been expected to be the case also for how these women define health (Viken & Nesje, 2010). This might be a result of assimilation into the Norwegian culture, but I can only speculate. The identified contrast is relevant to look more into in future research.

Secondly, the women in the present study see psychological health as a main source for overall good health, and they were in this study also willing to share thoughts on this. This is in contrast to two of the other studies (Lundberg, 1999; Meadows et al., 2001), where focus is found to be on physical aspects and performance of roles. It is also in contrast to research in Norway that has found psychological health to be a taboo among immigrant populations (Den norske legeforening, 2008). In this study, I was specifically concerned with building relations with, and trust among, the participants. In addition, the context, as earlier described, was characterized by openness, friendships and respect. These two aspects might have created a context where the women have felt safe and therefore shared thoughts also on psychological health. This implies an importance of use of qualitative methods in studies on this topic as well as enough time for fieldwork. This should be kept in mind in future studies.

Further, earlier studies in Norway have found that a higher number of immigrants in Norway, compared to ethnic Norwegians, experience psychological disorders and that more immigrant women, compared to immigrant men, report to have psychological health problems (Straiton et al., 2014). Based on these results, and the findings of this study, where psychological factors are experienced and defined as central for good health, this is an area that is important to prioritize within studies on migration health.

Thirdly, religious believes and spirituality is found by the three studies (Bonmatí-Tomás et al., 2016; Lundberg, 1999; Meadows et al., 2001) as an important part of health, but it is not among the identified themes in the present study. I experienced that most of the women themselves did not bring this up as a theme, and when asked about it they only briefly talked about it before switching to another topic. I believe that if more attention had been given to this topic, it would have been part of the findings. But I felt to not be in a position to ask further when the women clearly wanted to talk about other factors. It might be that the Norwegian culture, generally not focusing much on religion, have influenced the women, or that political and social trends in Norway and abroad, with skepticism towards immigrants and Islam, have made the women less open about their religious beliefs and practices.

This section shows that there are both similarities and differences in how immigrant women in different countries understand and experience health in their “new” life. I will

now look at the findings in relation to a qualitative study among ethnic Norwegians. This has earlier been mentioned as an important inspiration and source for this study.

7.2.2 Literature on Norwegians and understandings of health

The book by Fugelli and Ingstad (2014) is central when examining the findings of this study with a "Norwegian" understanding of health. In the book, ten themes are highlighted as representing the participants' definitions of good health: wellbeing, equilibrium, wholeness, adaptation, functioning, to move towards a goal, vitality, resistance, absence of thoughts about health, and absence of illness. In addition, the authors explain how the nature and religion also are factors that are important within a Norwegian definition of good health. So, are the understandings of immigrant women in Norway similar to, or very different from the "Norwegian" understandings?

The themes in the book are worded and grouped a bit differently than in this study, but looking beyond that I see several similarities between the findings of Fugelli and Ingstad (2014) and the findings of this research. I interpret the themes wellbeing, equilibrium, adaptation, moving towards a goal, and vitality as very similar to the findings of RQ1 in this study. Further, nature is identified as central to the understandings of health in both studies. However, the themes functioning, resistance, absence of thoughts about health, and absence of illness are not found in the present study. Religion, found by Fugelli and Ingstad (2014) to have a greater importance for informants than they expected, should potentially have received more attention in this study.

Through the discussions in the book (Fugelli & Ingstad, 2014), it is only nature that is argued to possibly have a unique position in the lives and health of the Norwegians, compared to most other cultures. This is supported by Krange and Strandbu (2004). Further, nature is not mentioned in any of the studies discussed in the previous section, implying that it is not of importance to the informants in these studies. It is therefore interesting that nature, as have been interpreted by me, is an important part of the health perceptions and experiences for the immigrant women in this study. This could possibly imply that the women in this study have learned to appreciate the nature in connection to their health through their integration into the Norwegian culture. On the other hand it

can also imply that nature is a central factor for understandings of health regardless of culture. This is an interesting aspect to examine further in future studies.

In Fugelli and Ingstad's (2014) further interpretations, they explain how their informants understands health as holistic and multidimensional, as subjective, but also social, as a process, and in addition as part of an everyday life with ups and downs in contrast to an utopia of "perfect" health. This is similar to, and supportive of, how I interpret the immigrant women's overall health understandings.

Based on this, it seems like the health understandings and experiences of ethnic Norwegians and immigrant women in Norway are not so different from each other. Despite some differences, there are also several significant similarities.

7.2.3 Literature on physical activity and health

It is well documented that PA is related to improved health, and as mentioned earlier in the report, PA in form of outdoor recreation is in the Norwegian society widely argued to be positively associated with several aspects of good health. In Norway one can find reports and studies that support the findings of the current research, where PA in the outdoors is associated with good psychological health and social wellbeing, feelings of learning and mastering, (Norwegian) identity-building, and rewarding nature experiences (Det Kongelige Klima- og miljødepartement, 2016; Miljøverndepartementet, 2009).

It is relevant to highlight Norwegian studies within sport and immigration that has examined how this activity is central in "identity work" (Walseth, 2006) or reflexive practices of defining and re-defining identity (Strandbu, 2005) among immigrants in Norway. This process is also observed in this study, and findings show that PA (like walking, hiking and skiing) is an arena for defining personal identities.

It is also of interest to again highlight the role of nature. Norwegian reports and studies conducted by Norwegians (Dervo et al., 2014; Det Kongelige Klima- og miljødepartement, 2016; Miljøverndepartementet, 2009) promote the importance of nature experiences for good health and recommend outdoor recreation activities for immigrants. On the other hand, texts by social scientists who are themselves immigrant

women, describe Norwegian outdoor activities and nature experiences as exotic, but strange and not something for them (Krange & Strandbu, 2004). One of these women nevertheless highlights how she has learned to like outdoor recreation activities in Norway. This might imply that experiences of nature and activities in the outdoor are culture-bound and learned, and with this that the participants of this study have learned to experience hiking, walking and skiing in the "Norwegian way" as good for their health.

Despite a growing number of studies within the field of immigration and sport/PA, I have not identified any studies examining the role that PA might have in immigrants' own experiences and understandings of good health, nor that look into how PA within a health promotion context is perceived by the participants themselves, and neither studies that look at PA as an arena for identifying, building and taking use of health resources. These are areas that might be of relevance in future studies.

7.3 Reflections on influences of the context

Through this thesis, I have highlighted the importance of the contexts of the study – both the overall setting and background of the study and the specific setting of the studied field – in regard to how it influences the research process and the findings. With this in mind, I see it as relevant to critically reflect on those aspects considered to have played a central role for the process, the produced data material and the findings of this study. This highlights those aspects that should be considered when reading and evaluating the findings.

7.3.1 The specific setting of the field

The uniqueness of the findings in this study, related to the studied field, is characterized by specifically two aspects worth highlighting: the characteristics of the informants and the main tour leader.

The participants in this study are, based on my understandings, resourceful women. A majority had learned Norwegian, took part in activities in the Norwegian society, and some also worked. Most of the participants joined the activities (hikes, walks, cross-country skiing) because they wanted to or saw benefits of taking part. They (generally) shared a positive attitude towards life, and showed an interest in trying and learning.

These factors are considered important as they create a specific setting, in which the findings must be understood. I see it as likely that a similar study with immigrant women not as integrated into the Norwegian society or with another approach to life in Norway would have resulted in partly deviating findings.

Related to this is the influence of the main tour leader of the activities. Her engagement and motivation within outdoor recreation activities, and health and integration of immigrant women, were central to how the participants approached the activities. As an immigrant woman herself, the tour leader was a role model through her own engagement in typical Norwegian activities, and through this showed other immigrant women what was possible and how these activities could be turned into positive experiences. Her presence and engagement is understood to have played a central role in defining the uniqueness of the setting of this study. Without this tour leader in that specific role, it is very likely that other experiences and understandings had been communicated by the informants.

7.3.2 The health promotion approach

The health promotion approach in this study has contextualized the research into a specific theoretical setting. By that, it has highly influenced the process, the produced data material and the findings.

With use of the salutogenic theory and the asset model, I have created a framework for how to focus and how to interpret the data material. With this, the approach has influenced me in my questions in the interviews, and in the understandings of the data material. It has further been used to structure the findings of RQ1 and RQ2 within a specific perspective on health. By this, the salutogenic theory and the asset model have (combined) played a central role in this study, and to my interpretations.

These theories have been used or examined in a number of other studies (Langeland & Vinje, 2012; Lindström & Eriksson, 2005, 2015; Mittelmark & Bull, 2013), and most highlight the usefulness of this approach within a health promotion setting. This supports the choice of approach in this study and further my interpretations related to RQ3, where I found that the theory can be applied to the findings of RQ1 and RQ2 and be used to structure the identified themes within a health promotion context.

It is additionally relevant to mention that also the informants are, most likely, influenced by a health promotion approach, regardless of my own perspective. The informants regularly take part in health promotion activities and with a tour leader that promote a salutogenic view on health and the importance of a health promotion perspective. It is my view that had a similar study been conducted within another setting of the immigrant women's lives, slightly other findings would have been revealed.

7.3.3 The hermeneutic phenomenological approach

The philosophical and methodological approach in this study is based within a hermeneutic phenomenological theory, and this has influenced my focus and methodological choices. I have taken use of my own understandings of health (my pre-understandings) through the research process, and while also being open for widening my own horizon, this is an aspect that has influenced the process and findings. My interpretations have been conducted in light of my own background. This highlights the importance of emphasizing that the set of chosen interpretations are only one of many possible interpretations. This is further related to the circulatory process of interpreting within hermeneutic phenomenology, termed the hermeneutic circle. By examining "the whole in terms of the detail, and the detail in terms of the whole" as described by Gadamer (as cited in Wilcke, 2002, p. 5), I have been part of an ever evolving and circulatory process where one will never be able to come to one definite truth (van Manen, 1990). I have, however, been able to identify themes that I mean represents the informant's understandings and experiences. It is nevertheless important to highlight that these themes do not represent an exhausted understanding or definition of good health, an exhausted description of the role of PA on good health, nor a definite way of applying theory to the findings. The findings are not static and final, but rather *one* interpretation in the circulatory process. These aspects are central prerequisites for understanding and evaluating the findings, as well as the process of coming to these.

7.4 Challenges, limitations and strengths of the study

The possibility for mistakes and limitations are present within all research (Fugelli & Ingstad, 2014) and cannot fully be eliminated. Reflections on this are considered important in this last part of the interpretations, which includes critical reflections of the process and findings. In this section, I aim to openly share and reflect on aspects that

possibly have affected the quality of the study and its related findings within the given methodology and connected to the purpose of the study.

A main challenge, and a possible limitation, is related to communication across cultural differences and language differences. I cannot guarantee that all the women felt able to communicate what they truly wanted by using Norwegian, which was their second or third language. Further, it cannot be guaranteed that I have been able to correctly communicate the messages of the women when translating quotes into English. Body language and expressions might also have been misunderstood across the cultural interpretations. Despite this, I believe that the findings and related quotes and descriptions are as close to the original messages as have been possible. I emphasized the importance of asking and clarifying my own understandings with the informants during the interviews/observations, and translation was done with great care.

Another challenge is related to the size and heterogeneity of the participant group. The relatively large number of informants, with very different backgrounds and Norwegian language proficiency, made it impossible to give equal attention and time to all the women. This influenced who were interviewed, which again possibly influenced the findings. This is a limitation to the study. Nevertheless, by using different data production methods, do in-depth interviews with three women who were selected based on representing different backgrounds, ages and life situation, and additionally interview or talk to most of the other participants (in addition to observing all), I consider the findings to represent the majority of the participants.

A third challenge is related to limitations in time and resources of the research. While data is based on a period of one and a half month, it still represents a snapshot of the lives of the participants. It would have been valuable to study health perceptions and experiences, and the role of PA in relation to this, over time. It would also have been valuable to have enough resources to do in-depth interviews with all the women. The "snapshot" in time, and the totality of data material, is nevertheless considered sufficient for coming to relevant findings and conclusions.

Looking at the strengths of this study, three are highlighted. A main strength is considered to be my regular presence at the activities through the one and a half month

of the fieldwork. I was able to build relations with, and receive trust from, the participants. This made the women share information that they would otherwise not have shared with one from "outside" of the group. Another central strength to the study is that it includes two data production methods. This has made it possible to produce different types of data, validate data and overall increase the quality of the findings. A third strength is related to the Hawthorne effect. All research is believed to have an effect on the participants, and by that also the results. However, the effects are assumed to be relatively small in this study. By observing and conducting interviews in the natural settings of the activities the informants participated in, by taking part as one of the group and not interrupt any activity, and further through being accepted very quickly as one of the participants, I interpret the Hawthorne effect to have had limited effect.

By openly sharing and reflecting on the limitations and strengths of the research, I have aimed at providing insights into the study process and those aspects that possibly have affected the quality of the study, and that further might have influenced the results.

This chapter has finalized the analysis process, and set the stage for concluding remarks.

8. CONCLUSION

The last chapter of the thesis includes a summary of the findings in relation to each of the RQs, and further looks into the main contributions and relevance of this research.

With the first RQ I wanted to explore the health concept and study how good health is understood among a group of immigrant women in Norway. I found that good health, according to the informants, is understood and defined to include a positive attitude and mindset, social interaction, meaningful days, family, confidence related to self-image and identity, and a sense of safety and belonging in a local environment. I further found that good health, as understood by the immigrant women, is a personal experience and feeling, at the same time a social phenomenon, multidimensional and holistic, as well as a dynamic process.

Through the second RQ, I aimed to get an understanding of how the informants see the role of PA in relation to their understandings and experiences of good health. I found that PA should be understood in broad terms, not only as physical movement of the body, and as an arena for building or experiencing good health. Five themes were identified to represent the women's conceptions of the role of PA: (good) psychological health, social wellbeing, re-establishing identity, learning and mastering, and nature experiences. These overall themes describe factors that the women experience through PA, and further perceive to be important for their (good) health. It is nevertheless important to underline that it is the totality of these factors, or the "whole pack" as one woman described, that makes PA an arena for experiencing good health.

The last RQ was defined based on a curiosity of how the findings were aligned with health promotion theories, as well as an aim of contextualizing the findings within a specific theoretical context. Through the interpretations of the empirical findings in light of the salutogenic theory and the asset model, I first found that the immigrant women's understandings of good health are similar to those health perspectives emphasized within these specific theories. Further, I found that by applying the theories to the findings, the identified themes of RQ1 and RQ2 can be structured and understood within a specific health promotion setting. The six identified themes describing the

informant's understandings of health are interpreted to be GRRs and assets, while PA is understood to increase the women's SOC.

The study's most important contribution is: 1) That it has put attention on the concept of health and emphasized the importance of examining and highlighting subjective understandings and experiences of good health. This topic and approach within health research has earlier not received much attention within academia in health research in Norway. 2) Further, that it has included a group within the population that in our societies are important and relevant to include and focus on (Kumar & Viken, 2010; Naidoo & Wills, 2000). While migration health has received attention within academia in Norway, there is a need for further research, especially where focus is on examining the experiences of the immigrants themselves. 3) Additionally, through coming to findings that have not earlier been revealed in similar studies – however are central in this study – the research contributes with results that are relevant to examine further. This is considered to be of high relevance related to two aspects in particular. The first aspect is psychological health, identified in this study to be the most important aspect of good health and at the same time highlighted in other studies to be reported as poor among immigrants in Norway (Straiton et al., 2014). The second is the role of the family contra individual/personal health, as other studies have highlighted the collectivistic culture of immigrant women (Lundberg, 1999; Meadows et al., 2001), while I find that the immigrant women might understand health in more individualistic terms. I consider it central for those working within health promotion that we expand the understanding, and have knowledge on, these aspects.

With basis in a hermeneutic phenomenological theory, I have emphasized the role of the context, both in broad terms relating to the overall background and approach of the research, and in terms of the specific setting of the studied field. It is the described aspects of these contexts that makes this study, and the related findings, unique. This means that the results cannot be generalized. On the other hand, the approach, process and findings of this study can be learned from and taken use of in future research of similar kind. Additionally, the findings should also be relevant for practical use in health promotion projects that are not identical to the one studied. Van Manen (1990, p. 58) explains that: "Phenomenology always addresses any phenomenon as a *possible human experience.* It is in this sense that phenomenological descriptions have a

universal (intersubjective) character." This highlights that the findings, though in one sense unique, might also reveal more universal aspects. Based on this, the findings can possibly be applied also in other settings.

I have produced knowledge on a topic not earlier studied to such an extent. I consider it of importance that future studies continue to explore understandings and experiences of (good) health within specific groups of the society. I further see the significance of including immigrants in the production of knowledge, thus use qualitative methods also within the field of health that traditionally has focused on quantitative methods.

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Appendix A – NSD request form

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

MELDESKJEMA

Meldeskjema (versjon 1.4) for forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt (jf. personopplysningsloven og helseregisterloven med forskrifter).

1. Intro		
Samles det inn direkte personidentifiserende opplysninger?	Ja ○ Nei ●	En person vil være direkte identifiserbar via navn, personnummer, eller andre personentydige kjennetegn. Les mer om hva personopplysninger. NB! Selv om opplysningene skal anonymiseres i oppgave/rapport, må det krysses av dersom det skal innhentes/registreres personidentifiserende opplysninger i forbindelse med prosjektet.
Hvis ja, hvilke?	□ Navn □ 11-sifret fødselsnummer □ Adresse □ E-post □ Telefonnummer □ Annet	
Annet, spesifiser hvilke		
Samles det inn bakgrunnsopplysninger som kan identifisere enkeltpersoner (indirekte personidentifiserende opplysninger)?	Ja ● Nei ○	En person vil være indirekte identifiserbar dersom det er mulig å identifisere vedkommende gjennom bakgrunnsopplysninger som for eksempel bostedskommune eller arbeidsplass/skole kombinert med opplysninger som alder, kjønn, yrke, diagnose, etc. NB! For at stemme skal regnes som personidentifiserende, må denne bli registrert i kombinasjon med andre opplysninger, slik at personer kan gjenkjennes.
Hvis ja, hvilke	Kjønn, alder, nasjonalitet og/eller opphavsland, evt også yrke.	
Skal det registreres personopplysninger (direkte/indirekte/via IP-/epost adresse, etc) ved hjelp av nettbaserte spørreskjema?	Ja ○ Nei ●	Les mer om nettbaserte spørreskjema.
Blir det registrert personopplysninger på digitale bilde- eller videoopptak?	Ja ○ Nei ●	Bilde/videoopptak av ansikter vil regnes som personidentifiserende.
Søkes det vurdering fra REK om hvorvidt prosjektet er omfattet av helseforskningsloven?	Ja ● Nei ○	NB! Dersom REK (Regional Komité for medisinsk og helsefaglig forskningsetikk) har vurdert prosjektet som helseforskning, er det ikke nødvendig å sende inn meldeskjema til personvernombudet (NB! Gjelder ikke prosjekter som skal benytte data fra pseudonyme helseregistre). Dersom tilbakemelding fra REK ikke foreligger, anbefaler vi at du avventer videre utfylling til svar fra REK foreligger.
2. Prosjekttittel		
Prosjekttittel	Physical activity and health among minority women in Norway - a qualitative study.	Oppgi prosjektets tittel. NB! Dette kan ikke være «Masteroppgave» eller liknende, navnet må beskrive prosjektets innhold.
3. Behandlingsansvarlig institusjon		
Institusjon Avdeling/Fakultet Institutt	Norges idrettshøgskole Seksjon for idrettsmedisinske fag	Velg den institusjonen du er tilknyttet. Alle nivå må oppgis. Ved studentprosjekt er det studentens tilknytning som er avgjørende. Dersom institusjonen ikke finnes på listen, har den ikke avtale med NSD som personvernombud. Vennligst ta kontakt med institusjonen.
4. Daglig ansvarlig (forsker, veileder, stipendiat)		
Fornavn Etternavn Stilling Telefon Mobil E-post Alternativ e-post Arbeidssted	Gunn Engelsrud Seksjonsleder, Seksjon for kroppsøving og pedagogikk 23262407 40875564 gunn.engelsrud@nih.no gunn.engelsrud@nih.no Norges Idrettshøgskole	Før opp navnet på den som har det daglige ansvaret for prosjektet. Veileder er vanligvis daglig ansvarlig ved studentprosjekt. Veileder og student må være tilknyttet samme institusjon. Dersom studenten har ekstern veileder, kanbiveileder eller fagansvarlig ved studiestedet stå som daglig ansvarlig. Arbeidssted må være tilknyttet behandlingsansvarlig institusjon, f.eks. underavdeling, institutt etc. NB! Det er viktig at du oppgir en e-postadresse som brukes aktivt. Vennligst gi oss beskjed dersom den endres.

Side 2

Adresse (arb.)	Sognsveien 220	
Postnr./sted (arb.sted)	0863 Oslo	
Sted (arb.sted)	Oslo	

5. Student (master, bachelor)

Studentprosjekt	Ja ● Nei ○	Dersom det er flere studenter som samarbeider om et prosjekt, skal det velges en kontaktperson som føres opp her. Øvrige studenter kan føres opp under pkt 10.
Fornavn	Ellen Fjeldheim	
Etternavn	Cartridge	
Telefon	97725247	
Mobil		
E-post	ellencartridge@gmail.com	
Alternativ e-post	ellenc@student.nih.no	
Privatadresse	Omsens gate 9a	
Postnr./sted (privatadr.)	0478 Oslo	
Sted (arb.sted)	Oslo	
Type oppgave	● Masteroppgave ○ Bacheloroppgave ○ Semesteroppgave ○ Annet	

6. Formålet med prosjektet

Formål	Hensikten med prosjektet er å få et innblikk i hvordan innvandrerkvinner i Norge opplever fysisk aktivitet, og sin helse knyttet til dette. Dette vil gi en dypere forståelse på hvordan de selv erfarer eller opplever sin helsehverdag i et nytt land. Prosjektet vil ha en kvalitativ tilnærming, forankret i fenomenologi. Det er deltagernes egen livsverden som vil stå i fokus. Forskningsspørsmålet som ligger til grunn for studien er: In an everyday context, how do immigrant women experience physical activity, and what factors are important for their wellness? Studien vil resultere i en masteroppgave som leveres på NIH, samt til "Foro Italico" (Roma), som har et samarbeid med NIH.	Redegjør kort for prosjektets formål, problemstilling, forskningsspørsmål e.l.

7. Hvilke personer skal det innhentes personopplysninger om (utvalg)?

Kryss av for utvalg	□ Barnehagebarn □ Skoleelever □ Pasienter ■ Brukere/klienter/kunder □ Ansatte □ Barnevernsbarn □ Lærere □ Helsepersonell □ Asylsøkere □ Andre	
Beskriv utvalg/deltakere	Innvandrerkvinner, eller kvinner født av to foreldre som er innvandrere. Kvinnene vil være mellom 18 og 60 år. De vil være medlemmer eller brukere av, lavterskeltilbud innen fysisk aktivitet/trening.	Med utvalg menes dem som deltar i undersøkelsen eller dem det innhentes opplysninger om.
Rekruttering/trekking	Strategisk utvelgelse. Utvelgelsen vil utføres enten av studenten (jeg) eller ved hjelp av leder/ansatte ved lavterkeltilbudet. Aktuelle deltagere vil muntlig bli forklart hva prosjektet går ut på og hva deltagelse innebærer, og deretter bli spurt om de kan tenke seg å delta.	Beskriv hvordan utvalget trekkes eller rekrutteres og oppgi hvem som foretar den. Et utvalg kan trekkes fra registre som f.eks. Folkeregisteret, SSB-registre, pasientregistre, eller det kan rekrutteres gjennom f.eks. en bedrift, skole, idrettsmiljø eller eget nettverk.

Førstegangskontakt	Førstegangskontakt vil opprettes etter å ha fått innvilget tillatelse til å foreta rekruttering av deltagere. Jeg vil da besøke og være med på aktivitet på det aktuelle lavterskeltilbudet, og slik komme i kontakt med kvinnene som vil være aktuelle deltagere. Besøk/deltagelse fra min side vil være etter avtale med min kontaktperson på stedet (leder eller annen ansatt). Informasjon om prosjektet vil gis muntlig, samt evt skriftlig på oppslagsverk om dette ses hensiktsmessig.	Beskriv hvordan kontakt med utvalget blir opprettet og av hvem. Les mer om dette på temasidene.
Alder på utvalget	□ Barn (0-15 år) □ Ungdom (16-17 år) ■ Voksne (over 18 år)	Les om forskning som involverer barn på våre nettsider.
Omtrentlig antall personer som inngår i utvalget	4-8 personer	
Samles det inn sensitive personopplysninger?	Ja ● Nei ○	Les mer om sensitive opplysninger.
Hvis ja, hvilke?	■ Rasemessig eller etnisk bakgrunn, eller politisk, filosofisk eller religiøs oppfatning □ At en person har vært mistenkt, siktet, tiltalt eller dømt for en straffbar handling ■ Helseforhold □ Seksuelle forhold □ Medlemskap i fagforeninger	
Inkluderes det myndige personer med redusert eller manglende samtykkekompetanse?	Ja ○ Nei ●	Les mer om pasienter, brukere og personer med redusert eller manglende samtykkekompetanse.
Samles det inn personopplysninger om personer som selv ikke deltar (tredjepersoner)?	Ja ○ Nei ●	Med opplysninger om tredjeperson menes opplysninger som kan spores tilbake til personer som ikke inngår i utvalget. Eksempler på tredjeperson er kollega, elev, klient, familiemedlem.
8. Metode for innsamling av personopplysninger		
Kryss av for hvilke datainnsamlingsmetoder og datakilder som vil benyttes	□ Papirbasert spørreskjema □ Elektronisk spørreskjema ■ Personlig intervju □ Gruppeintervju □ Observasjon ■ Deltakende observasjon □ Blogg/sosiale medier/internett □ Psykologiske/pedagogiske tester □ Medisinske undersøkelser/tester □ Journaldata	Personopplysninger kan innhentes direkte fra den registrerte f.eks. gjennom spørreskjema,intervju, tester, og/eller ulike journaler (f.eks. elevmapper, NAV, PPT, sykehus) og/eller registre (f.eks.Statistisk sentralbyrå, sentrale helseregistre). NB! Dersom personopplysninger innhentes fra forskjellige personer (utvalg) og med forskjellige metoder, må dette spesifiseres i kommentar-boksen. Husk også å legge ved relevante vedlegg til alle utvalgs-gruppene og metodene som skal benyttes. Les mer om registerstudier her. Dersom du skal anvende registerdata, må variabelliste lastes opp under pkt. 15
	□ Registerdata	
	□ Annen innsamlingsmetode	
Tilleggsopplysninger		
9. Informasjon og samtykke		
Oppgi hvordan utvalget/deltakerne informeres	■ Skriftlig ■ Muntlig □ Informeres ikke	Dersom utvalget ikke skal informeres om behandlingen av personopplysninger må det begrunnes. Les mer her. Vennligst send inn mal for skriftlig eller muntlig informasjon til deltakerne sammen med meldeskjema. Last ned en veiledende mal her. NB! Vedlegg lastes opp til sist i meldeskjemaet, se punkt 15 Vedlegg.
Samtykker utvalget til deltakelse?	● Ja ○ Nei ○ Flere utvalg, ikke samtykke fra alle	For at et samtykke til deltakelse i forskning skal være gyldig, må det være frivillig, uttrykkelig og informert. Samtykke kan gis skriftlig, muntlig eller gjennom en aktiv handling. For eksempel vil et besvart spørreskjema være å regne som et aktivt samtykke. Dersom det ikke skal innhentes samtykke, må det begrunnes.
10. Informasjonssikkerhet		

Hvordan registreres og oppbevares personopplysningene?	□ På server i virksomhetens nettverk □ Fysisk isolert PC tilhørende virksomheten (dvs. ingen tilknytning til andre datamaskiner eller nettverk, interne eller eksterne) □ Datamaskin i nettverkssystem tilknyttet Internett tilhørende virksomheten □ Privat datamaskin □ Videoopptak/fotografi ■ Lydopptak ■ Notater/papir ■ Mobile lagringsenheter (bærbar datamaskin, minnepenn, minnekort, cd, ekstern harddisk, mobiltelefon) □ Annen registreringsmetode	Merk av for hvilke hjelpemidler som benyttes for registrering og analyse av opplysninger. Sett flere kryss dersom opplysningene registreres på flere måter. Med «virksomhet» menes her behandlingsansvarlig institusjon. NB! Som hovedregel bør data som inneholder personopplysninger lagres på behandlingsansvarlig sin forskningsserver. Lagring på andre medier - som privat pc, mobiltelefon, minnepinne, server på annet arbeidssted - er mindre sikkert, og må derfor begrunnes. Slik lagring må avklares med behandlingsansvarlig institusjon, og personopplysningene bør krypteres.
Annen registreringsmetode beskriv		
Hvordan er datamaterialet beskyttet mot at uvedkommende får innsyn?	Notater/papir brukes under observasjon og/eller intervju, men skrives inn på bærbar PC rett etter observasjonen/intervjuene. Deretter makuleres disse papirene. Lydopptak lagres separat fra annen data. Slettes så fort sensur på oppgaven er gitt. Data på bærbar PC vil være beskyttet med innlogging som krever brukernavn og passord. Den bærbare PC'en vil være låst inne i privat bolig når den ikke er under oppsyn av student (meg).	Er f.eks. datamaskintilgangen beskyttet med brukernavn og passord, står datamaskinen i et låsbart rom, og hvordan sikres bærbare enheter, utskrifter og opptak?
Samles opplysningene inn/behandles av en databehandler?	Ja ○ Nei ●	Dersom det benyttes eksterne til helt eller delvis å behandle personopplysninger, f.eks. Questback, transkriberingsassistent eller tolk, er dette å betrakte som en databehandler. Slike oppdrag må kontraktsreguleres.
Hvis ja, hvilken		
Overføres personopplysninger ved hjelp av e-post/Internett?	Ja ○ Nei ●	F.eks. ved overføring av data til samarbeidspartner, databehandler mm. Dersom personopplysninger skal sendes via internett, bør de krypteres tilstrekkelig. Vi anbefaler for ikke lagring av personopplysninger på nettskytjenester. Dersom nettskytjeneste benyttes, skal det inngås skriftlig databehandleravtale med leverandøren av tjenesten.
Hvis ja, beskriv?		
Skal andre personer enn daglig ansvarlig/student ha tilgang til datamaterialet med personopplysninger?	Ja ○ Nei ●	
Hvis ja, hvem (oppgi navn og arbeidssted)?		
Utleveres/deles personopplysninger med andre institusjoner eller land?	● Nei ○ Andre institusjoner ○ Institusjoner i andre land	F.eks. ved nasjonale samarbeidsprosjekter der personopplysninger utveksles eller ved internasjonale samarbeidsprosjekter der personopplysninger utveksles.
11. Vurdering/godkjenning fra andre instanser		
Søkes det om dispensasjon fra taushetsplikten for å få tilgang til data?	Ja ○ Nei ●	For å få tilgang til taushetsbelagte opplysninger fra f.eks. NAV, PPT, sykehus, må det søkes om dispensasjon fra taushetsplikten. Dispensasjon søkes vanligvis fra aktuelt departement.
Hvis ja, hvilke		
Søkes det godkjenning fra andre instanser?	Ja ○ Nei ●	F.eks. søke registereier om tilgang til data, en ledelse om tilgang til forskning i virksomhet, skole.
Hvis ja, hvilken	Det vil bli sendt en forespørsel om prosjektet er fremleggingsplikitg for Regionale komite for medisinsk og helsefaglig forskningsetikk.	
12. Periode for behandling av personopplysninger		
Prosjektstart Planlagt dato for prosjektslutt	20.02.2016 24.04.2016	Prosjektstart Vennligst oppgi tidspunktet for når kontakt med utvalget skal gjøres/datainnsamlingen starter. Prosjektslutt: Vennligst oppgi tidspunktet for når datamaterialet enten skalanonymiseres/slettes, eller arkiveres i påvente av oppfølgingsstudier eller annet.
Skal personopplysninger publiseres (direkte eller indirekte)?	□ Ja, direkte (navn e.l.) □ Ja, indirekte (bakgrunnsopplysninger) ■ Nei, publiseres anonymt	NB! Dersom personopplysninger skal publiseres, må det vanligvis innhentes eksplisitt samtykke til dette fra den enkelte, og deltakere bør gis anledning til å lese gjennom og godkjenne sitater.

Hva skal skje med datamaterialet ved prosjektslutt?	■ Datamaterialet anonymiseres □ Datamaterialet oppbevares med personidentifikasjon	NB! Her menes datamaterialet, ikke publikasjon. Selv om data publiseres med personidentifikasjon skal som regel øvrig data anonymiseres.Med anonymisering menes at datamaterialet bearbeides slik at det ikke lenger er mulig å føre opplysningene tilbake til enkeltpersoner. Les mer om anonymisering.
13. Finansiering		
Hvordan finansieres prosjektet?		
14. Tilleggsopplysninger		
Tilleggsopplysninger		

Appendix B – NSD request answer

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Gunn Engelsrud
Seksjon for idrettsmedisinske fag Norges idrettshøgskole
Postboks 4014 Ullevål Stadion
0806 OSLO

Vår dato: 02.03.2016 Vår ref: 46937 / 3 / HIT Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 25.01.2016. All nødvendig informasjon om prosjektet forelå i sin helhet 09.02.2016. Meldingen gjelder prosjektet:

46937	*Physical activity and health among minority women in Norway - a qualitative study.*
Behandlingsansvarlig	*Norges idrettshøgskole, ved institusjonens øverste leder*
Daglig ansvarlig	*Gunn Engelsrud*
Student	*Ellen Fjeldheim Cartridge*

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

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

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

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

Personvernombudet vil ved prosjektets avslutning, 31.12.2016, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Hildur Thorarensen

Kontaktperson: Hildur Thorarensen tlf: 55 58 26 54

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

Avdelingskontorer / *District Offices*:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Vedlegg: Prosjektvurdering
Kopi: Ellen Fjeldheim Cartridge ellencartridge@gmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 46937

Prosjektet har vært lagt frem for REK sør-øst, som finner at prosjektet ikke er fremleggelsespliktig for REK.

Hensikten med prosjektet er å få et innblikk i hvordan innvandrerkvinner i Norge opplever fysisk aktivitet, og sin helse knyttet til dette. Dette vil gi en dypere forståelse på hvordan de selv erfarer eller opplever sin helsehverdag i et nytt land.

Personvernombudet legger til grunn at taushetsplikten ikke er til hinder for rekrutteringen, og at forespørsel rettes på en slik måte at frivilligheten ved deltagelse ivaretas. Det anbefales at noen andre formidler forespørsel om deltakelse til utvalget på studentens vegne, der de bes om å kontakte studenten dersom de ønsker å delta.

Utvalget informeres skriftlig og muntlig om prosjektet og samtykker til deltakelse. Informasjonsskrivet er godt utformet.

Det behandles sensitive personopplysninger om etnisk bakgrunn og helseforhold, .

Personvernombudet legger til grunn at forsker etterfølger Norges idrettshøgskole sine interne rutiner for datasikkerhet. Dersom personopplysninger skal lagres på pc/mobile enheter, bør opplysningene krypteres tilstrekkelig.

Forventet prosjektslutt er 31.12.2016, jf. informasjonsskriv til utvalget. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)
- slette digitale lydopptak

Appendix C – REK request and project description

European Master of Health and Physical Activity, 2014-2016

Project plan for master thesis 2016

Research question:

" Physical activity and health among minority women in Norway - a qualitative study."

- In an everyday context, how do immigrant women experience physical activity, and what factors are important for their wellness?

Focus areas and key words: physical activity, movement, everyday health, health, wellness, organized physical activity, low-threshold physical activity, immigrant women, multicultural women, culture.

Background: 15% of the Norwegian population are immigrants (approx. 669 000 people) or have both a mom and a dad that are immigrants (approx. 135 000 people) (Statistsisk Sentralbyrå, 2015). The number of immigrants is expected to increase in the coming years (Folkehelseinstituttet, 2014), and challenges connected to immigrant health will be of high relevance, both of societal, social and economic reasons. Surveys conducted in Norway show that fewer immigrants consider their health as good or very good, compared to ethnically Norwegians (Blom, 2008). Further, studies show that immigrants face different health challenges than what ethnically Norwegians do (Ahlberg & Duckert, 2006; Den Norske Legeforening, 2008), and that these health issues often are connected to preventable health conditions (such as diabetes type, overweight and depression) (Helse- og omsorgsdepartementet 2013).

It is widely recognized that regular physical activity is important for prevention of non-communicable diseases and can increase physical and psychological well-being. In spite of this more than 50 % of the non-Western immigrant population in Norway define themselves as inactive (Folkehelseinstituttet). Compared to ethnically Norwegians, fewer immigrants meet the national physical activity recommendations, and the number of physically active immigrant women is less than the number of physically active immigrant men (Helse- og omsorgdepartementet, 2013).

Objective: The aim is to increase the knowledge of how health in general and physical activity related to health in particular is understood and experienced by non-native women living in Norway. Thereby provide important information to those who work with health promotion among this group of women, or in other ways are engaged in planning and implementing of health promoting projects among immigrants in Norway.

Theoretical background:

A salutogenic view on health will build a framework for the master thesis. In addition, the thesis will build upon theories of feminism and/or hermeneutics.

Method:

A qualitative study will be conducted during the winter/spring of 2016. Data will be based on observation through own participation and in-depth interviews of a small number immigrant/non-native women now living in Norway. The group will consist of maximum ten women, if possible of different origin. No age exclusion above the age of 18 years. The interviews will be in the form of relatively open conversations, though based on planned topics. The qualitative research will be based on a thorough literature review of the topic, as well as being grounded in a specific scientific theory.

Ethics:

- Applications will be sent to NSD (norsk samfunnsvitenskaplige datatjeneste) and REK (Regionale komitter for medisinsk og helsefaglig forskningsetikk).
- A written document will be given to all potential participants, containing information about the study, description of what the participants will do, and information on rights as participants. Further it will contain information on how data will be taken care of during and after the data-gathering process.
- A written consent must be signed by the participants before any data will be gathered. The written consent will also be gone through orally with each of the participants to make sure everything is clear.
- All data will be anonymous and it shall not be possible to recognize participants in the finished paper.
- Confidentiality of the participants will be of importance. Only the researcher and the supervisor will have access to data, and all data will be kept in a secure manner (see bullet point underneath). The study will not ask for any direct personal information or any sensitive information.
- Data will be protected by keeping it on a computer with access only through use of a username and password, and the computer will be locked in a private home when not in use of the researcher herself. All data will be deleted when the thesis has been handed in and presented at the relevant colleges.

Time frame:

January	• Meetings with supervisor. • Revising research question • Create a plan and timetable • Send in NSD application, and REK? • Contact locations • Start literature review	
February	• Continue literature review • Prepare interviews	

March	• (Hopefully get confirmation from NSD by end of February/first part of March) • Interviewing • Starting transcription	
April	• Transcription and analysis	
May	• Put it all together and write	
June	• 30th of June, personal deadline for finishing writing the thesis	
September	• Read through last time and do any revising if needed. • Hand in thesis in Rome • Prepare for presentation in Rome	
October	• Hand in thesis at NIH (when present?) • Present thesis in Rome	

References:

Ahlberg, N. & Duckert, F. (2006). Minoritetsklienter som helsefaglig utfordring. *Tidsskrift for Norsk Psykologiforening,* 43(12), 1276-1281

Blom, S. (2008). *Innvandreres helse 2005/2006.* (Statistisk sentralbyrå 2008/35). Retrieved 04 Oct. 2015 from https://www.ssb.no/sosiale-forhold-og-kriminalitet/artikler-og-publikasjoner/innvandreres-helse-2005-2006

Blom, S. (2011). Innvandreres helse. Dårligere helse blant innvandrere. *Samfunnsspeilet,* 2011/2, 63-68.

Den norske legeforening. (2008). *Likeverdig helsetjeneste? Om helsetjenester til ikke-vestlige innvandrere.* (Den norske legeforening, statusrapport). Retrieved 04 Oct. 2015 from http://legeforeningen.no/Emner/Andre-emner/Publikasjoner/Statusrapporter/likeverdig-helsetjeneste-om-helsetjenester-til-ikke-vestlige-innvandrere/

Helse- og Omsorgsdepartementet (2013). *Likeverdige helse og- og omsorgstjenester – god helse for alle. Nasjonal strategi om innvandreres helse 2013-2017.* Retrieved 14

Dec. 2015 from https://www.regjeringen.no/no/dokumenter/likeverdige-helse--og-omsorgstjenester/id733870/

Statistisk sentralbyrå. (2015). *Innvandrere og norskfødte med innvandrerforeldre, 1 januar 2015*. Retrieved 04 Oct. 2015 from https://www.ssb.no/innvbef

Appendix D – REK response

Vår ref.nr.: 2016/192 B

Hei,

Vi viser til fremleggingsvurdering for prosjektet, «*Fysisk aktivitet og helse blant innvandrerkvinner - en kvalitativ studie*», mottatt 26.01.2016

I skjema og vedlagt prosjektbeskrivelse fremkommer det at formål med studien er «*å få et innblikk i hvordan innvandrerkvinner i Norge selv opplever fysisk aktivitet, samt sin helse knyttet til dette. Dette vil gi en dypere forståelse av hvordan de erfarer, forstår eller opplever sin helsehverdag i et nytt land*».

I henhold til helseforskningslovens § 4 forstås medisinsk og helsefaglig forskning som virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom.

Det er altså ikke ny kunnskap om helse eller sykdom per se som er formålet.

Prosjektet faller dermed utenfor bestemmelsene i helseforskningsloven, jf. helseforskningslovens § 4. Prosjektet er ikke fremleggelsespliktig for REK.

Komiteen antar for øvrig at prosjektet kommer inn under de interne regler for behandling av opplysninger som gjelder ved ansvarlig virksomhet. Søker bør derfor ta kontakt med enten forskerstøtteavdeling eller personvernombud for å avklare hvilke retningslinjer som er gjeldende. **Vi gjør videre oppmerksom på at konklusjonen er å anse som veiledende,** jfr. forvaltningsloven § 11.

Dersom dere likevel ønsker å søke REK vil søknaden bli behandlet i komitémøte, og det vil bli fattet et enkeltvedtak etter forvaltningsloven.

Med vennlig hilsen

Mariann Glenna Davidsen

rådgiver

post@helseforskning.etikkom.no

T: 22845526

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

Appendix E – Informed Consent

Ellen Fjeldheim Cartridge
Omens gate 9a
0478 Oslo

10.03.2016

Forespørsel om deltakelse i forskningsprosjekt

Mitt navn er Ellen Fjeldheim Cartridge og jeg er student ved Norges Idrettshøgskole (NIH). Jeg tar en mastergrad innen fysisk aktivitet og helse og er nå i gang med en avsluttende masteroppgave. Tematikken for oppgaven er hvordan et utvalg kvinner fra ulike land opplever sin helse, med særlig vekt på fysisk aktivitet.

Undersøkelsen vil resultere i en masteroppgave som leveres ved NIH samt ved «Foro Italico». (Dette er en idrettshøgskole i Roma som samarbeider med NIH om mitt masterprogram).

Hva jeg vil gjøre i denne studien

I studien ønsker jeg å intervjue deg som er med på DNT-aktiviteter. Jeg ønsker også å delta på disse aktivitetene sammen med deg og andre deltagere.

Det er din egen subjektive fortelling og opplevelse jeg er interessert i. Derfor er det et mål at intervjuet skal være en samtale mellom deg og meg (og ikke en utspørring). Intervjuene vil bli tatt opp (kun lydopptak), og i tillegg vil det være mulig at noen få notater gjøres underveis i samtalen. Det kan også være at noen notater blir gjort under selve aktiviteten der jeg deltar og observerer.

Om du ønsker å delta vil jeg be deg skrive under nederst på dette informasjonsskrivet. Ved å gjøre det samtykker du til å delta.

Hva skjer med informasjonen om deg som deltager?

All informasjon og alle opplysninger vil bli behandlet konfidensielt, både hva intervju og observasjon angår. Det er kun student (jeg) og veileder som vil ha tilgang til data som samles inn. All skriftlig data vil lagres på passord-låst PC. Denne PC'en vil være låst inne i privat hjem eller være under oppsyn av forsker. Lydopptak vil lagres separat. Direkte personopplysninger, som navn, vil ikke bli spurt om. Deltagere vil anonymiseres og vil ikke kunne bli kjent igjen i den ferdige oppgaven.

Studien skal etter planen være avsluttet innen utgangen av 2016. Lydopptak og transkribert data vil bli slettet etter sensur av oppgaven. Dette vil gjøres ved bruk av

programvare for sikker sletting. (Eneste unntak vil være hvis annet bli avtalt med de involverte grunnet videre forskning).

Frivillig deltakelse

Det er frivillig å delta i studien, og som deltager kan du når som helst trekke deg fra ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg vil all innsamlet data om og fra deg slettes og ikke brukes i oppgaven.

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Dersom det er ønskelig med ytterligere informasjon, eller du har spørsmål knyttet til studien, kan jeg (Ellen Fjeldheim Cartridge) kontaktes per telefon: 97725247 eller via e-post: ellencartridge@gmail.com. Det er også mulig å kontakte min veileder, Gunn Engelsrud ved seksjon for kroppsøving og pedagogikk, NIH på telefon: 23262407/40875564 eller e-post: gunn.engelsrud@nih.no

Med vennlig hilsen

Ellen Fjeldheim Cartridge
E-post: ellencartridge@gmail.com
Telefon: 97725247

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

---
(Signert av deltaker, dato)

Appendix F – Interview Guide

Intervjuguide – dybdeintervju, vår 2016

Brukes som utgangspunkt for intervjuer, men fokus er på å skape en samtale der deltager skal få fortelle og i stor grad styre samtalen selv. Intervjuguiden følges ikke strikt, men gir mulige temaer og mulige spørsmål for samtalen mellom informant og meg som intervjuer.

Utgangspunkt er at informant og jeg kjenner hverandre fra tidligere turer og samtaler. Denne intervjuguiden skal derfor brukes som et generelt utgangspunkt for en samtale tilpasset hver av informantene og hva jeg allerede vet fra tidligere samtaler med hver av kvinnene.

Introduksjon/før selve intervjuet:

- Forklar formålet med intervjuet og litt om hvordan intervjuet vil foregå, samt spør om det er ok at intervjuet blir tatt opp
- Gjenta samtykkeerklæringen som tidligere har blitt skrevet under av informantene og presiser deltagers rettigheter som informant
- Åpne opp for spørsmål fra informant

Gjennom intervjuet, pass på å samle informasjon om disse punktene (om du ikke allerede har dette):

- Tid i Norge
- Alder
- Familiesituasjon
- Jobbsituasjon

Innledningsvis:

Viktig å skape en atmosfære der kvinnene føler de kan samtale, og ikke føler de skal delta i et tradisjonelt intervju. Se an situasjonen. Start kanskje med å spørre om hvordan de følte seg etter den siste turen vi var på sammen, hvordan de har det eller noe lignende slik at de også forstår at jeg bryr meg. Dette kan brukes til å skape en innledning til temaene for intervjuet.

Intervjuet:

- Temaer som er relevante om de ikke allerede er dekt i tidligere samtaler/walking interviews med informant:
    - Helse i Norge
    - Fysisk aktivitet (og trenning?). Det å gå på turer
    - Natur og det å være ute
    - Kosthold
    - Sosialt, nettverk, samhold
    - Velvære og livskvalitet
    - Kropp
    - Nærmiljø
    - Klima og sesong

- Livsstil
- Kulturelle normer (damer på tur ok?)
- Hverdag (familiesituasjon/jobbsituasjon/aktiviteter)
- Språk (mangel på, betydning av)
- Tid (mangel på tid – mange gjøremål – eller for mye tid – sitter mye hjemme alene)

<u>Forslag til spørsmål rundt enkelte av temaene</u>:

<u>God helse:</u>

- Kan du beskrive en god dag for meg?
- Hva skal til for at du har det bra? / Hva er viktig for deg i din hverdag for at du har det bra?
- Kan du fortelle meg hva du tenker når du hører ordet god "helse"?
  - Hva forstår du med ordet "helse"?
- Hva betyr (god) helse for deg i din hverdag?
  - Hva (hvilke faktorer) skaper god helse for deg?
  - Hva gjør du for egen helse? Eller andres helse?
    - Mosjon, turer, natur, mat, sosialt……..
  - Er dette ulikt fra da du var i hjemlandet ditt, sammenlignet med nå og her i Norge?
- Kan du fortelle meg litt om hvordan du opplever det er å bo i Norge?
  - muligheter, utfordringer
- Hvordan påvirker det (viser til spørsmål og svar over) hvordan du føler deg i din hverdag?
  - helse, fysisk, psykisk

<u>Deltagelse/bruk av lavterskeltilbud:</u>

- Kan du fortelle meg om da du først startet her?
  - motivasjon?
  - hvordan fikk du vite om stedet?
  - utfordringer? muligheter?
- Kan du fortelle meg litt om hvordan du syns det er å være her nå?
  - Hvordan opplever du å være med?
    - i denne aktiviteten
    - i denne gruppen
- Hva slags aktiviteter er du med på? (Gåturer, skikurs/turer, lengde, med familie etc?)
  - Hva liker du? Og hvorfor?
  - Er det noen aktiviteter du ikke kan være med på? Eller ikke vil være med på? Hvorfor?
- Hva gjør turene med deg?
  - fysisk? psykisk?
  - kort tidsperspektiv og lengre tidsperspektiv
- Kan du fortelle meg hva det er du liker ved å gå på tur/gå på ski?
- Er det å gå på tur/ski noe nytt for deg eller noe du har gjort før? Kan du forklare?