The quest for health and the unhealthy 'others'. A critical case study of Syrian women newcomers' meeting with health promotion and civic integration discourses upon arrival in Denmark

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Increasingly restrictive immigration policies and political attention to newcomers' civic integration currently intersect with the individualisation of the responsibility for health care and health promotion in Western societies. This article aims to examine how such policies shape refugee and family reunified women's perceptions of health and experiences of civic health promoting activities in the first years after granted asylum and temporary residence permit in Denmark. Using conceptualisations of healthism as a super-value for the individual in Western societies, we analyse Syrian women newcomers' experiences as well as the ways in which they silently resist such discourses. In individual and focus group interviews, 29-50 year old Syrian women share their meeting with an all-encompassing and individualised concept of health that is promoted by various societal institutions in Denmark (including schools and leisure sites). Further, the women newcomers characterise white Danish women as a healthy and active group, while describing themselves as the 'unhealthy others'. Even though a number of structural barriers for their healthy and active living are evident, they still express that they are responsible for promoting their own health. Nevertheless, the Syrian women newcomers also deliver an implicit critique of the individual quest for health in Western societies and showcase more collective approaches to health care.

Keywords: refugees; migration; gender; sport; health promotion

Subject classification codes: Research paper

Introduction

In the wake of the so-called 'refugee crisis', during which around 1 million people applied for asylum in membership states of the European Union in the years around 2015[1], increasingly restrictive immigration and integration policies have developed in West European societies (Hernes, 2018). Illustrative of this development is the so-called paradigm shift in Denmark, through which the introduction programme for refugees and

family reunified persons was renamed into 'the self-supporting repatriation' programme in 2019[2]. Accordingly, in the first years after having been granted asylum and residence permit in Denmark, newcomers are expected to become self-supporting through internships and wage subsidy jobs as well as language education. In addition, it is pointed out that their residence permit in Denmark is temporary and has to be renewed every second year or every year[3].

Adding to this precarious and ambiguous situation of newcomers, Denmark is among the countries that have turned towards a restrictive civic integration policy (Borevi et al, 2017; Mouritsen et al, 2019). The current focus on civic integration extends the requirements for newcomers to encompass not only job and language training but also civil society participation and volunteering. Such understandings make newcomers morally obliged to participate in civic activities while leaving out attention to structural conditions and discrimination that may hinder them from getting jobs and from participating in civic leisure activities. In other words, intersecting societal structures shape the experiences of migration (O'Reilly, 2015).

As such, the development of civic integration policies in Europe (Joppke, 2007; Hernes, 2018) aligns with long-standing observations of healthism as an ideology that individualises the responsibility for healthy living (Crawford, 1980). Since healthism was first described with a background in popular discourses about holistic health and self-care among middle-class Americans, healthism has spread in Western societies and beyond, which has also led to identification of unhealthy 'others' (Crawford, 1984, 2006).

In this article, we turn attention to how intersecting structures arising from the current restrictive civic integration policy along with individualised health promotion discourses shape newcomers' perceptions of health and experiences of their options of

participating in civic health promoting activities in the first years after arriving to a Western society. We set out to answer this question in order to contribute to critical research that moves beyond the instrumental focus on civic sports and leisure activities as health promotion and integration (Author, Spaaij et al, 2019). When turning our attention to the experiences of particular groups of newcomers, we may also see alternative approaches to health care and civil health promoting activities.

Below, we outline the conceptual framework of this study and describe our study design and use of methods. Next follows our analysis of the Syrian women newcomers' experiences in the meeting with prevalent healthism discourses in Denmark as well as their wishes and challenges in relation to leading healthy and active lives. This leads to a discussion of the findings that alert attention to the ways in which health promotion and civic integration discourses in receiving communities may exacerbate feelings of low self-perceived health among women newcomers. Further, we also point to the ways in which the Syrian women newcomers showcase approaches that transgress the widespread health ideals in Western societies.

Healthism and civic integration

Four decades ago, Crawford defined healthism as an ideology that is concerned about but also places focus and responsibility on the individual to pursue his/her own health, "Briefly. Healthism is defined here as the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being." (Crawford, 1980, p. 368). According to Crawford, health has become a 'supervalue' for people in developed countries justifying an increasing number of life experiences and decisions in relation to health (Crawford, 1980, p. 360).

While Crawford described how healthism became a central part of the modern personal identity of the American middle class, he also pointed out how such

identification drew borders to 'unhealthy others' (Crawford, 1994, p. 1348). In short, healthism has become a socially dividing practice in which moral judgments (about your own and others' healthy living) and blaming (of the ones that do not lead healthy lives) are used in evaluating the success/failure of self and other (Crawford, 2006; Kristensen et al, 2016). Among others, this has been described in a case study from Denmark which points out that the individual citizen is not only free to but also obliged to pursue his or her health potentials (Mikkelsen, 2017).

Studies have pointed out that while the health care system in Denmark is increasingly seeking active health-seeking individuals (Kristensen et al, 2016), this development also intersects with other policies that among others seek to turn immigrants into active citizens. Since the 1990's an ideational and discursive turn towards civic integration policies in (West)European countries have set a range of requirements for newcomers to engage in language education, job training, as well as to pursue active citizenship (Borevi et al, 2017, Mouritsen et al, 2019). It has been pointed out that civic integration is characterized by four dimensions: 1. Expansion of what is desirable citizenship, 2. Individualization of the responsibility of societal participation, 3. State involvement in disciplining individuals, and 4. Civic screening of who are desirable entries into the country through regulation of among others residence permit and citizenship (Mouritsen et al, 2019). Through such policy, West-European nation states have increasingly involved themselves into the lives of individual newcomers.

Nevertheless, as Crawford points out in his description of healthism "… as political language, individual responsibility is highly problematic." (Crawford, 1980, p. 377). The critique goes that the current political focus on individual health (and civic integration) overlooks the social constraints and structural conditions that may amend our understanding in pointing out that active and healthy living is not simply an act of

'individual lifestyle choices' (Crawford, 2006, p. 417). Accordingly, Crawford's work may be aligned with Foucault's concept of governmentality (Foucault, 1991; Rose, 1999) in pointing to the ways in which policies of modern societies create expectations that individual subjects are capable of taking responsibility of e.g. their own health and civic integration. Such forms of self-governing have been identified to intersect with a neo-liberal rationality; for instance, in descriptions of how current ideals of self-improvement and hard work of the individual are directed towards improving bodily appearance, losing weight, etc. (Ayo, 2012).

While political campaigns have been found to reproduce the values of healthism, it has been pointed out that the ones that do not meet such self-responsibility of health often come to appear inferior and morally deficient (Lupton 1995, 2013). Specific studies indicate that migrant women often comply with discourses of healthism in Western societies and accordingly also come to understand themselves as unhealthy 'others' who do not succeed in taking up their individual obligation of healthy living (George and Rial, 2005). Yet, non-Western migrants may also partially resist dominant ideas about self-promotion of health and fitness by ignoring these messages and living according to, e.g., cultural and religious prescripts rather than science-based health discourses (Wray, 2007, 2011).

This aligns with research that points to the risk of falling back into dichotomous thinking according to which subjects are simply disciplined by political expectations of 'healthy citizenship' (Sharon, 2015). Rather people appropriate and reinterpret such policies through the 'creative tactics of everyday life' (Michel de Certeau cited in Sharon,2015). As such newcomer women may not necessarily be standing up against a repressive power, but rather 'carving out a livable space where some form of meaningful agency can flourish' (Sharon 2015, p. 311). Thus, in the following we will

pay attention to self-governing and yet divergent approaches to active and healthy living in order to interpret women newcomers' meeting with intersecting civic integration and health promotion discourses in Denmark.

Material and methods

In line with the dispersal policy in Denmark, newcomers are often moved to municipalities with a hitherto low percentage of minority ethnic population upon being granted asylum and/or temporary residence permit.[4] In such a predominantly white Danish municipality, we have been focusing on Syrian newcomers who have gained asylum in the subsequent years of the influx of refugees around 2015 and who were still attending the introduction programme at the point of the study (2018-2019). Furthermore, in this article we concentrate our attention to female newcomers who in earlier studies have been described as particularly at health risk and as reluctant towards participating in health promoting activities (Humphris and Bradley, 2018; Floyd and Sakellariou, 2017).

While remaining critical to the problematizing approach to women newcomers in former studies, we understand our study as a 'critical case'. Such a case may be identified as critical since it is 'least likely' or 'most likely' to decrease or increase our belief that something will be happening based in our theoretical expectations (Flyvbjerg, 2006). In this case we expect that healthism and civic integration discourses with expectations for newcomer women to become active and healthy citizen are particularly likely to intersect in a country that have adopted such policies rather clearly (Borevi et al, 2016). Also we expect that women newcomers are particularly likely to appear as unhealthy 'others' if they do not pursue such approaches in a municipality with a predominantly white and resourceful population. As such, our critical case study

can provide a condensed insight into the challenges that may follow when newly arrived non-Western migrants meet discourses of health promotion as well as restrictive civic integration policies in white Western settings.

Our study was conducted at a language centre which newcomers attend regularly throughout their introduction programme in the given municipality. In order for the language course participants to develop some acquaintance with us and our project, members of the research team spent time at the language centre during regular education days before asking the selected groups of newcomers about their willingness to participate in the interviews. All interviews were conducted at the centre in the time slot allocated for self-study and lasted around 40-60 minutes for each individual interview and 75-90 minutes for each focus group interviews. We used a semi-structured interview guide that encouraged participants to talk to us about their perception of health (including potentially both physical, mental and social well-being) and their experiences of civic health promoting activities partly in Syria and partly upon arrival in Denmark.

All interviews with the Syrian women were supported by a female translator to enable the participants to switch into their native language whenever they did not feel confident expressing themselves in Danish (or English). As suggested in the literature (Edwards, 1998; Squires, 2009), extensive talks were made with the translator before the interviews to ensure alignment. It was emphasised that she was expected to reproduce the informants' narratives as exactly as possible, while she was also encouraged to ask the informants questions in order to clarify their statements. After the interviews, the translator was asked about the process of translation, how she interpreted the informants' descriptions and how they related with her own experiences. As such, the translator became a co-interviewer (Suurmond et al, 2016) who helped identifying

the variety in approaches within the group of informants and who provided contextual information about the informants' backgrounds.

We conducted eight semi-structured individual interviews and three focus group interviews (with a total of 12 participants in the three focus groups). This span of interviews was chosen in order to seek out partly the individual newcomer's experiences and understandings of health and physical activity and partly the group interaction between women newcomers about their experiences and understandings of health promotion and physical activity upon arrival in Denmark. The focus group interviews provided a more informal setting that made it more apparent how the women creatively appropriated and reinterpreted expectations of 'healthy citizenship' (Sharon, 2015), when they were sharing their stories in between themselves. In both types of interviews, pictures (among others, illustrating a variety of physical activity ranging from walking to playing football and other sports) were used in accordance with the suggestions of supporting the dialogue between participants in interviews through photo elicitation (Harper, 2012).

In total, a diverse group of 20 Syrian women (8 in the individual interviews and 12 in the three focus group interviews) were interviewed. The women were in the age group 29-50 years. Their background ranged widely from growing up in Kurd or Arab parts of Syria, living in the countryside or in cities like Damascus, holding higher education qualifications or only compulsory schooling. At the time of the interviews, most of the informants were without jobs, but several attended job training along with the language course. All except two of the women were mothers and often described a demanding everyday life encompassing participation in job and language training, while also raising children and taking care of household obligations. The ones that did not have children appeared more often to participate in civic leisure activities.

Informed consent was received from all informants and the translator in line with research ethics guidelines (Brinkman and Kvale, 2015). The informants have been provided with fictive names to personalize the results and to provide a degree of transparency to the reader while at the same time adhering to the GDPR rules. Besides from the translator (who had a Syrian background as well), all interviewers (the first author in the individual interviews; the second and third authors in the focus group interviews) were white and sports active women that differed visibly from the Syrian women newcomers. Yet, similarities in gender, age and motherhood (for the first author) also led to sharing of experiences in the interviews, among others, about the challenges of finding time to engage in health promoting activities. The interviews provided a room for narration for the informants, but our questions may also have contributed to the women feeling an even stronger exposure to an individualised health promotion discourse that will be described in more details below.

When analysing the interviews, inspiration was drawn from Pirkko Markula and Richard Pringle's descriptions of an analytical strategy that is inspired by critical discourse analysis (Markula and Pringle, 2006). The first step was to *describe the content of the tex*t; simply examining what is mentioned in the text and what is not. The second step was to *engage in an intertextual analysis* of the relations between the texts produced (here interviews) and the relations between the people involved and their context in order to identify discourses and themes that cut across individual texts. The third step was to *connect findings with ideology and power*, which involved turning the attention towards the effects of prevalent understandings and power relations of the persons involved (see also Sparkes and Smith, 2014).

Results

At the beginning of all the individual interviews, the women were asked to present themselves, their experiences with physical activity and their understandings of health. All women had been introduced to physical education in school and had been engaged in physically active games in the streets as kids. Some of the women had been used to walking as part of their daily work in Syria, but they had also walked for recreational purposes. One of the women who had lived in Damascus had attended a fitness centre.

Upon arrival in Denmark, most of these patterns of daily physical activity had been disrupted and had not been re-stablished after gaining asylum. Nevertheless, some of the women still pointed out that physical activity was part of their daily house work, and several of the women were keen to walk. Hadiya even told the interviewer that she now and then went for a run for recreational purposes. Another woman Lakshmi had been introduced to cycling, while Ghazal informed us that she had participated in women-only swimming.

While the women mainly referred to their lives in Syria when describing their experiences of physical activity, questions about what health meant to them were mainly followed by descriptions of their current lives in Denmark. In fact, several of the women expressed that health was not to the same extent an issue for them when living in Syria. For instance, Fabia reflected on the unconscious approach to the healthy lifestyle she had led then,

> ”In Syria you are actually unconsciously healthy. Without deliberately trying to be healthy, you are actually healthy, because the raw materials you use are actually healthy, they are actually organic ... so it was actually healthy (in Syria) because all our meals contain vegetables.” (Fabia 50 years old)

Like Fabia, several Syrian women referred to a situation in which health was not a predominant and explicit ideal against which different parts of their lifestyle was

justified. Yet, after the migration the women's health had become more at risk and healthy living appeared as a greater concern for the women while surrounded by what we interpret as an all-encompassing ideology of healthism (Crawford, 1980).

Most of the Syrian women newcomers described their understanding of health with attention to physical as well as mental and social dimensions. For instance, several women pointed out how their physical well-being was challenged by among others severe back-pain, while they also observed how this was further connected to mental and social well-being.

> "If you feel well physically, you are all right, then you can get out of the house and participate in social life. Thus, when you are without pain you can be happy or something like that. If you are not all right physically, then you become a bit more isolated, you do not have the strength to get out of the door." (Ruth, 45 years).

As indicated above, the women expressed understandings of health that encompassed a multiplicity of dimensions and not merely a medicalised diagnosis or not. Also the women appear to link good health with engagement in the society outside of their homes (getting out of the door) in line with observations of the expansion of things involved in 'healthy citizenship' (Mouritsen et al, 2019, Sharon, 2015).

Through their descriptions, such that health is 'the whole matter', the Syrian women newcomers appear to perceive health in its broadest sense. This involves attention to how physical wellbeing is interlinked with mental and social dimensions, but an appropriation of such perspectives also opens for making the women responsible for engaging themselves in active and healthy living. The women's meeting with such all-encompassing and individualised health ideals will be elaborated further below where Syrian women describe their experiences of health promoting activities in Denmark.

The quest for health

In the focus group interviews, the Syrian women were asked to talk with each other about their meeting with and understandings of health promoting activities in Denmark. Here, the women talked about their experiences with the healthcare system but also with other societal institutions in Denmark. Fatima said,

> ".. it is very structured in Denmark. It is very programmed, how to really be healthy and what you really have to do to be healthy here in Denmark. Already as a child." (Fatima, 42 years old)

Like Fatima, several women described their meetings with various health institutions and professionals and not least an all-encompassing health promotion discourse. Yet, the focus group setting also provided an opportunity for the women to share their interpretation of such an approach. One of the women expressed how astonished she was when a health professional came to visit her and presented an early concern with health promotion already when her child was a few days old. Another woman described her surprise when being called to an interview at the school due to one of her children being overweight. A third woman was contacted by a teacher who told her to not include chocolate in her child's lunch pack.

This expansion of the health promotion discourse to involve various societal institutions outside of the most immediate health system, including the school and the leisure time activities of their children, was also noted by Nooda,

> " (in the school), they focus a lot on activities, and are concerned about what the children do in their leisure time, and that they are constantly active, for instance with sports, swimming, running or football." (Nooda, 29 years old)

As indicated in Nooda's description, the Syrian women remarked how encompassing the quest for health in Denmark is. Almost all of the women mentioned the great focus

on health in Denmark, among others, describing that as an inhabitant you are constantly up-dated about what is healthy and unhealthy. In addition, they described Denmark as 'a healthy country' and Danish women as 'healthy'. Thus health appeared as a 'super-value' (Crawford 2006, p. 411) against which both the entire nation and population is evaluated.

Several Syrian women also described their generalised ideas about Danish women pointing out that they prioritize health and their own health higher than, e.g., caring for their family. In further demonstrating their reinterpretation of such ideas the participants in one of the focus group interviews asked the moderators why Danish women are so obsessed with caring for themselves. Further, one of the participants described her general impression that in Denmark grown-up children do not have the time to care for their elderly parents, and in a specific incident, she had observed that a white Danish woman would rather go exercising than visiting her parents. Followingly, the women talked about how this also enhanced the call for parents to take responsibility for their own health since they cannot expect that their children will support them when they grow older. In showing their clear astonishment and worries about the consequences of this approach, the Syrian women also expressed their appropriation and reinterpretation of policies that individualise the responsibility for 'healthy citizenship' (Sharon 2015).

Agency and position as unhealthy 'others'

As mentioned above, the three focus group interviews provided the opportunity for the Syrian women newcomers to share their stories, while also demonstrating their agency in discussing the ways in which individual health makes up a super-value that reduces collective obligations towards caring for your family. While the Syrian women

appeared to be clearly astonished by this priority, they did not explicitly critique this quest for health. Notwithstanding, their descriptions showcased a more collective approach in which the primary focus is on the health and well-being of the family. For instance, one of the women described how straight after job and language training she turned her attention to the well-being of all the members in her family.

At the same time, almost all of the women also described a growing dissatisfaction with their own health and described their wishes to become physically active and healthy like white Danish women. Several of the women blamed themselves for having gained weight after arriving in Denmark and talked about their individual responsibility of caring for their own body and health; e.g. through losing weight.

> "... it is your own body, and you have to live with it, but in addition it is just your own fault how you are. In principle you can decide for yourself whether you want to be overweight or underweight. It depends on one's will." (Saadia, 31 years)

When simply attributing their gaining of weight to a deficit in their individual will to conduct healthy lives, the Syrian women appear to subject themselves to ideals about self-improvement and hard work that reflect the linking of healthism with neo-liberal governing in Western societies (Ayo, 2012).

In one of the focus group interviews, a women also commented on the ways in which Syrian women who tried to live up to the quest for physical activity through running deviated from white Danish women.

> ” Danish women, ordinary women, if they see a woman with a scarf running, then this will appear completely wrong to them. It will seem strange or whatever. It doesn’t really work.” (Souzan)
> Moderator: But do you find it strange to see Danish women running?
> ” It does not seem wrong when Danish women run. This is also what we (Syrian women) have been used to watching since we arrived in Denmark. It looks quite okay. But it will appear really wrong if a woman with a scarf is running and does

> not wear the right clothes because it is very inappropriate to run (without Muslim clothing). It will appear wrong. And the gaze we meet will be different." (Souzan, 29 years old).

Thus, Souzan pointed to Muslim women as a deviant group in relation to physically active and healthy living in Denmark. In other words, running in public space is linked with tight clothing and with Western women that appear to succeed in pursuing a healthy lifestyle. Furthermore, Souzan pointed out that Muslim women running with a scarf in Denmark would meet a different gaze, which may not be exclusively the case with running.

Studies have shown that Muslim women, who are veiled, refrain from going to the beach or go to remote places in order not to be pointed out as 'others' by the non-veiled majority population (Author). At the same time, this gaze may be interpreted as acts of looking which are shaped by internalised understandings of oneself and others (Foucault, 1977). Syrian women newcomers' descriptions are not only shaped by a health promotion discourse with encompassing advice about active living but also by the current political debates about civic integration that involve a screening of what kind of features are 'desirables' (Mouritsen et al 2019, 601). For instance, rising political and public attention has been given to Muslim women's clothing in, among others, burqa, which was the primary target for an official ban on face coverings in public places in Denmark from 2018.[5] In other words, the current political debate about civic integration appears to intersect with individualised health promotion discourses in shaping Syrian women's perceptions of their (limited) options of being physically active in public space.

Structural conditions for health promotion?

When connecting the findings across the interviews with contextual information, a considerable paradox appears. The vast majority of the women expressed a desire to become (more) physically active and to lead more healthy lives while blaming themselves for not being able to follow such health prescriptions. This is paradoxical considering the current situation in which Syrian women newcomers are embedded.

Meanwhile expressing such wishes, the Syrian women's descriptions pointed to a number of barriers making it difficult for them to lead healthy lives. The women reported that their limited economy made it difficult for them to buy organic and healthy food as well as to afford a membership in a fitness centre. They also described how they lacked access to home-grown vegetables and pure olive oil like they had in Syria. Moreover, several women described barriers related with their participation in the introduction programme. For instance, Tabina stated,

> " I feel that there is no time at all to be healthy (in Denmark). I get up at 5.30, and then it's just time to get out of the door. From one bus to the other bus... and then there is a meeting with the municipality. And then I'll have a number of conversations: "Now you must hurry." And again, the change of buses. So, I don't have time for myself, how on earth should I have time for my health?" (Tabina, 37 years old)

In line with the above statement from Tabina, Lakshmi also described a feeling of being tired when returning from job training or the language centre and pointed to the obligations she had in her home cleaning, preparing food, doing the laundry, taking care of the children, etc. Most of the interviewed Syrian women appeared to be responsible for the house work even though they were not merely house wives anymore. Thus, job training and language courses seemed to be added on top of the (often invisible) obligations of these women. This overload of obligations appears to make it difficult for

women newcomers to pursue a healthy living, while also more difficult for them to cope with the pressure arising from participation in the introduction programmes (Ikonen, 2015).

Still, other barriers were related to the women's situation as refugees with granted temporary asylum. Several of the women described their feelings of pain, fatigue and lack of energy while also describing a number of worries. Nadia said,

> " I think a lot about them (my family) and how is the situation (at home), I actually feel that the body is always tired… and I also think about our situation here in Denmark, what is the future. We worry a lot – is there a future, is there not a future (for us here). What will happen, all these things actually make you tired". (Nadia, 38 years old).

Another woman described her feeling of living like birds that have found rest for a while but never know when a strong wind will make it necessary for them to move again. Such descriptions indicate that the women worry both about the situation in Syria but also about their situation in Denmark following the recent paradigm shift and the change of the political focus towards self-supporting civic integration and eventually repatriation to the countries they fled from.

Thus, despite the Syrian women newcomers' wishes for an active and healthy living, their structural conditions make it appear highly unlikely that they will be capable of engaging themselves in health promoting activities and take responsibility for their own health. For these women, pursing active and healthy living does not appear to be simply an act of 'individual lifestyle choices' (Crawford 2006, p. 417). Rather, the weight of insecurities about living conditions makes allocation of a passport appear as a more relevant intervention than health promotion campaigns. Such discussions will be pursued further below.

Concluding discussion

Former studies have drawn attention to the reluctance of particularly women newcomers towards seeking health care and participating in health-promoting activities (Wångdahl et al, 2018; Lecerof et al, 2017). In seeking to transgress such problematizing understandings, this qualitative study contributes with insight into how Syrian women newcomers' experiences in the first years after granted asylum and residence permit in Denmark are shaped by an all-encompassing and individualised health promotion discourse as well as a civic integration policy that has become increasingly restrictive (Borevi et al, 2017, Mouritsen et al, 2019).

Since healthism ideals have reached beyond Western societies today, such discourses of health promotion did not appear entirely new to the Syrian women. Nevertheless, this article highlights that when asked about their experiences, the women newcomers mainly described their everyday lives in Syria as unconsciously healthy, while they in the receiving context came to appear as consciously unhealthy. This understanding reflects their current situation and resources but also their meeting with what appears as a more articulate health promotion discourse in Western societies.

Further, this article shows that the interviewed Syrian women newcomers describe white Danish women as a uniform group who pursue the healthy and active living that normatively stands out as the right way to conduct your life. While our interview analysis indicates that Syrian women newcomers to a large extent accept the highly individualised discourses of healthism and civic integraion, a number of limitations exist.

Firstly, a multi-methodological case study design with a large use of, among others, go-along observations (Kusenbach, 2003) also beyond newcomers' attendance at the language centre could have provided a better insight into the everyday lives of the women newcomers. Secondly, the theoretical basis of this article in healthism and self-

governing perspectives and methodological inspiration from critical discourse analysis tends to point to the ways in which Syrian women newcomers are subjected to Western healthism. So far our use of individual and focus group interviews have only led to limited insight into the agency of the diverse group of women newcomers.

Thus, this article provides only little attention to the ways in which the Syrian women resist individualized health promotion and civic integration discourses and pursue alternative approaches. Yet, when Syrian women newcomers talk about how white Danish women prioritise training rather than caring for their family, they implicitly demonstrate alternative understandings of the good life and point to dark sides of the individual quest for health. In line with this observation, anthropological studies have shown how minority ethnic women assign themselves as helpers to take care of elderly and dying family members in their own homes (Sparre and Rytter, 2019). Still, we have limited insight into women newcomers' role as collective health care givers and the ways in which this group of immigrants and their descendants may point to alternatives to the widespread individualised approaches.

Almost all of the interviewed women newcomers express a desire to become more physically active and to live more healthy lives, and several stress that it is their own responsibility. Yet, their descriptions point to intersecting challenges linked to their current situation such as pain and fatigue as well as lack of time and resources that, e.g., follow being full-time engaged in an introduction programme while remaining responsible for house work. In addition, the women express a more general feeling of cross-pressure due to uncertainty about their own and family members' situation in Syria, following the war as well as in Denmark following the restrictive asylum policy. Thus, our study points to the relevance of paying considerable attention to newcomers'

social and structural conditions rather than simply focusing on their individual participation in health promoting activities.

Considering this situation, it appears relevant to provide greater social support for health promotion among newcomers. For instance, group training could be organised as part of introduction programmes that besides from following the national requirements about job training and language courses can be organised by the municipality in charge. Yet, the findings in this study that an all-encompassing and individualised health promotion discourse may exacerbate women newcomers' feelings of not meeting the demands and expectations in the receiving societies may also serve as a knowledge-base for future programs. It appears relevant to reduce the focus on instrumental health promotion discourses and rather support intrinsic motivation towards participating in sport and physical activity, e.g. through activities that focus on joy and capability of movement along with social relatedness (Vallerand, 2012).

This could imply that public health researchers together with not only municipal but also civil society actors support groups of newcomers in becoming involved in sports and physical activity, e.g. through community-based action research designs. So far, an implication of the current findings is that Danish municipalities are called to consider their options for supporting newcomers' well-being rather than leaving it to groups at health risk to start promoting their own health.

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