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Promoting Health "Otherwise":

Culture and Infrastructuring as Mechanisms of Inclusion and Exclusion of Migrants in an Austrian NGO

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Abstract English

The Austrian state outsources its mental health care responsibilities for migrants and refugees to the non-governmental sector. So far, little is known about the NGOs that provide this care. This thesis thus looks at an NGO that offers holistic health promotion to people with refugee and migration experiences. Drawing on two months of ethnographic fieldwork, I investigate the practices through which migrants are both included and excluded from the NGO's health promotion. Specifically, I argue that it is useful to analyse culture and infrastructure as levels on which inclusion and exclusion are negotiated. Drawing on STS literature, I first conceptualise the NGO as an infrastructure of care. Doing so, I suggest that its visions of low-threshold health promotion are inseparable from attempts to collaborate with other infrastructures like schools or the child service office. Here I also reveal how such collaborations with the state can simultaneously lead to the inclusion and exclusion of potential beneficiaries. Second, I give insights into how the NGO's staff uses culture (un)consciously to create inclusionary health programmes. I then relate these various understandings of culture to anthropological approaches to culture, moralisation, biomedicine, and epistemic violence. This reveals the NGO's mentors' underlying hierarchies of knowledge, showcasing how in peer-led health promotion notions of "the other" can arise, whose cultural knowledge is disregarded as irrelevant to mental well-being. In summary, this thesis argues that practices aimed at creating inclusion, whether through cultural sensitivity or infrastructural work, can simultaneously produce and co-exist with mechanisms of exclusion.

Abstrakt Deutsch

Der österreichische Staat lagert seine Verantwortung für eine angemessene psychosoziale Versorgung von Migrant*innen und Flüchtlingen an den nicht-staatlichen Sektor aus. Über jene NGOs, die diese Versorgung auf sich nehmen, ist jedoch wenig bekannt. Diese Arbeit befasst sich daher mit einer NGO, die ganzheitliche Gesundheitsförderung für Personen mit Flucht- und Migrationserfahrungen anbietet. Auf der Grundlage einer zweimonatigen ethnografischen Feldforschung wird insbesondere der Frage nachgegangen, wie Migrant*innen in die Gesundheitsförderung einbezogen bzw. davon ausgeschlossen werden. Es wird argumentiert, dass es sinnvoll ist, Kultur und Infrastruktur als Ebenen zu analysieren, auf denen Inklusion und Exklusion verhandelt werden. In Anlehnung an STS-Literatur wird die NGO zunächst als „infrastructure of care” konzeptualisiert, was darauf hindeutet, dass Versuche, sich mit anderen Infrastrukturen (z.B. Schulen, Jugendamt) zu vernetzen, mit Visionen zur niedrigschwelligen Gesundheitsförderung verbunden sind. Ferner wird erörtert, wie die Zusammenarbeit mit dem Staat gleichzeitig zur Einbeziehung und zum Ausschluss potenzieller Teilnehmer*innen führen kann. Zweitens wird der Frage nachgegangen, wie Kultur bei der Gestaltung inklusiver Gesundheitsprogramme (un)bewusst eingesetzt wird. So werden die verschiedenen Auffassungen der Kultur besprochen und mit anthropologischen Ansätzen zu Kultur, Moralisierung, Biomedizin und Epistemischer Gewalt in Beziehung gesetzt. Die Arbeit deckt die zugrundeliegenden Wissenshierarchien der Gesundheitsmentor*innen auf und zeigt, wie in der von Peers geleiteten Gesundheitsförderung Vorstellungen des “Anderen” entstehen können, dessen kulturelles Wissen als irrelevant für das psychische Wohlbefinden gilt. Zusammenfassend wird in dieser Arbeit argumentiert, dass Praktiken, die auf die Schaffung von Inklusion abzielen, sei es durch kulturelle Sensibilität oder infrastrukturelle Arbeit, gleichzeitig Mechanismen der Ausgrenzung hervorbringen und mit ihnen koexistieren können.

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1. Introduction

In October 2022, around a dozen social workers gathered in Vienna, Austria's capital, to take part in a workshop on mental health after migration and flight. The workshop was led by the director and the project coordinator of an NGO that provides holistic health promotion for people with refugee and migration experiences [ganzheitliche Gesundheitsförderung]. Everyone sat in a wide chair circle in a dimly lit room lined with green linoleum flooring, listening closely, hoping to learn more about how to help their clients with their struggles in the aftermath of traumatic experiences. "Refugees often hope that everything will be better once they arrive in Austria.", the NGO's director declared, "But that is not what happens. In their home countries, they have traumatic experiences, the flight is traumatising and then in the host country, they experience many burdens [viele Belastungen]. It is not a single traumatising event, but multiple - over a long time." In the further course of the workshop, the structural difficulties that refugees face in accessing health care were discussed. An Afghan refugee, who works as a social worker in a shelter for unaccompanied minors, told us that in its common room, there is a list of doctors and psychotherapists, some of them marked in green, others in red. Those marked in green are considered "refugee-friendly", those marked in red should be avoided because of racist, Islamophobic or xenophobic experiences. As the workshop moved on, the social workers discussed the role of culture in their care work. A woman, working for a girl's hotline, asked "What should I do, if find cultural norms problematic or harmful?" To this, the director answered: "It is important to allow cultural practices you do not believe in. It is about juxtaposing multiple valid opinions without devaluing them. First listen and then explain your values." In the further course, we learned exercises on trauma symptoms, triggers, and coping strategies. During the final discussion, the social workers expressed their dissatisfaction about the lack of psychotherapy places in Austria, but also about the powerlessness they feel when they unsuccessfully try to convince clients with a migration background to undergo therapy.

This thesis is based on two months of ethnographic fieldwork with the NGO that organised the workshop described above. The issues brought up on this sunny October day reflect important concerns that are at the heart of this thesis. The workshop made evident that people with migration and flight experiences are especially vulnerable in regard to their mental health. It also showed that access to health care comes with various structural and cultural challenges. First, as pointed out by the workshop attendees, structural barriers, such as a lack of therapy places with translators and discriminatory health care practices, lead to refugees' exclusion from the public healthcare system. Second, cultural differences between refugees and Austrians were brought up, framed as an obstacle that needs to be overcome.

This thesis investigates how the NGO promoted health for refugees and migrants in Austria. It pays specific attention to how the NGO navigated the structural and cultural challenges addressed in the workshop. Specifically, I argue that the NGO's aim to offer low-threshold health promotion was implemented through structurally and culturally informed practices. First, I focus on the NGO's infrastructuring practices, showing how the staff tried to overcome structural barriers. Second, I trace the NGO's various understandings of culture and examine how these informed its programmes with the objective to promote health information in a culturally sensitive manner.

It is widely known that the detrimental impact of war and forced migration affects both physical and mental health (Kohlenberger et al., 2019). Forced migrants bear violence and discrimination, not only in the countries they fled but also in the countries they settle in (Kostoula, 2022). Although forced migration experiences differ greatly, they generally involve adverse risks to mental and physical well-being (Priebe et al., 2016). As the NGO's director pointed out, these range from the hardships forcing migration in the first place, over life-threatening flight and transit conditions, to the obstacles faced when resettling in a foreign country. In Austria forced migrants encounter various stressors, including family separation, language barriers, and discrimination, as well as stressors associated with the uncertainty of the asylum process, including seeking work and residency permits (Schiess-Jokanovic et al., 2021). Yet, as criticised in the workshop, there is a lack of therapy places for migrants and refugees, as there are not enough specialised offers. Any focused mental health interventions should be sensitive to how socio-cultural factors impact health needs (Kostoula, 2022). They should acknowledge how structural inequality intersects with mental health, address how illness and health are culturally informed, and "accept something one does not believe in”, to use my interlocuter’s words. However, in Austria such culturally sensitive mental health interventions are rare. Hence it is crucial to be attentive to how forced migrants are included and excluded from the health care they are entitled to. Thus, this thesis contributes to our understanding of the struggles associated with providing inclusive, focused mental health offers for forced migrants in Austria.

Most studies on migrants’ and refugees’ well-being and access to health care in Austria are quantitative. Their findings emphasise the impact of legal status, language skills, the lack of knowledge of primary providers and socioeconomic status, on health and treatment seeking (Kohlenberger et al., 2019; Saradadvar, 2014; Schiess-Jokanovic et al., 2021; Seidler et al., 2019). While these studies lay an important foundation in highlighting which inequalities exist, there is a lack of in-depth qualitative research engaging ethnographically with how the inclusion and exclusion of forced migrants take shape. Spahl’s (2022) recent ethnographic research is a noteworthy exception, arguing that the Austrian solidarity-based healthcare system is a form of refugees’ political inclusion. Although health services specialised in forced migrants in Austria are often outsourced to the non-governmental sector, there is little ethnographic research on their practices (Seidler et al., 2019). Drawing on two months of fieldwork, I thus aim to fill the existing research gap, tracing how the inclusion and exclusion of migrants was practiced through negotiations of culture and infrastructuring practices.

In this thesis, I will conceptualise the NGO as an infrastructure of care, arguing that its infrastructuring practices cannot be detached from the staff’s vision of offering low-threshold health promotion. Drawing on the STS concept *right to infrastructure* (Jiménez, 2014) and the analytic vocabulary of *seams* (Vertesi, 2014), I propose to understand the NGO’s infrastructure as *in beta*, constantly reaching out, shifting, and adapting. Highlighting how infrastructural alignments were informed by participants’ (assumed) cultural views and structural situatedness, I will propose that *structural competence* (Metzl & Hansen, 2014) should be understood in terms of *(infra)structuring competence*, the desire and ability to find ad-hoc creative solutions in moments of seamful alignments. In following the NGO’s seams, I will further analyse its collaboration with public institutions. Specifically, I will argue that, on the one hand, the NGO was dependent upon this cooperation to reach its target group. Paradoxically, on the other hand, I will argue that it was precisely this infrastructural alignment that became an exclusionary mechanism, as it led some participants to reject the NGO.

Furthermore, I will draw on anthropological concepts of *moralisation* (Brown, 2018), *illness narratives* (Kleinman, 1988), and *epistemic violence* (Dotson, 2011; Petteway, 2023), to outline how cultural differences were acknowledged, negotiated, and at times actively constructed. I will trace how essentialist notions of culture were established and implemented, arguing that the staff unmade patients, by refraining from using the diagnostic label trauma, which was deemed culturally unacceptable. Furthermore, I will explore the underlying hierarchies of knowledge, in moments where cultural knowledge was dismissed as irrelevant to proper mental well-being. This, I claim, makes visible how in peer-led health promotion problematic notions of “the other” can arise. Hence, I will make the argument that a shared nationality should not be confused with a shared acceptance of culturally informed notions of illness and health.

In the following, I will outline the Austrian policy landscape regarding immigration and health care policies. Thereafter, I will discuss the barriers migrants and refugees experience in accessing health care. This is followed by an elaboration on *cultural competence*, *structural competence*, and the term biomedicine. Moving on, I will familiarise the reader with the NGO with which I conducted fieldwork, followed by my methodological, ethical, and analytic considerations. Subsequently, in the first empirical chapter “an Infrastructure of Care”, I will critically engage with NGO’s infrastructuring practices. In the second empirical chapter “Culture”, I will move on to showcase how various understandings of culture were negotiated and applied to the NGO’s health promotion. After each empirical chapter, I will provide a short discussion of the implications of my analysis. Finally, in my conclusion, I will argue that in low-threshold health promotion, inclusion and exclusion are negotiated through culture and infrastructuring practices and that on both levels, barriers are simultaneously broken down and created. In writing this, I hope that this thesis will have an impact beyond the academic community and serve as a resource for organisations and practitioners who want to reflect on and improve the inclusivity of their services.

2. State of the Art

2.1. Politics of Exclusion

In general, the Austrian policy landscape concerning migration can be described by politics of exclusion, which include restrictive laws regulating residence and labour rights (Krzyżanowski & Wodak, 2009). Austria has a rich history of taking in large numbers of forced migrants, in 1968 more than 162,000 Czech refugees, and in the 1990s over 95,000 Bosnians (Schiocchet et al., 2020). In 2015, approximately 88,000 persons applied for asylum, most fleeing from Syria, Afghanistan, and Iraq (Bundeministerium für Inneres, 2015). However, the arrival of Arab, mostly Muslim refugees, led to a surge of concerns that were instrumentalised by right-wing and conservative political forces (Hafez, 2022). Refugees and cultural diversity were framed as a threat to Austrian society, resulting in politics of exclusion. As a result, in 2016, the country limited the number of admitted asylum applications to 80 per day. And in 2016/17 Sebastian Kurz, the former foreign minister and later chancellor, supported the closure of the so-called Balkan route, which was closed subsequently, restricting those fleeing from war to enter the European Union. During its coalition starting in 2017, the ÖVP (Christian democratic party) and FPÖ (radical right-wing populist party) further influenced negative institutional attitudes towards foreigners. As of October 2017, a ban on face coverings [Anti-Gesichtsverhüllungsgesetz] was introduced, making any covering of facial features in public buildings punishable with a fine of up to 150 Euros. A government website explains the law, which is clearly directed against Muslim women, with a graphic clarifying that wearing hats, headscarves or clown make-up is still legal, but wearing a face veil is not (oesterreich.gv.at, 2023). The law was followed in the autumn of 2019 by a ban on hijab [Kopftuchverbot] for girls attending pre-school and primary school. However, the Constitutional Court [VfGH] overturned the headscarf ban the following year, stating that it violates the principle of equality and is therefore unconstitutional. Both examples illustrate how Austria’s political approach to Islam is one of restriction (Hafez, 2022). Although the ÖVP’s and FPÖ’s term in government was cut short in 2019, following the Ibiza scandal video that exposed corruption, today both parties remain among the three strongest parties in the Austrian National Council. And the FPÖ continues to portray migrants as a problem population that takes something away from Austrians, be it jobs, housing, or social welfare money.

Both the FPÖ's and ÖVP's popularity cannot be detached from the "discursive construction of xenophobia among large parts of the Austrian public" (Krzyżanowski & Wodak, 2009, p.170). In media discourses, arriving refugees are referred to as a crisis or flood [Flüchtlingskrise; Flüchtlingswelle], using metaphors of natural disasters that portray them as rolling over Austria. Furthermore, notions of good and bad asylum seekers are created: those who truly fled from violence and those who came to take advantage of the Austrian welfare state. Often, crime rates are referenced in anti-immigration arguments (Reyes, 2010). Not only in public but also in research debates, forced migration is commonly discussed through the lens of integration [Integration]: the ability to adapt to Austrian society (Schiocchet et al., 2020). In integration discourses, it becomes migrants' responsibility to adopt Austrian values and to include themselves in a society from which they are considered excluded by default. During my fieldwork, which entailed many Google searches on asylum, immigration, and refugee status, I repeatedly received advertisements on Facebook showing two persons of colour standing in a car repair shop wearing overalls and smiling at the camera. When I clicked on the advertisement, which was run by the Austrian state, I was invited to "restart" my life, by voluntarily returning home to Ghana. While this showcases the (in)accuracy of targeted Facebook ads, it also exemplifies the state's efforts to exclude migrants quite literally, by asking them to leave.

As of the end of 2022 there were over 358,613 refugees, 108,087 asylum seekers and about 90.990 forcibly displaced Ukrainians living in Austria (Österreichischer Integrations Fonds, 2022; UNHCR, n.d.). These numbers, considering their amount, are difficult to grasp. Yet, I reference them to acknowledge that forced migrants constitute a significant percentage of the Austrian public, approximately 6.13%. However, this should not overshadow the fact that waiting times on asylum appeals are generally long, and between 2015 and 2022 only 165.610 of 345.840 applicants received some form of protective status. In 2022 alone, over 52% of the assessed proceedings were rejected (Gahleitner-Gertz, 2023). In the following, I will discuss how

Austria’s solidarity-based healthcare system can be framed as a form of political inclusion in this exclusionary immigration regime (Spahl, 2022).

2.2. Health Care of Inclusion

Asylum applicants [Asylbewerber*innen] and people under temporary protection are granted basic services [Grundversorgung] in Austria. These include accommodation, health insurance, food, financial support for clothes and school supplies (Asylkoordination, 2023). Furthermore, people receive a monthly allowance, which depends on whether a person lives in a private (260€) or state (40€) accommodation. Generally, asylum applicants are only allowed to work with an employment permit issued by the AMS [Labour Market Service]. If they receive a permit and find a job, the monthly allowance must be deducted from their income, making it quite difficult to effectively supplement living expenses.

Asylum seekers and persons under temporary protection who receive basic services have free health care access in Austria (Bachner et al., 2012). Asylum applicants receive an electronic health card, or e-card as Austrians tend to say, shortly after their application. The e-card, which must be presented at every doctor’s visit, holds all relevant details, such as a patient’s name, age, and insurance number yet it does not provide information about their legal status. As a result, migrants become “a patient among other patients” (Spahl, 2022, p.127). Generally, public health insurance covers various medical services, such as medication, public hospital visits, and psychological treatment. Recognized refugees are covered under the same public insurance scheme as Austrian citizens, which is solidarity-based. This means that insured persons with a higher income compensate for those insured with a lower or no income. With these health care coverage policies, Austria ranks 6th out of 56 in the health category of the “Migrant Integration Policy Index 2020”, which classifies Austria as a “migrant friendly country” promoting equal rights and opportunities regarding health (Solano & Huddleston, 2020). However, this is in stark contrast to Austria’s restrictive access to citizenship, where the country ranks 52nd out of 56 in the same index. Furthermore, third country nationals [Drittstaatsangehörige] hold no voting rights, restricting migrants’ political participation drastically (Moser, 2015).

In highlighting that Austria’s migration regime is one of exclusion, I would like to point out that free access to health care for migrants should not be confused with them having the same rights as Austrian citizens. Indeed, the generally restrictive policies reflect the prevailing anti-migrant attitudes among the population. Migrants’ access to health care should therefore be understood as a favourable exception in a policy landscape where there are “slightly more obstacles to than opportunities for the full participation of non-EU immigrants in Austrian society” (Solano & Huddleston, 2020, n.p.). In theory, asylum applicants and refugees experience the Austrian healthcare system as an inclusionary network. At the same time, barriers, or practices of exclusion, overshadow this principle of solidarity.

2.3. Barriers to Accessing Health Care

It is important to remember that being insured does not imply that migrants and refugees experience no barriers when accessing health care (Spahl, 2022). While costs may be covered, language can become an obstacle (Kohlenberger et al., 2019). Though some Austrian hospitals offer interpreter services, this is not the norm. Long waiting times are another hurdle and are especially prevalent when seeking psychotherapy. In Austria, refugees must wait an average of six to twelve months for psychotherapy with an adequate interpreter (Kohlenberger et al., 2019). Often, migrants turn to NGOs and other associations providing health care to avoid language barriers, discrimination, or legal and financial uncertainties (Castañeda, 2023; Seidler et al., 2019). However, NGOs are habitually overwhelmed by the number of people in need. For example, Hemayat, an NGO in Vienna that specialises in interpreted therapy for war and torture survivors, has a two-year waiting list (ORF, 2022).

There is a continuous effort in cultural and social anthropology, to follow how unequal health care access takes form for asylum applicants, unaccompanied minors, refugees, and undocumented migrants. Many of these studies focus on the clinical sector, following practitioners who provide care for migrant patients. Reviewing the literature on clinical encounters allows me to make sense of migrants’ and refugees’ struggles in the biomedical realm. In Austria, migrants’ and refugees’ health is negatively impacted by processes of exclusion within the healthcare system, including

“[…] the lack of interpreting services, financial barriers such as top-up payments, (un)conscious biases as well as stereotyping and discrimination by healthcare personnel and, ultimately, the larger living situation of refugees in Austria” (Spahl, 2022, p.128). Unfortunately, there is a lack of anthropological research investigating how these barriers manifest themselves concretely in the Austrian context. Therefore, I decided to draw on a variety of works from around the globe that explore barriers to health care access. Starting with “the other”, I move to notions of deservingness, introducing the role of bureaucracy and lastly elaborating on structural inequalities. Hereby, I do not aim to offer a complete overview, but to tell a story about which barriers migrants and refugees experience when accessing health care. From this point, I will then depart to introduce the intentions of my research venture.

For reasons of stylistic clarity, I will repeatedly use the term “migrant” in the following, which I utilize as an umbrella term for refugees, asylum seekers and other forced migrants. Obviously, each term has different legal implications. The term “refugee” is defined by the 1951 Geneva Refugee Convention and its 1967 Protocol, which further “outline their rights and the international standards of treatment for their protection” (UNHCR, 2023, n.p.). According to the Convention, a refugee “is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” (UNHCR, 2010, p.03).

Asylum applicants are still waiting for a decision on their claim, while the Federal Office for Immigration and Asylum examines whether there are grounds according to the Geneva Refugee Convention, or for subsidiary protection. If asylum is approved, persons receive the title “refugee”, granting them a temporary right of residence for three years. After this time, their status is reassessed and either revoked or a permanent right of residence is granted. However, if there is a substantial and lasting change in the specific, political, circumstances in a refugee’s country of origin, their refugee status can be revoked at any point in time.

People under subsidiary protection in Austria are neither refugees nor asylum applicants. Their asylum application was denied, but their life or health is nevertheless considered under threat in their country of origin. As such, they receive temporary protection from deportation, which is initially granted for one year and can then be reapplied for every two years. After 5 years of residence and proof of "good integration", one can apply for a permanent right of residence on humanitarian grounds, which the state regards as an exception rather than the rule (Bundesamt für Fremdenwesen und Asyl, 2023). While forced migrants usually apply for asylum as soon as they arrive in Austria, there is a special regulation for displaced Ukrainian citizens: they do not have to apply for asylum but are granted a temporary right of residence until the 4th of March 2024 (status July 2023). This entails certain advantages, for example, that they are allowed to work. As I hope I have made clear, terminology matters because it implies concrete rights. I will hence adopt the terms used by the studies reviewed to clarify the legal circumstances of the lived realities examined. However, in bringing them together, I refer to "migrants" and not to each category.

2.3.1. The Other

In public discourse migrants are often "positioned as 'the other', they are defined and treated as "separate, distant, and disconnected from the host communities in receiving countries" (Grove & Zwi, 2006, p.1931). In health care, *othering* is a process in which certain groups are identified to be different from oneself regarding their health, health needs or health-related knowledge (Johnson et al., 2009). Cultural beliefs, values and norms inform attitudes toward what well-being constitutes and how it is achieved (Kleinman & Benson, 2006). Likewise, migration and flight experiences can be connected to specific vulnerabilities, such as structural inequalities and high levels of trauma-related disorders among refugees (Dumke & Neuner, 2022). Yet an over-emphasize of difference produces notions of cultural and racial "otherness", which at times leave caregivers with the feeling that they do not know what patients with migration background expect and need (Torres et al., 2016).

Whether othering is done unconsciously or intentionally, it reinforces the marginalisation of often already disadvantaged groups. As such, migrant patients who realise that their clinical encounters were influenced by racial and cultural stereotypes report being discouraged from re-engaging with the healthcare system (Bowes & Domokos, 2010). Notably, othering also has direct effects on the quality of health care provision. For instance, it is reported that some German psychotherapists are less inclined to accept patients who are refugees from the Middle East, based on the assumption that they have unique characteristics and needs that diverge from the general (non-migrant) population, including traditional mental health beliefs and weak therapeutic alliance (Dumke & Neuner, 2022). Here, practices of othering are used to create normal and divergent patients, leading to the exclusion of those considered different from the dominant group. Often, othering "is done through a reductionist focus on problematic characteristics that are ascribed to subordinate groups" (Tallarek et al., 2020, p.02). Many beliefs and opinions about "the other" can be traced to Europe's colonial past. Kehr's (2018) research on tuberculosis care at a French Hospital, a former colonial institution, offers a notable example of the extent of patient *othering*. In her analysis, she points out how at the hospital "patients' origin [was] taught to matter – and [gained] priority over other aspects of their lived experiences'' (Kehr, 2018, p.664). Subsequently, African patients were regularly diagnosed with tuberculosis in the absence of bacterial evidence of the diseases, demonstrating continuity in biomedicine of treating migrants as "the other".

What becomes visible, is that even if health care policies are inclusionary, and migrants are formally entitled to health care, they are framed as "the other", as patients with certain attitudes, behaviours, and diseases. These stereotypical assumptions of medical professionals, in turn, create boundaries by either denying migrants equal health care from the outset or, if they do receive it, discouraging them from seeking treatment in the future.

Importantly, health-related beliefs about "the other" are closely related to notions of deservingness. In her book *Casualties of Care*, Ticktin (2011) explores the politics of care and its effect in present France. In the country, the "illness clause" grants legal papers to seriously ill undocumented migrants. This practice, in which diagnosis enables legality creates the public notion that a legitimate migrant suffers. This political practice in turn "maintains a racialized post-colonial nation-state, rendering migrants visible in French society primarily in the form of gendered and racialized victims […]"

(Ticktin, 2011, p.24). While *Casualties of Care* does not directly discuss barriers to health care access, it illustrates which legal significance is ascribed to the suffering body and how biomedical practices produce “the other”. As a result, the only legitimate refugee is a suffering one, creating a stereotype of whom is deserving, not only of health care but also of asylum.

2.3.2. Notions of Deservingness

Deservingness and its impact on health care is a well-studied phenomenon in medical anthropology. Sahraoui and Malakasis (2020) define it as “the ways in which some patients, but not others, are considered worthy of healthcare, particularly in settings of a receding welfare state and diminished public investment” (p.169). For instance, some practitioners providing medical aid to uninsured migrants consider children as most deserving (Castañeda, 2011). In contrast, in US policy discourses, older immigrants are often portrayed as not contributing to society, and therefore undeserving of social welfare (Yoo, 2008). These diverging notions can be traced back to children’s perceived innocence in the migratory undertaking. As Ticktin argues, innocence “can [...] create a distinction between worthy and unworthy victims in these same events” (2017, p.577).

Looking through the lens of deservingness allows us to pay attention to how health care access is negotiated, enabled, and restricted in everyday clinical encounters and which underlying moral values come into play (Willen, 2011). As such, deservingness constructs and reproduces moral economies (Villalona, 2021). Sahraoui and Malakasis (2020) examined practitioners’ perceptions of migrants’ deservingness of care in a maternity ward in Athens, where free health care access is guaranteed to all vulnerable persons. The anthropologists’ analysis reveals how deservingness is gendered, racialized, relational and embedded in socio-political structures. Medical staff considered migrant patients’ needs less pressing than those of Greek nationals, scrutinising their behaviour and giving cultural explanations for it. Pregnant migrants from Middle Eastern and Islamic backgrounds, who did not communicate much, were characterized as passive, voiceless victims of their husbands. Patients, who do not sufficiently speak a country’s dominant language, often experience “sentiments of frustration, self-blame, gratitude, trust, confusion and feelings of being uninformed" (Villalona, 2021, n.p.). Yet, instead of considering language barriers, medical staff at the maternity ward explained women's lack of communication through assumed cultural gender roles (Sahraoui & Malakasis, 2020). This racialised and gendered logic of *othering* alienates migrant patients from locals, feeding into the logic of them being different and hence undeserving of care. Assumptions about deservingness can even go so far, that medical treatment is denied, or limited due to patients' migration background, as such having "significant implications for the morbidity and mortality of migrant patients" (Holmes et al., 2021, p.01). Undocumented migrants may be refused psychiatric treatment because of their precarious residency status, even though they would formally be entitled to it (Holmes et al., 2021). Such rejections make visible the "subtle and often unspoken moral and ethical decisions that influence who does and does not access care" (Holmes et al., 2021, p.3). As Huschke's (2014) research of a humanitarian aid organisation in Germany reveals, undocumented migrants who were well dressed or did not perform severe pain were seen as underserving of practitioners' time. Hence, it becomes apparent that barriers to health care access are not exclusively legal. Instead, notions of deservingness, based on moral economies, feed into the decision-making processes of who receives care.

Importantly, public discourses about deservingness do not go unnoticed by migrants, instead they "produce immigrant subjects who feel underserving, and non-immigrant subjects who subjectivate immigrants as undeserving" (Larchanché, 2012, p.862). On the one hand, as discussed before, these discourses result in population hierarchies limiting migrants' rightful access to health care. On the other hand, they directly negatively impact migrants' health status, by causing them a great deal of psychological distress. Undocumented migrants in Germany reported that they do not feel entitled to make demands regarding their treatment (Huschke, 2014). Instead, they try to actively present themselves as deserving by performing severe pain and suffering. This showcases that the relationships between caregivers and receivers are inevitably shaped by power dynamics, and continuous evaluations and performances of deservingness.

2.3.3. Bureaucratic Practices

Health care is not only about biomedical treatment but also entails administrative practices. Patients must fill in forms and sign them. Administrative staff determines whether patients' details are truthful, files forms, prints prescriptions and more. Whoever goes to a hospital or doctor's office is confronted with at least one digital or non-digital form. As such, clinical encounters are also bureaucratic. Given this bureaucratic nature, Huscke (2014) emphasises the importance of social capital and explores how undocumented migrants in Germany use informal, often fragile social networks. Her work highlights, that the bureaucratic nature of accessing health care often hinders undocumented patients from obtaining medical care. Trapped between fearing the government and needing urgent care, they must use their "illegality knowledge" of which organisations and contact points are available to them. As such, bureaucratic practices at times become impassable barriers, and undocumented migrants are forced to accept severe pain in fear of being deported. Therefore, it is useful to understand clinics as borders within the state, where patients are documented as illegal and deportable. Conceptualising health care workers as frontline bureaucrats hence allows to emphasize their role in gatekeeping the nation-state (Bendixsen, 2019; Horton, 2004).

It is important to also focus on bureaucracy when researching access to health care for documented migrants, who do not have to fear deportation if they seek medical care. As Petel-Rochette et al. (2020) argue, bureaucratic practices can also lead to division here. Their anthropological long-term fieldwork in Spain reveals how bureaucratic tools to register uninsured emergency patients were at times not used, and migrants were instead registered as private patients and billed. Using the analytic framework of moral economy, they elaborate on how administrative staff are bureaucratic figures, whose "judgements are […] the result of hegemonic moral economies, institutional cultures, and their moral subjectivities" (Petel-Rochette et al., 2020, p.122). As such, migrants were excluded from the healthcare system, by disregarding administrative loopholes that would have gained them access. This showcases, how medical staff are not simply offering health care according to the law, but gatekeeping the healthcare system, deciding in situ who is worthy of care (Perna, 2017). Practices of restricting or withholding information about patients' rights to access health care are termed *bureaucratic disentitlement* (Danz, 2000). The administration of patients without legal residency status often requires additional paperwork. As Smith (2015) illustrates, overworked administrative frontline workers can perceive migrant patients as interrupting their workflow and hence undeserving of their time and care. Likewise, resource constraints and organisational and institutional decisions pressure front-line health care workers to exclude some migrants from the care to which they are entitled (Perna, 2021). Consequently, administrative staff resorts to bureaucratic disentitlement as a strategic tool to reduce their workload (Perna, 2021; Smith, 2015). As the literature demonstrates, it is useful to conceptualise health care workers as bureaucrats, who not only border the state, but also the healthcare system. This analytic lens allows us to stay sensitive to the ways in which bureaucratic practices give power to individuals and include and exclude migrants from the public healthcare system.

2.3.4. Structural Factors

However, as Parkinson and Behrouzan (2015) argue, we should not isolate health from everyday life, "by locating it solely in the structured/restricted space of the clinical encounter" (p.329). For instance, the intersection of refugee status, financial instability, and health, make hospitals a "potentially threatening environment" (Parkinson & Behrouzan, 2015, p.328) that renders migrants vulnerable. Importantly, access is not only negotiated in public health policies and clinical encounters but is further shaped by socio-political structures. As such, structural violence directly impacts migrants' health (Sargent & Larchanché, 2011). Introducing the term *social suffering*, Kleinman et al. (1991) argue that political, moral, and medical issues should not be attended to separately: "Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (p.ix). Examining migrants' access to health care critically, hence also entails the consideration of structural factors. These include working and housing conditions, economic situation, and education, but moreover "immigration must be understood as a key social determinant of health in its own right" (Castañeda et al., 2015, p.386). For instance, migrants subjected to restrictive immigration policies, including detention and temporary protection, show increased mental health problems, including depression, anxiety, and distress (Steel et al., 2011).

Simultaneously, discriminatory policies negatively impact migrants' abilities to attend to their health. And at times, well-intended health initiatives collide with hostile migration policies. For instance, as Gosselin and Carillon (2020) research on a French HIV prevention programme targeting migrants from sub-Saharan Africa shows, seemingly from health care detached changes in the Transport Solidarity Scheme, meant that migrants could no longer afford public transport and thus not attend check-ups. In a "hierarchisation of risks" (Gosselin & Carillon, 2020, p.73), a potential fine may weigh more than a preventive health measure. This illustrates a "clear tension between the requirements of regular medical care in hospitals [...] and the priorities of daily life in a hostile climate for immigrants" (Gosselin & Carillon, 2020, p.73).

Stonington et al. (2018) critique the "assumption that in clinical medicine, the biological and behavioural world of a patient's body is more important than the social world outside it" (p.1958). It is commonly acknowledged that social inequalities negatively affect health inequalities. However, Sardadvar (2015) illustrates how these inequalities are exacerbated for migrants in Austria due to discriminatory practices, language barriers, and lack of social capital. As a result, well-intended interventions that neglect migrants' lived realities outside of the clinic fail to overcome structural barriers and health inequalities. According to Heide Castañeda (2023), attentive health care should hence be sensitive to "the robust, patterned arrangements of social structure that produce and maintain health disparities […]" (p.61).

Considering the reviewed anthropological literature, it becomes apparent that migrants experience various barriers to accessing health care. They can take the form of policies, ticket inspectors on public transport, derogatory comments, racist and colonial stereotypes, notions of deservingness or plain refusal of treatment. Heyman et al. (2009) propose to understand these barriers not as singular, but as interacting with each other in a "web of barriers". Amid this web of discriminatory practices, the question arises how can it be done differently? What does it mean to practice migrant care in a responsible, accessible and sustainable fashion? Often, when states fail to offer adequate health care to migrant populations, NGOs come to the rescue (Castañeda, 2023). With this thesis, I aim to showcase the struggles faced by an organisation that attempts to tailor its health promotion to migrants' needs. I will be sensitive to how notions of culture are formed and contested, and how some structural barriers are broken down while others remain firmly in place. With this, I will contribute to anthropological understandings of how low-threshold migrant health promotion is imagined and practised in a non-governmental organisational setting on the levels of culture and infrastructuring. Before moving on to my methods and empirical material, I introduce cultural and structural competence, two concepts which aim to inform sensitive, inclusionary migrant health care.

2.4. Cultural Competence

When reviewing literature for the thesis project, I came across the *Sage Handbook of Cultural Competence* (Anand & Lahiri, 2009). In it, Rohini Anand, a businesswoman, and Indra Lahiri, an anthropologist and psychologist, introduce the reader to *culturally competent care*. According to both authors, (inter)cultural competencies require care workers "to recognize their own cultural norms, understand the patient's unique viewpoint, and effectively adjust their behaviors to maximize care" (p.387). At first glimpse, the instructions seem clear: reflect on your own opinions, listen to your client's cultural beliefs, adapt your treatment, and eventually the patient outcomes will be optimised. In the book, culturally diverse patients are framed as a challenge: their views are referred to as "cultural barriers" (Anand & Lahiri, 2009, p.392) that must be overcome for successful, cost-effective treatment. Whether it is the patient's inability to decide on treatment, confusion about the healthcare system or personal health beliefs, all of these negotiations that are common in medical encounters are assumed to be triggered by cultural differences. While culture certainly does inform one's frame of reference, it is important to acknowledge that is not all-encompassing: not every refusal of treatment, indecisiveness, or misunderstanding can automatically be attributed to cultural beliefs (Kleinman & Benson, 2006; Metzl & Hansen, 2014).

In anthropological writings, cultural competence is a contested term. On the one hand, its positive influence on health outcomes is praised, on the other hand it is argued that its application reinforces stereotypes (Kleinman & Benson, 2006; Lee & Farrell, 2006; Shaw, 2005; Taylor, 2001). By assuming that the consideration of culture will improve health outcomes, “culture […]]is[characterized at once as both source of dysfunction and therapeutic panacea]and[[…] hereby rendered a typified category rather than a dynamic source of knowledge that underpins modes of social action” (Santiago-Irizarry, 1996, p.09). As such, the term *competency* suggests that “culture can be reduced to a technical skill for which clinicians can be trained to develop expertise” (Kleinman & Benson, 2006, p.1673). It is assumed that this is due to the medical understanding of culture as synonymous with language, nationality, and ethnicity. Hereby, “cultural competency becomes a series of ‘do’s and don’ts’ that define how to treat a patient of a given ethnic background” (Kleinman & Benson, 2006, p.1673). This understanding, in turn, leads to stereotyping patients based on their assumed cultural background: Afghans believe this and Somalians do that. This focus on traits of particular cultures is problematic as it can “lead to reinforcement of racial stereotypes and deter the effective communication necessary for adequate health care” (Lee & Farrell, 2006, p.09).

Yet despite this criticism, Kleinman and Benson (2006) stress the importance of being sensitive and attentive to various cultural understandings of sickness, health and care practices. To avoid stereotyping, they suggest turning to the anthropological understanding of culture, which “rejects the idea of isolated societies with shared cultural meanings” (Kleinman & Benson, 2006, p.1673). Instead, culture is seen as a heterogeneous process that cannot be isolated from religious, psychological, economic, biological, and political conditions and informs ordinary practices giving them a moral and emotional meaning. When one takes this notion of culture seriously, as something that is not fixed, then acquiring cultural competence becomes a practice of listening and learning, instead of assuming. Kleinman and Benson (2006) propose that clinicians should be trained as ethnographers. Instead of working with a cultural “trait list”, they should “emphatize with the lived experience of the patient’s illness” (Kleinman & Benson 2006, p.1674). To do so, they developed a 6 step “revised cultural formulation” that practitioners should follow to understand how the patient experiences, makes sense of and responds to their illness, while avoiding stereotyping. They argue that only by setting aside their own expert knowledge and doing a mini-ethnography, carers can make sense of patients' lived realities. However, in his ethnography of cultural competence education, Jenks (2011) concludes that such a heightened sensitivity to cultural beliefs can have unintended consequences, as it "prevents any recognition of the social production of health inequality, as being culturally competent comes to signify an impartial, uncritical, 'open-mindedness'" (p.230). Metzl and Hansen (2014) further claim that cultural competence is failing to deliver its promise of improving health outcomes. In the following, I will thus introduce a concept that promises to compensate for the shortcomings of focusing exclusively on culture: structural competence.

2.5. Structural Competence

In the US many practitioners were trained to identify and adjust to cultural understandings of illness and health (Metzl & Hansen, 2014). Still, there seems to be no reduction in patients' stigmatisation, nor improved health outcomes. For instance, it is reported that Central American immigrants in the US at risk of Type-II diabetes often do not exercise. This is not the case because their cultural beliefs disregard the importance of weight reduction, but since they live in neighbourhoods without sidewalks, parks, or gyms. Building on this and other examples, Metzl and Hansen (2014) argue that clinical encounters are not only shaped by cultural variables but "[…] also by the economic and political conditions that produce and racialize inequalities in health in the first place" (p.127). Yet, in US medicine there seems to be a divergence between sufficient knowledge about the effects of wealth imbalances on health, and little being done to address them. To counteract existing inequalities, health care practitioners should move beyond the individual encounter and focus on structural factors, such as the organisation of institutions, policies, and living conditions. To broaden the focus from culture to stigma and structural inequalities, Metzl and Hansen "propose a new paradigm for medical education, *structural competency*" (2014, p.127).

Accordingly, health care practitioners should be trained in understanding how social and economic determinants, such as race, gender, ethnicity, and class influence not only health and illness but also the clinical encounter. Structure is understood as "[…] buildings, energy networks, water, sewage, food and waste distribution systems, highways, airline, train and road complexes, and electronic communications systems, […] the oft-invisible diagnostic and bureaucratic frameworks that surround biomedical interactions […]]and[assumptions embedded in language and attitude" (Metzl & Hansen, 2014, p.128). By training how structural inequalities arise and can be inquired about, physicians emerge "who are structurally competent (knowledgeable about the structures that create disparities) and who are structurally humble (understand the limits of their knowledge and the care that they provide)" (Salhi et al., 2020, p.95). For instance, structural factors have a critical impact on patients who struggle with their mental health (Hansen et al., 2017). People might develop an anxiety disorder because they live in a violent neighbourhood or unstable housing. Refugees living in Western countries are more likely to suffer from post-traumatic stress disorder than the local general population in their respective age group (Fazel et al., 2005). To address these inequalities, health must no longer be reduced to the patient's genetics and individual choice but rather understood as a product of social inequalities (Salhi et al., 2020).

Acknowledging and addressing these influences on mental health also demands intervening at the institutional level (Hansen et al., 2017). This may entail collaboration with schools and law enforcement or pressing the issue in the political realm. Moreover, physicians can connect with community leaders to build relationships and raise awareness about mental illness. Hansen et al. (2017) draw on biomedical statistics, showing the negative health effects of inequalities, to justify that health interventions need to address the structural level. Structural competence, therefore, requires that health care extends beyond medical practice into the social sphere. It is not only about recognizing social inequalities and adapting treatment plans but above all about intervening in institutional practices (Downey & Thompson-Lastad, 2023). Hence, the concept addresses practitioners, but further frontline workers, who can offer valuable insights into structural factors and unequal health care access (Pasquini, 2023).

As I have outlined, both cultural and structural factors are seen as important in shaping inclusive health care for migrants. In my analysis, I will therefore remain sensitive to the role both play in envisioning and practising low-threshold health promotion. However, before I introduce the field, I will briefly explain what is meant by biomedicine and why I have chosen to work with this particular terminology.

2.6. Biomedicine

Cultural competence and structural competence are specifically aimed at biomedical professionals. Biomedicine is what many know and refer to as “Western” medicine. Anthropologists traditionally researched “non-Western ethnomedicine” and only broadened their focus to “Western” medical practices from the 1980s onwards (Gaines, 2008). This resulted in the critique of the distinction between “Western” medicine and “non-Western ethnomedicine” as being ethnocentric, suggesting a misleading dichotomy, as if there were only two schools of medical thought, “ours” and “theirs”, even though many exist, including Ayurvedic Medicine, Traditional Chinese Medicine, and Unani Tibb, to name a few (Worsley, 1982). Furthermore, the address implies that “Western” medicine is only practised in the “West”, while it is indeed practised across the globe. What defines biomedicine and demarcates it from other medical schools is that disease is understood through biochemical processes in the body:

> The biological sciences on which biomedicine is based provide a set of standards, protocols and algorithms that enable the production of knowledge and practices to treat ailing individuals and improve the health of populations around the globe. Biomedicine, in theory then, is based on an assumption of the universality of human bodies that everywhere are biologically equivalent. (Lock & Nguyen, 2018, p.01)

However, even though biomedicine assumes universal bodies, this does not mean that biomedicine is homogenous or static (Burri & Dumit, 2007; Lock & Kaufert, 2001;

Tallarek et al., 2020). Medical knowledge is continuously reviewed, expended and at times abolished. Processes, such as the development of new medical technologies, the increased involvement of society in biomedical knowledge production, or the growing importance of self-reliant health, exemplify how “biomedical practices are situated in the context of the larger developments in science, medicine, and society” (Burri & Dumit, 2007, p.01). In unstable places, meaning hospitals or doctor practices that lack the technology and resources to diagnose and offer treatment, biomedicine is “continually reinvented, imagined, and done” (Tallarek et al., 2020, p.12). Moving a step further in the analysis of local practices, Annemarie Mol (2003) illustrates that bodies and diseases are enacted in practice. By analysing how different practices of doing atherosclerosis in a Dutch hospital are in alignment and discrepancy, Mol demonstrates that disease and the body are multiple. In my work, I will not, unlike Mol, open the box of ontology. Nonetheless, through her philosophical shift “knowledge is no longer treated primarily as referential, as a set of statements *about* reality, but as a practice that interferes with other practices” (Mol, 2003, pp.152-153). Through biological reductionism, biomedical norms of disease, health and treatment become objective, untouchable facts, contrasting “the other”: cultural beliefs (Anand & Lahiri, 2009). Acknowledging that biomedicine is enacted and upheld through practice does not make it less real, nor does it deny its effectiveness in healing. But it challenges the traditional hierarchy of sciences, which assumes that biomedicine is an assemblage of indisputable facts, which can neither be questioned by the general public, let alone by social scientists (Mol, 2003).

Even though my interlocutors were not biomedical practitioners, many of their practices were based on biomedical knowledge claims about trauma neurology (i.e., stress hormones). They promoted holistic health, considering physical, mental, and social well-being to be connected, in doing so, they referred to trauma neurology as medicine [Medizin]. As an anthropologist and after consultation with my interlocutors, I have chosen not to use the term “medicine”, but “biomedicine” for my analysis. This is because, as I hope to have made clear with this brief excurse, there is a certain ontological authority associated with this terminology, which was at times reproduced by my interlocuters (cf. chapter 8.4. Culture and Illness Narratives).

3. The NGO

The research site of my thesis project was a non-governmental organisation in Austria, which I simply refer to as the NGO. The organisation was founded after the increased arrival of refugees in 2015 and 2016. Its two founders sensed that Austria lacked not only psychotherapy places but also low-threshold, focused offers [niederschwellige, fokussierte Angebote] for migrants and refugees struggling with traumatic experiences. Importantly, the NGO did not offer psychotherapy but promoted holistic health [ganzheitliche Gesundheitsförderung] among migrants and refugees. Through various grants, the NGO could offer all programmes free of charge for the participants. Importantly, the received funds were almost entirely financed by the state, which illustrates how Austria outsourced its responsibility for migrant health care to the non-governmental sector.

The NGO was following a *salutogenic model* [Salutogenesisches Modell] in its health promotion. As such, the focus did not lie on identifying and targeting specific disease causes, but rather on promoting the maintenance of good health. Laura, the organisation's director, a trained nurse with a university education in international health, distanced herself from paternalistic approaches to health care. Before founding the NGO, she had worked for many years for an international humanitarian aid organisation, both implementing and evaluating emergency response projects. For her, there was no need to offer a diagnosis, nor to provide aid. Instead, the NGO should encourage mindfulness and self-care [Achtsamkeit und Selbstfürsorge]. In doing so, the goal was to create a room of joint sense-making. Where people come together and talk about their mental health, problems, and exchange ideas on how to maintain well-being. In the NGO's narrative, health was understood to be an important factor for arriving in Austria [ankommen]. It was assumed that only if one can cope with their mental health, they can focus on daily tasks such as studying, working or household chores.

At the time, the organisation rented two rooms in a community office in Vienna. Following this arrangement, the NGO had only six workstations, but access to multiple shared conference rooms. The little workspace it had, was occupied with cabinets filled with documents, books on mental health, own and other NGO's brochures, and things needed for exercises (i.e., stones, threats, scissors, etc.). On one of the closets was a communal prayer mat that the mentors, many of whom were Muslim, could use when they wanted to pray. The walls were decorated with pictures from over the years, capturing celebratory moments, such as the winning of awards. And in the common hallway, the NGO's mission statement [Leitbild] was hung up in various languages, including German, Arabic, Ukrainian, Somali, Russian, and Dari. Yet, the NGO's workspaces were often empty, especially in the afternoons. Because of its limited financial resources, Laura (the director) and all employees were working part-time or fewer hours. Thus, most mentors did not use the NGO's office but only came in to hold their programmes and attend required team meetings in the shared conference rooms.

Except for Laura (the director), a project coordinator, and a finance controller, the NGO exclusively employed first-generation refugees as mentors [Mentor*innen], aiming to create a culturally and language-competent peer setting. Therefore, it was the mentors' task to do the health promotion. The around twenty mentors had different national backgrounds, thus the NGO could offer its programmes in Arabic, Dari, Farsi, Kurdish, Pashto, Russian, Somali, Chechen, Turkish and Ukrainian. As such, the organisation aimed to cover the most spoken languages among refugees in Austria. Most of the mentors were highly qualified, some had a medical background and had been working as pharmacists or psychotherapists in their respective home countries, and others were trained lawyers, teachers, or chemists. In Austria, however, it is quite difficult to obtain an "Approbation" (recognition of a foreign degree), which is why none of the employed mentors were allowed to continue practising their learned profession. For instance, there was Aliyah (a mentor), a middle-aged woman from Afghanistan who had studied pharmacy and had multiple years of work experience with an international humanitarian aid organisation. She had brought her diploma to Austria, but the state required the syllabus to the grade list, which she did not have. Aliyah also had to have a B2 level of German, which she considered too difficult to achieve at her age. Consequently, she was denied the "Approbation" of her degree. Aliyah told me, however, that she no longer had a problem with this because at the NGO she could also aid people and moreover speak their native language. This makes it clear that the NGO was providing jobs for highly qualified refugees who wanted to work in the health sector and were qualified to do so, but whose degree was not recognised by the state. However, this inclusive approach was only possible, because the NGO was not practicing biomedicine or psychotherapy, but rather health promotion. To qualify as mentors, the staff had to go through an application interview and the NGO's training that differed for each programme. In the following, I will provide a short overview of the programmes. What unified them, is that they were offered in the participants' respective native language.

The most taken-up programme at the NGO was health circles. These constituted weekly meetings over a period of eight weeks, with groups from a shared national or linguistic background (e.g., female Afghan mentors offered health circles for Afghan women, Arabic-speaking male mentors for Syrian men). It was the mentors' responsibility to find participants for their workshops. To do so they contacted mother-baby institutions, refugee shelters, and advertised them on social media. As such, the NGO actively sought out its participants and approached them in their native language. Generally, the health circles were held in the organisation's office or at interested institutions (e.g., mother-baby institutions). The programme was mainly taken up by female refugees, a fact I will discuss in more detail in the empirical chapters on infrastructuring. To offer health circles, mentors had received training on holistic health, psychology, psychotherapy, trauma consequences and psychological stress. Moreover, they had acquired skills for coping with loss, death, and mourning. The focus of the health circles thus laid on strengthening participants' own resources and self-efficacy. As a part of this, mentors would do relaxation exercises, including breathing and physical exercises (e.g., Yoga). In the first session, participants were allowed to choose from various of topics, ranging from parenting issues to protection from violence to depression. In the subsequent sessions, the participants discussed these topics and talked about mental well-being, recommended doctors, and shared their experiences. After eight weeks, in the final session, participants received a participation certificate [Teilnahme Urkunde], stating that they took part in the weekly health circle. The issuing of the certificates was usually celebrated with group pictures or the sharing of homemade food. Some participants would bring plastic folders with various official documents and file the certificate. Two Somalian sisters told me that they planned to bring the certificate to an appointment at the immigration office hoping to show that they used their time wisely. This makes it clear that the health circle and its certificates had a meaning for the participants that goes beyond psychological well-being: certificates were associated with the hope that they could prove that they were doing something worthwhile.

Another prevalent programme at the NGO was its trauma course. In order to be able to offer them, the mentors participated in a three-day training, which I will discuss in more detail in my empirical chapters. The trauma programme had been developed by an international organisation, which aids children affected by war. Shortly after the NGO's founding, Laura (the director) and an associated psychotherapist had obtained the licence to train new mentors and offer the eight-week-long programme. The programme's aim was that participants learn to recognize, understand, and control the effects of trauma, by teaching them various tools and exercises to cope with stress, fear, and flashbacks. The programme was offered both at schools and in the family setting.

When taking place at schools, it was usually teachers or social workers, who reached out to the NGO, asking for support. Generally, all pupils above eight years with a migration background were invited to attend the programme, which took place on school premises. Groups were limited to ten participants and divided between boys and girls. This was for various reasons, as Hakim, a Syrian mentor who was working at the NGO since it was founded, explained to me: "It can be difficult to talk about sexual violence with someone from the opposite gender. We do not separate the groups because we are Arabs or Muslims. It can have cultural reasons, but the quality of our courses is simply higher like this." A student who had attended the trauma course told me that she appreciated that everyone kept each other's secrets to themselves, [das Alles in der Gruppe bleibt, dass nichts rauskommt]. She compared Samira, a Syrian mentor who implemented the programme, to a mother figure and explained that she could laugh with her and talk about everything in Arabic. Since the NGO's staff was not licensed to offer psychotherapy, its trauma courses were not concerned with the processing of individual traumatic events. Pupils were allowed to, but not encouraged to talk about their own experiences. Instead, certain tools and fictional stories (cf. chapter 7.4. Infrastructuring and Possibilities) had been designed to enable participants to recognise what impact traumatic events can have without having to share their own experiences. They then learned breathing exercises and created imaginary safe spaces to retreat to when they would experience a trigger.

As mentioned before, the trauma course was also offered in a family setting. Often, families received the NGO's contact from schools, social workers, or the child welfare office. Depending on the parent's wishes, the programme took place either at the NGO's premises or the family's home. A male and a female mentor from the same national background worked with them over eight sessions. If for instance, the mother was the only carer, two female mentors would hold the programme. Laura (the director) explained to me that parents often assumed their children did not remember what happened during war and flight. However, they were often aware of and affected by the events. The family environment thus provided an important framework to start a dialogue about what had happened and to strengthen each other. In these settings, family members would often recall very private histories, loved ones were mourned, wounds were shown, or experiences of physical violence were recalled in detail. This in turn made family trauma courses a very delicate matter for mentors. On the one hand, the setting allowed for in-depth exchange about specific family histories. On the other hand, mentors also had to consider the limits of their expertise as well as their own mental health. Being refugees themselves, they had also experienced hardships, such as losing family members to war. To support them, the NGO hence offered regular supervision, in which mentors could share their struggles and discuss group-related problems. As such, the NGO's staff dealt very openly with their feelings, and it was not frowned upon when mentors expressed their emotions.

The NGO further developed a parenting workshop for parents with a migration background in cooperation with another NGO. The programme aimed to strengthen migrants' parenting skills [Elternkompetenzen], focusing on communication, violence-free education, and cultural differences. During my fieldwork, the NGO lacked funding for the workshop and could not offer it. The staff expressed great regret about this, explaining that many parents struggled with bringing up children in a “new” culture. In the meantime, while I was writing up, the parent programme was restarted through a new funding structure. This illustrates the precarious situation of the NGO and its dependence on funding because in order to be able to offer free participation, the director had to regularly apply for various grants.

The NGO also offered a programme on emotion regulation. The workshop, which was mostly offered at schools and housing facilities (e.g., refugee shelters) took place over eight weeks with up to ten participants. The mentors were mainly concerned with educating participants on how to understand and control their emotional warning system [emotionales Warnsystem]. The course taught breathing exercises and other self-regulatory strategies to prevent escalation. Mentors approached the topic of emotions and anger through quotes from the Koran or Bible, depending on the group's religious background. What differentiated the course from the NGO's other offers was that it was funded by a project of the Ministry of Social Affairs for the prevention of extremism. Some staff at the organisation found it difficult to mix mental health promotion for refugees and extremism prevention, but the NGO was dependent on the funding opportunity. "You have to think about what it sounds like," one person told me, "to say refugee and extremism prevention in the same sentence. I don't like the sound of it." Given that in Austria danger of extremism came not necessarily from refugees, but further white nationalists, the NGO was able to offer the course also to persons without a migration background. As such, the programme was further offered in German and at times attended by whole school classes.

Finally, as referred to in my introduction vignette, the NGO conducted workshops on migration and trauma for educators. These were used to create awareness and trauma sensitivity at schools and other institutions working with children. Often teachers were not aware that traumatic experiences manifest themselves in "maladaptive" behaviour. As such, the NGO hoped to promote a school setting, in which teachers would understand refugee children's vulnerabilities. Furthermore, the workshops were an important opportunity to expand the NGO's infrastructure of care, which I will discuss in detail in my first empirical chapter.

In the present research, I will focus not only on infrastructuring practices but further on the role of culture in the NGO's work. Throughout the following chapters, it is important to remember that all mentors undergo specific training and have acquired expertise regarding mental health promotion. As such I ask the reader to not misunderstand my analytically driven interpretations as a refutation of the mentor's formal training. Instead, I want to offer an in-depth analysis of the ways in which practices of inclusion and exclusion take shape in the Austrian context, where an exclusionary migration regime hinders inclusive health care practices. In the following, I will shortly state my research questions and then discuss my methodological considerations.

4. Research Questions

As outlined, the guiding research question of thesis is: *how does the NGO's health promotion include and exclude migrants?* This research question will be studied along two lines, inspired by current debates on structural and cultural competence.

First, I investigate practices that were concerned with building an infrastructure, asking: *What becomes visible when conceptualising the NGO as an infrastructure?* Hereby, I attempt to explore the NGO's infrastructuring practices and their relation to attempts to craft low-threshold health promotion. As such, this research question investigates how the NGO collaborated with other infrastructures, and how its infrastructuring practices created inclusion and exclusion.

Second, I trace the staffs' various understandings of culture, asking: *which role does culture take in the NGO's health promotion?* With this question, I attempt to outline how the staff understood and negotiated culture. Furthermore, I explore how the various understandings of culture relate to the inclusion and exclusion of migrants.

5. Methodological Considerations

"[…] The colonial and racist violence that gave rise to the field remains with us even now. What to do in the face of this ambiguous heritage?" (Pandian, 2018, p.04)

Cultural and social anthropology has been, and still is, grappling with its past. As a discipline that studied the "exotic other", it depended on, supported and legitimised colonial power. Today, the discipline is constantly rethinking its relationship to the research field, global power dynamics and questions of representation. In my master's programme, I was taught to reflect on my own positionality and to examine the field's status quo critically. These are research principles that I was not necessarily familiar with. Having studied communication science for my Bachelor's, I was taught that there is an objective way of methodologically studying what's "out there", readily waiting to be categorised, analysed, and represented. In the last two and a half years I have learned that as ethnographic researchers we do not try to neutrally represent reality but rather actively intervene in it, which requires careful reflection on our methods and situatedness. But to be reflexive and critical is easier said than done. Nevertheless, in the following, I attempt to critically engage with my applied methods, research choices made, and the ethical dilemmas I faced.

5.1. On the Role of Ethnography

Pandian (2018) argues that ethnography is "a practice of critical observation and imagination, an endeavour to trace the outlines of a possible world within the seams of this one" (p.04). Following Pandian, I see ethnographic practice as an exploration of the "threshold of possibility" (2018, p. 04). Instead of legitimising imperialism and capitalist exploitation, I am interested in what Janina Kehr (2020) calls an "anthropology of the otherwise", one that studies "forces of biopolitics, hegemonic medicine and healthcare [...] from the perspective of the otherwise" (p.41). Accordingly, medical anthropology should pay attention to "alternative ways of existence" (Kehr, 2020, p.28). Anthropology should, as Khosravi (2019) suggests, research borders from "the other side", namely from the viewpoint of those experiencing them. What arises is a research practice, with careful attention to the underlying power structures and inequalities, that explores spaces of re-imagination where things are done differently. It was specifically Kehr's (2020) and Khosravi's (2019) work which inspired my choice of research topic. Knowing that I hoped to focus on places where health care is re-imagined, my supervisor, Janina Kehr proposed that I reach out to the NGO.

5.2. Participant Observation

My principal method of data collection during the two months of fieldwork was participant observation, which “is accepted almost universally as the central and defining method in cultural anthropology” (De Walt & De Walt, 2011, p.ix). As its name indicates, researchers following this method observe interlocutors and participate in their everyday life. The underlying idea is that accompanying someone over a certain period enables one to get an “intuitive understanding” (Bernard, 2018, p.283) that moves beyond the spoken. As anthropologists tend to say: information recalled in an interview setting can significantly differ from what people do in practice. In this sense, by doing participant observation I aimed to observe practices and understand my interlocutor’s viewpoint.

Moving away from the colonial practice of extracting data, cultural and social anthropologists are not only encouraged but also expected to “give back”. Following this notion, I offered myself as an unpaid intern at the NGO. Hereby, I hoped to gain access to the field, while simultaneously being of use to the organisation. In the first meeting with Laura, the organisation’s director, and Hakim, a mentor, we discussed the details of the research endeavour. Eventually, we decided that I would spend two months with the organisation, from August to December 2022, helping them with different tasks at hand. During this time, I had access to the organisation’s office and, if possible, was allowed to join sessions with participants. I would like to note that I was and still am overwhelmed by the confidence placed in me. Not only was I offered access to the premises, but also welcomed to meetings and trainings. This is not to say, that my intentions and politics were not questioned. Matter of fact, I was repeatedly probed as to why I was there and what I was trying to find out. Perhaps precisely because of these frequent enquiries, I would like to thank everyone at the NGO, since without the trust you have placed in me, this study would not have been possible.

5.3. Expectations and Responsibilities

Being a researcher and an intern at the same time proved to be challenging. Especially at the beginning of the fieldwork, I was struggling to find a balance between working and researching. How could I ensure to collect data, while at the same time finishing tasks which seemed useless for my thesis project, such as copying staff’s hour sheets, printing participants’ certificates or updating the network file? Only over time, I learned the importance of writing continuous field notes throughout the day, even about tasks seemingly negligible for answering my research questions. Even more so, these minor appearing assignments enabled me to grasp the importance of certain practices.

For instance, part of my work was about updating the network file. The network file was a digitally stored file that included the contact information of different organisations, psychologists, emergency hotlines and institutions. Vera, the NGO’s project coordinator had started the file a year ago but never found the time to work on it. As such, it only included a handful of contacts, many of whom I had overheard in earlier meetings. When giving me the task, Vera told me not to worry about finishing it, as it was a “never-ending undertaking”. This was not necessarily the motivation I had hoped for. But when analysing my notes, I realised that the file materialises the network the NGO was continuously building. As my analysis will showcase, it can be understood as an enactment of their response to the structural inequalities their clients faced. But it also reflects how responding was a never-ending task: the network file was constantly growing. Without going into too much detail, the example highlights how being an intern and researcher at the same time allowed me to gain a better understanding of the staff’s everyday practices.

This does not mean that balancing these different roles was always easy. I was not only a researcher, but also an intern, always an individual, at times a participant, and for a week even a supervisor (of a school intern). During the two months, my interests and responsibilities continuously shifted, depending on the situations I found myself in and the expectations put forward both from my side and from my interlocutors. In the following, I will briefly discuss a particularly challenging, but also thought-provoking, example of my inner conflict between these roles.

I was standing with a group of five women next to a white table in the black-tiled foyer of the NGO's office building. We were participating in an intercultural event organised by an organisation located on the same floor as the NGO. The event aimed to connect Austrian women and women with migration background. It was led by Samira and Mara, two Syrian women who were both working as mentors for the NGO. Samira had invited me to participate because she feared that only a few Austrian women would join. On the table before me lay a white big sheet of paper, drawn on it was a head with simple outlines depicting a mouth, nose, eyes, and ears. Mara handed each woman a couple of Post-it notes. We should write down a worry on each piece of paper and then stick it on the head. I knew the exercise, one of the NGO's staples, called "organising worries" [Sorgen Sortieren]. But at this moment knowing the exercise did not help me to complete it. I did not have to know what follows next, but rather which worries I had. And, which worries I wanted to share. Suddenly, I found myself full of reservations. Certainly, as a researcher, I did not want to share my intimate concerns and personal problems. Topics I hardly discuss with friends. But what if I would only tell those worries, which are small? How would it seem, when the woman next to me is worried about dying parents, about war, and I complain about rising gas prices?

In this particular instance, I found myself lost between my interest as a researcher and as a private person. I did not feel comfortable sharing my worries, but I still wanted to participate. The encounter made me realise how hard it is to be vulnerable in front of a group of strangers. A thought that had previously not occurred to me. I always assumed people would simply be thankful for the NGO's health promotion, hence ignoring the hardship that comes with sharing their stories. Even though I learned from the situation, it was uncomfortable. If I would not have been a researcher or an intern, I would have likely excused myself from the exercise. But that was no option. Instead, I had to find a balance between being a curious researcher and a somewhat closed-off individual. The encounter makes visible how my personal and professional interests and responsibilities were at times conflicting. But it also showcases how these frictions allowed me to reflect on my positionality and assumptions about the field.

5.4. Shadowing

In addition to participant observations, I worked with the method of shadowing. Shadowing can be described as a “one on one ethnography” during which the researcher closely follows a professional during their workday (Czarniawska, 2007; Gill et al., 2014; McDonald, 2005). Shadowing is particularly suited for studying organisations and their internal structures because it allows one to observe “the trivial or mundane and the difficult to articulate” (McDonald, 2005, p.457). In short, aspects of work that usually remain invisible. Initially, I had planned to shadow one person for an entire week, but I quickly realised that this was not feasible. Mentors’ work being mobile and schedules part-time, it was hard to plan when people would be where. Many of the NGO’s mentors only came into the office on Tuesdays for the weekly team meeting. This made it further difficult to build the necessary relationship and intimacy, which would have allowed me to follow them for such a long period. Moreover, schedules often changed spontaneously, with schools and shelters cancelling sessions last minute. Hence, I decided to abandon my plans and instead work with micro shadowing sessions, meaning that I followed mentors closely for one or two hours. During these sessions, I was able to accompany mentors in their work with clients. In total, I conducted three micro shadowing sessions, allowing me to sit in a trauma course family session, as well as health circles in Somali and Farsi. Other shadowing sessions were planned but cancelled. In one case, in an Arab health circle, the participants decided that my presence would be disruptive. And, in two other cases, the sessions were repeatedly postponed, at last beyond my fieldwork at the NGO.

5.5. Ethical Considerations

An important topic, which I will briefly discuss, is research ethics. Amongst others, such as causing no harm, conducting ethical research entails obtaining the informed consent of all interlocutors. In theory, this sounds straightforward. In other social sciences, researchers may carry and distribute consent forms, to be read and signed by those willing to participate. But in anthropological research, it is not as easy. Written and signed consent forms are not the norm. Instead, it is the researchers’ responsibility to inform interlocutors about their undertaking and, if necessary, remind them of it. While conducting research with the NGO, it was of utmost importance to me that everyone was aware of my role at the organisation. Therefore, I always introduced myself not only as an intern but also as a student of culture and social anthropology researching the role of culture in the organisation's work (my interest in infrastructuring only developed later on). The constant presence of my black notebook allowed me to further re-establish my role. It functioned as a constant reminder of my purpose at the organisation. The staff even joked about it, once saying that it had been a productive team meeting, given that I took so many notes. But in other instances, I struggled to fully establish my position.

I was sitting on a red carpet with flower patterns, surrounded by three bunk beds. Most of the free space below or next to the beds was filled with boxes, clothes, and suitcases. Miray and Aliyah had just finished today's family trauma session with a woman from Afghanistan and her two youngest children. The mother and her children were living in a small one-bedroom apartment, located in a homeless shelter in the Viennese 10th district. Since the woman only spoke a little German, the mentors had introduced me at the beginning of the session. Two hours later, the mother smiled and asked something looking in my direction. Miray laughed and shook her head, answering in Farsi. Turning to me, she explained: "They have an Andrea working at the reception, and she asked if you will be here this week. But I explained to her that you are not Andrea from the shelter, but Andrea from our NGO."

In this particular instance, I did not succeed in making my position clear. While there was consent regarding my presence, it was not informed. And what is consent worth when it is not informed? On the one hand, I do not know how I was introduced by the mentors. And on the other hand, the woman might have simply thought that Andrea from the shelter is doing research with the NGO. Either way, the encounter illustrates that just because one assumes that informed consent is given, it might not be the case. Moving on with my research, I tried to better establish my position. This also entailed reminding my interlocutors that the internship itself was my method of data collection.

5.6. How to know?

Finally, before moving on to discuss my analytic approach, I will shortly address an encounter, which led me to re-evaluate my methodological approach.

I was sitting in a small room next to a large white table, surrounded by twelve women chatting in Somali. We were in a mother-baby centre located in the fifteenth district of Vienna. At the time, every week, Imara and Lila held a health circle in the facility. On the shiny table, bright pink and orange ribbons laid scattered, surrounded by red hearts, grey and black stones, and colourful plastic flower pedals. Earlier today each woman had laid their way of life [Lebensweg]. In the exercise, ribbons were placed on a table, symbolising the participant's life. She then laid a stone for each bad thing that had happened in her life, and a flower or heart for each beautiful memory. Next door, the women's children were playing with the NGO's nanny. At times, some of the participants left the room to pray. Even though sad and hurtful events had been recalled in the session, the women were laughing. I was sitting next to them, not understanding a single word being said. Here and there, Lila translated. Suddenly one woman pointed at me. "She wants to know", Lila said, "how you, as an Austrian, feel that all these people are coming such a long way to stay in your country." The women looked at me expectantly. My palms started sweating. I had to give the correct answer: "Just so you know I am not Austrian", I started, "I am German." Lila laughed: "That does not matter, Germany and Austria, are the same thing."

At this moment my politics, not only as a researcher, but as an EU citizen were interrogated. And I was not prepared, at all. What followed was a discussion about Europe's, Russia's and the US's meddling in foreign affairs. I voiced my support for green corridors and an abolishment of permanent refugee camps at the EU's outer borders. Some agreed others did not. Thereafter, the woman, who asked my opinion, wanted to know what other Austrians in my age group were thinking of refugees. This question radically influenced my understanding of what and how I can come to know as a researcher. I was expected to represent my fellow Austrians' political views. But what were their opinions? I knew that anti-migrant sentiments are growing all over Europe, probably also in my age group. Still, I did not feel knowledgeable to make any representative statements. So how could I expect this setting to (re)present Somalian culture? And another to (re)present Afghan culture? How could I expect to simply observe instances of cultural and structural competence? Later the same day, while writing my notes, I realised that I would have to alter my methodological approach. Instead of expecting to observe the answers to my research questions, I decided to enter a more open dialogue with my interlocutors. While participant observation would still be my main method of data collection, I started to discuss with the staff the role of culture in their work. What do they think of it? When does culture matter? What is culture anyway? This eventually enabled me to gain a better understanding of my interlocuters' viewpoints and to answer my research questions.

6. Approaching Analysis

In November 2022, after two months of research, I “left” the field with a 200-page long A5 notebook packed with scribblings, field notes, analytic thoughts, and notes stuffed inside. The notebook was accompanied by what felt like an infinite number of prospects, teaching materials, programme curricula, Integration Reports by the Austrian state, and two 270 pages long books called “Us. Now and here” [Wir. Jetzt und Hier], which the NGO’s director gave to me on my last day, saying that they provide a compelling insight into the lives of refugees living in Austria. This is not to mention my digital data, including many pictures from workshops and the office, power-point presentations, and a shortly attempted field journal, which I had decided to quit after one week of fieldwork.

Before moving on to my empirical chapters, I wish to discuss how I analysed all this data. Analysis is an often-neglected topic in anthropological writings, leaving me looking for ways to organise and analyse the material, without having to digitalise and feed it through a qualitative data analysis programme. In my search, I came across the book *Experimenting with Ethnography* (Ballestero & Winthereik, 2021), in which various STS and anthropological scholars introduce their analytic techniques. Eventually, I mixed *situational analysis* and *contrasting*, as I attempt to describe in the following. Importantly, I decided against computer-assisted analysis and instead worked with a DIN-A4 notebook, in which I collected all my analytic thoughts. On the upside, one is not distracted by finding a suitable analysis programme, nor restricted in the often creative, yet messy, mapping out of analytic thoughts. On the downside, when working only with handwritten notes, the analysis is particularly prone to become indecipherable due to messy handwriting, rainy days, and spilled coffee.

Mostly, I worked with *situational analysis*, a strategy which entails drawing maps throughout the various stages of the research encounter (Clarke et al., 2016). In situational analysis, researchers think through *situational maps*, *social worlds/arenas maps*, and *positional maps*. A situational map is valuable to gain a first overview, as it entails the mapping of various discursive, human, and non-human elements relevant to the scientific inquiry. Usually, it is made during the early research stages and is supposed to guide data collection. However, I assembled a situational map only after finishing the fieldwork. Reading my notes, I mapped all keywords, which struck me as important. This map, which I drew over various weeks, indicated no relations, but rather an overview of floating terms, actors, and things I considered potentially relevant. This allowed me to lay out and think about “the many and heterogenous elements, their relations to one another, and the messy complexities of the situation” (Clarke et al., 2016, p.14).

At the same time, I drew various social worlds/arenas maps. These enabled me to lay out and think about collective actors “in the arena(s) of commitment within which they are engaged in ongoing discourses and negotiations” (Clarke et al., 2016, p.14). For instance, I created a detailed mapping of the workshop on depression at the NGO, which forms the primary foundation of my analytic thoughts articulated in the empirical chapter 8.4 Culture and Illness Narratives. The map became a visual interpretation of the workshop, following up on who said what in which moments, eventually revealing how culture becomes articulated by certain actors. Additionally, I mapped network events, micro shadowing sessions, weekly team meetings, programme curricula, and singular programme contents that caught my attention. This analytical technique allowed me to deconstruct my ethnographic data, pay attention to the emergent themes I considered important, and finally to identify similarities and frictions.

Furthermore, I worked with the analytic technique of *contrasting*, which “involves searching for tensions, resistance to affirming established theory, eschewing apparent coherence” (Laurent et al., 2021, p.186). In essence, the analytic ambition is to spot contrasts in your data and to refrain from forcing coherence. To do so, the authors propose the writing of multiple open-ended lists. For instance, I wrote a list on the child welfare office [Jugendamt], noting how the state institution was mentioned in my field notes. Within the list, I eventually spotted contrasts, as the following excerpt exemplifies:

- The child welfare office connects families with the NGO, the cooperation works well.
- Families equate the child welfare office with danger to the family [Gefahr für die Familie].

In writing a list, I assembled and contrasted my observations. Doing so, I came to realise that the NGO’s collaboration with the child welfare office is worth further investigation (cf. chapter 7.2.2. Infrastructuring Prototypes). Laurent et al. (2021) propose to explore such differences by writing more detailed open-ended lists on each contrast. However, I decided to write initial lists on various themes, such as disability, culture, language, or trauma and to then understand contrasts through mapping.

This brings me to positional maps, which “represent the full range of discursive positions on key issues in the broad situation of concern” (Clarke et al., 2016, p.14). By mapping out the contrasts I identified through lists, I was able to visualise how certain positions become articulated. For instance, I drew a map of the opposing situations that the child welfare office is both a facilitator and a boundary for participants’ access to the NGO. I then further connected this observation and interpretations with STS literature on infrastructuring.

By transforming and visualising my data in hand-written lists and maps, and connecting it with existing theoretical concepts, I was able to make sense of how my observations align with current scientific debates. Before writing up, I arranged a meeting with the NGO to discuss my preliminary interpretations. Regrettably, only a few mentors were able to attend, as it took place the day before Eid al-Fitr and many had to prepare for the festivities the next day. Nevertheless, I was able to gain first-hand insights into the director's, project coordinator's and a few relevant mentors' opinions on my interpretations and incorporate them into my writings. In the subsequent two chapters, I will describe my empirical observations and outline their analytical evaluation which followed this throughout sense-making process.

7. Empirical Chapter 1: An Infrastructure of Care

When Laura, the NGO's director, described the Austrian trauma aid context, she always used the metaphor of a pyramid. There exist different levels of support. Accessibility to each level depends on the position on the pyramid, with the highest level being the most difficult to reach. The base level is essential support [lebensnotwendige Versorgung]. For her, this included being in safety, that is, having applied for asylum in Austria. In a sense, the basis of trauma aid is about providing a location where refugees' lives are no longer in danger. The second level of the trauma aid pyramid is family and community support [Unterstützung Familie und Gemeinschaft]. And the third level is low-threshold, focused offers [niederschwellige, fokussierte Angebote]. The top level, the tip of the pyramid, which is the hardest to reach, is therapy. "There is a lack of therapy places in Austria", Laura told me, "The waiting list for therapy with an interpreter at Hemayat (an Austrian NGO specialising in psychological support for victims of war) is over one year. And therefore, the third level is so important, because the fourth is very difficult to reach." The lack of public psychiatric care and organisations that operate on the third level gave rise to the idea of founding the NGO. The director hoped to build an organisation that fills the gap left by the lack of governmental and non-governmental health care infrastructures, hereby strengthening migrants' and refugee's self-efficacy in dealing with trauma [die Selbstwirksamkeit im Traumumgang stärken]. In the NGO, trauma aid took the shape of low-threshold health promotion for participants with migration experiences.

In this chapter, I will show that this health promotion entails more than just engaging with participants, it also requires intricate knowledge of local support services**.** During my fieldwork, I was surprised to learn that the NGO's staff spent a lot of time and effort networking with potential participants, other NGOs, schools, and government institutions. Building such an extensive network and maintaining social relations with numerous stakeholders was a time and energy-consuming, yet integral part of the organisation's work. In the present chapter, I look at the work that was required for building what I call an "infrastructure of care"; the NGO's ever-evolving and heterogenous network of mentors, participants, doctors, institutions, and care practices that enabled low-threshold health promotion. Hereby, I aim to explore an attempt of holding up an infrastructure of care in Austria, where a lack of public psychotherapeutic care and an exclusionary migrant regime set the scene.

Larkin (2013) defines infrastructures as "built networks that facilitate the flow of goods, people, or ideas and allow for their exchange over space" (p.328). They include not only material technologies, such as bridges, electricity, or water systems, but are also inscribed with social relations, affective entanglements, and "forms of desire and fantasy" (Larkin, 2013, p. 329). In the present chapter, I will specifically draw on the analytic lens of infrastructuring to capture its processual and emerging nature (Simone, 2010; Street, 2014). A focus on infrastructur*ing* shifts the attention to the different ongoing processes and practices involved in building and maintaining a network or infrastructure (Karasti & Blomberg, 2018). Drawing on STS literature (Vertesi, 2014), I conceptualise the NGO as involved in ongoing efforts of infrastructuring, hence allowing me to focus on the (often invisible) work that facilitates and enables low-threshold health promotion. Here, I aim to be sensitive to the underlying power dynamics between the NGO and its stakeholders (Lockrem & Lugo, 2012).

Larkin reminds us that infrastructures are "intimately caught up with the sense of shaping modern society and realizing the future" (2013, p.332). In the present chapter, I argue that the NGO engaged in infrastructuring practices that transformed the traditionally restrictive access to health information and care. Specifically, I show how practices, such as listening, going to network meetings, or designing a poster, were intricate to the NGO's vision and provision of low-threshold health promotion.

Importantly, some of the NGO’s infrastructuring practices remain hidden. As Larkin (2013) points out, “the act of defining an infrastructure is a categorizing moment” (p.330). This is not so much a limitation, but rather an inevitable consequence of limiting one’s area of interest while constructing the field (Karasti & Blomberg, 2018). With my present research, I am leaving out the infrastructure building efforts of the various participants, individuals, NGOs, schools, or state institutions with which the NGO collaborated. I am further staying oblivious to the many material infrastructures, such as the Wi-Fi, electricity, and the printer, which were both essential to the NGO’s work and at the same time never seemed to work. These invisibilities are also a consequence of my methodological choices. I decided to focus my research interest on the organisation and its staff and will therefore not be able to write much about other actors and their practices in building this infrastructure. Instead, in the following, I will provide ethnographic insights into the staff’s infrastructuring practices and elaborate on their role in building and maintaining an infrastructure of care.

7.1. Infrastructuring and Listening

The NGO’s staff’s workday did not end when their participants had left the workshops. After each session, the mentors filled in a digital spreadsheet, which they called documentation [Dokumentation]. In the spreadsheet, they kept the course data (i.e., location, contact person, etc.), an attendance list, a short documentation of each session, and an overall reflection on the course. The goal was to be able to follow up on each group and to understand what went well, and what did not. In the documentation, the mentors would note which exercises they made in each session and how the group reacted. Each mentor had a different documentation style. While some described the emotional atmosphere, others focused on specific participants who seemed to have difficulties. Some mentors simply wrote a short sentence about whether the session had gone well or badly, and often the documentation was used to note organisational problems. The spreadsheets constituted an important part of the NGO’s material infrastructure. They allowed the NGO to keep track of sessions and to review and reflect on them later.

Studying the documentation of the completed groups gives noteworthy insights into the mentors' care practices. For one session, Hassan, a trained psychologist from Syria, who worked as a mentor at the NGO, simply wrote down the following: "The eyes of one of the participants were crying. Especially during the safe place exercise. I took an hour afterwards to listen to his story." From the reflection, we do not learn what the man's story is. Or how he felt after the session. But what we do learn, is that Hassan took his time to listen to the man's problems and that he hereby took care of him. It becomes apparent, that the organisation not only promoted health, but also provided a space where participants can exchange their feelings, experiences, and worries. Buch (2013) proposes to understand sensory practices such as tasting food, listening to stories, or smelling milk to determine if it is spoiled, as embodied care practices. Following this notion, I realised that listening was a frequently deployed embodied care practice by the organisation's staff. In what follows, I outline how listening can further be conceptualised as an infrastructuring practice.

I was sitting in the empty office and researching statistics on forced migration in Austria, which Laura (the director) asked me to do when Aliyah came into the room and took a deep breath, holding her chest: "This was really hard." The Afghan mentor just had a private consultation with a woman in her late 50s, who lost her son that took care of her. Aliyah closed the door behind her and took a seat. "The woman cried so much. She does not speak German, so she does not know how to get around the city. I will now bring her to the metro, so she comes home safe. But her life cannot continue like this. She has asthma and diabetes and lives on the fourth floor without an elevator. I will talk to Laura I think the NGO Nachbarinnen could help her. I told the woman, I am here for you, also after working hours. But I can only do so much. You know it also takes a lot from us to help." I nodded. What could I possibly say in the face of a story of so much suffering? Not knowing what else to say, I simply replied, "Yes, that sounds like a lot."

At this moment, Aliyah shared her struggles with me. It is important to remember, that the staff working at the NGO could "only do so much". All mentors were employed part-time. Therefore, they had limited time to spend with their participants. As described in the vignette, Aliyah realised that the woman she consulted needed more support than she and the NGO could provide. Therefore, she recommended an organisation, which offers social assistance and home visits. This makes visible, how Aliyah’s care practice of listening was inevitably linked to her providing the woman with information about another NGO. Through listening, she provided access to the NGO’s infrastructure of care. More than a care practice, listening, that is gathering knowledge about the person's problems and needs, is also an infrastructuring practice. Through listening to participants' stories, mentors decided to give access to the NGO’s infrastructure, which entailed connections to many organisations. Care and infrastructuring are deeply entangled, they are inseparable. Care also means fostering connections and circulating participants. It means acknowledging one’s limits and recommending participants to fellow institutions in the extended infrastructure of care.

7.1. Infrastructuring and Reaching out

Generally, the mentors had to advertise their own workshops and find participants. After all, their infrastructure of care was also dependent on having addressees for their health promotion. Hence, it was the staff’s responsibility to locate, and approach potentially interested parties. For this purpose, they contacted mother-baby institutions, mosques, or Hindu temples. Schools and refugee shelters often reached out to the NGO themselves and families were typically informed about the workshops by the child service office.

During my fieldwork, the mentor Hakim, who had fled from Syria where we worked as a school therapist, approached a mosque to offer an emotion workshop on their premises. He was excited about the opportunity and spent several afternoons at the mosque, praying with the men and ultimately asking the Imam for permission to present the workshop. Eventually, the Imam allowed him to do so. The following week, in the team meeting, Hakim recalled how the presentation went. He explained that when he introduced the NGO to the men, they first seemed fascinated. But they lost interest when he began to present the aim of the workshop. Hakim explained to the team: “These men are too old to learn about emotional regulation. They are in their 40s and 50s, of course they are not interested. We have to limit the age group of the emotion workshop.” On another occasion, Hakim told me that he had stopped offering men’s health circles. When I asked why, he answered that the men often work a lot and have no time, or that they simply do not want to talk about their mental health. This put the organisation in a tricky spot. As Laura (the director) once noted in a meeting: “Men are important multiplicators when they are informed about mental health. Maybe our offer is not attractive to them? Statistically more refugees are male, however our offers are mostly used by women.” The staff considered men as important beneficiaries of their health promotion. Nonetheless, most male participants came through referrals by shelters and schools or took part in family sessions. Only Hassan, who was also a mentor with a Syrian background, was successful in continuously finding male participants for his health circles. He told me that this is because he offers his workshops in the evening or on weekends. The organisation’s self-critical discourse as to why men were not participating in their workshops shows similarities with structural competence. As explained in my state of the art, structural competence involves recognising how structure and culture influence each other in creating inequality and stigmatisation (Metzl & Hansen, 2014). The mentors knew that refugee men work during the day and that for many, it is culturally not necessarily acceptable to discuss their mental health. Hence, the NGO seemed to be aware of how cultural and structural influences intersect in preventing men from taking up their offers. This awareness becomes visible through reflections on failed attempts of reaching out to male participants. At times, structural influences made it difficult to create an infrastructure of care accessible to all members of the target group. As such, some of the mentors had to improvise and put in work trying to tackle these structural challenges, for example by offering workshops on the weekend.

The organisation further made use of existing networks to extend its infrastructure of care. For example, it was part of a mini fair at a school network meeting under the theme of “healthy schools”. The network celebrated its anniversary in a magnificent ballroom of the town hall. Numerous teachers spent an early November day listening to presentations about pupils’ health, the role of climate change, and the importance of protecting your voice as a teacher. They grabbed snacks from a buffet of Schnitzel, Kaiserschmarrn and other Austrian bites. Lined along the sides of the stage stood approximately eight or ten tables, where selected institutions advertised their contribution to making Austrian schools healthier, the NGO being one of them.

Laura (the organisation's director), Samira (a mentor), a school intern, and I were standing behind a small table next to a roll-up advertising the organisation. On the table lay flyers describing the NGO’s various course offers and on the wall behind us, we also hung up some flyers. The lunch break had just begun, and the teachers started strolling along the fair. Some stopped at our table. “Oh your work is so important.”, one woman said, “we have so many children from the Ukraine at our school. And they cry a lot. One child is so unwell, her mother comes to school with him.” Laura replied, “Yes, they have a really hard time.” The woman looked at her shrugging her shoulders: “Well, sometimes I have the feeling they make it a lot harder on themselves than it has to be.” She then took some fliers and moved on. Another woman approached Laura wanting to know what exactly the organisation is doing. Laura explained that they offer trauma courses for children. “Oh, we have many children from the Ukraine. But I will have to think about that first,”, the woman replied, “whether we have a case of trauma”. Laura looked at her and replied, “Every person who has fled is burdened [belastet].”

As both conversations illustrate, the teachers were unsure whether their students were “suffering enough” to attend a trauma workshop, or whether they and their families were just making life harder for everyone involved by “suffering too much”. These thoughts on whether children are traumatised raise the question of “what counts as ‘morally legitimate’ suffering” (Ticktin, 2011, p.222). In Austrian media discourses, refugees’ deservingness and moral legitimacy are regularly vocalised as depending on skin colour, nationality, gender, and religion (Drüeke et al., 2021; Hayek, 2016). This eurocentric discourse in turn legitimates the differential treatment of European and non-European, female and male, and black and white refugees. In my interlocuters’ view, everyone who fled was considered a deserving beneficiary of their health promotion. Yet the teachers seemed particularly concerned for the newly arrived children from Ukraine. Virtually none mentioned children in need from other countries, such as Syria, Afghanistan, or Somalia. However, even though I did not observe any favouritism in the NGO’s treatment of participants, the organisation had to adapt to the changing demands. As mentioned before, more and more schools were asking for trauma workshops for Ukrainian children. This presented the NGO with structural and organisational challenges. During my fieldwork, the NGO was in the process of adapting its infrastructure of care to the changing refugee population. More Ukrainian and Russian speaking mentors had to be educated and, as I will discuss later, questions arose about the appropriateness of the course content.

The organisation used the network meeting to reach out to various local teachers, who were unfamiliar with the NGO. In doing so, the staff engaged in *infrastructuring*, by answering questions and raising awareness of the psychological impact of fleeing. They established their position within the existing network for healthy schools and hereby expanded their own infrastructure of care. Jiménez (2014) worked with open-source urban infrastructure, arguing that they resemble an infrastructure *in beta*: “more than many and less than one” (p.348). An infrastructure *in beta* is characterised by its never reaching closure, hence it is less than one. But it always enables novel extensions and forks out, in this sense, it is more than many. Similarly, I argue that it is useful to conceptualise the NGO’s infrastructure of care as an infrastructure *in beta*. During my fieldwork, the organisation was adapting to both changes in the refugee population and changes in funding. In this sense, there was no “finished” version of the NGO in sight. This is not to say that the NGO and its infrastructure were an unfinished project, rather they were always in the making. The staff was always reaching out, the infrastructure always changing.

7.2. Infrastructuring and Low-threshold

When conceptualising the NGO as an infrastructure of care, it is useful to also understand other institutions it worked with, for example, schools, as infrastructures. This allows me to pay attention to infrastructural *seams*, those moments when infrastructures overlap, align, or collide with each other. Vertesi (2014) argues that seams “draw out attention to those places where multiple infrastructures are stitched together to achieve fleeting, constable, even ephemeral moments of alignment” (p.279). In the following, I pay attention to the moments, in which the NGO’s low-threshold health promotion required collaboration with other institutions. Doing so, I aim to show how certain infrastructural collaborations, necessary for low-threshold health promotion, required work from the NGO’s staff to align the seams.

Generally, the NGO had to be known to school social workers, teachers, or directors to be able to offer health promotion. The school staff contacted Vera, the organisation's project manager, whenever they felt that pupils could benefit from a workshop. Then, two mentors with the required national background came in, met the teachers and the director, and introduced the NGO's health promotion. If the school director approved, the mentors organised an informational evening for the parents. On behalf of the NGO, teachers handed out invites for an "Elternabend" (parent meeting, which takes place during the evening). During this evening event, the mentors informed the parents about the workshop and answered questions, all in their native language. Following this, the mentors did an introduction session with the children in question. To do this, they came to school on an appointed date and gathered the children from their respective classes. Only after this session, the trauma workshop could start, with children under 14 requiring a consent form signed by their parents. Since each workshop meeting took place during regular school hours, the children were asked to leave their regular class.

Considering these various meetings and introductions, which often stretched over multiple weeks, allows us to understand how the organisation tried to implement low-threshold health promotion. The NGO's presence at the school network meeting can be described as an attempt to expand its network through school contacts. Only by being known to school personnel, the NGO was able to reach its target population: children with migration background. I hence argue that distributing promotional materials, debating with teachers whether students are traumatised, or introducing the NGO's workshop to school personnel and parents, can be understood as infrastructuring processes that cannot be detached from the NGO's health promotion. Their low-threshold approach depended upon the alignment of heterogenous infrastructures of schools and their own. Working across *seams*, to draw on the vocabulary of Vertesi (2014), the NGO's staff used various practices trying to create *seamlessness*: an alignment of heterogenous infrastructures, in which "the gaps between each system […]]become[invisible to the user moving between, across, and within […] platforms" (pp.268-269). Or, in less abstract words, the NGO's infrastructuring efforts, were on the one hand necessary to reach pupils. On the other hand, in the mentors' eyes, they created a seamless experience for the participating children. In their view, the children could move effortlessly from the school infrastructure to the NGO’s infrastructure of care. Whether this experience was also perceived as seamless by the children, I can’t say based on my data.

7.2.1. Infrastructuring Alignment

However, as I will show in the following, the assumed seamless infrastructural alignment, which the NGO considered to be necessary to offer low-threshold health promotion, was not always achieved. For example, some school staff did not see the NGO’s workshops as relevant. This becomes visible, when we consider the following debates, which both took place during the weekly team meetings.

A couple of mentors, Laura (the organisation’s director), Vera (the project manager), and I were sitting around a table in one of the shared conference rooms. On the table stood bowls with mandarins, biscuits, and apples, tea, coffee, and water. It was the usual setup for the weekly meeting taking place on Tuesdays, which was mostly attended by those mentors who were employed part-time. Everyone exchanged how their past week went and gave an outlook for the coming days. “Yesterday, at the school, it did not go well.” Hakim explained to his fellow mentors. “Some children had to stay in their class. The teacher had no idea what I was doing there. He saw me and assumed that I am an Arabic teacher. So the children had to stay in class. The communication at the school is really bad. We have to give the teachers a workshop.” I was not surprised by his complaint, as I had been told that this has happened before. Thus, let me consider another weekly team meeting, which took place a couple of weeks later. Again, we were sitting around the conference table, our voices muffled by the grey office carpet. “When we came to the school there were not enough rooms.” Hakim complained. “Since the Ukrainian group was mixed girls and boys, they assumed it was the same for the Arabic children. But the Arabic kids are split. So, we had to find an extra free room. It took a long time and was very exhausting.” Vera (the project coordinator) looked at him. Vera was concerned with all organisational matters at the NGO. Half of the week she spent either in the office or at home answering emails and phone calls, dealing with enquiries and coordinating schedules. Most organisational tasks were completed by her and if there was any issue, mentors did turn to her. She answered Hakim with a firm voice: “It is very important that we ask up front whether the school has enough rooms. Many schools want multiple groups at the same time, but there are simply not enough rooms available.” Ziad, another mentor who only worked a few hours a week at the NGO, added: “But at this one school, the school guard is very aggressive. It is not easy to work with him. And the teachers suddenly stop replying to my e-mails. Also, the director, he is definitely racist, the way he talks to us and looks at us.”

I would describe the discussed organisational issues as mundane in the NGO’s work. Sometimes, things did not work out as planned. I argue, that looking at these moments through an infrastructural lens, makes visible how boundaries arose despite all efforts to ensure low-threshold health promotion. Next to seamless, Vertesi (2014) also introduces the term *seamful*. She proposes that “actors […] construct boundaries in and through practices of seamful infrastructural alignment” (Vertesi, 2014, p.274). In these moments of seamful infrastructural alignment, the infrastructures between which users are moving, become visible to them. For example, let us consider the moment, in which Hakim wanted to pick up the children, to create an anticipated seamless experience for them. But the teacher thought Hakim is an Arabic teacher and denied the pupils to leave class. It is unclear why the teacher did not know about the organisation’s work at the school. However, his reaction led to a seamful infrastructural alignment and created a boundary. The children were no longer able to move between the NGO’s and the school’s infrastructure. This also makes visible the underlying power dynamics. Ultimately, the teacher had the decision-making authority, whether the children were allowed to take part. At other times, boundaries were constructed because of racist and Islamophobic attitudes. Giving looks and speaking in a not respectful manner, were practices that made mentors feel unwelcome and made them aware of the fact that they were moving between infrastructures. This also makes visible how each infrastructure has its “own politics, standards, ways of knowing, ontologies, temporal rhythms, and interactional possibilities” (Vertesi, 2014, p.266).

7.2.2. Infrastructuring Prototypes

Moving on, I want to focus on the practices that the NGO developed and deployed as a reaction to such seamful infrastructural alignments. During my fieldwork, Laura (the director) and Vera (the project coordinator) decided the NGO should have a poster to put up in the teacher lounges. This way, they hoped to ensure that teachers were informed about the NGO's presence at schools. Given my prior studies in communication science, I was instructed to design and print the poster. The poster I edited (it may no longer be the current version) included short informative texts about the NGO, explaining why it is as the school (to teach pupils trauma coping skills) and what exactly it is doing there (an eight-week workshop), and a scannable QR code to the NGO's website. It also informed teachers about how they can help and instructed them to allow pupils to leave their classes. In addition, the text pointed out that children can only concentrate with "a calm mind" [Ruhe im Kopf], making the case that the teachers would also profit from a calm learning environment once burdened pupils had learned how to cope with their traumatic experiences. Furthermore, the poster featured two blank spaces, where mentors could fill in the dates of the workshops and their contact information. In a sense, the poster became an actor in the infrastructural alignment. Its purpose was to create a seamless experience for all those travelling along the seams. It was supposed to do so by informing school staff about the NGO's doings, eliminating misconceptions about their work. Following Jiménez (2014), I understand the poster as a *prototype*, an infrastructural being that has the power to destabilise epistemic formations and to travel as an infrastructure itself. The poster held information that then travelled across time and space. Its blank spaces made it sustainable and durable, always adaptable to the given circumstances. As such, the poster had the potential to be an important actor in the NGO's infrastructure of care. It informed schools, advertised the NGO, and prepared teachers for upcoming workshops. Through these practices, seamless infrastructural alignment could become possible. However, as I will discuss next, such "fixes" were not always a possibility.

In almost every team meeting, the child welfare office [Jugendamt] was brought up. The office was a close collaborator of the organisation. Caseworkers who suspected that families were struggling with trauma recommended they reach out to the organisation. This practice was underlying the NGO’s quest of offering low-threshold care: no one must search the organisation. Still, interested families had to reach out themselves, to ensure the organisation's bottom-up approach. Accordingly, the staff’s mantra was that you can only work with those who are willing to make changes in their lives. However, this practice, in which the child welfare office recommended families to reach out, often created confusion about the NGO’s independence.

It was a Tuesday, hence I attended the weekly team meeting, during which the staff discusses pressing matters. When it was Samira’s turn, she leaned forward placing her hands on the table. Like every other day, she was wearing a white close-fitting headscarf. I would describe her as a very attentive person, actively campaigning for women’s rights in both Austria and Syria. On this day she raised concerns about a family that had contacted her: “The child welfare office reached out and said that they are working with an Iraqi family who could make use of our programme. So Esra (a mentor) had a first meeting with the mother. And then, suddenly, we could not reach the family anymore. They stopped answering the phone. So, we asked why they stopped replying and it turned out they thought we are from the child welfare office. Even though we told them from the beginning on, that we are not.” The others listened quietly. Samira shook her head and leaned back: “What else can we possibly do than tell them that we are not the child welfare office?”

The mother’s reaction exemplifies how the child welfare office is equated with danger. It is an institution that holds the power of taking away your children. The mother’s confusion and subsequent fear were not an exception. Quite often, mentors reported that participants assumed they were part of the governmental institution. Hakim once told me that he had worked with a family that repeatedly inquired whether the NGO was from the child welfare office. Only when he talked to the father a couple of months after completing the trauma programme, he believed Hakim that the NGO was truly a non-governmental organisation. So even though the NGO’s close collaboration with the child welfare office was only a temporal infrastructural alignment, recommended workshops were not mandatory, and the NGO does not report back to caseworkers, at times participants failed to perceive it as such.

Miray, herself a mother, once shared that she understood parent’s fear of the child welfare office: “Of course, parents are very afraid, it can simply take away your children” [Natürlich haben Eltern sehr viel Angst, sie können dir deine Kinder einfach weg nehmen]. For many, it is a threat to family unity. The perception of the NGO as part of the child welfare office clarifies how participants feared that the organisation controls them and can exercise power by reporting back to the child welfare office. Naturally, the NGO and the child welfare office differed, one being a governmental institution, the other a non-governmental organisation. The NGO did not hold the same institutional power, nor did it report back about parents’ “performance”. However, both embodied institutions with certain values and ideas about how to do parenting properly. And in their cooperation, the NGO was sometimes perceived as a controlling body of the child welfare office.

As a result, families resorted to practices such as not picking up the phone or not calling back, thus creating boundaries between them and the NGO. Unlike with the case of the school poster described above, here the NGO did not have a solution. Kind of paradoxical, the NGO’s alignment with the child welfare office both facilitated seamless health promotion and hindered it. Extending the NGO’s network, aligning infrastructures, thus always also created new boundaries and moments of resistance.

Even though the infrastructural alignment with families was not always as seamful, the organisation strived to create an as seamless experience as possible. As I learned during my fieldwork, many families experienced immense hardships. Such as living in homeless shelters and struggling with new family roles marked by forced unemployment and social isolation. The NGO’s workshops were free of charge for participants. Moreover, families could choose whether the workshop should take place at their home or the organisation’s office. This way, mentors did adapt to each family’s unique needs. Especially for families with many children, or those who struggled with public transportation, home visits were assumed to enable participation. Whereas others reportedly enjoyed the possibility to leave their homes. These various flexibilities in the NGO’s approach to health promotion worked towards the creation of what they understood as a seamless user experience of infrastructural alignment.

Again, we witness an entanglement of the NGO's health promotion and infrastructuring practices.

7.3. Infrastructuring and Reflexivity

Earlier in this chapter, I argued that it is useful to understand the NGO as an infrastructure *in beta* (Jiménez, 2014). This allows us to pay attention to how the organisation was always adapting, sometimes growing, and at other times discontinuing collaborations. I now focus on the role of reflexivity in the NGO's infrastructuring practices to show how the organisation made sense of failed health promotion interventions, in this case caused by participants actively resisting infrastructural alignments. As the following vignettes showcase, the staff often critically reflected upon the boundaries that emerged in moments of infrastructural alignments.

For six weeks I had tried to accompany Ashraf and Ziad, two of the NGO's mentors, to an emotion-management workshop at a residential home for unaccompanied minor refugees. In the first weeks, the sessions were repeatedly rescheduled by the administrative personnel of the shelter. Later, the mentors were unsure whether my presence would be beneficial. They told me how the boys did not participate regularly and that there was a lot of tension in the group. In Ziad's opinion, my presence would disturb the dynamic further. Ashraf, a psychotherapist in training, did not mind my presence as much, but he was unsure how this particular group could be beneficial to my research since the mentors could barely keep up with the schedule. Eventually, we agreed that they would do one more session and let me know how to proceed. A week later Ashraf called me: “I am sorry, but I do not think it will work out. Last session went badly, we waited over 30 minutes and only one person showed up. The shelter's administrative staff called the other boys and they said they would be there in 5 minutes. Then they said they are only two train stations away. But it did not make any sense. The boys simply did not want to come at all. I do not know how we are going to proceed with this group. But maybe this can also be interesting for your thesis project. With voluntary health work, it is difficult to keep the audience involved. Especially with psychological topics, which are not taken seriously. And Arabs very rarely take it seriously.”

While talking to Ashraf on the phone, I scribbled “Arab culture” and “not taking mental health seriously” in my notebook. I thought this was a classic example of the impact of culture on mental health concepts. And an example of the limits of cultural competence, a case where the mentors failed to mediate between “Arab” and “Western” notions of emotion regulation. However, my interpretation of the incident changed when I remembered how the mentors had discussed the group in the supervision, a regular meeting the NGO organises with Jana, an Austrian psychotherapist, that took place a week before our phone call. At these supervisions, mentors could ask questions and discuss difficult cases. Usually, not only Jana but the whole group became involved in actively finding solutions. In the given supervision, Ziad and Ashraf had explained that they were unsure how to proceed with their group.

“We have this group at a shelter for unaccompanied minors. It is tough.”, Ziad said. He was a tall, sporty man from Syria who, like almost all mentors, was also committed to helping refugees in Austria when he was not working for the NGO. As part of his aspiration, he founded an NGO for the integration of children through soccer. Thus, he only worked a few hours a week at the NGO. “In the group the atmosphere is very tense [angespannt]. These boys always fight with each other. It is very difficult to create a room where everyone can say what they want to say. And they told us that sometimes they must go to school without receiving breakfast. Can you imagine?” Ashraf, who led the group with him, continued to explain: “Yes the shelter has organisational issues. The boys simply do not come to the session. We do not know if the supervisors do not tell them our schedule or if they do not want to come.” Jana (the psychotherapist) looked at them and said, “Well, it does sound tough. But these kids are alone. They were on their own for so long, coming here to us all alone. And now after accomplishing this, they live in a foreign country, with a foreign language. They have absolutely no private life and so many rules. They must live with people they do not like. In such a situation it is completely normal to be restless [unruhig]. And regarding these organisational difficulties, in the end, it is the target group. So, the question is what should we do if the target group is not interested?” I was surprised by her answer, and by her reflections on the boys' situation. And at the same time, I felt disillusioned when I heard that the shelter, an institution that should protect these children, fails to serve them breakfast.

The discussion between Jana and both mentors showcases that in moments of seamful infrastructural alignment, it was not always clear, who was constructing boundaries. Was it the shelter’s supervisor, who did not inform the boys about the workshop? Or was it the boys, who reacted aggressively, because they did not want to move between infrastructures? I do not have the answer to this question. Instead, I want to reflect on Jana’s comments, which concerned the latter assumption. Here, it becomes apparent that the boys’ disinterest in the workshop was not assumed to stem from cultural norms. Instead, she suggested that the staff should consider their unique living circumstances. How could the organisation have expected from these young men to spend even more time together and to share their beliefs and concerns if they were already disliking each other? Why should they have been interested in sitting down together and openly sharing their feelings and being vulnerable in front of the other when they had to protect themselves for so long?

In this case, she suggested that the participants themselves had created the infrastructural boundaries that had made difficult seamless health promotion. Participants should thus not be seen as passively moving between infrastructures but rather as infrastructural actors who actively influenced, enabled, or disabled infrastructural alignment. For example, by taking the train to the city, they quite literally created a physical boundary to the NGO’s infrastructure of care. Moreover, they established emotional boundaries through aggressive behaviour, signalising the mentors that they were not interested in infrastructural alignment. In being attentive to their lived experiences Jana thus tried to find an explanation for their construction of boundaries. This attentiveness shows similarities with *structural competence*, the ability to understand how medical encounters “are shaped […] by the economic and political conditions that produce and racialize inequalities in health in the first place” (Metzl & Hansen, 2014, p.127). When boundaries hindered infrastructural alignment, the staff tried to find various explanations, often rooting them in stakeholders’ actions and situatedness. In being aware of structural factors, such as the reality of living in a refugee shelter as a minor, the staff attempted to reflect on the participants' position within the NGO’s infrastructure of care. When presenting my preliminary interpretations to the staff, the exceptionality of this case was emphasised. The mentors insisted that unaccompanied minors were usually happy to engage in their workshops. Nevertheless, I assume this example to be an important instance that allows me to analytically reflect on the NGO’s infrastructuring efforts and I thus decided to include it in my final thesis.

7.4. Infrastructuring and Possibilities

Moving on, I want to shift my focus to the organisation’s materials. The NGO was undergoing many changes due to the arrival of Ukrainian refugees in Austria. For example, it trained new Ukrainian and Russian speaking trauma course mentors. In the following, I will draw on vignettes from the training session of new mentors. On the first training day, the organisational structure, the different workshops, and some ground rules were introduced. On the second and third days, the mentors in training went through the course programme as if they were participants themselves. Hereby, the mentors should learn about the workshop’s subjects and gain first-hand experience of how it feels to take part. As I will show in the upcoming vignette, the organisation expected the new mentors to sense and understand the needs of their participants. Following these expectations, I argue that the infrastructural changes were understood as a source for improving health promotion.

I was sitting in a chair circle with the Ukrainian and Russian speaking mentors in training. The group consisted mostly of women, only one man had signed up. In my hand, I held a folder with the trauma programme’s curricula. Before us stood Anna, an Austrian psychotherapist, who was holding the trauma course certificate training. On the same morning, I had approached Anna because I was unsure if the training would be too intense, too intimate. I had already met some of the women and the man because I was present during their interviews with the director and the project coordinator of the NGO. So I knew that many of those sitting in the room today have only been in Austria for a short time, that they have family in Ukraine, and that were deeply insecure about the future. Anna had promised me that if it gets too much, I could just leave the room and claim that I have something else to do. Looking around the room, talking slowly, Anna explained: “We must learn how the trauma workshop works with Ukrainian children. Our experience is that refugees have multiple, sequential traumata. People who fled from Syria or Afghanistan experienced a long escape route. And those, who arrive now, they experienced a very, very long journey. And they are still not protected. When they arrive, the asylum process starts, and nothing is secure. But for the Ukrainian children this is different. They had a short escape route and often experienced a rather short trauma. We must learn what does and what does not work with Ukrainian children. Therefore, we will have supervisions to receive your feedback and to understand what we need to change.” The mentors in training were listening carefully and making notes. One woman raised her hand, she did not understand what Anna had said. Another woman volunteered to translate and started explaining in Ukrainian.

Anna’s statement highlights that she did not assume that the current trauma workshop could benefit all refugees equally if not adapted to their unique circumstances. This attentiveness to the different experiences of conflict and fleeing can be described as structural competence (Hansen & Metzler, 2014). In the following, I want to focus on this adaptability of the organisation. The recent changes in the refugee population and the NGO’s reaction to it make visible its status as an infrastructure *in beta* (Jiménez, 2014). Meaning that its infrastructure did not reach closure, but rather always branched out. In his work on open-source urbanism, Jiménez (2014) proposes that infrastructures in beta challenge institutions of urban governance and property relations. He reveals how open-source urbanists, such as urban gardeners, traverse local boundaries through built networks of skill and expertise and how they challenge the political as the community assumes the expert role, “transforming the stakes in models of urban governance” (Jiménez, 2014, p.343). Taken together, Jiménez concludes that infrastructures in beta become a source of possibilities in “*their own right*” (2014, p.343). His analysis is fruitful to understand the NGO’s approach to low-threshold health promotion. In the organisation, knowledge and expertise were always travelling. Anna (the psychotherapist) and Laura (the director) did not assume a gold standard of how to hold workshops. Rather, they trusted mentors to know how to impart their knowledge to participants. They expected them to learn what works and what does not. Laura (the director) once told me, that in her opinion, both mentors and participants were experts. Mentors as trained experts with specific biomedical knowledge. And participants as experts in their own suffering and potential treatment. In this vision, the community assumed the expert role. This bottom-up approach to health promotion confronted the established politics of biomedicine, by challenging the division of roles between expert and layperson in its health promotion.

Laura assumed this approach to expertise to be the future of health promotion for migrants in Austria. She understood the organisation as a source of possibilities: “We are not providing health care [Gesundheitsversorgung]. Health care provision requires a diagnosis. This must and will change. Health promotion and prevention [Gesundheitsförderung und Prävention] are important. Medicine sees a headache, but we see being burdened.” The director identified, what she saw as the limits of biomedical health care. In Laura’s view, addressing trauma sequelae [Traumafolgestörungen] did not require a diagnosis, it might even hinder seeing the “true” underlying reasons for suffering (e.g. mistaking being burdened as a headache). Laura further explained that the NGO’s work was about giving participants tools that were useful regardless of diagnosis. As I have already highlighted, there was a shortage of therapy places for migrants in Austria, which made psychotherapy and diagnosis a lengthy process. Navigating a public infrastructure that failed to provide sufficient mental health care, Laura aimed to shape an infrastructure of care that was not bound to diagnosis. In her view, low-threshold health promotion was the future for Austrian migrant trauma aid. This also shows how infrastructures are “intimately caught up with the sense of shaping modern society and realizing the future” (Larkin, 2013, p.332).

Moving on, I engage with how the NGO adapted its course materials for Ukrainian refugees. Generally, the organisation only accepted participants who were granted some protective status. Consequently, they usually have been living in Austria for at least a year. However, this was not the case with Ukrainian participants, who had often only arrived recently. As Vera, the project manager, explained to me, this lead to a complicated situation: “With the Ukrainian children it is quite different. For the children the whole situation is not complete, they think they can go back home.” This in turn influenced which contents the NGO deemed to be appropriate for trauma workshops with Ukrainian refugees. In the trauma workshop for new mentors “Ahmed’s Story”, a course material, was critically debated. It was a fictitious short story about Ahmed, a young boy, who walks to school and witnesses how armed men kill an elderly man. After experiencing this, Ahmed can no longer walk to school, as he is too afraid. He has nightmares. Participants encounter this story at the very beginning of the trauma workshop. In the final session, they are then asked to write Ahmed a letter, in which they offer him tips on how to live with what he experienced. In this sense, Ahmed offered the participants the possibility to talk about feelings and coping strategies without having to name what they themselves had experienced.

The mentors in training were listening to Ahmed’s story. Some had their eyes closed, were looking to the floor. The woman next to me wiped a tear from her face. I felt tense. After a few minutes, Anna (the psychotherapist) had finished the reading. I took a deep breath and straightened up in my chair. “I do not think ‘Ahmed’s story’ is appropriate for our children.” one of the Ukrainian mentors in training said. She was a neatly dressed woman who had worked as a teacher in Ukraine. The other women nodded their heads in agreement. Hakim, who served as an experienced mentor during this part of the trauma course, agreed: “Yes. It is too much for the Ukrainian children. Because they do not have any experience with this kind of trauma. But it is the entry point to our trauma work. Therefore, you will read a different story, about Artem.”

“Ahmed’s story” and “Artem’s story” differed not only by name but also by content. They both functioned as an entry point to talk about traumatic events. However, each one tried to remain sensitive to the target’s groups heterogeneous experiences. You cannot introduce children to the horrors of killing military if their fathers remain in the country referred to. Likewise, Arabic or Somali speaking trauma mentos were instructed not to refer to beaches or the open water when doing relaxation exercises, because most Arabic and African refugees had to cross the water during their flight and see it as a source of danger. While this might seem obvious, it required attention to the varying lived experiences of refugees. Moreover, the mentors changed the boy’s name if a participant was called Ahmed or Artem. Just like the poster I discussed before, I understand “Ahmed’s story” as a *prototype* in the organisation’s infrastructure of care. The story travelled across time and space, always adjustable to the required group setting. This adaptability gave the story power to destabilise epistemic formations and to enable new compossibilities (Jiménez, 2014). What was considered appropriate in one group setting, did not necessarily fit in another. This experience-based way of producing knowledge formed the basis of the NGO's approach to trauma. I hence argue, that in its infrastructure of care, moments that required adaption should be seen as a source for knowledge production.

7.5. Discussion on Infrastructuring

During my field research, I kept getting the feeling that I was in a large network. A kind of safety net in which the NGO was only one of many nodes. With the present chapter, I hence aimed to see the organisation as an infrastructure of care. This enabled me to show how the NGO's infrastructuring practices were deeply entangled with its efforts to offer low-threshold health promotion.

Conceptualising the NGO as an infrastructure of care made visible how it did not exist independently, but rather had to relate and connect to other infrastructures, such as NGOs, schools, and social services. Engaging with the various practices that revolved around creating and maintaining its infrastructure, I showed how they were deeply entangled with the NGO's vision of offering low-threshold health promotion for migrants and refugees in Austria.

Here, I outlined how infrastructural alignments with other institutions were not always *seamless*. Boundaries may be created by schoolteachers who were unaware of the NGO's doings in their school, unaccompanied minor refugees who did not show up to a workshop or interested families who were afraid that the NGO was working with the child welfare office. Creating seamlessness in such moments required a lot of, not always successful, efforts. These took the form of posters, reflections, meetings or simply listening to participants' stories. Solutions were often informed by *structural competence*, the ability to understand the cultural and structural situatedness of participants. I hence argue that structural competence can also be understood in terms of *(infra)structuring competence*, the ability to find ad hoc solutions to align heterogeneous infrastructures.

Discussing how the NGO engaged in infrastructuring, how it practiced low-threshold health promotion with all its challenges, means that we can understand it as *in beta*, as emerging, adapting, never fixed. The NGO had to navigate various public infrastructures, including schools, the child welfare office, the public healthcare system, and a restrictive immigration regime. I argue that understanding the NGO's infrastructure as *in beta* makes visible the "failures of public health in the present" (Kehr, 2016). For instance, the NGO's infrastructural alignments with public infrastructures, show how the state failed to provide public psychotherapeutic care for migrants. The NGO had to work with public infrastructures to reach their target group, which illustrates that the state had access to vulnerable groups but did not provide them with adequate health care. Through its alignments, it further becomes visible how migrants eventually feared state institutions, as something that will do them harm (e.g. take away their children). However, the NGO also somehow depended on the state, being almost entirely funded by the Federal Ministry and the Federal Chancellery. What we witness, is an outsourcing of health care responsibilities to the non-governmental sector and a subsequent entanglement of public and third sector infrastructures. According to my interlocutors, this financial structure and everyday cooperation with public infrastructures were necessary for the NGO to pay its staff, reach its target groups, and offer low-threshold health promotion. Yet, often unexpected challenges arose along the seams in moments of alignment that had to be overcome through infrastructural measures.

8. Empirical Chapter 2: Culture

"Language and culture are very important to convey meaning [um Inhalte zu vermitteln]. Imagine, it would be the other way round and it was Austrian refugees coming to Syria. As a Syrian, I could not tell you to wear a headscarf and a long skirt. I would have to find Austrian people who could mediate [vermitteln]. For you to accept this, an Austrian person would have to tell you." (Hakim, Syrian mentor)

With his words, Hakim described to me the importance he attached to culture in his health promotion. When talking about culture, he often resorted to metaphors, trying to emphasise its power to connect people. He knew that as part of my field research, I desired to study the role of culture in the organisation's day-to-day work. Working with migrants and refugees, the NGO labelled itself as an "intercultural health promoter" [interkulturelle Gesundheitsförderung]. The staff was expected to provide information in a way that participants could easily understand and accept, using Hakim's words: "Inhalte zu vermitteln". As his thought experiment exemplifies, the rather abstract notion of culture appeared to take an important place in this approach to health promotion. In the present chapter, I critically engage with the various definitions, roles, and functions of culture. I outline how the term was used (un)consciously, by whom, and to which ends. What do certain understandings of culture hide and what do they show? Moreover, I study the relationship between culture and biomedicine in the NGO's health promotion. I engage with the underlying hierarchies of knowledge, focusing on what is at stake. Taken together, in the present chapter, I answer the question of what does culture do – and for whom?

8.1. Culture as Resource

During my fieldwork, I quickly learned that the "inter" in intercultural health promotion referred to the staff's mediating role between Austrian and the participants' respective culture. The mentors became intercultural communicators who helped the participants cope with their mental health while settling in Austria. This not only entailed adaptation to a new language, unfamiliar surroundings, and different habits but also cherishing and holding on to familiar traditions.

Laura, the director of the NGO, had invited me to an event organised by one of the organisation's funding agencies. At the meeting, politicians, city officials, and organisations were presenting the results of a funding call for initiatives supporting school parents with migration background. The call had also contributed a short-term fund to the NGO's now halted parenting programme. The programme had entailed workshops for parents with tips on parenting styles, communication, and on how to embrace cultural traditions while bringing up their children in Austria. At the event, Hakim and Samira, the two mentors who were in charge of the programme, were also present. After the formal talks, everyone was invited to a buffet. There were drinks and dumplings with different fillings. The hosts explained that this is a buffet in the spirit of interculturality because filled pastries exist all over the world. Here, Samira came into conversation with a city official, who wanted to learn more about the NGO's parenting programme. He was intrigued by the NGO's approach that refugees were holding the workshops. "For the children school and home are two different worlds." Samira explained, looking into his eyes. "Oh, really? Is it that different?" he asked, smiling with a glass of Spritzer (white wine with carbonated water) in his hand. "Yes, it is.", Samira answered: "And I know the parents fear. It is about losing your culture while learning the new Austrian culture. But I tell them they do not have to fear. I always say, without roots, we cannot grow."

In the conversation, Samira referred to refugees' respective culture and Austrian culture as "two different worlds", creating a distinct binary. In this case, Samira used culture to mark differences. This understanding implied distinct cultures, each homogenous, coherent, and timeless. Abu-Lughod (1991) has argued that evoking such a cultural binary inevitably suggests a hierarchical order. As I outlined in my state of the art, this "container" view of culture is commonly used in biomedical practices. It reduces culture, often synonymous with nationality, to a list of "do's" and "don'ts" of how to treat patients from a certain background (Kleinman & Benson, 2006). This updrawing of stereotypes stands in stark contrast to the anthropological understanding of culture. Here, culture is seen as a heterogenous, fluid process that informs but not determines ordinary practices.

However, I argue that Samira used this static view of cultural differences as a resource for her health promotion. A resource, which at times became exhausted. First of all, Samira saw culture, specifically her shared culture with other refugees, as a resource that enabled her to relate to, understand, and provide better help to people with similar experiences. I want to pay attention to Samira's subjectivities as a refugee and mother, without reducing her to these experiences. Less than ten years ago, Samira had fled from a civil war-torn country to Austria. In our many conversations, it became clear that through her experiences as a refugee, coupled with being a mother, she saw herself as able to relate to parents' struggles with parenting while making a new home. In a sense, her own experiences and cultural knowledge became an integral resource for her expertise as a mentor.

Second, Samira saw culture as a resource that could help parents adapt to Austrian culture. This becomes apparent in her use of the metaphor "culture as roots". By emphasising culture as roots, she made the case that, for parents, culture is a resource in making a home. Here, culture is something that should not be lost but cherished. This shows parallels with Ilcan and Squire's (2002) research with Syrian refugees, which found that often "home is understood not only as a material environment but also as a configuration of expressive moments, relationships, memories, and aspects of belonging" (p.138). In both cases, refugees' home-making practices also entail embracing their culture.

By promoting cultural continuation, Samira further challenged the colonial hierarchical order of the culture binary. Usually, when evoking a binary between "Western" and "Eastern" culture, this is used as a form of *othering* to legitimate the continuity of colonial power relations (Said, 1995). "Western" ways being the rightful norm and "Eastern" the other. These values are also reflected in dominant discourses on integration, which encourage refugees to become Austrian. In Samira's encounter with the city official, we can see a positive recognition of her culture. She not only acknowledged but embraced differences. For her, "Eastern" culture enabled and facilitated integration. To repeat her words, "without roots, we cannot grow".

Being peers to their participants, the NGO's mentors at times saw themselves as having a role model function. They were not only certified health mentors but also refugees, who had settled and built a life in Austria. Mentors were familiar with both their respective and "Western" culture, which, as explained above, were often understood as distinct. In the NGO's health promotion, the mentor's biomedical expertise, as well as their own experiences made them experts.

I was sitting in a chair circle in one of the shared conference rooms at the organisation's office. Ukrainian and Russian speaking women, one man and two of the NGO’s mentors were sitting next to me. It was the first day of the three-day trauma course certificate training. The demand for trauma workshops for Ukrainian children was very high, schools were calling almost daily, asking for support. At the training were those present, who either already worked for the NGO, but did not have the trauma course certificate, and those, who had applied and were selected in a first interview round. The normally bare room was decorated with flowers and posters. Laura (the organisation’s director) was sitting in the front, explaining the NGO’s approach: “Our work is low-threshold [niederschwellig]. This means that it is accessible and easy to accept.” She turned to Lila, one of the Somali mentors who already worked for the NGO, “Imagine, if a school recommends therapy for a student from Somalia, the mother might not understand what it is about and disagree. But if you explain it to her in Somali, she will understand it and might agree. Working low-threshold [niederschwellig] means that we go to schools and organisations. No one must search us. So, our mentors speak their participants’ language and share the same country of origin [Herkunft].” Laura pointed at the only man in training: “You know the context, you know the history, you do not have to ask or talk about it. This knowledge is a competence that no one can acquire.” She put down her hand, “And it creates trust. Often it is easier to talk with somebody from the same origin, who understand one’s concept of illness. Everyone has different concepts of mental illness. So how can we come together? Answering this question is the responsibility of you and your colleagues. To not only translate but to mediate [vermitteln].”

During the fieldwork, I observed the director introduce the NGO multiple times. And every time, she described this knowledge of local culture and politics as something inherent to the mentors’ origin [Herkunft]. As something that was not even worth trying to gain because one will never master it likewise. Importantly, this does not mean that she believed in *cultural essentialism*. The term, with lengthy social and political history in Europe, refers to a system of beliefs which is “grounded in a conception of human beings as […] bearers of *a* culture, located within a boundaried world, which defines them and differentiates them from others” (Grillo, 2003, p.158). In our many discussions on the role of culture, the director always clarified that culture was not something one is born with. She was also careful not to reduce every opinion and behaviour to cultural explanations, always actively speaking out against *cultural racism*

(Grillo, 2003). This approach to health promotion did not explain every health-related behaviour with culture. Instead, it understood culture and socio-political knowledge as two among many resources, a method that is generally favoured in medical anthropology (Hansen et al., 2017; Kleinman & Benson, 2006; Metzl & Hansen, 2014). Like Samira, the director understood the mentors' cultural background and knowledge of local conflicts and concepts of illness as a resource in their health promotion. Yet, she did not share Samira's static view on cultural differences.

In understanding culture as roots and drawing up a distinct binary, Samira established a view of culture as a "concrete and bounded world of beliefs and practices" (Sewell, 2005, p.39). On the one hand, this allowed her to validate participants' experience that parenting was done differently in Austria. On the other hand, this marked participants as bearers of their culture (Grillo, 2003). Making it undesirable to change culturally informed parenting. Consequently, Samira's approach to culture as a resource at times became exhausted. For instance, when participants' culturally informed parenting practices and Austrian law conflicted with each other.

In such cases, Samira, a trained lawyer, used the law as a resource: "In the health circles we often critically discuss the Koran, whether hitting your children is haram or halal. But I always say, it does not matter, because in Austria it is forbidden by law to hit your children and you will get in trouble." These referrals to the law were commonly used by mentors. "A group of schoolgirls asked me whether FGM (female genital mutilation) is haram or halal. But I did not feel like I should give my subjective opinion," Imara, a Somalian mentor, explained, "so I told them to talk to their parents." The NGOs director advised Imara to clarify that in Austria FGM is illegal, so there were clear boundaries. These instances exemplify how law became a discussion-ending tool. For many mentors FGM and hitting your children were unacceptable practices, yet they understood them as culturally informed. As Hakim, once explained in a network meeting: "Emotion regulation is also important for my country. In Syria people are educated that it is normal to be violent. It is our responsibility as a society in Austria to take care of the people." For him, Syrian and Austrian values of violent behaviour stood in conflict. Yet, he saw it as his responsibility to Austrian society, to promote non-violent behaviour among fellow Syrians. Similarly, Miray, who gave parents workshops, told me that in her opinion, many Afghan parents saw beating as an acceptable parenting practice. In her workshops, she hence tried to approach the topic through human rights, telling parents, that in Austria, children have human rights, and these included protection against violence. By referring to Austrian law, the mentors thus tried to convey to the participants what they understood to be the appropriate way of dealing with violence in Austria, namely not being violent. This allowed them to promote certain values without having to pass their judgement on whether practices were “haram” or “halal”.

Interestingly, this practice underlies the understanding of Austria as a state under the rule of law (“Rechtsstaat”). Once I asked Hakim, which role he ascribed to Austrian culture in his “intercultural health promotion” and he answered: “Austrian culture? It plays a big role. I mean you are here in a country and your rights are protected” [deine Rechte sind geschützt]. And for trauma work, it is important that you feel safe. This is also why we cannot work with Asylum applicants. […] So Austrian culture is a resource for our work.” In Hakim’s view, Austrian culture took shape in laws, which formed the most fundamental resource of trauma work: without laws, there was no “Schutz”, no Asylum. In his intercultural health promotion, it seems that Austrian culture became reduced to Austria being a “Rechtsstaat” with certain rules and regulations. A view, I would argue, in which law-abidingness (e.g., non-violent behaviour) becomes equal to practising Austrian culture.

8.2. Culture and Moralisation

As I have shown in the previous chapters, tensions arose between the director and the mentors’ distinct understandings of culture. These differences further become visible in the training of new trauma course mentors when an exercise on the daily structure was debated. The logic behind the exercise is that people who suffer from trauma benefit from clear schedules. Therefore, participating families and pupils are asked to create a daily structure. But everyone in the room was quite critical of the exercise.

“With Somali people, it is really hard to make plans.”, Lila, a Somali mentor proclaimed. “With Afghans and Syrians, it is also hard to plan.” another mentor added. “Ukrainians are very spontaneous.”, one woman said, “You cannot tell your family when to come by, that is not how it works.” Anna, the instructing psychotherapist looked around the room nodding, “Austrian culture is not always great, and one does not need to adopt every habit. We do not suggest that families become like Austrian families, who plan two months ahead. It is rather about deciding on bedtime, mealtimes, and family time. This is very important for people who live with trauma.” Later the same day, at lunch, I told the organisation’s director about the debate. Rather than finding it an interesting example of the role of culture, she reacted irritated, “I do not like this”, she said making a disapproving hand gesture, “Not everything is culture. People simply have different habits.”

The director’s reaction opens an interesting debate: where does culture’s area of influence end and where do personal habits start? How can one know, if a person is unorganised or whether they are following a cultural habit of spontaneousness? I do not have an answer to this question, but would like to pose another one: why does it matter if the absence of bedtime, or fixed mealtimes is cultural or personal? When the best way to cope with trauma was to follow a schedule, mentors had to give participants a good reason for its presence. For the organisation’s director, this was about having an open dialogue and not deciding a priori whether a behaviour is informed culturally. She did not understand culture as a clearly bounded entity of behaviours and opinions. For her, culture was something that informed but did not predetermine behaviour. This approach follows the anthropological blueprint of culturally competent health promotion (Kleinman & Benson, 2006).

When I asked the mentors about the role of culture in their health promotion, I often got similar responses. “Culture is everything”, some mentors told me. “Allowing the participants to pray when it’s time to”, another one answered. For them, their health promotion entailed providing a room free of prejudices. Where people could speak about mental health in their native language and feel comfortable when taking place on their prayer mat. Mentors’ health promotion entailed providing information about mental health, the connectedness of mind and body, giving tips and showing exercises for self-empowerment and self-care. Brown (2018) argues that such an informative approach to health promotion often creates “moral responsibility for one’s health” (p.1005). Health promotion underlies the idea that people who are well informed about their health and healthy lifestyle choices are also in control of it. Behaviour is not necessarily labelled as morally good or bad, still, this informative approach contributes to the moralisation of health. Generally, moralisation “[…] involves the transition of something from the non-moral to the moral” (Brown, 2018, p.1001). Morals refer to the standards for good (right) and bad (wrong) behaviour, moralisation makes phenomena judgeable according to these. Importantly, moralisation is not so much a practice, but rather a process that takes place in society. Following Brown, providing information about the harms (e.g., smoking) and benefits (e.g., exercise) of lifestyle behaviour, “[…] encourages the perception that people are both in control of their behaviour and that they understand the implications of their behaviour for future health” (2018, p.1004). She argues that using such language of empowerment and current trends towards healthism, contribute to the moralisation of health-related behaviour, making it people’s moral responsibility to adopt healthy behaviour. I hence argue that mentors’ provision of mental health information and promotion of self-empowerment [Stärkung der Selbstwirksamkeit] created a moral responsibility for their participants, to act upon the information provided.

Turning back to the mentors’ discussion on schedules, it becomes apparent that in their experience participants were not eager to take up daily structures. Participants had been informed that living with trauma becomes easier when one follows a schedule. Yet they decided not to. Following Brown’s (2018) insights on health moralisation, they hence made “bad” health-related choices. The mentors reduced this choice to cultural stereotypes, like Ukrainian’s “spontaneousness” or Somalian’s “difficulties” to make plans. Often, mentors referred to their own experiences to verify such typification. For example, the Somali mentor later explained that she could never have a fixed mealtime with her family, because this simply does not work for Somalis. On the one hand, this portrayal of culture as “a set of discrete characteristics refies hegemonic understandings of otherness” (Vanderlinden, 2011, p.261). On the other hand, such universal reductionist statements allowed the mentors to explain health-related behaviour and exempt themselves and participants from the moral responsibility of making the healthy lifestyle choice. What motivations these exemptions underlie remains ambiguous from my point of view. However, the director did not accept this use of culture as an excuse for making unhealthy lifestyle choices.

8.3. Culture and Language

I further consider the relationship between culture and language in the NGO's day-to-day work as intriguing. Throughout my fieldwork, the mentors repeatedly emphasised that speaking their participant's respective language [Muttersprache] was the foundation for low-threshold intercultural health promotion. For many, language constituted an integral part of culture. In the following, I illustrate the NGO's approach to and language use of the term trauma. First, I outline the shared, institutional understanding of the terminology. Second, I describe how the term trauma was carefully avoided when communicating with participants. By doing so, I argue, the mentors engaged in culturally informed linguistic practices to "unmake" patients. Hereby, they hoped to promote mental health in a way that participants could easily accept.

The term trauma repeatedly resurfaced throughout my fieldwork. It appeared in varying modes: trauma, traumatic, traumatised, trauma pedagogy, trauma therapy, trauma symptoms, and triggers. But it was also a term that the mentors should not apply to the participants. To discuss the shared institutional understanding and prohibition of trauma, it is helpful to consider the trauma course certificate training, which I referred to earlier.

Laura, the NGO's director had just introduced the organisation and now explained the purpose of the course: "The goal is that your participants can recognise, understand, and control trauma sequelae. We support their self-efficacy. Basically, they learn to control trauma sequelae. But we do not give therapy. This really is important. We are journalists, lawyers, and school psychologists. We are not allowed to offer therapy." After she had made sure that everyone understood this, she moved on to the topic of diagnosis: "And diagnosis doesn't matter. When we know that a child came from a country with war and that it had a hard time coming to Austria. Then it can take part in the trauma course.” The mentors in training listened carefully. All Ukrainian women had arrived only recently in Austria. Some had their phones in their lap, translations apps running. Later, Anna (the instructor) started talking about trauma symptoms: “So which symptoms of trauma can children experience?” Some mentors in training raised their hands: “aggression”, “crying”, “isolation”, “fear”, “flashbacks”, “nightmares” and many more were named. Anna wrote each symptom on a Post-it note. Then she wrote “intrusion”, “aversion”, and “hyperarousal” on the flipchart. Anna moved on to define the three categories and asked the mentors in training to assign each symptom to a category. She explained that these shape the organisation’s trauma course. For each symptom category existed certain tools and exercises, which the mentors would train with the participants.

With this vignette, it becomes apparent how the director created a shared understanding of trauma as a diagnosis, which only licensed practitioners could make. Though some mentors had studied and worked as psychologists before fleeing, Austrian law prohibited them from practising their profession. Generally, the NGO worked with the terms burdened [belastet] and high stress [Hochstress]. I was often told that the participants should not be called “traumatised” [traumatisiert] because the organisation simply could not claim that they were. In her research with humanitarian psychiatrists in post-war Kosovar, Kienzler observed how “[…] patients’ complex experiences of distress [were reduced] to singularly mapped war traumas” (2019, p.60). She argues that by fitting women’s symptoms into “ready-made diagnostic categories” (2019, p.60) they were “made” patients. As a result, their complex experiences of distress were rendered invisible. Similarly, Fassin and Rechtman (2009) argue, that trauma obscures diversity and reduces people’s experiences to symptoms. I argue, that by deliberately refraining from labelling participants as “traumatised”, the NGO “unmade” patients. The mentors practiced a health promotion that did not necessitate diagnosis. On the one hand, this originated from their strict adherence to trauma as a diagnosis, which they could not make. On the other hand, it followed from the shared attitude that the tools promoted were beneficial, detached from diagnosis.

As the training moved on, Laura (the director) drew attention to the trauma programme's title: "In German our trauma programme is called 'Energie gewinnen - Trauma überkommen'. How would you call it in Ukrainian or Russian? And how about in Somali? Because we will need to advertise the programme in each language. Let's form groups and take five minutes to come up with translations in each language." The mentors in training started talking to each other. The two women beside me invited me to join, but I told them that I cannot help because I only speak German and English. They laughed and continued their discussion in Ukrainian. When it was time to present, Lila a mentor and trained journalist, walked to the flipchart and wrote a few words in Somali. "This translates to 'the techniques to recover'." she explained in English, "In Somali, you cannot say trauma. It is a taboo, trauma means being crazy." She looked around the room and continued with her voice raised: "You cannot say it. And I know my language, I know what my people, my Somali people, would like to hear. What we can say. And when I do not understand something or need help, I ask. It is a great responsibility."

The exercise of finding a name for the programme highlights the responsibility mentors had in knowing the respective cultural concepts of mental health. For them, speaking the same language hence not only entailed knowing words and grammar but also linguistic customs. By referring to "my Somali people", Lila implied that Somalians share "a core set of beliefs about illness owing to fixed ethnic traits" (Kleinman & Benson, 2006, p.1673). Hereby, "culture is […] made synonymous with ethnicity, nationality, and language" (Kleinman & Benson, 2006, p.1673), which is a common pitfall of culturally competent care. Ultimately, the mentor's goal was to convey meaning in a way that could be accepted by her participants. And by refraining from diagnostic labels, the NGO aimed to open a space, where mental health could be discussed without stigma. Often, diagnosis influences social relations (Jenkins, 2015), hence it is important "to consider what is chiefly at stake for patients as they face a particular […] mental illness" (Kleinman, 2004, p.454). I argue, that by offering health promotion, which did not imply a diagnosis, for example PTSD, the NGO "unmade" patients. To do this, however, mentors relied on culture-based stereotypical assumptions about their participants' attitudes toward trauma.

As Fassin and Rechtman (2009) write, “rather than a clinical reality, trauma today is a moral judgement” (p.284): the acknowledgement of political refugees as traumatised has become a form of their social recognition. In today’s world, trauma signifies that past violence and misfortune leave traces in the present. And over time, trauma became a tool for claiming one’s rights by appealing to compassion. Fassin and Rechtman (2009) point out that not everyone who witnesses a traumatic event is labelled as traumatised, some are refused this label of compassion which has become a moral statement about legitimate and illegitimate victims. So, the question arises, what does it mean that the NGO did not describe the migrants and refugees it worked with as traumatised? Based on my observations, the NGO showed compassion but did not ask participants what happened during war and flight, consequently, participants did not have to provide evidence of traumatic events. Following this notion, their moral legitimacy was not questioned and their rights to health promotion were not bound to traumatic evidence. Yet at the same time, the NGO understood everyone who fled as burdened [belastet]. Similarly to trauma, the term marked the traces of past violence in the present. But even more, it hinted towards present stress factors, including financial hardships, learning a new language, and grieving the loss of home. For the NGO, I argue, burdened [Belastung] became a tool to give moral legitimacy to all refugees and migrants as rightful beneficiaries of the NGO’s health promotion. However, I would argue, unlike trauma, it did not necessitate evidence beyond flight to claim rights and receive moral legitimacy.

In the following, I will discuss the NGO’s use of the term depression, which was commonly applied to participants. The staff used both terms, depression and trauma, differently. For instance, on the contrary to trauma, the term depression was used in front of the participants. As such there was no “unmaking”, but rather a “making” of patients (Kienzler, 2019).

8.4. Culture and Illness Narratives

Miray, a mentor at the organisation, had decided to hold a workshop on depression for the staff. She felt that in order to respond appropriately to the needs of their participants, everyone had to learn more about the causes, symptoms and effective treatments of depression. The workshop was attended by six mentors from Syria, Afghanistan, and Somalia and supported by Jana, an Austrian psychotherapist, who worked as a supervisor and advisor for the organisation. The workshop constitutes an important example of how the staff at the NGO was making sense of depression. Throughout the exchange, it was elaborated on how depression could have different causes and symptoms, and how these were influenced by culture.

I was standing in the conference room circling my arms steadily. “Now the wrists,” Miray said with a broad smile. I started to circle my wrists. Next to me stood some of the mentors and Jana (the psychotherapist). Next, we all circled our feet, then our legs, hips, and heads. Then, we were instructed to roll our eyes. Finally, Miray told everyone to stop and asked: “Why do you think we made this exercise at the beginning of the depression workshop?” Jana (the psychotherapist) answered: “Because people who suffer from depression are often very tense and their thoughts are just circling in their heads [ihre Gedanken kreisen im Kopf]. So, by circling their body [Körper kreisen], they can release the tension.” Miray nodded her head in agreement. She stood next to three flipcharts on which she prepared handwritten notes on depression: “Today, we will talk a bit about depression.” Earlier she had told me that she was nervous because she usually only speaks about the topic in Farsi. But during the workshop, I could not detect any nervousness in her voice or posture. Miray continued: “Depression always needs a diagnosis and treatment. In my country, Afghanistan, people do not talk about depression. You simply stay at home and do not talk about it. Nowadays it is getting a bit better. But in Afghanistan, the word depression is not used, it is called sadness. What about your countries? What is depression there?”, “In Arab, we have a term for depression,” Samira answered, “it is a form of resigning and sadness”. “It is the same in Kurdish” Aliyah, a mentor from Afghanistan, said. “In Somali, there is no word for depression,” Imara explained, “we simply say the English term”. “In German,” Jana continued, “the term derives from Latin and means being in low spirits. Like melancholia, which is a Greek term for black bile. You know, doctors say when the body’s fluids are not in balance one gets sick.”

In the workshop, Miray gave a clear definition of depression, as a biomedical diagnosis. And it was not presented as an empty category but as having a clear function: treatment. Only after establishing this fact, she continued to elaborate on the terms meaning in Afghanistan and invited her colleagues to share their country-specific knowledge. Her colleagues' insights followed, explaining whether the term depression was used in their respective languages and what it meant. Hereby, Miray first determined depression as a singular biomedical category before exploring its multiplicity in cultural meanings. When juxtaposing these multiple understandings next to the singular category, I want to explain what follows through Arthur Kleinman's (1988) concept of *illness narratives*. According to Kleinman (1988), "disease is what practitioners have been trained to see through the theoretical lenses of their particular form of practice" (p.05). And *illness* "refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability" (Kleinman, 1988, p.03). Kleinman also differentiates the term *sickness*. It refers to a disorder "as a reflection of political oppression, economic deprivation, and other social sources of human misery" (Kleinman, 1988, p.07). However, in the present analysis, I do not focus on depression as a sickness. Again, *illness* refers to the personal lived experience of symptoms, and *disease* is the diagnostic entity provided by practitioners. Similarly, on the one hand, Miray referred to depression as a singular disease, with certain symptoms that can be translated into effective treatment. And, on the other hand, she referred to depression as an illness with varying culturally informed realities of living with this disease. With Anne-Marie Mol (2002) we can argue that when working with this divide one does not challenge the biomedical reality of being sick, an area of expertise that is usually reserved for doctors and therapists. There remains a "singular" biomedical reality out there that is simply inscribed with different cultural meanings. Similarly, as I will show in the following, the staff did not question the biomedical category of depression.

"So, depression is culturally informed." Miray continued, "In Western countries people who suffer from depression talk about their feelings and moods. But in our Eastern countries, depression is described as pain. Depressed patients complain about headaches and stomachaches. Feelings cannot be named." Hakim raised his hand: "But if you are depressed, you are afraid and your hormones produce cortisone which has an effect on your organs, so you do feel physical pain." Jana agreed: "The body and the spirit are connected," she added, "and you can actually detect depression in the blood."

Kleinman (1988) argued that in every society, there are normal as well as anomalous ways of being ill. What we can see in the NGO's meeting, is a comparison and negotiation of different illness expressions. However, eventually, the underlying biomedical reality of depression was stressed. Whether people confessed their sadness or complained about headaches, their physical body was assumed to experience a singular disease, which becomes visible in cortisone levels and bloodwork. As such, which symptoms were voiced depended on "Eastern" or "Western" cultural influences. Here we see the production of knowledge, which builds on generalisation: "Eastern people do this." "Western people do that." A common pitfall of culturally sensitive health care, which "leads to dangerous stereotyping […] as if entire societies or ethnic groups could be described by […] simple slogans" (Kleinman & Benson, 2006, p.1673). However, as I will explain later on, for the mentors this generalisation seemed to have a clear function.

By explaining that people really feel physical pain due to biological processes within their bodies, Hakim attempted to validate their suffering. Cortisone levels are universal and are supposed to make suffering tangible. In a sense, he explained "Eastern" ways of experiencing depression, by giving biomedical explanations. Interestingly, he did not provide such explanations for "Western" ways of illness expressions. It was not necessary, because "Western" ways of being ill with depression were assumed to overlap with the biomedical symptom catalogue of the disease. Lock and Kaufert (2001) investigated the symptoms during and the disease profile post-menopause in Japan, the United States, and Canada. Their analysis shows that the symptoms and diseases described in medical journals overlap with the experiences of North American women, but not with those of Japanese women. The authors hence challenge biology's assumed universalism and suggest talking of *local biologies*. These should "reflect the very different social and physical conditions of […] lives from one society to another" (Lock & Kaufert, 2001, p.494). What we can observe in the workshop on depression, is how "local expressions of distress are translated into 'locally untranslatable Western disorders', such as depression […]" (Kienzler, 2019, p.61). Symptoms were identified and „reduced to discretely named mental disorders that are tied to specific forms of treatment" (Kienzler, 2019, pp.61-62). Often, in emergency contexts, such translation processes, which ignore the multiplicity of biology, are applied to provide urgent care in times of scarce resources (Pedersen et al., 2015). In the workshop, the NGO's staff was translating local illness concepts into depression. On the one hand, the discussion made visible the variety of local disorders. On the other hand, the discussion eventually hid these local biologies under the assumed universal biomedical category of depression. However, as I will show in the following, mentors did so because they hereby hoped to provide useful information in their health promotion.

"This often makes the diagnosis of depression harder." Miray stated with a concerned look on her face, "If you suffer from depression and go to an Austrian psychotherapist and tell them about your headache and stomachache, they will send you to a general practitioner. But they will not find anything wrong with your stomach and head and send you home. How symptoms of depression are described is culturally determined. Therefore, it is very important that we recommend our participants to look for a psychotherapist from the same country." The other mentors nodded their heads in agreement, only Hakim intervened: "But in Syria, both exist. It depends on the education level. People with higher education will talk about their feelings and people with lower education about physical pain."

Using the example of symptomatic descriptions of depression, Miray reminded her colleagues that it was important to know how people talk about their suffering. To detect when a participant was talking about depression. This is an important skill in culturally competent care (Kleinman & Benson, 2006). Furthermore, the staff encouraged participants to see psychotherapists from their respective countries. This was because foreign illness concepts were not assumed to be among the skillset of Viennese psychotherapists. During my fieldwork, I had accompanied Miray and Aliyah to a health circle in Farsi on the topic of depression. After the class, both mentors told me how the women were surprised to learn about depression because each woman experienced at least one symptom. One woman said to experience all symptoms, thus both mentors recommended her a Farsi speaking psychotherapist. What becomes visible, is the assumed function of translating local illness concepts into the biomedical category of depression. Hereby, mentors tried to promote a mental health concept to their participants, which enabled them to make sense of their suffering and to seek care in the Austrian mental health care landscape.

In the workshop on depression, the staff shared and made sense of their different opinions and experiences. Often, their stories aligned, and distinct cultural variations of the same underlying disease arose. Herewith, the mentors frequently reinforced binary narratives about “Western” and “Eastern” ways of being ill. However, Hakim also addressed the influence of education on symptomatic descriptions. He emphasised that they were not only influenced by culture but by various factors and heterogeneous experiences. By acknowledging this intersectionality, he asked the mentors to consider how “cultural realities, in all their complexity, are lived and experienced” (Mason et al., 2020, p.480). This challenged the assumption that people “belong to a singular ‘culture’ based on their association with a particular nation-state, demographic category, or ‘population’” (Mason et al., 2020, p.477). This also challenged the prior established “Western”/“Eastern” dichotomy of symptom descriptions. However, this does not mean that the role of culture in depression was arbitrary. Instead, what we see are discursive “practices of making and unmaking differences” (Lentz, 2017, p.202). As the workshop went on, it became apparent that the mentors considered cultural values to have a significant impact on the causes of depression.

“I have already listed some causes on the flipchart: trauma, genetics, living conditions, physical illnesses. Which other reasons can you think of that make people depressed?” Miray asked. Jana was the first one to reply: “In Europe, people who suffer from depression often have very high expectations of themselves. When they do not meet them, they get depressed. And for refugees, it’s the living conditions. Having to wait for Asylum, being unemployed and financially unstable. Especially here in Austria being unemployed is very shameful.” The mentors agreed and Samira explained: “It is the same in Syria. Arab men take value from working, so when they come here and cannot work, they feel useless.” Hakim added laughing: “Imagine, it is like being a man in the stone ages who can no longer hunt.” Jana raised her hand appeasing and explained, “Culture does determine value. After fleeing, women still have their mother role. But men are more at risk of developing depression because they lost their role as financial caretakers.”

The exchange highlights that not only the symptoms but also the causes of depression were assumed to be culturally influenced. Culture was assumed to determine values, which influence feelings of worthlessness that can result in depression. Here, the broad cause of “living conditions” allowed the staff to fit their cultural expertise into the existing biomedical classification. Additionally, what becomes apparent is the mentors’ sensitivity to refugees’ unique circumstances. Not being allowed to work, being unsure of one’s future whereabouts, and financial instability put refugees at higher risk for developing depression. The staff at the NGO had a very throughout awareness of these structural influences.

Taken together, the mentors saw depression as a concept that captured very different things. On the one hand, all acknowledged that depression was a biomedical concept, a disease with treatment and culturally informed illness experiences. On the other hand, in their everyday work, the mentors used it as something detached from biomedicine. The term depression made it possible to speak about suffering in an abstract sense. As referenced before, Fassin and Rechtman (2009) provide an extensive historical inquiry into the social and medical co-production of trauma. The authors conclude that trauma today is a “floating signifier”, that is more “serving to identify legitimate victims […], than it is a diagnostic category […]” (Fassin & Rechtman, 2009, p.284). Similarly, I showed how the mentors used depression to give legitimacy to their participants’ various experiences of suffering. To do so they translated culturally informed, *local biologies* into a preestablished biomedical category. This, I argue, obscures participants’ diversity of suffering.

8.5. Culture and Epistemic Violence

As I have demonstrated at the beginning of this chapter, mentors’ national background was usually assumed to equip them with cultural sensitivity. It was understood to be something they automatically acquired while growing up and living in their home country. In this sense, their cultural knowledge was seen as inherent to their national origin. But the following vignette from the workshop challenges this assumption.

We took a short five-minute break. Hakim went into the kitchen to make more black tea and Aliyah left for the office room to pray. Some of the mentors started talking to each other in Arabic, so I tried to catch up with my notes. Then the workshop continued. “We also have to tell them about post-partum depression.” Samira said, “I had this one participant from Syria who struggled to connect with her baby for one year. She told me that it is because someone used magic on her. But I explained to her, no that is not it, you have postpartum depression. The woman was not very educated so she could not know better.” Jana looked at her, making a soothing hand gesture: “It is important to remember that there are different concepts of disease. Do not tell the woman this is nonsense but tell her: ‘This is what you believe, this is what we believe’. In a sense, cultures not against each other but with each other.”

One would assume that cultural sensitivity entails being empathic to patients’ experiences, feelings, and opinions. Still, the use of magic was dismissed as an irrational belief coming from low education. Hereby, the mentor adopted a position of “knowing better”, which made visible the underlying hierarchies of knowledge within health promotion. The analytic concept of *epistemic violence* allows us to inquire about these hierarchies. Petteway (2023) defines epistemic violence as “the manner in which the speaker can have their knowledge dismissed or otherwise be perceived/portrayed as incapable of possessing any relevant/credible knowledge within a given context/exchange (testimonial quieting) - with the audience incapable and/or unwilling to ‘hear’ the speaker’s truths” (p.38). In the described encounter, the Syrian participant was the speaker, testifying her explanation for the disconnect with her child, and the mentor the hearer, who was unwilling to hear the woman’s truth. The mentor hereby engaged in *testimonial quieting*, a mode of epistemic violence that is a central issue in health promotion (Petteway, 2023). In this instance, she dismissed the participant’s local knowledge as irrelevant to the issue at hand. Such practices of epistemic violence may be unintentional, but often underly stereotypic assumptions about whom is knowledgeable (Dotson, 2011). The disregard for magic can be ascribed to the mentor’s situatedness, which follows from her epistemic location with respect to biomedicine. For her, the described symptoms fit a clear disease: postpartum depression. Of course, I have not been present during the encounter recalled and I do not know how the mentor reacted in situ. Still, the way the encounter was described highlights that only because the NGO’s staff shared the same nationality as their participants, this did mean that they were accepting of the respective cultural disease concepts. Instead, at times their health promotion reflected hierarchies of knowledge, which prioritised biomedical explanations over local diseases.

However, Jana’s reminder of how to communicate in such moments made it visible that the NGO’s supervising psychologist tried to challenge such hierarchies of knowledge. She asked Samira to acknowledge different disease concepts and to value them equally. I also want to note that not all mentors shared Samira’s dismissive attitude towards magic. However, it was not possible for me to learn more about the role of magic or ghosts in their health promotion. During the workshop break, I had asked one Afghan mentor about “jinn” (invisible creatures in Islamic belief). I had been told that she would know more about it. However, she did not want to talk about “jinn” and proposed that she could gather information from the participants. The mentor’s reaction and unwillingness to talk about magic might have been a direct result of my timing. Given that her colleague had just attributed magic to low education, it made sense that she did not want to share her understanding of it. Of course, I can only assume that I chose the wrong moment to inquire about the mentor’s cultural expertise. Dotson (2011) labels such withholding of knowledge as *testimonial smothering*. If a speaker feels that the audience is ignorant of their expertise, they may decide to self-silence. This further makes visible how at this moment, biomedical explanations were valued over local disease concepts. This does not mean, that all mentors reinforced this hierarchy in their everyday work. By suggesting that the participants could tell me more about “jinn”, the mentor identified them as knowers but also demarcated herself from this knowledge. After my fieldwork, the NGO’s director told me that the organisation aspired to create a setting, where participants shared their knowledge, gave each other tips, and used the group setting as a resource. The mentors should only take a guiding role. However, as my analysis reveals, in their health promotion, the mentors attributed differing validity to local, culturally informed disease concepts. This in turn influenced their guidance. These divergent hierarchisations of knowledge were based on their subjectivities, which also became visible when the topic of religion came up.

The time for the workshop was almost over. The conference room was booked by another NGO and there was only time for some final thoughts. “So, what can we take away for our work?” Miray asked. Foremostly, the staff decided that it would be important to raise awareness about depression. Moreover, everyone agreed that the organisation could provide a space for participants to talk about their problems. And, that it was the staff’s responsibility to ask why someone is feeling down. Jana added: “You can also make breathing exercises. They are important to cope with fear. And physical touch is also important.” Hakim replied: “This we know already. Prophet Mohammed says that we must always touch each other, that it is very important to touch the head and the body.” Miray affirmed him, but Samira looked at Hakim, shrugging her shoulders: “I have this participant, and she is really struggling, she has a lot of stress and burdens. And she always says she wants to visit Mecca to get well. And I asked her: would you go to Mecca with a broken arm? She replied no. So, I told her: then you should also not go to Mecca with depression.”

When the staff’s discussion moved on to the topic of religion, friction became apparent. In one case religion was seen as a resource for medical care practices. There was no necessity to teach Muslim mentors that touch was important. Prophet Mohammed had already taught them. However, when a woman wanted to heal her depression at Mecca, Samira saw it as a distraction to proper treatment. Hereby, she failed to recognise the participant’s understanding of the illness. As mentioned previously in this chapter, participants often sought guidance and asked whether certain practices were “haram” or “halal”. During my presentation of the preliminary analysis, Samira told me that these heated discussions often took up too much time in her health circles. Her remark was quickly opposed by Miray, who explained that many women found themselves more relaxed after prayer. In this instance, religion constituted a resource for mental health promotion. When considering this friction of religion as a resource vs. a distraction to proper treatment, the mentors’ subjectivities become visible. Mentors’ advice was as much shaped by their biomedical expertise, as by their experiences, personal opinions and beliefs. Therefore, at times hierarchies of knowledge remained firmly in place, devaluing participants understanding. What remained at stake in their health promotion was the participants' "moral meaning of suffering" (Kleinman & Benson, 2006, p.1676). What did the Syrian woman, who struggled with her mental health, gain when told to see a psychotherapist instead of Mecca? And what did she lose? What were the moral meanings she ascribed to her suffering? Samira did not address these questions. Neither can I, because I have never met the woman. Still, such inquiries allow us to pinpoint why cultural sensitivity matters in health promotion. When the goal is to promote mental well-being, it is essential to understand what this constitutes.

8.6. Discussion on Culture

In this chapter, I outlined how the various actors at the NGO understood and used culture consciously and unconsciously. Through close analysis, I set out to inquire what these varying understandings allowed to do, what they made visible and what they hid. Similarly, to Kehr's (2018) thoughts on culturally competent care at a French hospital, I claim that the NGO's "attempts to be sensitive to cultural difference […] were ambivalent affairs" (Kehr, 2018, p.665). The mentors aimed to promote health information in a culturally informed manner. I showed how in doing so they created specific notions of "the other". Sometimes essentialist approaches to culture became a resource to offer low-threshold health promotion. Other times cultural knowledge was disregarded, and the moral meanings participants attached to their suffering remained unnoticed.

The organisation's mentors, who were refugees, saw culture as something static, a set of attitudes and behaviours that can be ascribed to certain groups of people, often defined through national borders. Hereby, they often "unintentionally slid into cultural essentialism" (Kehr, 2018, p.665). However, I argue that this allowed them to make differences in behaviour visible and attitudes understandable. For example, mentors validated participants' experience that parenting was done differently in Austria, than in Ukraine, Somalia, Syria, or Afghanistan. Furthermore, mentors hereby evaded the moralisation of health-related behaviours when they or participants did not adopt them. Moreover, stereotypic assumptions about attitudes toward trauma led mentors to refrain from using diagnostic labels. In doing so, they aimed to create a workshop setting that was free from the stigma that a diagnosis brings. On the contrary, the NGO’s director and supervising psychotherapist, who both have longstanding experience with international and humanitarian health care, avoided and explicitly rejected such cultural essentialism. They understood culture not as fixed, but as “[…] lived and experienced” (Mason et al., 2020, p.480). Hereby, they unmade differences between groups and rather focused on the individual level. While the directors and the supervising psychotherapists tried to reduce stereotypes with their approach, the mentors actively constructed them to use as resources.

I further set out to understand the relationship between culture and biomedicine in the NGO’s health promotion [Gesundheitsförderung]. To do so, I applied Arthur Kleinman’s (1988) concept of illness narratives. This made visible how the mentors differentiated between disease as something strictly biomedical and illness as the multiple, culturally informed, experiences of living with disease. I further investigated the hierarchies of knowledge in the mentors’ health promotion. Often, biomedical explanations were valued over local disease concepts, such as magic. As a result, local biologies (Lock & Kaufert, 2001) were translated into presumed universal, biomedical, categories. On the one hand, this allowed the NGO’s staff to validate participants suffering and to aid them navigate the Austrian healthcare landscape. On the other hand, this practice failed to address participants’ moral meaning of suffering and to ask what is at stake. This challenges the assumption that shared nationality equals sensitivity to the respective cultural understandings of illness. Being familiar with something can also entail being critical of it. Mentors’ subjectivities thus played an important role in their health promotion.

9. Conclusion

With this thesis, I set out to tell a story about refugees’ and migrants’ access to health information and care in the Austrian context. In Austria, migration is generally addressed through politics of exclusion, that result in restrictive laws limiting migrants’ rights to work and reside in the country (Krzyżanowski & Wodak, 2009). Refugees from the Middle East and African countries are often portrayed as problem communities that need to be controlled whether in their entry by closing migratory routes or in their assumed religious beliefs by banning face coverings (Hafez, 2022). Yet, in this web of exclusionary political practices, Austrian healthcare politics appear to be an exception (Spahl, 2022). The Austrian healthcare system is a solidarity-based scheme financed through income-related contributions. In this system, forced migrants hold the same rights as Austrian citizens. Asylum applicants are granted basic services [Grundversorgung] after filing their claim for refugee status, which among other rights entails health insurance. The Austrian healthcare system can therefore be understood as a form of political inclusion and an opportunity for migrants to build trust with state institutions (Spahl, 2022).

However, as I outlined and argued in this thesis, these practices of inclusion coexist with various barriers to accessing health care. Practitioners draw on racial and cultural stereotypes, creating distinct ideas about whom is ill and deserving of their care (Johnson et al., 2009; Kehr, 2018; Kohlenberger et al., 2019; Sahraoui & Malakasis, 2020). Research has shown that forced migrants who have experienced war and flight are particularly vulnerable in terms of their mental health (Castañeda et al., 2015; Sargent & Larchanché, 2011; Steel et al., 2011). Yet in Austria, a country where in 2022 more than 199.000 people sought protection, psychotherapy spaces with translators are rare, and waiting lists are long. The Austrian state outsources its responsibility to care for refugees and other particularly vulnerable groups to non-governmental organisations (Seidler et al., 2019). These, in turn, are supposed to care for those the state does not provide for. And although the interventions are made possible through government funding, NGOs cannot offer support unconditionally but must keep finding and applying for new grants. In other words, as my thesis makes explicit, a lack and outsourcing of focused mental health offers exclude migrant patients from the care they are formally entitled to. With this web of barriers and the outsourcing of care responsibilities in mind, it becomes clear that in Austria’s officially inclusive healthcare system, practices of exclusion persist.

Within this context, I studied an Austrian NGO that offered low-threshold, intercultural health promotion for migrants and refugees [niederschwellige, interkulturelle Gesundheitsförderung]. I understand the NGO as a place of the “otherwise”, a space where health promotion was re-imagined (Kehr, 2020). This, for instance, took shape in the sole employment of refugees as mentors who offered health promotion in their native languages. Drawing on two months of ethnographic fieldwork, this thesis argues that the NGO sought to implement inclusion on two levels: through infrastructural practices that enable low-threshold and by drawing on different notions of culture to foster cultural sensitivity.

9.1. Infrastructuring

With this thesis, I demonstrated how the NGO navigated its position somewhere in between the Austrian healthcare system, public institutions, and migrants, through a series of infrastructuring practices that seek to make health care more inclusive. Drawing on anthropological and STS literature (Jiménez, 2014; Larkin, 2013; Vertesi, 2014), I conceptualized the NGO as an infrastructure of care, arguing that its infrastructuring practices cannot be disconnected from the goal of caring for migrants and refugees. By focusing on how low-threshold health promotion was realised, I illustrated how various infrastructuring practices, such as meetings, posters, or simply listening, underly the ambition of counteracting exclusionary practices restricting migrants' access to information and health care. Mainly funded by the Austrian state, the NGO was able to offer its health promotion free of cost for participants. Furthermore, the NGO reached out to potential participants, collaborating with various institutions, and adapting their programmes' location to participants' needs, being flexible to hold them at participants' homes, the NGO's office, schools, or refugee shelters. Based on these constant adjustments, I conceptualised the NGO's infrastructure as in beta, always adapting, never reaching a finalised version (Jiménez, 2014). This allowed me to show how the organisation adapted to both changes in the refugee population and changes in funding. With this, I argue that there was no "finished" version of the NGO, it was always in the making.

As many infrastructuring practices sought to overcome structural barriers, I described them in terms of structural competence (Metzl & Hansen, 2014). In line with the staff's ascribed importance of facilitating low threshold, with this thesis, I propose that structural competence can be understood in terms of *(infra)structuring competence*, the ability to find ad hoc solutions to align heterogeneous infrastructures. For instance, the staff aligned the NGO’s infrastructure of care with public infrastructures (e.g., child welfare office, schools) and other NGOs’ infrastructures (e.g., shelters, mother-baby facilities) to get in touch with the target group.

Further, I take the position, that the NGO’s infrastructural practices make visible how the Austrian state fails to provide sufficient health care for migrants. The staff had to collaborate with public institutions (e.g., schools, child welfare office) to reach the target group. I suggest that this exposes that the state has access to vulnerable groups but does not provide them with adequate health care, instead outsourcing responsibilities to NGOs. This, I argue, resulted in an entanglement of public and third-sector infrastructures, making the NGO dependent on funding structures by the state. Further, I argue that by collaborating with state institutions, which operate through politics of exclusion, frictions arose. When potential participants were informed by the child welfare office about the NGO’s health promotion, they became wary that the NGO was a covert collaborator of the state and at times refused to take part. On the one hand, I claim that this makes visible how migrants and refugees experience the child welfare office as an institution that harms rather than aids them. And on the other hand, I argue that it shows how a singular infrastructuring practice can simultaneously facilitate inclusion and exclusion. Paradoxically, while the NGO was able to offer low-threshold health promotion by cooperating with the state, it was exactly this infrastructural alignment that led participants to refuse its offers.

9.2. Culture

In addition, this thesis contributes to the academic debate on how cultural sensitivity shapes inclusionary health care (Kehr, 2018; Kleinman & Benson, 2006; Santiago-Irizarry, 1996). Specifically, I traced how the NGO’s staff attempted to make sense of what wass deemed culturally appropriate and acceptable health information. In the NGO, professionals were peers, they were refugees from Syria, Afghanistan, Somalia, Ukraine, and Chechenia. And as peers, in the NGO’s everyday work, they took on the role of a representative of their nation. They asked each other, how do Somalis understand depression? How do Afghans think about trauma? I argue that in these moments, the distinction between culture and nationality became blurred. And through this representative role, in which mentors were reduced to their national background, and asked to speak for a whole nation, essentialist notions about culture arose. With this thesis, I argue that attention to culture simultaneously makes for inclusive and exclusive health promotion.

On the one hand, the resulting cultural assumptions about people with a shared nationality influenced the way health information was communicated, aiming to enable more inclusive health promotion. For instance, I outlined how mentors insisted on the term “trauma” being deeply stigmatised in “Eastern” culture. While the Austrian title of the NGO’s trauma workshop included “trauma”, the term was not translated into its Somali, Arab, Dari, or Farsi title due to the fear that the target group would not participate in a trauma workshop. Thus, I argue that essentialist notions of culture were used to inform and implement inclusionary health promotion that embraced participants’ assumed cultural values and norms. Further, I argue that the NGO unmade patients by refraining from using the biomedical diagnostic label trauma in its health promotion (Kienzler, 2020).

On the other hand, however, I revealed how assumptions about culture can become practices of exclusion. Drawing on Kleinman’s concept of illness narratives (1988), I outlined how the NGO’s staff differentiated between biomedical (disease) and cultural knowledge (illness). When participants attributed their suffering to magic practices, some mentors dismissed their claims as cultural, coming from low education, and instead provided biomedical explanations. I argue that in these moments, a hierarchisation of knowledge becomes visible, through which we can observe mentors’ subjectivities (Dotson, 2011). It becomes evident that some mentors did not accept participants with low education as knowers, describing them as “the other” who cannot know better. Therefore, I argue that in peer-led health promotion, problematic notions of “the other” can arise, a practice of exclusion that regards cultural knowledge as irrelevant to mental well-being. In these moments, I claim, participants’ moral meaning of suffering remains unnoticed. Furthermore, my analysis challenges the assumption that shared nationality necessarily always translates into sensitivity to culturally informed understandings of illness. This follows Kleinman and Benson’s (2006) critique of cultural competence, which rejects notions in which culture is "made synonymous with ethnicity, nationality, and language" (p.1673). Taken together, I argue that attention to culture simultaneously makes for inclusive and exclusive health promotion.

9.3. Further Outlook

My research offers a glimpse into how an NGO collaborated with and depended upon state infrastructures in its attempt to take care of those the state failed to care for. In my fieldwork, I observed the doings of a singular NGO, predominantly studying its staff's perceptions. Therefore, it would be valuable for future research to focus on how these levels are perceived and actively shaped by migrants and refugees, those who are ultimately affected by mechanisms of inclusion and exclusion.

Perhaps, the final question to answer is how can we think about culture and infrastructuring in relation? I argue that infrastructuring practices and notions of culture are deeply entangled with the goal of offering low-threshold health promotion. Claims about culture are used to navigate differences between "Western" and "Eastern" habits and norms, biomedicine, and magic. The NGO's staff moved between various worlds, negotiating, and acknowledging but also creating differences. Infrastructuring practices created alignment between the NGO and public institutions, the state, and other NGOs. These infrastructural collaborations facilitated inclusion, yet simultaneously exclusion occurred.

With this thesis, I hence argue that it is useful to analyse culture and infrastructure as levels on which inclusion and exclusion are negotiated. In the end, in low-threshold health promotion, some boundaries are dismantled through efforts of infrastructuring and cultural sensitivity, and inclusion becomes crafted, yet other boundaries arise, and exclusion takes shape. In tracing and disentangling these contradictions, this thesis has made explicit that practices aimed at inclusion, whether cultural or structural, are not straightforward but rather produce and co-exist with mechanisms of exclusion.

Therefore, I would like to suggest that we reconsider whether cultural competence should be abandoned in favour of structural competence. Perhaps, it is useful to recognise that both approaches are not without flaws, but that they rather offer two entry points to address different, at times intersecting, causes of suffering.

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