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**Title: Health communication among ethnic minorities with Turkish background in relation to physical activity and prevention of lifestyle diseases**

**Problem and background**

Recent decades’ experience with the prevention of an increasing number of cases of lifestyle diseases advocates research in health communication from a health promoting perspective. This is especially connected to a realisation that the dominating top-down addition of statistical knowledge on illness risks cannot stand alone in influencing the population’s health behaviour (Danish National Board of Health, 2005). The problem with the risk communication’s traditional sender-receiver perspective is that it does not take into account the knowledge and resources of the actors concerned (Jensen and Halkier, 2008). But as far as diet, smoking, alcohol and exercise-related risks are concerned; it applies that the motivation and communication for development and change cannot be separated from the identity, meaning and the social and cultural conditions which establish these everyday life practices (Gannik, 2002).

The illness preventative challenge is reinforced and clarified further by an increasing inequality in health. In relation to this, too little is actually known about the role of communication and the importance of different communicative approaches. However, what is certain is that there is often a small target group among the majority, which in practice translates the general knowledge about health (Danish National Board of Health, 2005). The vulnerable groups are often described as difficult to come into contact with, reach and retain. This is particularly seen among the group of ethnic minorities with non-western backgrounds, which stands out with a considerably higher ill health than the ethnic majority (Singhammer, 2008; Schläger, 2005). Dominating arguments indicate vulnerable groups’ social and communication marginalising. For example, the Danish National Board of Health writes about ethnic minorities that, by virtue of the ethnic and migration conditions, they do not have the same access to the western risk thinking and risk behaviour like the majority, but are characterised by a vulnerability to the handling and control of more abstract and long-term dangers as risk factors (Mygind, 2006).

But health is not created by statistical knowledge, informed in a closed universe free of values. Health and illness are created in everyday life in an interaction between the individual family and in the small and large networks and communities, which the individual is part of (Gannik, 2002; Iversen et al. 2005; Ottawa, 1986; the Government, 2002). In other words, the health promoting learning potential is contingent on history, situation and relation. The argument for the ethnic minorities’ vulnerability is made visible and exemplifies the limitation of biomedicine’s normative, reductional and deniable recognition logic. When this is applied to a human scientific domain, the non-normative is reduced to objective risks and as a result is not seen, which is why the individual acts as he/she does and thereby the positive connections for development of healthy behaviour (Albertsen, 2002; Jensen & Johnsen, 2004; Tones and Green, 2004). On the other hand, the result of deficit theoretical health communication will become, in worse case, a stereotype fixation of groups, which supports social categories as stable characters within dominating discourses (Bradby, 2003; Staunæs, 2004). And in extension of this, the parties retain their practice and make equal health promoting dialogue impossible (Hamburger, 1997).

Therefore, there is a need for health promotion research, which involves and supports the network communicative resources and learning processes in everyday life, since these are a crucial prerequisite for the prevention of lifestyle diseases.

**The overall aim**

The project’s overall aim is to clarify how health promoting health communication can be established and constituted in the social practice and how this knowledge can be included, supported and promoted in the direction of illness preventative behaviour. In extension of this, focus will be on health and illness perceptions which are practiced in everyday life and where network communicative conditions can potentially function as support of learning and the spreading of these.

**Ethnic minorities**

The case for the project is the social practice among ethnic minorities with Turkish background in relation to physical activity and exercise. By virtue of the target group’s communication vulnerability, increased ill health and non-normative background, it is an extremely relevant group for forming theories on health promoting health communication. In other words, the target group illustrates the health promoting area’s focus on positive resources and makes exemplary knowledge forming possible on health communication in the relation between normative majority perspectives and specific importance and meaning-structures among minority groups.

**The overall thesis on health and health education**

In the project, health is studied based on a human scientific definition which is closely connected to the presence of outlook on life and quality of life (Jensen and Andersen, 2005; Jørgensen, 2009; Tones and Green, 2006). Outlook on life and quality of life is meant as cultural behaviour, which structures the way in which life is lived, which demonstrates something more normative and worthy of pursuance than something else (Ibid). It is the ideals or normative standards, which in a given historical, cultural and social context are prevalent as to how a valuable life is lived and which strategies are ideal and possible (Ibid). The perspective on health is adopted with the rational purpose of opening widely for the target group’s total life situation, health promoting space for action and point of departure (Gannik, 2002). The general theme of the project will be an abductive approach (Halkier, 2008), understood as an interaction between theoretically informed knowledge of illness prevention based on specific knowledge of the target group’s health and illness perception in relation to physical activity and exercise. Knowledge of the connection between illness prevention, quality of life and health promoting communication about this will, in extension of this, operationalise with, among other things, the following question: What role does exercise play in daily life and who has influence on this? In this way, the project will look for insight into the target group’s health promoting space for lifestyle change by standing on shoulders and benefiting by the positive resources that are evident in the target group. Thus, it is expected that the health behaviour, health understanding and motivation in which insight is looked for, will give rise to health communicative thoughts which can increase the demand and space for action for preventative behaviour (Jensen and Johnsen, 2004; Gannik, 2002).

**General theoretical perspectives**

The project’s theoretical basis generally draws on prevalent socio-constructivist assumptions on the relational and productive of the social life. A practice theoretical and a network analytic network communicative perspective has been provisionally compiled. With the practice theory’s micro-sociological eye, a varied understanding is opened for the reflective process between socio-cultural conditions and the individual subject, which establishes and constitutes the health promoting space for action. The network theoretic perspective is generally used with a concept theorem about the importance of the role of communication and interpersonal relations for the establishment of health and illness perceptions in the target group’s network. The perspectives follow the project’s focus on: How, why and where health is created, analysed, communicated and promoted.

* **Social network analysis – network communication**

Because prevention is related to health promotion in everyday life’s social practice, this means that the actors’ social networks and network communication becomes pivotal.

Analysis of social networks (SNA) is an approach, which in the study of social phenomena, privileges interpersonal relations and processes instead of individual abilities (Burt, 1978). What is crucial to SNA is the recognition that as people, we are always connected to other people and that this connectedness is crucial to how we think, feel and act (in groups, organisations, nations). In other words, a social network quite simply consists of a number of actors and relations or connections between these actors. And the study of social phenomena is a study of these connections (Wasserman & Faust, 1994). This means that focus is moved from the individual and the individualistic explanation as a basis for knowledge of social phenomena, to the interpersonal and relational.

SNA’s historical development is, on one hand, very complex. It is an analytical perspective which has originated from, has been constructed and developed within a large number of scientific disciplines such as anthropology, social psychology, geography, mathematics, biology, physics, economy, marketing, sociology, politology, communication, etc. (Freeman, 2004). At the same time, SNA has been used in relation to a large number of areas; everything from the spreading of disease to terror research, traffic research, research in consumer habits, IT, urbanisation processes, etc. On the other hand, SNA has a very simple history, since through the years the complex multidisciplinary and professional processes have mainly been built up to a quantitative understanding and approach to SNA (Edwards, 2010; Heath et al. 2009). As Linton Freeman states: “*Social network analysis is motivated by a structural intuition based on ties linking social actors - It is grounded in systematic empirical data - It draws heavily on graphic imagery and it relies on the use of mathematical and/ or computational models”* (Freemann, 2004:3). Generally, the quantitative approach to network analysis is to explain the structure in the network by mapping and measuring where connections between actors are either present or not present. This means individuals and social relations are, so to speak, raised to numerical values and precise, but also simplified, absolute characteristics of importance to the structure and the functionality in the network (Edwards, 2010; Jensen & Halkier). Despite the fact that SNA is dominated by the quantitative approach, there is also a tradition for qualitative driven SNA’s (Heath et al., 2009), which builds on anthropological analyses (Edwards, 2010). The criticism of the quantitative approach is that in addition to structure and form, the network is also about processes and content. In other words, the qualitative approach focuses on the processes, constructions and dynamics which establish and constitute the connection between actors in the network. Like Heath et al. who studied how the decision on the choice of further education for the individual is anchored in social, cultural and financial capital in larger familiar and friendly relationships (Heath et al., 2009).

The linear sender-receiver approach, which also characterises the prevailing prevention work does not, from a network communicative perspective, have an eye for the quality, the dynamic and complexity in the communication processes that take place between people (Rogers, 1986). It simplifies and insulates the individual from the social communication context in which the individual finds himself. Instead of communicative dialogue, mutual understanding and acts, the one-way strategy is cybernetic persuasion information (Ibid). The network perspective, on the other hand, accelerates the research in the direction of new ways in which to think preventative interventions, by attributing the target group’s network central importance for the communication. This means, recognising the target group’s communicative resources and the importance of interpersonal relationships for health and illness perceptions for illness prevention. As Jensen and Halkier state: *“Network communication strategies attempt to take more into account the context of the practices communicated as well as the resources and social relations of the communications users”* (Halkier og Jensen, 2008). Within network communication research, work is often done with concepts such as connectedness, integration, diversity, openness, etc. These are concepts, which on the whole cover the establishment of the communication in the network. A concept like openness concerns, for example, to which degree a given group communicate with their surroundings and is thus receptive to information from outside (Windahl, 2009). A frequently referred claim within network research is that the more diversity there is among the actors in a network, the easier new ideas are added to the network via weak relations (Granovetter, 1973). Research in network communication often makes use of ideal typical understanding such as opinion leaders, membership role, liaison role, star role, isolated role and boundary spanning role (Monge, 1987). The condition for communication processes to create change is that a broad range of relation types are involved (Rogers, 1995). As can be read between the lines, the quantitative and structural focus, which dominates SNA generally, also applies to a certain degree to the network research concerning communication. Important actors such as Everett Rogers and Lawrence Kincaid formulate thus: “*A communication network analysis is a method of research for identifying the communication structure in a system, in which relational data about communication flows(…) ”* (Rogers & Kincaid 1981: 75). In other words, the content in the interpersonal communication relations is under-theorised within the network research (Halkier and Jensen, 2008).

The project uses a qualitative approach to SNA by thinking in health promoting, interaction process and communication network in a practice theoretical perspective. In this connection, the project leans on, among other things, the work Iben Jensen and Bente Halkier have done with the concept development network communication from a practice theoretical perspective (Ibid). In general, it is about focusing on communication in the target group’s network as established and constituted by social acts in the social practice. Consequently, communication is not only thought of in the usual sense as the spoken language, but as bodily-mental routines, which are performed in the social practice by *doing* what is *said.* And instead of asking questions such as “who is connected to who”, “who communicates with who”, rather focus on what is being done by focusing on practices in the network rather than individuals. Thus, the project focuses on the target group as a “network” of the social order in the social practice. With a qualitative focus on social networks, the project breaks with the dominating individual thinking and sender-receiver communication which characterises the current prevention work. It is about making the target group privileged as being a motivated participant which, depending on its conditions, for example, for co-influence on preventative initiatives, has the possibility of exercising influence on the social practice of which it is a part.

In the following section, the project’s practice theoretical perspective is explained. This perspective must be read as the frame of reference which is used in the project to describe the health promoting processes (including communication) in the target group’s network.

* **Practice theoretical perspective**

Practice theory is a form of culture theory, which within the ongoing sociological discussion is positioned and defined in relation to, among other things, the phenomenological, structuralistic and discourse analytical approach (Halkier & Jensen,2008).

In general, the discussion is tied to where the social is placed and thus, what is the object of the cultural analysis. With the project’s practice theoretical framework, the object of analysis for the target group’s network communicative acts patterns is neither defined in terms of text, mentally nor inter-subjectively. Where other above mentioned culture theories often have a tendency to over-focus on a particular determinant for the processes in the social life, the project places the social in practice, which allows an openness to multi-relational configurations between each individual aspect (Ibid:50).

The practice theory is not a new overall theory, but a reading of a number of different perspectives on practice, including the body, performance and social action. Practice theory “*(…) is an attempt to develop a thought combination of elements in existing sociological theories to a new analytical perspective on the establishment and conditioning of micro-processes in the social life”* (Ibid:50). Central to this thought combination is Theodor Schatzki, Andreas Reckvich and Allan Warde who draw on earlier theorists such as: Pierre Bourdieu (1990), Anthony Giddens (1984) Michel Foucault (1978), Judith Butler (1990) and Bruno Latour (1993). By considering culture as practice and thus not as an imagined quantity in the human’s consciousness, culture becomes an organisation of social actions and thus something we *do* (Halkier & Jensen 2008:54) instead of something we *are* and are bearers of: *“In replacing the word “identities” with the word “identifications”, however, we have taken a liberating analytical step. We no longer see any identity as fixed beyond question and change* (Baumann, G. 1999:137). When the target group’s acting patterns are not considered as a static and unchangeable character, like *“identities”,* but on the contrary as a dynamic process that is created in practice – like *“identifications”* – as a flow of organised practice actions, the analytical eye for the target group’s health promoting change potential is opened (Jensen, 2005). *“Organised”* does not mean organised in the sense of a consistent cultural act pattern. *"Organised”* means *“(…) a tangle of sameness and similarities among the activities involved.”* (Schatzki 2001:43).

Placing culture and quality of life in social network communication practices, makes health and illness perceptions observable and it becomes possible to analyse our way forward empirically as to how the target group develops opportunities to act, in social interaction with normative and accepted adjustments in cultural and communicative acts in everyday life (Halkier & Jensen, 2008). By focusing further on the body and bodily acts, the practice theory has the eye for the same analysis subject as biomedicine. With the body as the mutual point of reference, a close discussion and mediation therefore opens between the project’s perspective on objective knowledge of risk minimising and the specific empirical underlying basis.

### The social order – the socially organised

With reference to Schatzki, the social order in the target group’s exercise practice is considered as an arrangement where all elements (things, people and acts) and activities are organised and related in correlation with each other: “*(…) Social order can be defined as arrangements of people and the organisms, artefacts, and the things through which they coexist.* (Schatzki, 2001: 43). This means that each element has a specific position and, as arranged/organised, the positions refer to each other. The way in which the positions relate is by their mutual and equal practical intelligibility. The practice theoretical perspective aims for a methodical openness, based therein, that knowledge of practical intelligibility alone can be empirically based. So for example, one could say that the positions or practice acts in connection with the target group’s exercise practice refer to each other in a way where, together, they constitute an arrangement or an important fellowship. *"A practice ... is a routinized type of behaviour which consists of several elements, interconnected to one other.(...) A practice – a way of cooking, of consuming, of working, of investigating, of taking care of oneself or of other etc....” (Reckwitz, 2002: 249).* Characteristic of the social order in the social practice is thus, that elements and acts are arranged to be meaningful and identity-giving wholes, which become possible to act and position oneself in (Schatzki, 1996: Chap. 6). A specific social practice comes across as qualities with the routine, repeated activities and their coordinating elements and not as special qualities of the individual (Halkier and Jensen, 2008:6).

### The social practice that establishes the social order

The social practice is what organises the social order. According to Schatzki, a practice generally consists of what is *done* and what is *said. “A doing or saying belongs to a given practice if it expresses components of that practice’s organisation”* (Schatzki, 2002:87).But what is done and what is said is, again, organised by mental conditions such as: *“understandings”, “rules” and “teleo-affektive structures”.* *“A practice is a set of doings and sayings organized by a pool of understandings, a set of rules and a teleo-affektive structure”* (Schatzki, 2001:53) *Understandings* cover what it means to understand and know *how* one should do something. *Rules* is understood as clear and specific linguistic formulations which indicate *what* must be done, *what* can be done, *what* is important to do. This means what people keep to or take into consideration when they perform the one or the other act physically or linguistically. *Rules* do not only include rules, but also principles, definitions and instructions. The last of the mental conditions is the *teleo-affective structures.* The term is a fusion of teleology and affectivity. Teleology is a direction within the philosophy, which attempts to explain the universe with the concepts *ends* and *final cause.* Teleology is based on the assumption that the universe has a fundamental construction and has a fundamental purpose. Whether this makes sense for a person to act, depends on the importance the action is given. So you orientate yourself towards *ends.* This means that teleological philosophy is orientated towards the universe’s fundamental formula and purpose so the human orientates himself, according to Schatzki, towards what a given act will lead to. Whether the individual perceives it as appropriate to launch into this act depends on his faith, hopes, expectations, feelings and moods. In this way, the affective is connected to the teleological (Schatzki, 2001:49-51). *”(…) a teleo-affective structure is a range of normatized and hierarchically ordered ends, projects, and tasks, to varying degrees allied with normatized emotions and even mood* (Schatzki, 2002:80) With the connection of the affective element, the orientation towards *ends* does not only become a rational, but an act based on feeling. So this is not about a close pre-determined direction as the term *ends* otherwise connotes, but more motivation or commitment, as Andreas Reckwitz expresses it, *“states of emotion and motivational knowledge”* (Reckwitz, 2002: 249).

When the mental conditions organise *doings* and *sayings*, the practical intelligibility is formed in practice. This means the intelligibility by which one becomes involved with other elements and by which one act in practice: “*(…) So practices establish social order, first, because they help mould the practical intelligibility that governs their practitioners’ actions and thereby help determine which arrangements people bring about”* (Schatzki, 2001:54)*.* The practical intelligibility is embedded in the body and thus that which characterises the social order. *“(…) A social practice is the product of training the body in a certain way: When we learn a practice, we learn to be bodies in a certain way (…) A practice can be understood as a regular, skilful “performance” of (human) bodies.* (Reckwitz, 2002:251). With the mental condition’s organisation of the activities in practice, they are of crucial importance to the establishment of the social order (Schatzki, 2001).With the operationalisation of the concepts aboutthe mental conditions, what is strived towards here is knowledge of which meaningful relationships establish the target group’s exercise practice. In other words, how what is said and what is done constitutes the communication in social networks’ relations.

Even though the mental level defines the combination of concepts for the lowest analysis level, it is placed socially, both mentally and in practice. As Reckwitz puts it, “*(…) the individual is the unique crossing point of practices, of bodily-mental routines”* (Reckwitz, 2002:256). To take the starting point in the individual’s mental conditions is, at one and the same time, like taking the starting point in the collective.

Where social constructivism at all construction levels is often construed with special focus on the discourse, as that which generates the construction of the world, I position the constructing influence with a certain comparison in relation to practice: *“Discourse, in other words, is being, while practice is the becoming from which discourses are the precarious fixities that precipitate from human practice and from which further practice arises”* (Schatzki, 2001:45). Since discourse and practice are interwoven, that they, so to speak, stand on each other’s shoulders in relation to change and development, a processual splitting up and thus a comparison between these could, on one hand, be considered as arbitrary and uninteresting. When, on one hand, a splitting up is interesting and quite crucial in relation to the discursive, which with an interpreting description of bodily acts, is detached from practice. If, for example, the empirical knowledge only included *why* the target group act, one would obviously not have a description of acts, but just opinions, importance, etc. connected to it. Such a statement would be an interpreted and distanced knowledge of the practice theory’s subject. Obviously, it is not tantamount to it not being interesting to know *why* the target group acts as it does: “*Analysis must be concerned with both practical activity and its representation”* (Warde, 2005), but it means that prior to the question of *why* (methodical and analytical), the question is about *how.* In other words, the project’s comparison between practice and discourse, between what is *done* and *said* on one hand, and on the other, the mental structures that establish the actions. This must not be understood so that the mental structures are considered as discourse. But if the descriptions of these are not linked to descriptions of *doing* and *saying,* but just accounts isolated from there, then the answer will subsequently be a discourse theoretical matter and not practice theoretical.In other words, it would not be practice theoretically relevant to take the starting point in the mental structures, since one can only speak about something being mental structures when one knows which actions they relate to. Added to this is that the mental structures are often unreflective and silent witnesses. But by varying between questions of *how* and *what* is saidand *done,* and *why,* the relation between the mental and the body is operationalised. However, an important point is that the comparison between practice and discourse must not be understood as a comparison between *doings* and *sayings.* Both *doings* as well as *sayings* are considered as bodily acts. The question *how*, is asked so that, at one and the same time, it is possible to be oriented towards routines with and *without* words *(What did you do? How did you say it?).* Social constructivism’s claim about focus on social construction processes thus operationalises by focus on what is *said* and what is *done,* as bodily socially arranged order.

### Reproduction and development within the social practice

Focus on the target group’s change potential, on the possibility of changed health behaviour will, with the project’s practice theoretical perspective, among other things, focus on how similarities and monotony is reproduced and developed. “*(…) the sources of changed behaviour lie in the development of practice themselves. The concept of practice inherently combines a capacity to account for both reproduction and innovation.”* (Warde, 2005:140).

Internally, a practice is differentiated at many different levels. This means, constituted in the mental structures, a practice accommodates many different abilities, skills, resources, etc. The difference within a practice, which is relevant to analysis of the structure, is the different positions by which the social order can be linked together and which the involved persons adopt (Ibid:138). By analysing the differences and similarities among the interviewees’ mental structures and see how these are connected in various ways to social acts, it becomes possible to describe from where the practice is reproduced and developed.

In relation to the question of reproduction, there is however certain inertia attached to the process in a practice (Ibid:140). This inertia is partially connected to the fact that what establishes the social practice is often at a routine, unreflective and, not least, bodily level. By comparison to Warde, this inertia is what Bourdieu, for example, comments on with his focus on habituation. Practices have *“(…) their own distinct, institutionalised and collectively regulated conventions, they partly insulate people (…)”* (Ibid:140). In addition, there will always be people who refer to earlier codes and precepts in relation to behaviour and thus retain a reproduction of conventions (Warde, 2005).

But a practice is not hermetically sealed from other adjacent and parallel practices: *(…) the social field is a nexus of practice, and that sociality therefore consists fundamentally in the coexistences opened in nexuses of practice* (Schatzki, 1996:200). In other words, understandings, rules and procedures, values, norms between intersecting practices are exchanged and copied (Warde, 2005, Schatzki, 1996). Contrary to the aforementioned people who retain a reproduction of conventions, Warde emphasises the new generations, in relation to possible convention changes who are, as he describes *“(…) new generations, seek to replace current orthodoxies with new prescriptions”* (Ibid:141). It is with focus on diversity, on the balance between inertia and flexibility and openness, between mental structures, which reproduce and renew the target group’s exercise practice, which the practice theory will contribute to the analysis of possible change potentials in relation to prevention.

**Empirical data and methods**

The project is generally designed as a qualitative intensive research design (Halkier, 2001: Neergaard, 2007) with a combination of individual, qualitative interviews (Kvale, 1997: Atkinson et al. 2003), participating observation (Hastrup, 2004; Kristiansen and Kogstrup, 1999), as well as network-based focus group interviews (Halkier, 2008; Putnam, 2000; Schatzki, 1996; Warde 2005). The sufficient and possible number of interviews that is expected to be conducted in the period is currently estimated to be 12-14 individual interviews, 6-7 participating observations and 6-7 focus group interviews.

In simple terms, one could say that the individual interviews are those that deliver the in-depth knowledge to use for an understanding and clarification of current health and illness perceptions in the target group’s network. From there, critical social practices are indicated in relation to exercise, to observation via active participation. This means where the individual interviews are generally used to gather empirical data on *what* bears opinion and importance and *why,* participating observation is used to focus on *how* this bearing of meaning and importance is performed as practised bodily and linguistic acts. With the combination of these studies, the project’s central practice theoretical point on knowledge formation on the social life’s establishment and changeability, in the configuration between specific performed actions and the linguistic representation and interpretation of these is thus operationalised. Added to this is that bodily movements are best observed by active participation.

The focus group interviews is the method by which the development, change and negotiation potential of health and illness perceptions will be studied by an exemplary combination of interview persons from the individual interviews, which additionally brings along persons from their small and large networks. In the focus group interviews, photos are used which the participants from the individual interviews have taken by autophotography. As a scientific method, the photo has shown to be particularly effective at tapping latent memory and stimulating the interviewee to come with statements on emotional aspects of their lives (Harper, 2002: Heisley & Levy, 1991: Keller et al. 2008; Wang et al. 2000 & 1996). In this way, the aim is to open up for the health perception’s often unreflective and routine character in everyday social acts and practices. The interviewees will be generally asked to take a photograph of which actions, in relation to things and people, that mean the most to them in their daily life. In this regard, there will be a methodical connection between the social practices that are indicated for participating observation and those elements that are reflected in the photos. In this way, empirical data is found which can form the background for analysis where knowledge on health promoting and health communicative network resources and space for acting are interwoven descriptions of the practised bodily which *does,* and the discursive which *says.* Data will be analysed by using methods for qualitative coding, categorising and interpretation (Coffey and Atkinson, 1996: Halkier 2002). The validity of data, conclusions and recommendations will follow applicable rules for qualitative, exemplary and analytical generalisable knowledge (Halkier, 2001; Kvale, 1997).

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