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

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Abstract

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

Keywords

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

Introduction

The observation that trust is important in the context of health care is far from novel (e.g. Parsons, 1951). This qualitative study explores trust in relation to immigrants' integration into new health care cultures. Across country contexts, a lack of trust has been identified as a prevalent barrier to immigrants and ethnic minorities' health care utilization (Manderson and Allotey, 2003; Ayazi, 2006; Feldmann et al., 2007; Vozikis and Siganou, 2015). A lack of trust has been associated with worse self-reported health, reduced willingness to pursue services, lower relationship-quality with health care providers, lower treatment adherence, and poorer service satisfaction (Benkert, 2006; Halbert et al., 2006; Hsieh, Ju, and Kong, 2006; Whetten et al., 2006). Still, the question of how notions of trust and mistrust are informed, manifested, and responded to in the context of immigrants' integration has received limited sociological attention.

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

language and culture. However, critical contingencies exist regarding the efficacy of cultural health capital mobilizations.

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

Trust and Immigrant Health

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

According to the German sociologist Niklas Luhmann, 'familiarity is the precondition for trust as well as distrust, i.e., for every sort of commitment to a particular attitude towards the future' (Luhmann, 1979: 19). When familiarity is in place, however, trust can be a solution to risk and vulnerability, as it can work to enable or guide social action in situations where actors are overwhelmed with ambiguity or fear regarding the future consequences or outcomes of different choices (de Luzio, 2006; Luhmann, 2000). The instrumental advantage of trust in the context of health care is thus that it allows for calculated risk-taking by making decisions based on expectations and presumptions about the benefits secured in the moral and skilled practice of professionals (Gilson, 2003). Another important function is in this respect that 'trust, by keeping our mind open to all evidence, secures communication and dialogue' (Misztal, 2013: 95), enables benefit from available health care services.

The centrality of familiarity and trust in the context of health- and health care utilization is underscored by studies that attribute negative health status to a lack of trust. In a Swedish study, limited trust in general, combined with limited trust in institutions has been associated with a higher ratio of low self-reported mental health (Mohseni and Lindstrom, 2007). The same correlation appears in a study involving 22 Chinese villages, where trust and mistrust at both the individual and collective level was associated with better and worse mental health (Wang et al., 2009). It is notable that studies among Somalis in Sweden (Svenberg, Skott, and Lepp 2011), and among Somalis in Norway (Ayazi 2008), have found trust to be a fragile construct beneath differences in culture and communication. Moreover, in the case of Norwegian-Somalis, experiences of 'humiliation' in their contacts with other public institutions (Fangen 2006), could thus work to compromise familiarity and health care trust. Hence, in examining Somalis' health care integration in Norway, which is also a matter of general integration, both trust and mistrust requires consideration.

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

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

Cultural Health Capital

Although many Norwegian-Somalis are wary of investing their trust in the bureaucratized health care institutions of a highly individualized society, trust can nevertheless be swayed towards improvement through familiarization, positive experiences, and through the vouching or convincing of presumably trustworthy others. Trust is also a collective enterprise, as group

perceptions about social phenomena often inform individuals' sense of trust. This is evident in that trust is a defining attribute of both stable, collaborative, and cohesive social networks and relations (Misztal, 2013). Here, I will examine the dynamics of trust in immigrants' health care integration through the concept of cultural health capital to forefront 'the fluid yet durably structured relationships between health professionals, gatekeepers, and patients' (Shim, 2010: 11).

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

A central aspect of social capital is its interlinkage with the characteristics of networks, social norms, and trust (Putnam, 1996). Hence, as suggested by Strang and Ager (2010), rather

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

Methods and Approach

The Somali Civil War, which escalated into a full-scale clan-based conflict in 1991 has displaced and dispersed more than two million Somalis around the globe. Relatedly, the Norwegian-Somali population has nearly doubled since the mid-2000s, making them the largest non-western immigrant group in Norway. There are currently 35 912 Norwegian-Somalis, of whom 16 108 have arrived as refugees and 8 887 by way of family reunification with a refugee, whereas 9 750 are born in Norway to Somali parents (Statistics Norway, 2015). In addition, about 1 300 are not listed with a reason for immigration. Considering that the first Somalis to seek asylum in Norway arrived in the late 1980s, combined with the fact that the authorities did

not discriminate based on clan (Assal, 2006), the Norway-Somali population is highly heterogeneous in terms of both age, duration of residency, clan composition, war, migration, and resettlement experiences, as well as levels of education and integration. To account for this complexity, the aim was to recruit a diverse set of interviewees, particularly in terms of gender and affinity to the main clans of Dir, Isaq, Hawiye, Darod, Digil, and Rahanweyn, as this defines Somali notions of identity and collaboration (Lewis, 2002, 2004).

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

claimed neutrality. The data collection commenced upon ethnical approval by the Norwegian Centre for Research Data (NSD).

Individual, in-depth interviews of one-two hours were conducted with 26 Norwegian-Somalis between the ages of 20 and 64. The interviewees included eight persons representing the organizational sphere, nine health care professionals (psychiatrists, psychiatric social workers, and nurses), two high-ranking mosque representatives, and seven laypersons with only informal health knowledge and organizational experience. The interviews took place in various settings, such as cafés, hospitals, and organizations, depending on the participants' convenience. In addition to the individual interviews, assisted by two organizations I arranged two focus group discussions with four and eight participants, respectively. These discussions were moderated to attain insights on conflicting attitudes and perceptions towards the Norwegian health care system, health care experiences, and determinants shaping health beliefs and health care seeking practices. All the interviews were in Norwegian and were recorded upon informed consent for subsequent transcription, coding, and analysis. To assist recollection, I jotted field notes following each interview.

The analysis and data-collection constituted an integrated and continuous process as it involved iterative revisions of semi-structured interview guides and testing of emerging themes in the expanding data. In analysing the participants' stories, to identify patterns of actions and meanings related to health care integration, along with the social circumstances and processes that informed them, I applied a narrative analysis approach (Gubrium and Holstein, 2009; Riessman, 2008). Granted narrative analysis concerns what individuals subjectively convey in storytelling, and how, it was by drawing out and interpreting elements of similarity and difference across several narratives that sociological insights pertaining to the general question of inquiry was attained (Reissman, 1993). The work of 'bridge-building' emerged early on as a central analytical theme in relation to health care integration and recurring stories of

unfamiliarity and mistrust between Norwegian-Somalis and the health care system. Although leaders of immigrant organizations were more inclined to refer to themselves as bridge-builders compared to health care employees, I here extend the term to encompass variations of cultural health capital mobilisations. In presenting the central findings regarding the various formations and influences of the Somali bridge-builder role, I focus on case-examples from a birth-clinic, a measles-outbreak, and everyday consultancy. Pseudonyms are applied to conceal participants' identities.

In the Birth-Clinic: Countering Unfamiliarity and Establishing Trust

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

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

> I had to have a full consultation over the phone where I tried to explain why the caesarean was necessary for both the woman and her child. Some people think that this is done to sterilize them, but this is a myth. The problem in this case was that what people had told her still had great influence.

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

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

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

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

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

The next day, before her night shift, Basma made sure to see the woman. The surgery had been successful, and her first utterance was, ‘oh my God, how lovely that narcosis was.’ Although Basma was relieved, her frustration with the woman, the husband, and her friend made her determined to ensure that the woman departed with her previous scepticism. It was here that she learned about the reasoning behind the refusal. According to Basma, and as Arif narrated, this kind effort was particularly important because of the Somali culture of storytelling, wherein negative health care stories often weigh heavily on the convictions upon which people act. Notwithstanding mistrust is a protective mechanism (Wang et al., 2009), part of the problem is that it can also be a contributor to risk and unequal treatment.

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

Responding to a Measles-Outbreak in Oslo

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

Realizing the barriers to a swift response, local health authorities proceeded to engage Norwegian-Somali health care employees, who by their medical training and community bonds

could address Somalis. Arif, the psychiatrist, talked about his involvement in the counter-efforts following the abovementioned measles outbreak:

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

In this situation, Arif was able to vouch for the vaccine because he could provide explanations for biomedical concepts that have no direct Somali translation. In this sense, he gained authority through his command of the very system that other Somalis viewed with scepticism. These retrospective preventative efforts led 25 Norwegian-Somali children to receive vaccinations the subsequent weeks (Steen et al., 2012).

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

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

In these cases, it was not only necessary for the healthcare apparatus to address proactively the Somali community in order prevent further disease, but to appear with trust and credibility there was also a need for involving Somali health care employees. As both Arif and Mohammed were

selected as mediators because of their background, combined with their formal competency, this indicates that the healthcare system's capability and credibility is situationally contingent upon putting informal kinds of competency in motion.

Formations of Everyday Consultancy: Strains and Gains

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

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

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

According to Mariam, the reason small signs might be exaggerated, and vice versa, is because people from Somalia often have different experiential prerequisites for distinguishing between serious and harmless symptoms. Somalis might therefore adhere to different notions of treatment, but also of giving and receiving help. This was exemplified in the two focus group

discussions, where doctor's visits were highlighted as frequently unproductive, because 'nothing happens.' This perceived passivity, exemplified by the advice to 'stay hydrated and rest,' was highlighted both as explanation for why some participants reported not going to doctor 'unless one is injured or really ill,' and for why Somalis pick up on advice to pursue treatments abroad, a practice common also among Swedish-Somalis (Svenberg, Skott, and Lepp, 2011). It could also partially explain why Norwegian-Somalis resort to emergency room services, which do not require appointments or referrals, more often than other immigrant groups (Sandvik, Hunskaar, and Diaz, 2012).

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

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

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

A third challenge behind the engagement of Norwegian-Somalis in bridge-builder roles was that of comprehension of and compliance with treatments and advice. In an interview with Habiba (52) and Salma (48), two central women in a large Somali organization, explicated that

Somalis have a precarious need for translated information about both biomedicine and available services. Leaning forward to underscore the seriousness of the problem, Habiba said that:

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

In some cases, this kind of unfamiliarity and mistrust is also the basis for exerting influence on others. This was exemplified by Bilal (52), the leader of a Somali recreational organization, who explaining that his friend, in response to him being prescribed blood-pressure medications by his doctor, suggested that he should quit and instead make use of herbal remedies, like him. Direct involvement within the Norwegian-Somali community was thus identified as crucial to establish first contacts, facilitate communication between patients and providers, but also to counter misconceptions and advice that could restrict utilisation and beneficence from available services.

Although the capacity, focus areas, and aims to provide help varied among the organization leaders and the health care employees, they reported being utilized as reference points, or steppingstones both within and beyond the health care system. A notable difference between the different actors, however, was that health care employees tended to engage as bridge-builders upon the request of employers, colleagues, and acquaintances, whereas the formal engagements of representatives of organizations involved personal initiatives combined with an awareness of pressing health challenges. Occasionally, the organizations would also invite health care professionals to convey health and services information and answer questions.

Different forms of bridge-builder involvements were also accompanied by potential limitations to their impact and outreach capacity. Hala (33), for instance, who was interviewed

at the nursing home where she works, said that she rarely saw any Somalis at work, but explained that she would get contacted by family and friends 'when someone is experiencing symptoms or have questions, for example about typical woman's issues like urinary infections.' By contrast, Arif, the psychiatrist's role as bridge-builder, which had attained a transnational character, was limited not in outreach but his capacity and time. He explained that:

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

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

The starting point for this study was to establish contact with Somali immigrant organizations to attain further contacts and insights on health issues among Norwegian-

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

Reflecting a community relatively fragmented by clan, as well as gender, there are currently no pan-Somali organizations in Norway. While Norwegian-Somali children and youth tend to place less emphasis on clan than do their parents (Fangen, 2008), the 'invisible differences' associated with clan affinity continue to define how Somalis relate and who they might trust (Lewis, 2004). This might be both a challenge to and motivation behind some types of organizational work. According to Basma, as well as Hala, they knew women who chose not to attend various health-related meetings arranged by some of the largest Somali organizations because of the leaders' clan background. Hence, as observed among Somalis in London (Hopkins, 2006), even organizations that claim clan neutrality and that are working to achieve this image have possible limitations to their inclusiveness and outreach capacity.

Invisible extensions of the health care system

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

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

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

the perceived distance to health care providers among Somalis underscores that integration is not only a two-way process, but one that generates mediation in both directions.

However, although the identified bridge-builders were said to for instance have a better understanding of how Somalis conceptualize symptoms and ask for help, a shared background was synonymous with a foundation for familiarity and trust. Several of the bridge-builders in this sample explained that they had to prove themselves trustworthy by having a record of and reputation for helping others. In practice, this meant that bridge-builder trust was a precondition for convictive power and facilitation of health care contacts.

Conclusion

Health care institutions demand both the formal and informal competency of its members. Yet it is becoming increasingly clear in a time of new and perpetual migration flows that the informal is becoming of greater importance for the realization of the overarching ideology of equitable health care. This is because trust, which pertains to a particular attitude towards the future outcome of decisions (Luhmann, 1979), and health beliefs are often shaped indirectly, based on immigrants' exchange of experiences and stories. Notwithstanding cultural insights and person-centeredness among health care staff is important for immigrants' health care integration, the health care system's reputation and trustworthiness, and its ability to address public health matters, this study highlights that the challenges of unfamiliarity and limited trust not only surface in clinical encounters, but also requires addressing within realms of social life. Hence, despite the Norwegian policy focus on improving the cultural skills of health care professionals, in practice, current shortcomings are partially compensated by employees of immigrant backgrounds and the activities of different organizations. In this sense, the need for cultural competency can be said to 'fix itself', at least to the extent that resourceful Norwegian-

Somalis have successors or the sustained capacity to extend themselves to newcomers. Notwithstanding several participants said that they would prefer not to act as bridge-builders, it was difficult for them to decline requests for help, both out of their own conscience and presumably out of concern for their positions and reputations.

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

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

resettlement contexts, and with a concern for the culture and social organization of different immigrant groups. In this respect, a focus on trust can yield invaluable insights about immigrants' resettlement and integration experiences.

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References

Alba R and Foner N (2015) *Strangers no more: Immigration and the challenges of integration in North America and Western Europe*. Princeton: Princeton University Press.

Assal M A (2006) Somalis and Sudanese in Norway–Religion, ethnicity/clan and politics in the diaspora. In: Manger L O and Assal M A (eds) *Diasporas within and without Africa: Dynamism, Heterogeneity, Variation*. Uppsala: Nordiska Afrikainstitutet, 165-94

Ayazi T (2006) Oppsøkende arbeid blant pasienter med somalisk bakgrunn: Et prosjekt i psykisk helsevern i Oslo. *Tidsskrift for norsk psykologforening* 43(12): 1330-32.

Benkert R, Peters R M, Clark R, and Keves-Foster K (2006) Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *Journal of the National Medical Association* 98(9): 1532.

Bhatia R and Wallace P (2007). Experiences of refugees and asylum seekers in general practice: a qualitative study. *BMC Family Practice* 8: 48.

Binder P, Borné Y, Johnsdotter S, and Essén B (2012) Shared language is essential: communication in a multi-ethnic obstetric care setting. *Journal of Health Communication* 17(10): 1171-86.

Binder P, Johnsdotter S, and Essén B (2012) Conceptualising the prevention of adverse obstetric outcomes among immigrants using the 'three delays' framework in a high-income context. *Social Science & Medicine* 75(11): 2028-36.

Bourdieu P and Wacquant L J (1992) *An invitation to reflexive sociology*. University of Chicago press.

Cherrington A, Ayala G X, Elder J P, Arredondo E M, Fouad M and Scarinci I (2010) Recognizing the diverse roles of community health workers in the elimination of health disparities: from paid staff to volunteers. *Ethnicity & Disease* 20(2): 189-94.

Dubbin L A, Chang J S, and Shim J K (2013) Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine* 93: 113-20.

Engebrigtsen A I (2007) Kinship, Gender and Adaptation Processes in Exile: The Case of Tamil and Somali Families in Norway. *Journal of Ethnic and Migration Studies* 33(5): 727-46.

Fangen K (2008) *Identitet og praksis: Etnisitet, klasse og kjønn blant somaliere i Norge*. Oslo: Gyldendal Akademisk.

Fangen K (2006) Humiliation experienced among Somali refugees in Norway. *Journal of Refugee Studies* 19(1): 69–93.

Farah N (2000) *Yesterday, tomorrow: Voices from the Somali diaspora*. London and New York: Cassell.

Feldmann C T, Bensing J M, De Ruijter A, and Boeije H R (2007) Afghan refugees and their general practitioners in The Netherlands: to trust or not to trust? *Sociology of health & illness* 29(4): 515-35.

Giddens A (1990) *The consequences of modernity*. Cambridge: Polity Press.

Giddens A (1991) *Modernity and self-identity: Self and society in the late modern age*. Stanford University Press.

Gilson L (2003) Trust and the development of health care as a social institution. *Social Science & Medicine* 56(7): 1453-68.

Green G, Davison C, Bradby H, Krause K, Mejías F M, and Alex G (2014) Pathways to care: how superdiversity shapes the need for navigational assistance. *Sociology of Health & Illness* 36(8): 1205-19.

Gubrium J F and Holstein J A (2009) *Analyzing narrative reality*. Sage.

Halbert C H, Armstrong K, Gandy O H, and Shaker L (2006) Racial differences in trust in health care providers. *Archives of Internal Medicine* 166(8): 896-901.

Hopkins G (2006) Somali community organizations in London and Toronto: Collaboration and effectiveness. *Journal of Refugee Studies* 19(3): 361-80.

Hsieh E, Ju H, and Kong H (2009) Dimensions of trust: the tensions and challenges in provider-interpreter trust. *Qualitative Health Research* 20(2): 170-81.

Johansen R E B (2006) Care for infibulated women giving birth in Norway: an anthropological analysis of health workers' management of a medically and culturally unfamiliar issue. *Medical Anthropology Quarterly* 20(4): 516-44.

Lewis I M (2002) *A Modern History of the Somali*. Oxford: James Currey Publishers.

Lewis I M (2004) Visible and invisible differences: The Somali paradox. *Africa* 74(04): 489-515.

Luhmann N (2000) Familiarity, Confidence, Trust: Problems and Alternatives, In Gambetta D (ed) *Trust: Making and Breaking Cooperative Relations* (electronic edition) 94-107. University of Oxford.

Luhmann N (1979) *Trust and Power: Two works by Niklas Luhmann*. Chichester: Wiley.

McGown R B (1999) *Muslims in the diaspora: the Somali communities of London and Toronto*. Toronto: University of Toronto Press.

Magnussen J, Vrangbæk, K, Saltman R B, and Martinussen P E (2009) Introduction: The Nordic model of health care. In: Magnussen J, Vrangbæk K, and Saltman R B (eds) *Nordic Health Care Systems. Recent Reforms and Current Policy Challenges*. Open University Press, 3-20

Manderson L and Allotey P (2003) Storytelling, marginality, and community in Australia: how immigrants position their difference in health care settings. *Medical Anthropology* 22(1): 1-21.

Misztal B (2013). *Trust in modern societies: The search for the bases of social order*. John Wiley & Sons.

Mohseni M and Lindstrom M (2007) Social capital, trust in the health-care system and self-rated health: the role of access to health care in a population-based study. *Social Science & Medicine* 64(7): 1373-83.

Norwegian Institute of Public Health (2012) *Barnevaksinasjonsprogrammet i Norge*. *Report for 2011*. Oslo: Oslo Norwegian Institute of Public Health.

Norwegian Ministry of Health and Care Services (2013) *Equal Health and Care Services – Good Health for Everyone. National Strategy on Immigrant Health 2013-2017*. Oslo: Norwegian Ministry of Health and Care Services.

Næss A and Moen B (2015) Dementia and migration: Pakistani immigrants in the Norwegian welfare state. *Ageing & Society* 35(8): 1713-38.

Parsons T (1951) *The social system*. Routledge.

PROBA (2013) Evaluering av forsøk med linkarbeidere. Report 2013-8. Oslo: Proba samfunnsanalyse.

Putnam R D (2000) *Bowling alone: The collapse and revival of American community*. Simon and Schuster.

Riessman C K (2008) *Narrative methods for the human sciences*. Sage.

Riessman C K (1993) *Narrative analysis* (Vol. 30). Sage.

Sandvik H, Hunskaar S, and Diaz E (2012) Immigrants' use of emergency primary health care in Norway: a registry-based observational study. *BMC Health Service Research* 12(1): 308.

Shim J K (2010) Cultural health capital a theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior* 51(1): 1-15.

Small R, Gagnon A, Gissler M, Zeitlin J, Bennis M, Glazier R, et al. (2008) Somali women and their pregnancy outcomes post migration: data from six receiving countries. *BJOG: An International Journal of Obstetrics and Gynaecology* 115(13): 1630–40.

Statistics Norway (2014) *Population Statistics*. Oslo: Statistics Norway.

Steen T W, Arnesen T M, Dudman S G, Gustafsson A-L, Rojahn A, Rønning K, et al. (2012) Meslingutbrudd ved økt reisevirksomhet og lav vaksinedekning. *Tidsskrift for Den norske legeforening* 132: 937-9.

Strang A and Ager A (2010) Refugee integration: Emerging trends and remaining agendas. *Journal of Refugee Studies* 23(4): 589-607.

Svenberg K, Skott C and Lepp M (2011) Ambiguous Expectations and Reduced Confidence: Experience of Somali Refugees Encountering Swedish Health Care. *Journal of Refugee Studies* 24(4): 690-705.

Sørbye I K, Daltveit A K, Sundby J, Stoltenberg C and Vangen S (2015) Caesarean section by immigrants' length of residence in Norway: a population-based study. *The European Journal of Public Health* 25(1): 78-84.

Unit for Diversity and Integration (EMI) (2016) *Innvandrerorganisasjoner*. Oslo: Municipality of Oslo.

Vainio, K., Steen, T.W., Arnesen, T.M., Rønning, K., Ånestad, G., and Dudman, S. 2011. Measles virus genotyping an important tool in measles outbreak investigation in Norway. *Europe*, 12(13).

Vissman A T, Eng E, Aronson R E, Bloom F R, Leichliter J S, Montaño J, et al. (2009) What do men who serve as lay health advisers really do?: Immigrant Latino men share their experiences as Navegantes to prevent HIV. *AIDS Education and Prevention* 21(3): 220-32.

Vozikis A and Siganou M (2015) Immigrants' Satisfaction from the National Health System in Greece: In the Quest of the Contributing Factors. *Health* 7(11): 1430.

Wakefield A J, Murch S H, Anthony A, Linnell J, Casson D M, Malik M, et al. (1998) RETRACTED: Ileal-lymphoid-nodular hyperplasia, non-specific colitis, and pervasive developmental disorder in children. *The Lancet* 351(9103): 637-41.

Wang H, Schlesinger M, Wang H and Hsiao W C (2009) The flip-side of social capital: The distinctive influences of trust and mistrust on health in rural China. *Social Science & Medicine* 68(1): 133-42.

Whetten K, Leserman J, Whetten R, Ostermann J, Thielman N, Swartz M, et al. (2006) Exploring lack of trust in care providers and the government as a barrier to health service use. *American Journal of Public Health* 96(4): 716-21.

Yaqub O, Castle-Clarke S, Sevdalis N, and Chataway J (2014) Attitudes to vaccination: a critical review. *Social Science & Medicine* 112: 1-11.

Yosso T J (2005) Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race, Ethnicity, and Education* 8(1): 69-91.

Biography

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