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Loneliness cannot be seen, but it can be talked about

Social Capital's Role in the Health Promotion of Immigrant Women

Author: Heléne Schreber

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Supervisor: Dalia Abdelhady

Abstract

Studies and public health reports indicate that newly arrived refugees in Sweden experience poorer health and well-being compared to the general population, particularly among women. Research has also demonstrated that migrants' health not only starts off deprived upon arrival but also deteriorates over time. This thesis investigates the health challenges faced by immigrant women in Malmö and the role of social capital in promoting their health. It is a case study on the Women's Connections Association where interviews were conducted with key informants and immigrant women who are members. The findings reveal that women experience language barriers and reduced social support networks in whcih contribute to involuntary loneliness and social isolation. The study highlights the different forms of capital between bonding, bridging, and linking in promoting the health of immigrant women. Specifically, the significance of supporting social inclusion and cohesion, particularly from the host community. The findings contribute to understanding the role of social capital in health research and encourage its application to investigate interpersonal relationships, cooperation, and community involvement in health promotion across various contexts.

Introduction

People have always migrated, voluntarily or involuntarily. Over the last few years, more individuals than ever before have migrated to seek refuge in Europe. The population of Sweden is home to one of the largest proportions of immigrants. A total of 10,5 million people live in Sweden, of whom one-fifth were born in another country, and one in four have both parents born in another country (Statistics Sweden, 2022a & 2022b). In today's discussions, globally and in Sweden, there has become an increased concern about the health of immigrants. Migration can both benefit and harm health. In one sense, migration can improve the health and well-being of individuals by providing better access to healthcare, education, and employment opportunities (Abubakar et al., 2018). Meanwhile, migration may also expose individuals to health risks such as infectious diseases, environmental hazards, and social stressors, all of which can negatively impact health (ibid.). Thus, Sweden is a particularly suited place to research migrants and their well-being.

Studies and public health reports show that health and well-being among newly arrived refugees in Sweden are worse than the rest of the population (Tinghög et al., 2016; Hollander et al., 2013). In several European countries, it is reported that mental health is poorer among foreign-born populations than native-born populations (Gilliver et al., 2014). Scientific study shows that this refers especially to women's health (Nyampame, 2008). It is not only that migrants' health is poor when they arrive, but it also deteriorates over time (Thomas, 2016; Nilsson, 2006). Hence, it is vital to better understand the drivers of migrant health disparities, particularly mental health inequality.

The notion that social conditions influence health is not new, Durkheim (1987) wrote about the profound social experience, that of social integration and how it was related to suicide. Immigration is more than simply a process of individual adaptation to a new environment; it involves a complex and often extensive process of negotiation with social structures, political forces, and economic forces (Castañeda et al., 2015). The International Organization for Migration (2019:106) defines migration integration as:

> the two-way process of mutual adaptation between migrants and the societies in which they live, whereby migrants are incorporated into the social, economic, cultural and political life of the receiving community. It entails a set of joint responsibilities for migrants and communities and incorporates other related notions such as social inclusion and social cohesion.

Social capital has often been described as the glue that holds societies together (Puntam, 2000:3). It refers to the internal social and cultural coherence in society which enables people to work together and cooperate for mutual benefit (Bourdieu, 1986). The core idea is that relationships matter, looking at the social connections and the shared understandings that influence our interactions with each other. What this thesis aims to bring is the importance to look at social capital as more than just social networks. The concept attaches the 'capital' to the 'social' in such a way that makes it measurable, and has the ability to create other forms of capital (Robison, Schmid, and Siles, 2002). It contributes to the expansion of our knowledge production that is theoretically coherent and empirically valid where we measure the social relationships thus understanding how we can embrace it in developmental aspects.

This study is based on a case study on the non-profit organisation Women's Connections Association (WCA) to understand if and how social capital can facilitate the health promotion in their activities with immigrant women. I have been engaged as a volunteer worker at the organisation and attended several activities which allows me to maintain a trusting relationship with its members and its informants that has provided an opportunity to gain insights into the research area. I have had a chance to observe and attend the space where women share experiences and engage with each other's lives; places where trust, enjoyment and expansion of women's well-being is something that I believe is worthy of greater attention and acknowledgement.

The research follows a qualitative method of inquiry with interviews as the main method of data collection. By using this method, I am able to answer research questions regarding behaviours, beliefs, and attitudes related to the topic (Robson & McCartan, 2016: 285). It is an applicable

method to allow the expression of subjects' perspectives, both the members and informants, to capture their perceptions of the phenomena being studied.

The analysis brings several theoretical dimensions into dialogue to present different perspectives on health such as migration, intersectionality, identity and social capital to strengthen and inform each other. More specifically, the thesis draws on the theoretical tools of Social Determinants of Health and the classifications of Social Capital by Puntam (1993 and 2000) and Szreter & Woolcock (2004). This contributes to a nuanced and complex understanding of the phenomena being studied which aims to expand and contribute to the existing research area.

Purpose

The purpose of this thesis is to explore the health challenges of immigrant women in Malmö, with a focal point on the social determinants at individual and community levels. This will gain a deeper understanding of the experiences and needs of immigrant women's health and well-being in order to find suitable measures to promote it which can be useful in further work for health promotion within integration work. Specifically, the purpose is to analyse the resources and benefits that might arise from social relationships and networks within a community or society. By framing social connections as a form of capital, it highlights their potential value and influence in various aspects of immigrant women’s health outcomes. Additionally, the study contributes to the broader literature on migration, health, and social capital, to understand the complex interactions between them. Ultimately, the purpose of the study is to generate knowledge that can be used to promote the health and well-being of immigrant women in and to contribute to the broader understanding of migration and health.

Delimitations

Delimitations in a study refer to the boundaries of the research, which can help to define the scope of the study and provide clarity on what the study is not examining. Some potential delimitation of a study on the health challenges and social capital of immigrant women, with a focus on integration work and health promotion is the geographical delimitation. The research only focuses specifically on the experiences of immigrant women in Malmö. This does not include other areas within Sweden or other countries. This does not only refer to Malmö, but also

the sample size and selection of the case study of WCA. The study only has a limited number of participants that are from specific communities or neighbourhoods in Malmö, which may not be representative of the broader population of immigrant women in the city.

Moreover, another obstacle that I encountered even before the initiation of the study was that in activities, specifically the language cafés, the women were from different places and came to Sweden at different points in time. This leads to a complex situation to define and deal with due to every individual having varyingly independent experiences. It also entails a risk of homogenising the group and ascribing the same characteristics to everyone in the group. This might lead to stereotyping and ignoring diversity within the group. It could potentially 'other' a group of migrants discriminating against them rather than representing their true circumstances, even though it is instrumental when classifying migrants for protection, assistance, or research (Abubakar et al., 2018).

Specific aims

The study identifies the specific health challenges that immigrant women face and explores the social determinants that contribute to these challenges. It aims to understand if and how social capital has an potential value and influence in the health outcomes of immigrant women's health. Furthermore, framing social relationships as capital allows for comparisons and analysis of different forms of social capital between bonding, bridging, and linking. This makes is possible to map the types of networks available, as well as determine what types of networks promote or harm health. Moreover, understanding the specific case study of WCA will add to the literature for further research since it can capture the complex context-specific dynamic.

Research question

This leads to the overarching research questions;

What are the perceived health challenges of immigrant women in Malmö?
And what role does social capital have in health promotion for them?

Disposition

The first section of the paper will introduce the case and setting where the research problem is investigated. More specifically, it clarifies the concepts of integration, health and health promotion which sets the context for the whole paper. The second section provides several scientific studies with information that is relevant which identifies the distinguishing contribution of this study. The third section presents the theoretical frameworks of Social Capital that are used to analyse the data findings. The fourth section presents the design of the study and the fifth present the data findings and analysis of the study. Lastly, the last section consists of a conclusion based on a summary of the purpose, research questions and main results.

Background

Integration and Malmö

To move to other continents or countries means that individuals face societies where they might not know the language, culture or rules. Those who are newly arrived migrants to Sweden can receive support in the form of activities and education through the establishment programme (Arbetsförmedlingen, 2023). The aim is to learn Swedish, enter the labour market, and become self-sufficient. According to Swedish law, during the establishment program all refugees with a residence permit have to receive 60 hours of community orientation in their language (Swedish Parliament 2010). For the receiving countries, this has meant extensive organisation and demands in order to achieve worthy recipients, effective establishment and inclusion. The Country Administrative Board, the Migration Agency and the Public Employment Service have together with the municipalities the common responsibility for the receipt and establishment of newly arrived migrants in Sweden.

As a result of growing global migration movements, Malmö has developed an extensive diversity that distinguishes it from many other cities in Sweden. It is the third-largest city in Sweden, with a location at the southern border to Europe which has made it one of the main cities of arrival for people seeking asylum in Sweden. One third of Malmö's population is foreign-born originating from no fewer than 186 countries (Malmö Stad, 2023). This has led to the considerable amount of discussion about integration in recent years. Generally speaking, integration is concerned with

the relationship between different constructed groups within a society (Geugjes, 2021). There is a strong consensus in research, policy, and practice regarding the importance of bridging for the integration of newly arrived migrants and social cohesion. Righard (2022) write from the super-diversity perspective of Malmö, that there is a need for discussion about how diversity affects social relationships in residential areas and cities. The high diversity in Malmö makes it a particularly important city for trusted relationships since if trust between groups is lacking it can in the long run make it more difficult for the integration of certain groups (Dinesen et al., 2020). Civil society organisations are considered to be a potential facilitator for contacts between groups and can thereby bridge social distances and it is also considered to offer possible routes into society for newly arrived immigrants. Wallman Lundåsens (2022) anlysis on contacts in civil society organisations in Malmö and their contributions to positive relations and trust between groups in different local communities. It showed that contacts within civil society were important for the degree of trust and it pointed to positive experiences from contacts can dampen the significance of living in an area that is characterised by diversity.

Women's Connection Association

WCA is a non-profit association whose purpose is to work for the rights of all women and an equal and inclusive society thus, all activities are guided by the core values of democracy, human rights and equality. They run various projects and activities, all of which are basically about health promotion in establishment work in Malmö. Activities that are held include language cafés, cycling courses and Swedish language training for asylum-seeking women. Together with the members, they also highlight important days and topics related to women's rights in society, such as men's violence against women. In the context of health promotion, establishment work can have important implications for immigrant women's health outcomes. Thereby this study focuses on the experiences of WCA's activities to understand if social capital through community involvement can provide important sources of support that promote health and well-being.

Health promotion

Health is not merely the absence of disease and infirmity, the World Health Organisation define it as a "state it as of complete physical, emotional and social well-being" (WHO, 1948). They mean to enjoy the highest attainable state of health is a fundamental right of every individual

without any distinction of race, political belief, religion, economic or social condition. Health promotion focuses on the ability to realise this state which is defined by WHO (1986) in the Ottawa Charter as "the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment". The 1986 Ottawa Charter organised five areas of action for health promotion; 1) building Healthy Public Policy, 2) Creating Supporting Environments, 3) Strengthening Community Actions, 4) Developing Personal Skills, and 5) Reorienting Health Services. This research focuses on the areas of actions which WCAs activities attend to which are; 2, 3 and 4.

Various forms of social capital have been linked to health. Firstly, social capital can benefit health by enhancing caring social relationships and meaningful community connections (Berkman et al., 2000). Furthermore, social capital facilitates community self-help, enabling communities to work together more easily to identify and resolve collective problems (Kawachi, 2000). On that note, communities and environments that are supportive are characterised by participation, mutual support, and trust. Thus, social capital is seen as an important facilitator and outcome of community development. Goals 2 and 3 for health promotion in the Ottawa Charter align with the theory of social capital since collective action is viewed as a consequence of social capital at the community level. Consequently, mobilising social capital in communities is viewed as a key goal for health promotion approaches. Although, more research is needed to understand what role the social context has and the use of holistic approaches in health promotion strategies for migrants. This is further explained in the next section of the thesis.

Research Overview

Immigrant women's health challenges

As aforementioned, immigrants health is worse than the rest of the population and it deteriorates over time. More specifically, Hollander (2013) concluded in her study that the relative risk of being hospitalised because of depression followed by unemployment was highest among immigrant women. She promotes that to help mental health and reduce mortality amongst

immigrants it is important to consider the temporary aspect of migration and the general Social Determinants of Health. Ingleby (2012) mean that even though there is a need for healthcare, refugees do not seek care because of hindrances such as poor knowledge of Sweden's care institutions and language barriers. Sweden provides all newly arrived with free healthcare examinations in the establishment programme, however, they can be unsuccessful due to the same obstacles as aforementioned (Wångdahl et al., 2015 and 2018). When looking at post-migration factors that negatively affect migrants' health in Sweden, Al-Adhami et al. (2022) conclude that these are socio-political factors such as uncertainty about asylum processes, socio-economic factors such as housing, unemployment, and contextual factors such as isolation and discrimination. They emphasise that these structural factors that influence health are extremely important, however, they mean many receiving countries do not address or resolve them despite their significance.

Ikonen's (2015) study shows a perspective of the health and well-being of newly arrived migrants participating in the establishment program in Malmö. The study highlights that it is several factors related to the individual and environment, beyond the usual categorisation such as education or profession, that influence their health. The author means it is the individuals' life goals, how strongly they have been internalised and social exclusion in society that matters most to their well-being. The study found that most informants have a stronger issue with their mental health than their physical one, such as feelings of identity loss and hopelessness. Brance et al, (2023) conclude the same that the adverse experiences that negatively impact the well-being of migrant populations were prejudice, disconnection from previous identities and issues of integration into the host country.

Svanholm's (2022) study shows that there is an importance to promoting health in integration work because it affects health inequities, and actions on the social determinants of health that are systematic, socially produced and unfair. It found that there is a limited focus on health and health promotion in the efforts for integration in Sweden. Migrants' perspectives are marginalised in health perspectives in decision-making processes and it is generally not seen as a resource within integration. The research implied that to extend the scope of the field the perspectives of migrants should be encouraged to activate their participation in research.

Social Capital and Health in Migration Literature

Research shows that there is a significant health risk with social isolation and a lack of social support and networks (Thomsson, 1996). This is most apparent for men but when women are studied it is less consistent. House (1981) implies that one of the effects of social support is that it meets important human needs such as security, social contact, belonging and approval, nevertheless, it reduces levels of stress. Kawachi et al., (2008) agree when looking at the associated lack of social capital and its several adverse health outcomes. Emphasises that social participation through social engagement, contact and influence leads to a sense of belonging and meaningfulness (Berkman & Kawachi, 2001).

According to previous studies in Sweden, immigrants with low social capital are closely related to socioeconomic health disparities and it plays a critical role in mediating these effects (Brydsten et al., 2019; Lecerof et al., 2016). Johnson-Singh (2021) indicates that social capital as well as the ethnic composition of the neighbourhood can affect immigrant mental health. More specifically the weaker and more diverse ties of bridging social capital can help prevent mental ill-health whilst the bonding networks appear to offer greater protection for newly-arrived migrants. Johnson et at., (2017) conclude from their cross-sectional study that social capital has an explanatory effect on immigrants' mental health inequalities in relation to the native-born population in Sweden. Furthermore, these findings show that immigrants with persistently low social capital over time may be particularly vulnerable to psychological distress. It highlights the importance of incorporating social capital as a factor in health promotion and the need for empirical evidence. Lecerof et al. (2015) conclude that socio-economic determinants in Sweden have a significant impact on newly settled migrants' mental health. It is emphasised that enabling bonding and bridging social capital may provide resilience against this, although more research is needed to understand how successful interventions by strengthening social capital are for the health promotion of migrants. Thereby this study aims to enhance the field in providing just such.

Evidence from Brance et al. (2023) suggests that social identities can be used as a health promotion against psychological strain and protect well-being. They mean that this is especially important in ethnic minorities, who experience exclusion and discrimination from the host

community where the social identity provides purpose and a sense of belonging to the social world. The research brings in the role that social context plays in migrant mental health and the importance of worthy recipients of migrants and integration with the host society. Furthermore, Llácer et al., (2007) write that social support networks are especially important for immigrant women since they have little opportunity to recreate functional social support networks or by being invisible and limited in the possibility of establishing social relationships. An important aspect that Hobfoll (1991) writes about is that there might be a negative component for women in engaging in social support networks. This is due to them experiencing a strong social pressure to maintain an active interaction with their social network which leads to an expectation to remain the key support for others whatever happens. Hence, this study aims to incorporate a nuanced lens with a potential risk of social capital to explore the subject under study.

Social Capital's Role in Health Promotion

Cambell (2020) researches the role of social capital in the health promotion of marginalised groups in South Africa. The research means that community mobilisation is a core strategy for increasing the power of marginalised groups to improve their health and well–being. Even though community mobilisation and social capital are two separate notions, I bring in their view on emphasising more holistic approaches in health research. Moreover, the authors advocate qualitative case studies of varyingly successful health-enabling social change which this research aims to do.

Ogden et al. (2014) study focuses on social capital and interventions in health. It concludes that social capital creates and facilitates effective inclusion of community voices (by creating bonds within communities, connecting communities and linking communities to institutions of power) in the health policy process. They conclude that it can provide an important facilitator for the integration of both within and between sectors. The authors mean it will improve social development overall hence it improves communications and opens up new ideas, norms and practices. Even though this research explores the phenomena on a lower scale, it brings in the idea that social capital is an important aspect in the promotion of health and well-being amongst the participants it aims to benefit.

Wakefield and Poland (2005) discuss the role of social capital in health promotion through a critical lens in the conceptual terrain. Their dialogue between social capital and health promotion suggests that social relationships and community connections have strong beneficial and important effects on health. Moreover, preserves health by maintaining social cohesion when there are changes in society since it contributes to more effectively solving collective problems.

Theoretical Framework

This section brings up theories that will function as conceptual tools to analyse and interpret the subject under study. To answer the first research question; *What are the perceived health challenges of immigrant women in Malmö?* the thesis draws on the Social Determinants of Health framework in order to understand the perceived perspectives of the health challenges of immigrant women and what might contribute to them. To answer the second research question; *what role does social capital have in health promotion for them?* the thesis draws on the concept of social capital and discusses its role in promoting the health of immigrant women.

Social Determinants of Health

WHO's Commission on the Social Determinants of Health (SDH) report (2008) writes that individual environments are shaped by social and economic factors that play a crucial role in shaping health outcomes. The framework identifies several social determinants that impact health, such as socioeconomic status, health behaviours, communities in which individuals live, social support networks and access to healthcare. It implies that there is an importance to address underlying social and economic conditions to contribute to understanding health disparities since it recognises that health is impacted by factors beyond individuals' genetics and personal behaviours. The SDH occur across different scales, these are defined as downstream, referring to biological and behavioural risk factors; midstream, which is relating to socioeconomic position, social networks and other collective factors; and upstream, including structural factors such as policies (Braveman et al., 2011). In light of these definitions, migrant status can be considered an SDH in and of itself, with implications for both individual health, as well as health inequalities, as a result of the uneven distribution of more general social factors between nativity and migrants (Castañeda et al., 2015). This research focus on the midstream SDH due to the limited

time frame of the thesis and the case study of the association has a focus on the collective feature.

There is a strong gender component to both population mobility and migration's health implications (Abubakar et al., 2018). Among the most important issues of gender inequality are gender relations of power, which influence SDH (Sen & Östlin, 2008). The analysis of gender and how it operates with other power relations are complex, mobile and situation-dependent in time and space (de Los Reyes, 2006). Since the subjects under study are immigrant women the research analyses migration, gender and ethnicity and how it impacts health. Thus, this thesis takes an intersectional perspective to be sensitive to several power orders intersect which gives an instrumental and important part in analysing inequalities in health. Nevertheless, the same point of view can make use of finding new ways of solutions and social justice in health promotion. On another note, there is the importance of considering the diversity of migrant populations (Abubakar et al., 2018). Migrants come from a wide range of cultural, linguistic, and socioeconomic backgrounds, and their experiences of migration and health can vary greatly depending on these factors. Taking a culturally sensitive and context-specific approach to migration and health research and practice is therefore critical to promoting health equity and reducing health disparities among migrant populations.

Social Capital

Social capital is a relatively new concept but it does not represent new ideas. Sociability is something that always has been important to humans and the development of our societies. It can be viewed as one of the most interesting concepts in sociology that has been the most adopted in other disciplines. However, it might also be considered the most critical in social sciences due to its ambiguity.

To understand it this thesis draws on Bourdieu's (1986) and Putnam’s (1992) definitions, where the first mentioned is a proponent of an individual approach whereas the second has a more collective feature. Bourdieu's theory of social capital means that individuals secure benefits by being members of social networks and other social structures which would not be obtainable in the absence of these networks. The idea implies that the resources do not lie within the individual

but rather in the structure of the social network the individual is within. According to the theory, inclusion in these networks is not something one inherently possesses. Power and inequality can manifest in these networks in such ways as some networks are more valuable than others and who is included in those.

On the other hand, social capital through the collective perspective, Putnam suggests that besides being a private good, it is a collective and non-exclusive which can be beneficial for those who have inadequate social connections. By living in communities with high social capital, strong organisations and active citizens, the benefits will be distributed to those who have poorer connections. This is because others can put the public before the private good, citizens are equal with the same rights and trust is high which encourages people to cooperate and act on reciprocity. Putnam has developed classifications of the structural dimension of social capital which distinguish different forms of social relationships. *Bonding* social capital is good for underpinning reciprocity and social movement. It describes collective and trusting relations between members of a network who see themselves as similar in terms of their shared social identity. In contrast, other networks are outward-looking and include individuals from a variety of social groups. These are connected to *bridging* social networks which are purposeful when looking at external assets, such as information diffusion and are characterised by respect and mutuality between people who are different in socio-demographic senses. These bridging social ties are probably more valuable for the creation of collective resources as they facilitate cooperation between dissimilar people in a given social structure.

Szreter & Woolcock (2004) add a political dimension to Putnam's definition of developing trusting norms, where they stress the importance of social ties within and between groups in the community but also between individuals and political institutions in society. In the context of the research I seek to understand social capital's role in health promotion I conform to their distinction of three classifications. The authors provide empirical evidence regarding the mechanisms connecting the structure and social relations to health outcomes. Moreover, the research draws on the classification because they provide a clear deductive operationalisation of social capital hence the framework will be used as a thematic indicator in the answers to the interviews. The first is viewing *bonding* social capital as networks of unifying individuals within

communities; the second is *bridging* social capital as networks unifying groups of individuals across communities; and the third *linking* social capital as networks linking individuals to institutions of power.

Method and Data

In this section, the design of the study is presented, why the qualitative case study is developed and how the data is collected with potential limitations and mitigations.

Research Design

The research utilises a qualitative approach through a case study of WCA. The research draws on the advantage of the approach to identify general patterns and features of organisational behaviour (Punch, 2005:150). Moreover, the approach captures contextual complexities through intense and prolonged contact with situations that reflect the organisation's everyday life (Robson & McCartan, 2016:81). It gains a holistic overview of the case context and a broader notion of how social capital operates for health promotion in integration work. An open-ended case study is most likely to capture the complex context-specific dynamic where the strategy leads to the discovery of important features, the development of an understanding, and the conceptualisation for further research.

The 'human element' of qualitative inquiry has its strengths and weaknesses. The strength is that the research draws on valuable insights and individuals are recognised for their own stories. However, they are based on social interaction, which gatherers data from language, which leaves room for interpretations and misunderstandings (Punch, 2014). The women who are members of WCA that I have interviewed struggle to express themselves in Swedish and they are helping each other translate. This introduces errors and/or biases in the translation processes. It is important to realise that language barriers are a limitation of the study. Although, the use of language fascinatingly opens up a window to understanding what lies behind actions (Robson & McCartan, 2016: 286).

Sources and data

Data is gathered from the case to develop a full understanding of the role of social capital in health promotion for integration work. This has been done by recognising its complexity and context. To have a clear cut of what the case is and to set its boundaries, this research focuses on understanding WCA's health promotion work for immigrant women. It focuses on the activities in which immigrant women participate. Multiple sources of data collection have been used which are semi-structured interviews with the informants and focus groups with the members.

To ensure anonymity all the names of the participants have been changed, including the name of the association. They have been changed to new names since the research do not want to loose the personal connection to the participants. Otherwise, to just name them as "participant 1" there is a risk of dehuminasing them. All participants granted their new names and ages, also they had a chance to quote check their statements to make sure it is presented in line with their answers in the interviews.

Key informants

Four semi-structured interviews have been conducted with key informants in the association. The interviews include a list of topic headings and essential questions. However, they have been free in sequencing questions and in the amount of time and attention, they devote to different topics. The sampling procedure of key informants has been carefully chosen depending on observation and contact with the organisation. Key informants are valuable in exploring the phenomena since they have experience, essential skills and knowledge of the case. Moreover, they know how to effectively communicate on the topic which provides rich information and saves time for the study (Chambers, 2008:77). Nevertheless, the informants work continuously with the research area over a long period of time and thereby meet the members and have a temporary perspective.

Interviews are appropriate as a method since they provide valuable insights into the organisation's informants' views. Therefore, the findings are realistic and trustworthy, reflecting the complexity of the organisation's work (Robson & McCartan, 2016:147). Interviews also reveal what lies behind the actions beyond observations and give people an opportunity to answer questions directly. The interviews have been audio-taped if consent is obtained. There is

a concern with the participants' participation bias that individuals tend to look competent in the work in the organisation. They also answered their questions in the interview, which affects the research reliability. Providing information about the purpose and bringing awareness to this concern will mitigate it.

Sampling

The first key informant is Melina Petrovic who is one of the founders of WCA and has valuable insights from a lifelong experience of working with associations. The second key informant is Isabella Larsson who is a project developer at another non-profit organisation in Malmö. Isabella is engaged in leadership at WCA, which gives comparative insights from her own work and a broader view of the phenomena from outside the organisation. The third key informant is Leyla Ahmed who is an immigrant woman that came to Sweden eight years ago from Syria. Leyla is an active worker in the association who has a strong relationship with the members since she meets and speaks to the members daily. The fourth key informant is Sofia Nilsson who is the project developer at WCA and also a founder of the association.

Focus groups

Since the aim is to explore the social capital's role in the health promotion of immigrant women, their experiences, stories and attitudes are important to explore, thus interviews with the members are a complementary appropriate method for data collection. Six women have been selected and interviewed in two focus groups. The selection depended on their language skills since they are at very different stages of speaking Swedish thus they can help each other out, while still keeping the sample size small to give time for every individual to speak and share their experiences. Some of the women have migrated from the same country which entails that they can help each other translate and formulate themselves in Swedish.

A flexible guide consisting of a checklist of questions was used but it had the opportunity to unfold even if the agenda is already set, hence the interview differs depending on the local conditions of the groups. The checklist had the same structure as the interviews with informants to connect codes and themes in the data management and analysis. Although, they were open to not closing off to capture the subject's directly lived experiences and understanding the

complexity of their own perspectives. Henceforth, the focus groups were semi-structured to have a checklist but also allow the respondents to speak more freely to bring the in-depth exploration (Robson & McCartan, 2016: 285). There have been important aspects by me as a researcher to approach these questions with sensitivity and a willingness to listen to every individual's unique perspective. The interviews have been audio-taped if consent is obtained.

Group interviews bring advantages because people in groups tend to feel more confident about their responses and can feel less threatened to give truthful answers since they might share the same experiences. Also, since they are in an environment where they usually meet up and speak there is a belief that they trust each other which contributes to correcting each other for a more realistic understanding of their experiences (Chambers, 2008:78). However, focus groups entail a limited time for every individual to give a response and share their experiences. There is also a social desirability bias that the group dynamics influence the individual to be hesitant to share their true thoughts if they believe they are different from the rest of the group.

Sampling

In the first focus group Nadia Al-Amin from Syria, Amirah Hassan from Iraq and Derya Öztürk from Turkey was interviewed. Nadia has a high level of Swedish which entailed that she could interpret and understand the questions fairly well and help the others translate and answer the questions. The second focus group consisted of Amani Arian from Iraq, Fatima Khalifa from Libanon and Maya Hamdan from Syria. They all have a good level of Swedish from all attending Language for Migrants (SFI) and all speak Arabic. Thus they all helped each other translate and understand the questions to be able to answer them in their own varyingly experiences. I have had language cafés with all of the members that were interviewed so a relationship was already established with them which made the interviews open and relaxed.

Data management, findings and Analysis

In this section the data findings and analysis of the study are presented, how the data has been managed with potential limitations and their mitigations as well as an analysis of it and connected with theories to interpret the subject under study.

Data management

In order to manage the vast amount of data, a system for connecting the different data points haas been developed for analysis. Data items will be summarised by key features of the qualitative data linked to Putnam's (2000) and Szreter & Woolcocks (2004) classifications using a thematic deductive coding approach (Robson & McCartan, 2016:461). To gain an understanding of the coding process and the themes, familiarisation was initiated during the data collection process. The themes guiding the interviews (see appendices) are mainly two categories, which are focusing on immigration and health, and social capital and health promotion. The second category is divided into three classifications: bonding, bridging and linking of social capital and how it is perceived discernible during activities held by WCA. This enables a clear thematic network of the transcription of the interviews, both with members and with informants.

The interviews are coded and it is useful due to the research question asking for an analysis of social capital's role in health promotion (Robson & McCartan, 2016:473). Coding is followed by the identification of themes and memos related to the research question. Data can be abstracted and thematic networks will be constructed to show how themes relate to each other and fit together. In this way, the concepts in the conceptual framework will be visualised with the help of the organisation's thematic networks. It has advantages because it categorises and connects data from different methods (Robson & McCartan, 2016:465). After data management and analysis, WCA and other practitioners in the field are informed of the findings.

As the analyst, the researcher has limitations, like the amount of data to analyse and ignoring conflicting data. To ensure a traceable transformation of data, methods for data analysis must be systematic, disciplined, and transparent. Also, by allowing WCA to evaluate the findings, the process of member checking honours the agreement between the researcher and the association.

Ethical considerations

The ethical consideration of moral dilemmas throughout the research was considered and reasoned with. This part will bring up such dilemmas, discussing their limitations and mitigations.In creating a project that is not impeded on values there has been an importance of transparency, reflexivity, and objectivity on the part of the researcher. I have recognised my own

position as a Swedish-born researcher studying immigrant women. My social position can be influenced by my beliefs, judgments, and practices coming from the dominant culture studying a marginalised group in it. This might impinge on the perception of me by the participants (Scheyvens, 2014:160). Using relationships to conduct inquiry introduces power dynamics, where they are asymmetrical due to the interviewer setting the scene, and controlling the sequence and outcomes (Kvale, 2007). A power bias is also present in those who are selected and excluded from participating (Scheyvens, 2014:62). As a result, the research risks being skewed in favour of elites by not reaching everyone in marginalised groups. To mitigate this, I have kept in mind key factors such as honesty and modesty when working with the members and limiting power imbalances. Hence I have considered showing respect and commitment to the participant's experiences and being sensitive to my presence of me as a researcher. I have also ensured that the research outcomes are beneficial to the participants and the broader community that can be accessible and meaningful to demonstrate the impact of their participation.

The research has also been conducted within the organisation's structure with informants as participants. There has already been established trust in the association, both with its informants and with its members which has allowed for mutual respect. Moreover, the objectives, procedures and outcomes of the research were presented at every conducted interview. Thus providing understandable consent, allowing free participation, and being honest about the true nature of the research. Lastly, there is a ethical consideredation that time and resources from the associations have been used. Participants in the study are compensated for their time and effort by ensuring that the research is valuable to them. Participants have been able to communicate and provide feedback on the findings, demonstrating a commitment to knowledge production between the researcher and the organisation (Scheyvens, 2014:162).

Data Findings and Analysis

The interview findings are disclosed and discussed through the analytical lenses of the theoretical frameworks of SDH and Social capital. The first thematic section focuses on the interviewees' perceptions of immigrating women's health, covering themes such as the perceived importance of language and social support networks. The second thematic section focuses on the

experiences of participating in WCA, highlighting how the interviewees perceive different types of social capital (bonding, bridging and linking) in health promotion in integration work.

Immigrant women's health challenges

The interviews have revealed that there seem to be several aspects that interplay in a system when looking at immigrant women's health in Malmö. Sofia Nilsson, the project leader at WCA, emphasises that what matters to an individual's health is not just good food and exercise. Society matters, such as relationships, finances and housing that affect the individual. She implies that immigrant women face the same health challenges as the rest of the population but due to the resistance they face in society it deteriorates. This adheres to the SDH theory that addresses the underlying social conditions that impact health as she says are "the structural constraints that immigrant women cannot impact themselves" (Sofia Nilsson, 38). She stresses that the possibility of establishing oneself in society, such as in the labour market or in education, increases significantly through activities promoting improved living conditions and good health.

One main theme that all interviewees bring up when talking about immigrant women's health challenges is the lack of the key to society - the language. As Derya Öztürk who came to Sweden one year ago says "I did not understand anything when coming to Sweden, I did not know simple things such as the bus, the bank and cycling. Without Swedish it is very hard." (Derya Öztürk, 31, Turkey). Länsstyrelsens report (2021) on immigrant women in Sweden shows that there is a stigma and exclusion that comes with not being able to read and write. They mean this does not only affect their ability to participate in social life but is an extension of their mental and physical health. Furthermore, it requires good health to learn a language which causes a continuous negative trend as the founder of WCA Melina mentions.

> To be able to learn Swedish you have to have good health. The challenge to good health is that you sit at home on your own because you can not speak to anyone. Many do not have a social network when coming to Sweden and in the home country that was your family and here you have no one. (Melina Petrovic, 58).

Ingleby (2012) suggests that the SDH influences migration patterns and health outcomes in complex ways. The author writes that being a migrant leads to ill-health by lowering one's socioeconomic status, for example by experiencing linguistic or cultural barriers and the reduction of one's social capital. As mentioned by Melina, the language barrier in turn affects the women's social support network. The member Nadia Al-Amin from Syria agrees with this.

> When I first came to Sweden I thought it was good. But it is hard if you do not know English or Swedish. [...] There is loneliness when coming to Sweden without a social network. It is hard without anyone who can teach you about society, the system and language. Such as the culture, education and general rules in society that are so different from where I come from. It is good if you have just one person here, to help you take the first step." (Nadia Al-Amin, 55, Syria).

This can be also defined to be a reduction of ones cultural capital, when drawing on Bourdieu's (1986) theory this refers to the knowledge, skills, and cultural resources such as language proficiency that individuals possess and can use for social advantage. These structural factors that influence health are extremely important just as Ikonen (2015), Al-Adhami et al. (2022) and Brance et al., (2023) showed in their studies. An important thing to consider here is the disparities between immigrant women which entail that they have different determinants in learning the language, as informant Leyla Ahmed who works at WCA mentions

> "…You have to look at the several levels of women's competencies, there are some with a high education level but there are also some who are analphabetic. There is a problem with this since we need to consider them all the same, to ensure equality. [...] This makes it hard for some to learn a new language since they do not acquire skills to educate themselves." (Leyla Ahmed, 41).

Thus, there is importance of taking a context-specific approach since there are different factors impeding immigrants' health depending on their backgrounds and to be sensitive when reducing them (Abubakar et al., 2018).

The SDH approach suggests that health inequalities are in general terms a consequence of the uneven distribution of resources and power (Honkaniemi, 2022). The influence it has on health is through perceived inequalities which manifest in a feeling of social deprivation and stress, which may become more pronounced with a longer duration of residence (ibid.). Isabella Larsson complies with the intersectional perspective of the marginalisation of immigrant women and says "[...] those who are most vulnerable are the ones who have the worst luck when there are deteriorations in society in general" (Isabella Larsson, 44). Such as Sofia also mentions that "They fall into the cracks when there are challenges in society". (Sofia Nilsson, 38)

Moreover, just as Al-Adhami et al. (2022) concluded that the socio-political factors influence migrants' health such as the stressor of waiting for residency. Isabella mentions this "And when talking about depression, that you are just waiting, this eternity and that you don't see anything getting further in your citizenship." (Isabella Larsson, 44). Just as the member Amirah from Iraq states "I have waited for eight years for citizenship without any luck with several submissions. It is not what I thought it was going to be. [...] It is a long-lasting stress that makes me feel bad." (Amirah Hassan, 62, Iraq).

Another social stressor for migrants is not getting official recognition or accreditation for their skills. As Layla expresses "That your former education has no purpose here, that I as a person with an engineering degree got sent to a cleaning job through the employment agency is shocking. I cried for a week. I have two university degrees, which is humiliating" (Leyla Ahmed, 41). Sofia Nilsson recognises this as well and means that there is an identity loss connected to it since it strips you of your former identity connected to your skills. "Imagine someone telling you that you are suitable as a child nurser, even though you do not feel that are good with people." (Sofia Nilsson, 38).

In conclusion, the main themes found in the interviews from this research were the language barriers and the deterioration of social support networks which socially isolate immigrant women and lead to involuntary loneliness. Further on, the analysis will discuss social capital's role in counteracting such challenges.

WCA and the Role of Social Capital in Health Promotion

Bonding

All interviewees were positive and thought bonding social capital has a big role in health promotion amongst immigrant women in integration work at WCA. The main feature that several interviewees brought up was “The importance of connecting immigrant women to other immigrant women thus creating social networks which bring a sense of belonging and recognition. A feeling that you are a part of something that others are a part of.” (Melina Petrovic, 58).

As stated by previous studies in the research overview, bonding social capital has health benefits amongst immigrants in the case study of WCA. In Putnam's school of thought (1992:171) social capital measures typically include social participation and trust in others. Social participation influences health through social engagement, contact and influence, which all create a sense of meaningfulness and belonging (Berkman & Kawachi, 2001). As the member Fatima Khalifa from Libanon expresses.

> Before I came to WCA it was the same routine every day. Do the dishes, do the laundry and cook the food. Every day the same routine and then I just sat and did nothing. I wanted to do something that activated and stimulated me. It feels very good that I can go out and do something different instead of just sitting at home. Otherwise, it is very depressing. I felt that I needed to be strong and find something that gives me meaning. (Fatima Khalifa, 48, Libanon)

Putnam (2000:136) suggests that trust in others is something that comes out of high social participation. A theme in the interviews was that the space at WCA builds on trust and members feel secure coming there. Sofia Nilsson explains that it is very hard to gather the members in another meeting space since they have been gathering at the association for such a long time. Furthermore, trust comes out of activities where one shares common values, as one of the members states.

> I feel better when coming here. I am learning a lot from other women and by speaking to them. When all the women have the same problems you can feel with them. Then you understand that it is not just me who has these kinds of problems. You do not feel alone because you share the same experiences. (Amirah Hassan, 62, Iraq).

Identity plays a crucial role in understanding and promoting migrant health (Abubakar et al., 2018). As a migrant, aspects of oneself are regularly reshaped and redefined due to the imposing of labels, such as migrant or foreigner (Geugjes, 2021). It is an excluding dominant discourse in which immigrant women tend to be othered in Sweden. Bonding social capital is based on homogeneity through a social network that connects individuals which refers to the strong ties between individuals that share a common social identity (Putnam, 2000:22).

According to Fukuyama (2018), an identity is created based on ambiguous notions of human dignity, which are the essential identification of one's inner self and recognition of such by the outer world. As member Amirah concludes, sharing your own experiences and seeing that others have the same, result in a recognition of one's identity in the group. A security in which the development of group identity may therefore be an important aspect of the ability of marginalised or excluded groups to create a consciousness and resistance to dominant groups and their exclusionary practices. Just as Brance et al. (2023) suggested, the identification with one's own group serves as a source of social capital and a motivational force for immigrant women in Malmö to support and recognise each other.

WCA has also helped with practicalities such as Maya Hamdan that came to Sweden seven years ago mentions. “WCA has helped me with school, the public employment service, and the other things that establish me in society.” (Maya Hamdan, 36, Syria). This specifically connects to goal number 4; Developing Personal Skills in the health promotion action plan of the Ottawa Charter (1986). Just as Szreter & Woolcock (2004) state that in order to improve health there is a requirement for material needs, although extracting the benefits from these material needs often goes through social relations.

Isabella Larsson means that health-promoting activities in groups give women increased self-esteem and agency due to them reaching their self-set goals. This improves health by increasing motivation to move closer to a job or an education (Länsstyrelsen, 2021). Which, health-promoting efforts contribute to immigrant women being able to successfully establish themselves in society. She exemplifies this with the cycling courses and means that it is so much more than just a physical health improvement.

> Many who learn to ride a bike say that it strengthens their confidence, they say that they have seen others being able to ride a bike and say "Yes, I didn't think I could myself, but now I've learned and I can be just like everyone else". [...] The most important thing is that it reduces alienation, to feel like a part of your context and be like everyone else who can cycle." (Isabella Larsson, 44).

Bonding social capital is often intertwined with the concept of social support. The interviewees explained that most do not have any social support networks when they came to Sweden, if there were any it was mainly close family members. Lecerof et al., (2015) write that migrant women's social networks, which often consist mostly of family and friends rather than friends or community engagement, may actually harm their health due to social isolation and role engulfment. While the importance of family networks is widely accepted, there are also situations where they can have a negative influence. Leyla and Sofia who work together both said that traditional roles in the family can limit women to the household which is a barrier in integration work. The informants emphasise that WCA is a space of social support networks that advocate women's equal rights with the purpose of empowerment and active agency of women to effectively establish themselves.

A critical perspective of bonding social capital in its nature is exclusionary within the group, of those with different norms and identities (Fukuyama, 2002). The result is pressure to conform to group norms, which can result in threats to more vulnerable segments within marginalised communities (Habermas, 1985). As a result of neutralising shared meanings within the group, an essentialist understanding of self and others is forged, segregating groups from each other and reinforcing social hierarchies (Bourdieu, 1986). Sofia is aware of this risk.

> It might be that we build up new norms and strengthen them in a group. The main goal of the association is to work for an equal society. But in a tight group with only women, there is a risk to strengthen already existing norms. The work we do entails being aware of them and adhering to the aims of the association and connecting to the gender equality objectives. Otherwise, it can preserve traditional patterns. (Sofia Nilsson, 38).

Another critical point of view is that bonding social capital can have a negative impact on health because it cements relationships and thus limits opportunities (Lecerof et al., 2015). Sofia mentions she is concerned that this can make it harder for some women to establish themselves and interact with the rest of society. As well as, Leyla says that sometimes it is a problem because, even though this might be the case for a few, some do not want to learn Swedish and integrate with the rest of society and other groups. She means that it is easier to come to WCA and speak their native language with each other because it is familiar and safe. Nevertheless, a lot of members are from different countries and experiences, thus they have a lot to offer each other from their differences. Wakefield and Poland (2005) highlight that it is easy to build groups around essentialist identities thus minimising the differences within groups and at the same time grow the differences from others. However, they mean that there are those examples of groups building identities which include and might even celebrate the differences. Just as the member Nadia says "I get to meet women from other countries and we teach each other. Everyone wants to help each other so much." (Nadia Al-Amin, 55, Syria).

Bridging

Bridging social capital, on the other hand, enables residents to access resources outside their immediate social milieu. It is a concept that explicitly links social capital to structural inequalities in power, resources, and authority (Berkman & Kawachi, 2001). Putnam (1992) suggests that participation in civil organisations creates important ways into the host society. It also can lead to increased opportunities for linking social capital thus increasing power over the SDH, but further on that analysis will be presented in the next section.

Putnam (2000:349) means that by living in communities with high social capital, strong organisations and active citizens, the benefits from it will be distributed to those who have poorer social connections in society. This is because others can put the public before the private good, citizens are equal with the same rights and trust is high which encourages people to cooperate and act on reciprocity. Sofia Nilsson says that the majority of the population needs to be a part of the establishment and integration of immigrants, and the host community needs to teach about norms and rules in society. Putnam (2000:22) emphasise the diffusion of information from one community to another in bridging social capital. One activity that WCA has had are book circles where they have read short stories of women in history together. The attendants have been both seniors, Swedish-born women and asylum-seekers. She said it created good conversations where women talked about many values that are important in the establishment and integration which they shared with women that were new to Sweden. "You learn from each other in the similarities and differences. There are many similarities in being human and in being a woman." (Sofia Nilsson, 38).

Fatima Khalifa from Libanon that came to Sweden 32 years ago said that it plays a big role. She says that the language is important, that you have to speak to Swedish people as she did in the beginning when she came to Sweden. This made her establish and integrate herself and promote her health as it resulted in bringing down the language barrier and building on her social support network. "You think the school teaches you Swedish, but it does not teach you for real. Here (at WCA) you get to meet so many different groups and talk to each other. That teaches you." (Fatima Khalifa, 48, Libanon). The intrinsic value of social capital is that it is relational thus it only exists when it is shared (Robison, Schmid & Siles, 2002). Melina Petrovic also points out the importance of bridging immigrant women to other communities in Malmö. Although, she means that this has not been as visible as she has hoped for.

> Connecting immigrant women to other groups in society has been a struggle, and there is a need for support from Swedish-born women. There is a lack of mutual integration in society and it is very important for health promotional work since it is important for everyone to feel and know they are part of a community and society. (Melina Petrovic, 58)

Geugjes (2021:53) writes about the collective identity and integration in Sweden and implies that as a result of integration, different societies are forced to come together and confront each other and their differences. In order to get the measure of another, one must establish a distinct image of oneself. Similarly, otherness calls into question what constitutes the self. Thus, when societies are faced with otherness, they often feel the need to define themselves in comparison to 'the other'. Forging identities is thus a result of integration and as stated in the previous section, it creates an exclusionary discourse. Bridging social capital can facilitate cooperation and trust over the disparities between people. Isabella Larsson agrees with Melina and says it is difficult for immigrants to make contact with the Swedish-born population. This is because they usually live in areas which are segregated from the rest of society. She means bridging social capital has a big role because you create inclusion in society. “It can gain an increased understanding of each other and, above all, of differences.” (Isabella Larsson, 44).

Layla Ahmed concurs and says that bridging social capital can teach each other different experiences and knowledge. She means that some of her own life experiences are so different from some members which makes it hard to connect, thus a diverse group with different life trajectories brings diversity in the emotional assistance. The member Nadia says that it is hard sometimes, but it is all about finding the right connection and knowing how to express the help you need. “WCA has so many activities that make you find it, which is good.” (Nadia Al-Amin, 55, Syria). The concluding words from Melina were the need to evolve as an association is to understand how to attract other groups than immigrant women to WCA so they can create a room of different groups. She means that this is important so women can learn from each other and show respect for each other, thus extending everyone's views.

Linking

Lastly, all interviewees thought that linking social capital has a big role in health promotion in integration work. The member Nadia says the activities at WCA are very good because “politicians come and listen to us” (Nadia Al-Amin, 55, Syria). Szreter & Woolcock (2004) write that linking social capital is crucial because it facilitates social relationships across power differentials, especially to those representatives of institutions that are responsible for delivering

the material provisions of resources. Melina says that it is a mutual knowledge exchange when politicians come to WCA and give lectures on different themes such as democracy.

> Both the politicians get to learn from the women, and the women learn from the politicians. It is important that politicians listen and make use of what they have to say. It is useful for society. The politicians get to see that immigrant woman are engaged and interested as they ask them questions which is important that they get to see that and learn. Visits to different institutions around Malmö give the women a sense of hope, that they can do self-evolving things in society. (Melina Petrovic, 58).

Isabella Larsson points out empowerment in linking capital, as she also did in bonding social capital. She means that it gives one the feeling of the opportunity to influence society and the situation one finds oneself in. “I don't like to say we help people because we don't. We support people to help themselves”. (Isabella Larsson, 44). Additionally, that linking social capital is important because of democracy and the importance of voting becomes very clear. As the member Nadia says “We learn what the rules are, how the parliament works, and how to vote. [...] Nurses and other speakers give a lot of good information about health.” (Nadia Al-Amin, 55, Syria).

Another key point, is that Lecerof et al., (2015) imply that many migrants may have negative experiences with local democracy and NGOs. They may come from places where there is no trust in governments and the family is perceived to be the only reliable network. Fatima Khalifa says “I feel it is hard because I feel that I cannot discuss with them. I decide to be silent. Im good at listening but I do not want to be part of the discussion. It is important. But you have to be brave enough to ask and talk to them.” (Fatima Khalifa, 48, Libanon).

When looking at the political determinants of health there are democratic deficits, or insufficient participation of civil society, health experts, and marginalised groups, in the decision-making process regarding migrants (Abubakar et al., 2018). Just as Svanholm’s (2022) study showed that migrants’ perspectives are marginalised in health perspectives in decision-making processes and

it is generally not seen as a resource within integration. Ogden et al. (2014) concluded that all forms of social capital provide an important facilitator for integration and improvement of social development overall. It is argued in their paper that linking social capital approaches may be most effective when coupled with community mobilisation and structural interventions that aim to challenge existing power structures and address entrenched structural drivers of health inequalities in contexts that are not oriented around equity.

In addition, Wakefield and Poland (2005) suggest that in addition to providing a setting for complex cultural differentiation, institutions can also act as mechanisms for introducing other forms of capital where they are needed. They point out, however, there is a need for a more comprehensive understanding of how institutions are integrated into existing social capital distributions that would provide valuable insights into social exclusion processes. Such as Szreter & Woolcock (2004) mean that the circumstances for linking social capital have to be constituted in a vigorous, open and politically conscious space of mutual respect. In such societies where this is possible, there has to be undistorted communication between individuals and their elected local governments. Otherwise, it may easily be used as a resource for exclusionary and sectional interests, which can have an ambivalent or even negative consequence for the health of immigrant women. It is, then, entirely dependent on politics, public morality and ideology, and not on the resources of social capital.

Sofia Nilsson also notes the importance of linking social capital from a democratic perspective. She emphasises the significance of politicians coming to WCA and meeting this specific target group of immigrant women. This is because she feels that they do not meet them as much as they should. It creates important communication, especially in a space where they feel safe, and then they can ask more questions and express their opinions. “Members have a lot of opinions and points of view just like everyone else. It is important to feel like you are a part of the society that you live in and in the development of that. More specifically, to have their demands in that.” (Sofia Nilsson, 38).

Conclusions

This section will go back to the initial purpose and research question and answer it with the main results found in the analysis. The purpose identifies the specific health challenges that immigrant women face and explores the social determinants that contribute to these challenges. The question posed to analyse this was; *What are the perceived health challenges of immigrant women in Malmö?* The SDH framework was drawn upon in order to understand the perceived perspectives of the health challenges of immigrant women. All interviewees concluded that language barriers and reduction of social support networks lead to involuntary loneliness when establishing oneself in Sweden, as a result of social isolation and exclusion. Moreover, socio-political factors that marginalise immigrant women in Sweden lead to social stressors which adversely impact their health.

Furthermore, the purpose was to understand if and how social capital can facilitate the health promotion of immigrant women. The purpose was to distinguish the different forms of social capital between bonding, bridging, and linking, which enables the operationalisation and mapping of the types of networks available. This determines what types of networks promote or harm health. The second research question posed to analyse this was; *what role does social capital have in health promotion for them?*

Bonding social capital has a definite role in health promotion amongst immigrant women. WCA is a space which the interviewees perceive to have high social participation and trust which creates social engagement, contact and influence. This brings a sense of meaningfulness and reduces feelings of isolation and loneliness. It helps them adjust to their new environment which is important in the work for health promotion migrants. Bonding social capital facilitates the recognition of identity in a group that shares the same experiences which creates a space of belonging in a society that may have exclusionary practices and discourses. Although, there has to be sensitivity to how individuals are embedded in the social structures of the group so that the work for health promotion in establishment work does not lead to increased social control.

Bridging social capital also has an important role in health promotion in the establishment and integration work at WCA. This is because it creates a diffusion of information, norms and

practices that can be extracted from the relationship between people who are different in socio-demographic senses. This can be particularly important for migrants who may not be familiar with the language, norms, and rules. However, this form of social capital is characterised by respect and mutuality where integration entails joint responsibility for migrants and native communities which is something that has not been as visible as hoped for.

Lastly, linking social capital has also had a health-promoting effects on immigrant women in Malmö. This is because it provides an opportunity for the target group to influence the situation they find themselves in through relationships between individuals and political institutions in society. Also, it facilitates important communication where elected representatives can recognise immigrant women and their perspectives. However, for that communication to be inclusive it has to be undistorted, open and based on mutual respect.

The concluding words in this thesis are that the case of immigrant women in Malmö at WCA illustrates an example of where relationships matter. When immigrant women in Malmö establish and integrate into a new society they face health challenges determined by social factors. For the health promotion of immigrant women, there is an emphasis on supporting social inclusion and social cohesion specifically from the host community. This thesis aimed at measuring the social relationships and health outcomes of this specific population and hoping to provide insight into other areas where such measurement can give an empirical meaning. For future research, there is an encouragement to apply the role of social capital in health research because it can offer new perspectives on the mechanisms influencing interpersonal relationships, cooperation, and community involvement in health promotion across a range of contexts.

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Bibliography

Abubakar, I., Aldridge, R.W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M.L., Dhavan, P., Fouad, F.M., Groce, N., Guo, Y. and Hargreaves, S., 2018. The UCL–Lancet Commission on Migration and Health: the health of a world on the move. *The Lancet*, *392*(10164), pp.2606-2654.

Al-Adhami, M., Berglund, E., Wångdahl, J. and Salari, R., 2022. A cross-sectional study of health and well-being among newly settled refugee migrants in Sweden–The role of health literacy, social support and self-efficacy. *Plos one*, *17*(12).

Arbetsförmedlingen. *The establishment programme*. Available at: https://arbetsformedlingen.se/other-languages/english-engelska/extra-stod/stod-a-o/etableringsprogrammet. [Accessed:05/05/2023].

Berkman L. F., Kawachi I. O. 2000. *Social Epidemiology*. Oxford University Press, Oxford, New York.

Berkman, L.F., Glass, T., Brissette, I. and Seeman, T.E., 2000. From social integration to health: Durkheim in the new millennium. *Social science & medicine*, *51*(6), pp.843-857.

Bourdieu, P. 1986. *The Forms of Capital.* In Richardson, J. (Ed.), Handbook of Theory and Research for the Sociology of Education. New York: Greenwood Press.

Brance, K., Chatzimpyros, V. and Bentall, R.P., 2022. Increased social identification is linked with lower depressive and anxiety symptoms among ethnic minorities and migrants: A systematic review and meta-analysis. *Clinical Psychology Review*, p.102216.

Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: coming of age. *Annu Rev Public Health*, 32, 381-398.

Castañeda, H., Holmes, S. M., Madrigal, D. S., Young, M.-E. D., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annu Rev Public Health*, 36, 375-392.

Campbell, C. 2020. Social capital, social movements and global public health: Fighting for health-enabling contexts in marginalised settings. *Social Science & Medicine*, *257*, 112153.

Dahl, E. Malmberg-Heimonen, I., 2010. Social inequality and health: the role of social capital. *Sociology of health & illness*, *32*(7), pp.1102-1119.

De los Reyes, P. 2006. Global o(jäm)likhet och intersektionalitet: om feministiska gränsdragningar och hegemoniska röster. *Tidskrift for kjonnforskning*, 15(1), 1-3.

Dinesen, P. T., Schaefer, M., & Sønderskov, K. M. (2020). Ethnic diversity and social trust: a narrative and meta-analytical review. Annual Review of Political Science, 23(1), 441-465.

Durkheim, E. 1897. *Suicide: a study in sociology.* Glencoe, IL: Free Press

Fukuyama, F., 2002. Social capital and development. *SAIS Review (1989-2003)*, *22*(1), pp.23-37.

Fukuyama, F. 2018. *Identity: The Demand for Dignity and the Politics of Resentment.* New York: Farrar, Straus and Giroux.

Geugjes, M., 2021. *Collective Identity and Integration Policy in Denmark and Sweden*. Springer VS.

Gilliver, S.C., Sundquist, J., Li, X. and Sundquist, K., 2014. Recent research on the mental health of immigrants to Sweden: a literature review. *The European Journal of Public Health*, *24.* pp.72-79.

Habermas, J., 1985. The theory of communicative action: Volume 1: Reason and the rationalization of society (Vol. 1). *Beacon press.*

Hobfoll, S.E., 1991. Gender differences in stress reactions: Women filling the gaps. *Psychology and Health*, *5*(2), pp.95-109.

Honkaniemi, H., 2022. Mental health after migration to Sweden: The role of the social determinants of health (Doctoral dissertation, Department of Public Health Sciences, Stockholm University).

Hollander A. C. 2013. Social inequalities in mental health and mortality among refugees and other immigrants to Sweden--epidemiological studies of register data. *Global health action*, 6, 21059.

House, J.S., Umberson, D. and Landis, K.R., 1988. Structures and processes of social support. *Annual review of sociology*, *14*(1), pp.293-318.

Ingleby, D., 2012. Ethnicity, migration and the 'social determinants of health'agenda. *Psychosocial Intervention,* 21(3), pp.331-341.

International Organization for Migration. 2019. IOM AND MIGRANT INTEGRATION. IML Series No. 34. Available at: https://www.iom.int/sites/g/files/tmzbdl486/files/migrated_files/What-We-Do/docs/IOM-DMM-Factsheet-LHD-Migrant-Integration.pdf [Accessed:05/05/2023].

Ikonen, A. M. 2015. Perspektiv på etableringsprogrammet Hälsa och välbefinnande: nyanlända migranters röster. Malmö högskola (MIM), *Malmö Institute for Studies of Migration, Diversity and Welfare.*

Johnson, C.M., Rostila, M., Svensson, A.C. 2017. The role of social capital in explaining mental health inequalities between immigrants and Swedish-born: a population-based cross-sectional study. *BMC Public Health* 17, 117.

Johnson-Singh, C., 2021. Social integration and immigrant mental health: the role of social capital and neighbourhood ethnic composition. Doctoral dissertation: Karolinska Institutet (Sweden).

Kabeer. N. 2018. In Kabeer. N. Sweetman. C. Gender and Inequalities. *Practical action publishing. Oxfam Gb.* Rugby, Warwickshire, UK. pp. 5-20.

Kawachi, I., Subramanian, S. V., & Kim, D. 2008. *Social capital and health.* New York: Springer.

Kvale, S. 2007. Doing Interviews. *SAGE Publications.* Thousand Oaks.

Llácer, A., Zunzunegui, M.V., Del Amo, J., Mazarrasa, L. and Bolůmar, F., 2007. The contribution of a gender perspective to the understanding of migrants' health. *Journal of Epidemiology & Community Health*, *61*(Suppl 2), pp.ii4-ii10.

Lecerof, S.S., Stafström, M., Westerling, R. and Östergren, P.O., 2015. Does social capital protect mental health among migrants in Sweden?. *Health promotion international*, *31*(3), pp.644-652.

Länsstyrelsen. 2021. 'UPPSÖKANDE OCH MOTIVERANDE ARBETE FÖR ATT NÅ UTRIKES FÖDDA KVINNOR, Länsstyrelsens återrapportering av uppdrag 29 enligt regleringsbrevet för 2021', [online] Available at: https://integration.lansstyrelsen.se/wp-content/uploads/Lansstyrelsernas-aterrapportering-av-uppdrag-29-enligt-RB-2021.pdf. [Accessed: 03/04/2023].

Malmö Stad. 2023. Population. Available at: https://malmo.se/Fakta-och-statistik/Facts-and-statistics-in-english/Population.html. [Accessed: 23/05/2023].

Mulinari, D. and Lundqvist, Å. 2017. Invisible, Burdensome and Threatening. The Location of Migrant Women in the Swedish Welfare State. S*ocial Politics: International Studies in Gender, State & Society*, 24(3), pp. 313-334.

Nilsson, M., 2006. Sjukfrånvaro bland invandrare i Sverige: Utvecklingen under perioden 1981-91. *Arbetsmarknad & Arbetsliv*, *12*(1), pp.17-26.

Nyampame, I., 2008. Invandrade kvinnors hälsa i Sverige. *Socialmedicinsk tidskrift*, 3, pp.219-226.

Ogden, J., Morrison, K., & Hardee, K. 2014. Social capital to strengthen health policy and health systems. *Health Policy and Planning,* 29(8), 1075–1085.

Ottersen, O.P., Dasgupta, J., Blouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J., Fukuda-Parr, S., Gawanas, B.P., Giacaman, R., Gyapong, J. and Leaning, J., 2014. The political origins of health inequity: prospects for change. *The Lancet*, *383*(9917), pp.630-667.

Punch. K.F. 2005. *Introduction to social research quantitative and qualitative approaches*. SAGE publications inc.

Putnam, R.D., Leonardi, R. and Nanetti, R.Y., 1992. *Making democracy work: Civic traditions in modern Italy.* Princeton university press.

Putnam, R.D., 2000. *Bowling alone: The collapse and revival of American community.* Simon and schuster.

Righard, E., 2022. Integration i städer med en omfattande diversitet i befolkningen: Teoretiska perspektiv, empirisk forskning och en diskussion om implikationer för politik och praktik i Malmö. Malmö stad.

Robison, L.J., Schmid, A.A. and Siles, M.E., 2002. Is social capital really capital?. *Review of social economy,* 60(1), pp.1-21.

Robson, C. McCartan, K. 2016. *Real World Research*. A Resource for Users of Social Research Methods in Applied Settings. 4th ed. Chichester: Wiley.

Scheyvens, R. 2014. *Development Field Work: A Practical Guide.* London: SAGE Publications Ltd.

Statistics Sweden. 2022a. Utrikesfödda i Sverige, Available at: https://www.scb.se/en/finding-statistics/statistics-by-subject-area/population/population-composition/population-statistics/pong/tables-and-graphs/foreign-born-citizenship-and-foreignswedish-background/population-in-sweden-by-countryregion-of-birth-citizenship-and-swedishforeign-background-31-december-2022/, [Accessed:05/05/2023].

Statistics Sweden. 2022b. Sveriges befolkning, Available at: https://www.scb.se/BE0101-en [Accessed:05/05/2023].

Svanholm, S., 2022. Health promotion in the integration of newly arrived migrants in northern Sweden (Doctoral dissertation, Mid Sweden University).

Szreter, S. and Woolcock, M., 2004. Health by association? Social capital, social theory, and the political economy of public health. *International journal of epidemiology*, *33*(4), pp.650-667.

Thomas, F. 2016. *Handbook of migration and health*. Cheltenham, UK.

Thomsson, H. 1996. Women's opportunities for well-being. Studies of women's work, leisure and health-related behaviour patterns, Doctoral thesis, Department of Psychology, Stockholm University.

Thomsson, H. 1998. En fråga om underordning. En analys av möjligheter till välbefinnande hos kvinnor med utländsk bakgrund. Rapport nr 102, *Psykologiska institutionen,* Stockholms universitet.

Tinghög, P., Arwidsson, C., Sigvardsdotter, E., Malm, A., & Saboonchi, F. 2016. Nyanlända och asylsökande i Sverige. En studie om psykisk hälsa, trauma och levnadsvillkor [Newly arrived and asylum-seeking in Sweden. A study on mental health, trauma, and living conditions]. Röda Korsets Högskolas rapportserie 2016:1. Stockholm: Röda Korsets Högskola.

Wallman Lundåsen, S., 2022. Engagemang i civilsamhället i Malmö: Betydelsen av kontakter mellan grupper för tillit. Malmö Tillväxtkommission-för ett inkluderande och hållbart Malmö. Malmö stad.

Wakefield, S.E. and Poland, B., 2005. Family, friend or foe? Critical reflections on the relevance and role of social capital in health promotion and community development. *Social science & medicine*, *60*(12), pp.2819-2832.

World Health Organization. 2008. Closing the gap in a generation: Health equity through action on the social determinants of health. Commission on Social Determinants of Health. WHO/IER/CSDH/08.1. [Accessed: 12/04/2023].

World Health Organization. 1946. Constitution of WHO. Available at: https://www.who.int/about/governance/constitution. [Accessed:23/03/2023].

World Health Organization. 1986. Ottawa charter for health promotion. WHO/HPR/HEP/95.1. [Accessed: 23/03/2023].

Wångdahl, J., Lytsy, P., Mårtensson, L., & Westerling, R. 2018. Poor health and refraining from seeking healthcare are associated with comprehensive health literacy among refugees: A Swedish cross-sectional study. *International Journal of Public Health*, 63, 409–419.

Wångdahl, J., Lytsy, P., Mårtensson, L., & Westerling, R. (2015). Health literacy and refugees' experiences of the health examination for asylum seekers – A Swedish cross-sectional study. *BMC Public Health*, 15, 1162.

Appendices

Interview Guide for key informants

- 1. Informed consent
    - Introduction of myself and the aims of the research.
    - Provide information about the intention of the interview and clarify how the material will be used and published.
    - Explain how the interview is confidential, that they are anonymous and data will not be able to access.
    - Provide information about interviewees' right to withdraw from the research at any point.
    - Receive informed consent of participation and the use of information for research purposes.
    - Ask for permission to record.
        - Are there any questions before we start?
- 2. Introductory questions
        - Can you tell me where you come from?
        - What do you do for work?
        - How did you come in contact with the organisation?
        - Can you describe what you do in the organisational work?
        - What do you consider to be the association's goals and activities?
- 3. Working with immigration and integration into Swedish society
        - What do you think are the health challenges that immigrant women face in Sweden?
        - How does connecting them with other immigrant women play a role in overcoming these challenges?

        - How does connecting them with other groups in society play a role in overcoming these challenges?
        - How does connecting them with politicians or other powerholders play a role in overcoming these challenges?
- 5. Closing questions
        - How can the concept of social capital be integrated into existing health promotion programs for immigrant women in Sweden? What are the benefits and potential challenges of doing so?
        - How can policymakers and government agencies support the development and maintenance of social capital among immigrant women in Sweden? How can research be used to better understand the relationship between social capital and health promotion for immigrant women in Sweden? What are some potential research questions or areas of focus?
        - Is it something that you want to ask me? E.g in relation to the research, what will happen next etc?
    - Thank you for taking the time to participate!

Interview Guide for focus groups with members

- 1. Informed consent
    - Introduction of myself and the aims of the research.
    - Provide information about the intention of the interview and clarify how the material will be used and published.
    - Explain how the interview is confidential, that they are anonymous and data will not be able to access
    - Provide information about interviewees' right to withdraw from the research at any point.
    - Receive informed consent of participation and the use of information for research purposes.
    - Ask for permission to record.
        - Are there any questions before we start?
- 2. Introductory questions

        - Can you tell me where you come from?
        - What were your reasons for moving to Sweden?
        - Did you know anybody in Sweden before you moved here?
        - What were some of the things you worried about before moving to Sweden?
        - What was your first experience like?
        - How did your worries compare with what you experienced?
- 3. Immigrating and integrating into Swedish society
    - Now I will ask you some questions regarding your experiences since you came to Sweden.
        - Can you tell me about your time when you first arrived in Sweden?
        - How long have you stayed here?
        - How has your migration experience impacted your mental health and well-being?
        - Are there any particular challenges that you have faced as a migrating woman in Malmö?
        - Are there any barriers to social integration that you have encountered?
        - Have you experienced any discrimination or prejudice in Sweden? How has this impacted your health and well-being?
        - Can you tell me about your experiences adapting to life in Sweden? How has this impacted your sense of self and identity?
        - How does your social network look like and how has it changed since moving to Sweden?
        - Have you been able to form new connections or support systems?
- 4. Experiences of participating in Winnet Malmö
        - Why did you choose to engage in Winnet?
        - What expectations did you have when you applied?
        - Can you tell me about your experiences of being a part of a group of migrating women?
        - What are your experiences meeting other women at Winnet that are not migrants?

        - What are your experiences meeting politicians and people of power?
        - Has being a part of winnet helped you to get better health?
        - If not, what could have been better?
- 5. Closing questions
        - What is the most important thing to consider when new to Sweden?
        - What has been most important for you?
        - What are your goals and aspirations going forward?
        - Do you wish something would have been different?
        - Is there something more you want to tell me about your experience in Sweden?
        - Is it something that you want to ask me? E.g in relation to the research, what will happen next etc?
    - Thank you for taking the time to participate!

The author keeps all collected materials of the interview transcripts.