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Immigrants in Norway: Resilience, challenges and vulnerabilities in times of COVID-19

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ABSTRACT

Immigrants have been found to be disproportionately impacted during the COVID-19 pandemic across the world. Our study, exploring the experiences of immigrants in Norway during the pandemic, is based on interviews and focus group discussions with 10 and 21 immigrants, respectively. Our analysis showed that participants perceived the circumstances induced by the pandemic to be difficult and voiced the challenges experienced. Their experiences encompassed social, economic, and the public sphere, where immigrants felt themselves to be in more vulnerable positions than before the pandemic. Our analysis identified four main themes: 1) Feeling stagnated, 2) Perceptions towards government and health authorities, 3) Boundaries of us vs them, and 4) Coping. We conclude our paper by stating that government and health authorities should consider both short-term and long-term consequence of the pandemic to mitigate impact on communities at risk.

1. Introduction

As the impact of COVID-19 unfolds, the evidence indicate that immigrants have been disproportionately affected by the pandemic (Centers for Disease Control and Prevention, 2020; Lopez, Hart, & Katz, 2021). In Norway, immigrants have been found to have higher reported rates of COVID-19 and related hospitalizations than non-immigrants. The positive reported rates have been particularly high among immigrants from Somalia (2057), Pakistan (1868) and Iraq (1616) (Indseth et al., 2020). Such differences between immigrants and non-immigrants were found to increase when adjusting for increasing age, especially for mortality. Immigrants also have had a high number of hospitalizations relative to number of positive cases compared to non-immigrants (Indseth et al., 2020). Similar patterns of over-representation of minorities have emerged from other Scandinavian countries such as Sweden (Rostila et al., 2020) and Denmark (Diaz et al., 2020; Statens Serum Institut, 2020) as well as from the UK (Williamson et al., 2020) and the US (Clark, Fredricks, Woc-Colburn, Bottazzi, & Weatherhead, 2020).

Scholars have postulated several reasons for immigrants' increased risks of vulnerability. For example, immigrants are overrepresented in low-education groups, as workers in low-income and temporary employment positions, and in occupations with increased risks of exposure due to public contact (Hutchins, Fiscella, Levine, Ompad, & McDonald, 2009; World Bank, 2020). Moreover, many live in crowded housing (Indseth et al., 2020) and have higher prevalence of pre-existing risk factors for COVID-19 such as obesity, diabetes and cardiovascular diseases (Ahmed, Meyer, Kjøllesdal, & Madar, 2018; Kjøllestad et al., 2019; Rabanal, Lindman, Selmer, & Aamodt, 2013). Additionally, across Europe, immigrants lack easy access to translated COVID-19 risk communications (Maldonado, Collins, Blundell, & Singh, 2020).

In Norway, immigrants constitute 14.8% of the total population (Statistics Norway, 2021a). Norway is well-known for its generous welfare system with universalised access to health care (Ringard, Sagan, Saunes, & Lindahl, 2013), and health equity is an important policy goal in Norway (Meld St 13.[Parliament] 2021, 2018–2019). On the social front, Norway is recognised for its egalitarianism embedded in the concept of '*likhet*' meaning sameness or similarity (Gullestad, 2002). It is important to understand how immigrants in Norway are experiencing the COVID-19 crisis, because this knowledge can help guide appropriate response efforts and address health disparities within the political and social context of Norway. Therefore, in this study, we conduct a qualitative exploration of the experiences of immigrants in Norway during the COVID-19 pandemic. Our findings shed light on immigrants' expe-

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riences of structural barriers as well as their specific circumstances that influence their experiences during the COVID-19 crisis.

2. Immigrants in Norway

In Norway, immigrants constitute a diverse group proportion of people from Poland, Lithuania, Sweden, Syria, Somalia, and Pakistan (Statistics Norway, 2021a). Not only do immigrants differ based on their country of origin but also based on their reasons for migration. labor migrants comprise the largest group of immigrants, followed by family reunification immigrants and refugees (Statistics Norway 2021b). While they are a heterogenous groups, they nevertheless share common challenges in the social, economic and political spheres.

Firstly, there are significant disparities in the health of immigrants compared to the general population, and also within different populations among immigrants (Abebe, 2010). For example, cardiovascular disease is more widespread among immigrants from Southern Asia and the Balkans than in the general population (Rabanal et al., 2013). Similarly, mental health issues have consistently been found at a higher rate among adult immigrants, specifically among women and those from low- and middle-income countries compared to Norwegians and the general population (Abebe, 2010).

Secondly, on the labor market front, immigrants' earnings and employment rates are considerably lower than those of native Norwegians (Brekke & Mastekaasa, 2008; Vrålstad & Wiggen, 2017). Findings from the survey about living conditions in Norway illustrate immigrants struggle more with their economy than the general population in terms of making ends meet and managing unforeseen and ongoing expenses (Vrålstad & Wiggen, 2017). Furthermore, stereotypes about immigrants are prevalent across generations, and children of immigrants encounter attitudes and prejudices when entering the labor market (Midtbøen, 2014, 2018; Midtbøen & Rogstad, 2012). Immigrants and their children hear comments about their gender, ethnicity, skin color and religious background more frequently than native Norwegians when participating in public debates (Midtbøen, Steen-Johnsen, & Thorbjørnsrud, 2017).

Lastly, immigrants encounter barriers in accessing healthcare services in Norway due to language barriers, and these barriers are exacerbated by cultural influences or values, difficulties encountered in navigating the healthcare system, and experiences of discrimination (Arora, Straiton, Rechel, Bergland, & Debesay, 2019; Kumar & Diaz, 2019; Mbanya, Terragni, Gele, Diaz, & Kumar, 2019; Straiton & Myhre, 2017; Thyli, Hedelin, & Athlin, 2014). Furthermore, the ethnicised cultural and often negative discourses about immigrants in the public sphere have also been found to influence their experiences with healthcare providers in Norway (Arora et al., 2019). Such findings point towards immigrants' precarious circumstances in the health, social, and economic spheres of Norway.

3. Methods

This qualitative study is based on semi-structured interviews and focus group discussions (FGD) with 31 immigrants living in Stavanger and Sandnes municipalities in Norway with high share of immigrant population 19% and 18.4% respectively (IMDI, 2021). We recruited the participants through key informants at two Norwegian language learning centres. Recruiting through language centers helped to reach out to immigrants from diverse age groups, gender and ethnic backgrounds. Two FGDs were conducted with 10 and 11 participants in each group at these language centers (Women=13, Men=8). In the next step, we invited participants from the FGDs to participate in individual semi-structured interviews. A total of 10 interviews (Women=7, Men=3) were conducted at multiple locations such as language centers, cafes and public parks depending on participants' convenience and preferences. Our recruitment criteria were being an immigrant aged 18 years or older and being permanently settled as a legal resident in the municipality. The participants were from Asia, the Middle East, Africa, and Europe, aged between 25 and 60 years and had been living in Norway for 2 to 20 years. They ranged from those who were unemployed or students to those employed in high skilled jobs.

Both the semi-structured interviews and FGDs focused on the participants' a) perceptions and understanding of the COVID-19 pandemic, b) experiences and challenges, c) perceived impact of COVID-19 on their lives, and d) coping strategies.

All authors were involved in data collection and had prior experience of conducting interviews in vulnerable communities and were thus sensitive to participants' needs (Kavanaugh & Ayres, 1998). Participants were provided with both written and verbal information about the study, as well as the right to refuse participation at any period of the study. The interviews were conducted in multiple languages (English, Norwegian and Urdu) and lasted for 30–45 minutes. Data collection was ended when no further data were found. We found that the complementary data from the FGD and interviews justified the themes and concluded that saturation was reached. The study was approved by the Norwegian center for Research Data. All participants were informed that their data will be processed anonymously. In addition, the participants in FGDs were informed that their participation shall not entail confidentiality as other participants will be aware of the information shared. The interviews were audio-recorded, transcribed verbatim and translated into English. All identifying information was removed during transcription to ensure anonymity, and participants were assigned numbers.

The data was analysed as follows. In the first step, read and re-read the transcripts to familiarise ourselves with the data, and later open-coding or line-by-line coding was used to generate descriptive and summarizing codes for immigrants' experiences and perceptions, staying as close as possible to their original words. This step was followed by a more focused coding where the most frequently used codes were categorised into "code families" and later to conceptual categories that eventually formed the organization of the results section of this paper. During the coding of the data, the authors worked together to reach consensus and create a code book. The data was coded and analysed thematically according to the relevant literature and Braun and Clarke's (Braun & Clarke, 2006) six-phase guide. Once the code families were created, and consensus was reached among the researchers, the first author coded the remaining interviews. The analysis of the code families allowed the authors to bring together salient categories. For example, categories that emerged as significant in the process for coping were resilience, everyday coping, solidarity, knowledge and awareness. The program Nvivo was used to aid the coding process.

4. Findings and discussion

All participants in the FGDs and interviews perceived the circumstances induced by the COVID-19 pandemic to be difficult and voiced the challenges experienced in their everyday lives. Their experiences encompassed social, financial, and the public sphere, where immigrants felt themselves to be in more vulnerable positions than before the pandemic. Participants perceived that the pandemic had stalled their opportunities in the Norwegian society and put them in stagnated position both socially and economically. Nevertheless, they voiced overall positive experiences towards the Norwegian government's and health authorities' handling of the pandemic, with most comparing the situation in Norway with their country of origin. In the everyday social sphere, some participants experienced a stigmatizing narrative about immigrants due to the pandemic. Lastly, our findings highlight the ways of coping adopted by the participants during such challenging times.

Our analysis is thus organised into four main themes: 1) Feeling stagnated, 2) Perceptions towards government and health authorities, 3) Boundaries of us vs them, and 4) Coping.

4.1. Feeling stagnated

One of the prominent themes that emerged from both interviews and FGDs was feeling of stagnation. Participants described feelings of helplessness in not being able to support and care for family members in their home country, their financial precarity, and not being able to socialize and network. Immigrants in Norway have been found to feel a strong sense of belonging to their countries of origin, while also maintaining a strong sense of belonging to Norway, and they do not perceive any contradiction between the two orientations (Vrålstad & Wiggen, 2017). Thus, even though some might understand 'home' more in a practical sense of where they live their everyday life, they often maintain a dual sense of belonging and identity (Erdal, 2012). However, due to the travel restrictions and risks of contracting COVID-19, the physical ties of the participants to their homelands were disrupted. For example, one participant (P1, FGD), discussing the travel restrictions due to COVID-19 stated:

> Many of us need to go to our country, for any reason such as illness [of parents], because [they] are old. I heard about some friends whose mother or father died of corona, and it is very difficult to go there…It is very difficult and stressful [for us].

Moreover, the feeling of helplessness and complications about travelling 'home' were also found to be coupled with feelings of being worried and anxious about family members back in their country of origin, as reflect by another participant's (P2, interview) account:

> [I am not worried about myself] but the first thing I thought of were my parents back in France who are old. If something happened, I had no way to go help them because the country was closed.

Thus, detached physical ties from their home countries posed challenges in maintaining transnational identities. The feelings of being helpless were also voiced by participants in relation to their economic vulnerabilities, which were exacerbated by the pandemic, as reflected through the account of a participant who worked as a taxi driver (P3, interview):

> there are those people who are like engineers and getting higher incomes, then there are those who… are surviving. Now for those [the latter], the problem is that they are not told to stop working from their jobs, they worry that they will lose their homes, so they continue working due to their helplessness…I am also one of them.

The above quote reflects how the participant weighs the financial challenges against health risks imposed on him due to the nature of his job during the pandemic. The taxi-driving industry is largely composed of first-generation immigrants and offers one of the few jobs in the Norwegian labor market where people with limited language skills can earn a living (Brox, 2016), and so additional risks are imposed on immigrants. Individuals from low-income backgrounds who are more likely to work in informal employment (e.g., domestic work, farm labor), and belong to racial and ethnic minority groups do not have the economic safety net to endure extended social distancing measures such as lockdowns (Hutchins et al., 2009). Further, people with low education and low income in Norway have been found to face challenges in adhering to the formal recommendations regarding social distancing (Steen & Ingelsrud, 2020). Thus, such institutional actions force individuals to put their physical health and psychological wellbeing (e.g., fear of contracting COVID-19) at risk to ensure economic security and provide necessary services to others (Lancet, 2020).

Some participants also reported losing their jobs as a result of layoffs during COVID-19 or due to the temporary nature of their jobs (for instance, as substitute kindergarten employees) which made it difficult for them to get called for work, in line with the complexities of following COVID-19 risk measures. To quote another participant who worked as a substitute at kindergarten (P4, Interview):

> I lost my job. And when I spoke to them, they said there are so many rules, and especially for substitutes who work in different kindergartens. Because if they were to get infected, the question would be where, at what kindergarten? It would be very difficult, so they would not continue calling in substitutes.

At of the end of 2020, registered unemployment among immigrants in Norway was found to be at 9.2% with unemployment among immigrants Asia and Africa being particularly high (10.3% and 13.7%, respectively), compared to 2.7% among the non-immigrant population (Statistics Norway 2021cStatistics Norway 2021c). The temporary nature of jobs that immigrants often find themselves in (Friberg, 2016) coupled with a general loss of employment for many in Norway (Statistics Norway 2021c) has thus exacerbated economic precarity for immigrants.

Participants with higher education and high-skilled backgrounds were concerned about the lack of socializing and networking opportunities due to COVID-19, which they perceived as further stagnating their opportunities. Such feelings of being stagnated (i.e., experiencing helplessness due to lack of control over their situation in the job market due to COVID-19) were echoed by several participants both in interviews and FGDs. This was in line with the research conducted on Ghanaian immigrants living in Norway where it was found that immigrants' abilities to obtain jobs were determined by more than simply having the appropriate educational and language qualifications. Getting a job, then also largely depended on having favourable social identities and being embedded in social networks beyond the immigrant community (Badwi, Ablo, & Overå, 2018).

Furthermore, learning institutions such as language centres have gone digital during COVID-19 in an attempt to minimize risk of infection and accommodate the learning needs of students. While such routine adjustments are in line with public health initiatives during COVID-19 and are indeed helpful from the perspective of pandemic management, these solutions do not necessarily help to buffer the precarity of immigrants as their employability is highly dependent on their networking opportunities.

Economic and labor market challenges during the pandemic were thus heightened by their pre-existing vulnerabilities of poor language skills, lower networking capital, temporary employment, and jobs that impose increased health risks. Such findings are in line with other research which shows that the pandemic has led to social isolation and economic precarity among immigrants, further putting their mental health and well-being at risk (Barker, 2021; Johnson et al., 2021; Guadagno, 2020; Sánchez et al., 2021). This highlights both short and long-term consequences of the pandemic.

4.2. Perceptions towards government and health authorities in Norway

Most participants in our study perceived the handling of the COVID-19 situation by Norwegian government and health authorities positively. Such positive perceptions were reflected through exhibition of high trust in the authorities and institutions in Norway and through feelings of 'being grateful'. As one participant (P6, FGD) stated:

> I think we are really lucky to be here in Norway…to be honest I am actually very grateful for the way the government has handled the situation.

Our participants often compared the situation in Norway with their country of origin, for example, one participant reflected (P7, interview):

> … if we look at our own countries then I believe we are lucky that we are here. Because in our countries, because of the governments, many people have lost jobs because of corona. Here nobody is going hungry. The government thinks about people. NAV [Norwegian labor and welfare administration services] also supports When we think of our families, our relatives [back home], we are more worried for them.

Similar perceptions were echoed in FGDs, where participants compared their situation in Norway by comparing it to their family and friends in their country of origin. People in Norway have been found to express a high degree of trust in the health care systems and authorities with respect to the Norwegian government's handling of the pandemic (Helsingen et al., 2020). The Survey on Living Conditions among Persons with an Immigrant Background (Vrålstad & Wiggen, 2016) even found that immigrants in Norway expressed more confidence in the country's political institutions than Norwegians. This result is surprising given the generally less favourable positions of immigrants in many societies (Röder & Mühlau, 2012) and the participants' own accounts in this study.

The participants perceived the authorities in Norway with a frame of reference of their country of origin. When comparing to Norway, they described the COVID-19 situation in their home country as challenging because there is no welfare system in place to support families (when breadwinners have lost their jobs), or because society is poor, with few schools (and those few being closed due to the pandemic), or because there is little access to information and the health care system (for which they had to pay for treatment). A study using data from a European social survey (including Norway) examined this 'frame of reference effect' and argued that it is largely the relatively lower expectations of immigrants from countries with poorer institutional performance that account for the higher trust exhibited by immigrants than natives (Röder & Mühlau, 2012). Thus, it is plausible that the trust in authorities in Norway is influenced by different expectations developed in the immigrants' countries of origin.

Despite the generally positive perceptions of government and health authorities in Norway, some participants also spoke about what they viewed as problematic aspects in the government's handling of the situation. For example, some were "shocked" and found it paradoxical that they could "live a normal life" [i.e., to not quarantine] even if their family members were suspected of having COVID-19 (P6, FGD).

Some also questioned the Norwegian government's recommendations for face masks. They felt that communication about face masks was confusing and that it should have been stringently enforced at the beginning of the pandemic. The following quote illustrates such confusion (P3, interview):

> Here they [authorities] themselves created a confusion… [Earlier]the government's [stance] was also such that wearing mask doesn't have any effect, even though cases were rising at that time…the ones who were wearing the mask then were being looked at in contemptuous way. As if [they] have [COVID-19]

The same participant (P3) stressed the need to communicate more clearly about the implementation of masks and introduce stricter and timely regulations:

Most participants in our study had higher education and spoke and understood English well, and they were able to find information from multiple sources, including information given by the health authorities. The participants who had lower skills in the Norwegian language spoke about the need for more information, specifically information pertaining to new regulations, to be available in different languages. However, a few pointed out the barriers beyond language that make it difficult for immigrants to navigate access to information and services. For example, a participant (P7, interview) discussed how their family struggled to get a doctor's consultation for their sick daughter because of lack of information about accessing non-corona related health services:

> Believe me the condition in which we spent those 6 hours, only we know… it is not just about problem of language. The biggest problem is… for example, if you are working in this profession, so you know on which site, what option is available, you know where every form is, on which internet site. We are told like "you go to the internet and open this form from there". But how can a person find when one doesn't know about these things?

The participant above points out the challenges of navigating healthcare and welfare services in Norway Straiton and Myhre (2017). in their study found that gaining system knowledge can be challenging for immigrants, as formal language (with which immigrants lack familiarity) is often used in official information, and immigrants often do not understand how to access services and information in Norway. Some immigrants' also lack digital skills, which may result in additional challenges for them to learn about (digital) solutions and gain access to information (Fagherazzi, Goetzinger, Rashid, Aguayo, & Huiart, 2020).

Despite some critical perceptions towards the authority's management of the pandemic, most participants in both interviews and FGDs expressed feeling 'safe' because of the support measures by the welfare state in Norway. However, for others, the nature of their job made receiving compensation more difficult during periods of quarantine. For example, the participant who worked as a taxi driver shared that he was told that if he gets an infected passenger in his taxi, he would be directed to stay in quarantine for 10 days. However, he stated that since if is not sick himself, he will not be compensated for the days he does not work. This loophole shows that institutional mitigation measures put some populations at higher risk of economic precarity.

Thus, while most participants in our study expressed confidence in the Norwegian government's handling of the pandemic, they also highlighted the need for better clarity and information related to COVID-19 measures as well as support with navigating services during the pandemic. Indeed, barriers in accessing information and navigating healthcare services for immigrants have existed even before, as pointed earlier. However, recent studies have shown such barriers to be exacerbated on account of the pandemic (Elisabeth et al., 2020; Germain, S. and Yong, A., 2020). Linguistically and culturally appropriate public communication and information is thus vital to mitigating the impact of the pandemic (Orcutt, 2020).

4.3. Boundaries of US vs them

Some interview participants in our study viewed themselves from the eyes of the majority and thus felt that they were perceived as 'careless' and responsible for the spread of infection. For example, a participant (P7, interview) who was fearful of contracting COVID-19 because she was worried that people would 'avoid' her even after recovery, said:

> I have seen it myself in [name of municipality] and here too… if for example one is coughing, the Norwegians would move to the side… My mother was telling me that she was at the bus stop the other day and she coughed a little… she told me, "I just had a little cough and the Norwegians there, they moved to the other side completely." Maybe when they look at us they think that we don't care much. I think maybe they have this thing in their minds that because of us [COVID-19] is spreading more… that we [immigrants] don't care much."

This way of perceiving relates to DuBois' (1994, p. 4) concept of double consciousness, which is defined as the "sense of always looking at oneself through the eyes of others." Such feelings of double consciousness have also been found to be embedded in the everyday life of being an immigrant in Norwegian society (Arora, 2020).

Another participant (P3, interview) recalled an incident where he was perceived as Somalian and therefore indirectly stereotyped as being responsible for the spread of infection, as reflected by the participant's quote:

> Last week I was at the airport so the first thing a Norwegian passenger asked me was, "er du fra Somalia? [are you from Somalia]. I said, "nei" [No]. I asked him why are you asking? He said, "I have heard that the Somalian drivers are infecting everyone."

Studies have shown that perceived vulnerability to disease can enhance social boundaries along racial, ethnic or religious lines. For example, placing blame during an outbreak on those who are perceived of

as responsible can make people feel control over situations characterized by uncertainty and fear (Nelkin & Gilman, 1988). In the context of COVID-19, studies have shown that minorities have been subjected to blame and stigmatization in several countries (Chung, Erler, Li, & Au, 2020; He, He, Zhou, Nie, & He, 2020; Silva et al., 2022). The identification and labeling of such 'risk groups' in society thus creates boundaries of *us* vs. *them* that creates and legitimizes the stigmatization of already marginalized populations (Goldin, 1994). Ethnic boundaries can also have material consequences (Wimmer, 2013) and such consequences are made visible through manifestations of power in everyday majority-minority relations, as reflected by the participant (P3, interview) who recalled an incident in his work as a taxi driver:

> I picked two boys, they were Norwegian. They must have been between 22–25 years old. They sat and I said to them, "Can you please use masks, because you know corona situation." He said "Who are you to tell me this? You are just a taxi driver, your job is just that you shut your mouth and you take us to that place." I replied back to him, "If you kindly use mask, then I can drive you, if you don't use it, then I can't." You know what they did, they said "Who are you to… you came to our country and now you are telling us what to do?"

Participant (P3) reflected on this incident as a manifestation of the general power imbalance in Norwegian society, and further stated:

> Actually, what I have observed is that when a Norwegian person talks to a Norwegian, it is taken in a different way. If an immigrant talks to a Norwegian like this, then it is taken as an insult… [they say] this disease is among immigrants… since then you can say the aggression inside people has increased a bit. But the fault is actually of the government. The government doesn't have anything to say so the blame game is being played.

The above account reflects this participant's experience of the increase in making of the ethnic boundaries among majority-minority relations in the everyday life in Norway and the inability of an immigrant with limited language skills and power to unmake those boundaries. It sheds light on the risks of legitimizing cultural blame that disguises the political and economic factors that create at-risk populations (Eichelberger, 2007), further deepening the ethnic boundaries in the public sphere. It also reflects participant's perception of the failure of the government in de-legitimizing ethnic and cultural blame.

4.4. Coping and resilience

Given the unique challenges and circumstances our participants found themselves in, several spoke about their experiences of coping during COVID-19 to compensate for the lack of family and social support as well as to escape the collective stigma of being an immigrant. Coping is defined as an individual's use of behavioural and cognitive strategies to modify adverse aspects of their environment, as well as to minimize or escape internal threats induced by stress or trauma (Gil, 2005). In our study, participants spoke about how the everyday adjustments they had made in their lives helped them build a bridge between their lives here in Norway and with their friends and family in their home countries. For instance, although they were longing to meet their family and wanted to visit their country of origin, they also knew that this was not possible soon. Hence, they compensated this longing by talking to them digitally. For example, a participant stated (P8, interview):

> We took a big decision not to go to India this summer. So, I think people should see in that perspective, that you know, I know you do miss your family. But now technology is so good that you can use Skype you can do a video chat and stuff.

Similar ways of staying connected to their family and country of origin were also shared in FGDs. During these talks they not only checked on their loved ones, but also shared advice and guidance on how to follow COVID-19 precautionary measures. They used apps like WhatsApp and Skype to reach out, to help and to receive help. Participants with higher education or skilled backgrounds also reported widespread use of digital media technologies to help them take part in the wider migrant community in the municipality. For instance, one of our participants talked about how they were informed about the COVID-19 restrictions through their church WhatsApp group and that they even had their church meetings online via Zoom. A Facebook page for expats was followed by most participants with higher education, where the group's moderators provided translations of the official statements into English and kept the migrant community up to date.

Digital media thus played an important role in this process and has helped generate bonds among individuals who then communicate and exchange knowledge. Similar findings have been reported in other studies which show that digital technology is increasingly being used for collective coping and maintaining well-being during COVID-19 (Flecha Ortiz- et al., 2021; Wang et al., 2021).

For some participants in both interviews and FGDs, spirituality was an important source for coping with the pandemic, while for others it was long walks in the nature or spending time with their nuclear family. Such strategies helped them to cope with the stress and worries during the breakdown of physical ties with their homeland during the pandemic. Indeed, the pandemic has affected the mental health of people, specifically immigrants who have been found to be at an increased risk of psychological distress and reduced mental well-being both in Norway (Harris and Sandal, 2020) and internationally (Habtamu et al., 2021; Shen and Bartram, 2020; Devaraj & Patel, 2021).

Coping strategies were not only used to navigate access to information and social communication with family, but also to escape the collective stigma associated with being an immigrant. For example, to cope with the negative conceptualisation of immigrants as 'careless' in the public sphere during COVID-19, some participants resorted to conceptualizing other immigrant groups as those who do not take COVID-19 seriously. In such ways, they distanced themselves from the other immigrants while simultaneously viewing their own identity favourably. Two participants (P7 and P10), in separate interviews, gave accounts that both reflected this strategy:

> But I feel these people… they think that immigrants are careless. Maybe not for us specifically but for other immigrant groups like the ones who do more parties or have a lot of get-togethers… like Somalians. That's how our [group's] name also get affected. Everyone gets affected, this is the thing (P7)

> … some, to be honest, I think that some immigrants are not hygienic. But like, for me…I always carry antibacterial with me (P10).

The strategy of contingently detaching oneself from other community members has been found to reflect acts of agency in immigrants (Arora et al., 2019; Celik, 2018; Wimmer, 2013) Rydzik and Anitha (2020)., in their work on immigrant women's experiences of unfair treatment at work, conceptualize the notion of agency as the practise of resilience. They argue that immigrants' acts of resilience become strategies that are geared towards changing and/or adapting to the existing circumstances and creating a more viable everyday life. Studies have shown that immigrants utilize a variety of sources to promote resilience during the pandemic such as shared family beliefs and relationships (Prime and Wade, 2020); spirituality and faith (Ekwonye and Truong, 2022), among others. In this sense, participants' acts of agency to help them cope with collective stigma and the disruption of familial and social ties also reflect their resilience.

5. Strengths and limitations

This study adds to the knowledge about experiences of immigrants in Norway during COVID-19 pandemic. By recruiting the participants through language centers, we were able to meet the participants face-to-

face while maintaining a safe distance. Our recruitment approach also helped us to reach out to participants from varied ethnic backgrounds, gender and age. However, conducting FGDs, especially at the language center, could have also impacted the information shared by the participants. This is possible, considering that only in the interviews, participants shared their perspectives and experiences on sensitive topic such as that of feeling stigmatized during the pandemic, as compared to sharing in FGDs among the presence of others.

6. Conclusion

Our study points to the various social, economic and structural challenges that immigrants have experienced during COVID-19 pandemic in Norway We showed how immigrants' pre-existing vulnerabilities may be further exacerbated during crisis leading to inequity in health and welfare. Therefore, it is vital that institutions go beyond the traditional measures to ensure the well-being of populations-at-risk (Warren & Bordoloi, 2020). Also, there is a need for better clarity and information related to COVID-19 measures as well as help with navigating healthcare services during the pandemic. Government and health authorities should consider both short-term and long-term impact of the pandemic such as isolation, economic precarity and stigmatized discourses about immigrants in society. More knowledge is needed to understand immigrants' ways of coping to promote resilience.

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Statement of ethical approval

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Declaration of Competing Interest

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