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Vulnerability in health literacy: Racialization, gender, and disability in welfare-state spaces

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This linguistic ethnography compares discourses circulating among civil servants in Norway's public health and welfare system with the lived experiences of migrant women living with disabilities. The article investigates how discourses and experiences of vulnerability influence organizational and subjective health literacies. Vulnerability emerges as a dual phenomenon: i) a structural phenomenon, discursively racializing, gendering, and disabling subjects and ii) a collective, relational, and deeply embodied experience illuminating the universal nature of vulnerability as a human phenomenon. The first form of vulnerability sheds light on discursively structured inequalities in health and welfare spaces, and the ways that multiple social factors increase subjects' exposure to health-related risk through lack of access to health information. Moreover, normalizing discourses of vulnerability produce and order knowledge hierarchies, adding more value to scientific, state-directed information than diverse and experiential health literacies. When internalized by subjects rendered vulnerable (in this case migrant women living with disabilities), such discourses may further victimize, pacify, isolate, and exclude, thus obstructing rather than enabling subjects to enact more relevant health literacies for themselves. The second form of vulnerability identified in the study, sheds light on vulnerable experiences not as marginalizing, but universal. Such experiences of vulnerability enable novel forms of microlevel agency – wiggle room – *to recast existing knowledge hierarchies and pursue more relevant literacies. A deeper exploration into discourses of vulnerability will contribute to the undressing of epistemic injustices that regulate subjective and organizational health literacies at the intersection of migration and disability in Norwegian welfare and beyond.*

Keywords: ***health literacy; vulnerability; racialization; gender; affect; wiggle room.***

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1 Introduction

The notion of vulnerability has gained traction in recent research, policy, and practice in welfare and healthcare contexts (e.g., Virokannas et al., 2020; Peterie et al., 2021). This linguistic ethnography (see e.g., Copland & Creese, 2015) investigates how vulnerability manifests in discourses circulating in the Norwegian health and welfare system at a time of increased diversity. Exploring interactions between migrant women on long-term sick leave and their caseworkers at the welfare office, as well as the discourses of civil servants at different levels of the welfare and healthcare system, the study asks about the relationship between health literacy and vulnerability in discourses and lived experience in the welfare state.

Health literacy is defined as "people's knowledge, motivation and competences to access, understand, appraise, and apply health information in order to make judgments and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course" (Sørensen et al., 2012, p. 3). Because vulnerability is often viewed as a self-evident and, to some extent, static category assigned to specific groups or people (due to their vulnerability in the nation-state and global contexts), scholars argue the vulnerability label has stigmatizing, victimizing, and top-down effects (Virokannas et al., 2020, pp. 335–336; Butler et al., 2016). Meanwhile, "[o]nly rarely does academic research or policy making ask about the respondents' own definitions of vulnerability" (Honkasalo, 2018, p. 10).

Building on recent developments in the vulnerability research (see e.g., Butler et al., 2016; Virokannas et al., 2020), this study explores vulnerability as a phenomenon that may be *imposed* (McAllister, 2024), but which may also be universal and relational (Butler et al., 2016). The jurist Fineman (2010, p. 267) defines vulnerability as that which "arises from our embodiment, which carries with it the imminent or ever-present possibility of harm, injury, and misfortune." Some bodies are more exposed to harm than others (due to war, citizenship status, climate crisis, socio-economic status, and social categorizations of gender, race, and ability) – what I have previously examined as what Bourgois et al. (2017) refer to as *structural vulnerability* (see Valen-Sendstad, 2023). Meanwhile, vulnerability is also a fundamentally human, and therefore relational experience (Virokannas et al., 2020, p. 236). Centrally, vulnerability is about both the "individual position" and the "institution relationships" of subjects and the state (Fineman, 2010, p. 269).

Following Fineman, social work scholars Virokannas et al. (2020, p. 236) call for a deeper exploration into "the temporal, situational, relational and structural nature of vulnerability" in "life situations, social processes, society and its institutions, including social work and the entire welfare service system." Crucially, this approach encourages a move away from viewing vulnerability as a fixed category or process of marginalization alone toward viewing vulnerability as a fluid, ever-changing phenomenon, and an essential aspect of human nature and relationships. By exploring the relationship between vulnerability and health literacy in the Nordic welfare state, my study seeks to respond to this call.

This sociolinguistic study interrogates social and discursive processes of vulnerability through the analytical lens of health literacy. I analyze the ethnographic data material I co-constructed with civil servants at different levels in the welfare system, with women with migrant backgrounds living with disabilities in Norway's welfare state, and in my own ethnographic fieldnotes. This analysis involves a systematic tracing and comparison of how vulnerability figures in the discourses of civil servants and migrant women navigating the welfare system at the interface of sociopolitical processes of immigration, gender, and dis/ability. The article combines recent theoretical innovations to understand how affective discourses (Wetherell, 2012) are produced and reproduced across different scales (see e.g., Gal & Irvine, 2019) in the welfare and healthcare system – across subjective experience and the broader institutional discourses of the state.

2 The biopolitics of health literacy

2.1 Health literacy in a sociopolitical context

Health literacy is a crucial term in public health initiatives and has, moreover, been central to the Norwegian policy landscape since before the official outbreak of the COVID-19 pandemic (Ministry of Health and Care Services, 2019). Health literacy is considered an individual ability but also increasingly "an organization-wide effort to make it easier for people to navigate, understand, and use information and services to take care of their health" (Farmanova et al., 2018, p. 1). Indeed, *organizational health literacy* addresses the intersection of individual literacies with organizational systems (Pelikan, 2019), thus addressing the complexity of health literacy as a layered literacy activity, co-constructed from different perspectives, at different scales, and for different purposes.

Reorientations toward viewing literacy generally and health literacy specifically as socially embedded activities has important implications for health literacy. The linguist Barton (2007, p. 29) has proposed an *ecological approach* to literacy as a model for examining the "interaction between individuals and their environments." While the social context of health literacy activities is increasingly addressed in research and policy, compliance with state-provided information and expertise remains a crucial aspect of health literacy and interventions. Social scientist Samerski (2019, pp. 1–2) has argued that health literacy theory continues to expect patients to act as rational decision-makers, rather than social subjects relying on a multitude of experiences, knowledges, and relationships as part of caring for their own health.

By prioritizing rational choice and scientific, state-directed intervention, one may neglect the situated, culturally bound health knowledges passed down in local communities (Samerski, 2019, p. 4; Dutta, 2010). Indeed, a dimension of health literacy that "has not yet been adequately studied" is how individuals "struggled to find health information that fitted their experience and recognition in the medical system" (Samerski, 2019, p. 7). There is a need to forefront the experiential and cultural complexities that play into health literacy.

As I have illuminated elsewhere (Valen-Sendstad, 2024), health literacy unfolds within institutional norm systems and ideological frameworks, becoming part and parcel of broader, socially scripted processes. Besides, state-citizen interactions imply navigating rigid, complex, and sometimes contradictory norms. Drawing on Foucault's extensive scholarship of normalcy and discipline, the sociolinguistic researcher Hanell (2017, p. 233) has argued that being healthy, and moreover being perceived as such, is historically considered both an *imperative* and a "civic duty." Moreover, the critical health communication scholar Dutta (2010) has argued that the efficiency, relevance, and ideological neutrality of scientific claims and health interventions should always be critically examined.

Recent sociolinguistic research in the Scandinavian context has demonstrated that state-directed health advice may be imbued with a racializing logic and politicized ideals. To take but a few examples, Karrebæk's (2012) research has explored how pupils of multicultural backgrounds in Denmark were encouraged to eat what was considered normatively healthy diets. The child's choice to eat healthily, say rye bread, was established as a "moral standard in that it is treated as the right choice, the good choice, the choice that positions the child as a respectable individual" (Karrebæk, 2012, p. 5). Similarly, Milani et al. (2021, pp. 763–766) have explored how Swedish integration programs encouraged participants to learn 'appropriate' dietary practices according to national advice (eating whole-meal bread and fruit, drinking enough water). These scholars shed light on how discourses of healthy lifestyles converge with racialized discourses about what counts as legitimate in the context of integration politics.

2.2 Vulnerability in health literacy

As illuminated in the previous section, the state's promotion of scientifically sound and healthy advice may imply moral and normative pressures along racialized lines. Such advice may also, as illustrated by Hanell (2017), have gendering effects. New mothers in Sweden experienced moral transgression – failure to perform motherhood – when unable to breastfeed and thereby meet national health advice and expertise (Hanell, 2017). Hanell's (2017) research spotlights how failure to act in accordance with state directions may elicit shame in citizen-subjects performing tasks that are also deeply personal and bodily. As argued by the feminist philosopher Dolezal (2015, p. 573), "shame is frequently, if not inevitably, a feature of the clinical encounter" because of the "inherent vulnerability of the body coupled with the stigma that is often attached to illness" and, we may add, health.

Vulnerability is connected to health literacy in various ways. Marginalized groups, positioned in different ways within overlapping power structures (e.g., immigration and citizenship status, socioeconomic factors, language barriers, diagnosis, compromised immunity, and so forth), are at risk of having vulnerabilities externally *imposed* on them (McAllister, 2024, p. 5). This may lead to *structural vulnerability,* namely the "condition of being at risk for negative health outcomes through their interface with ... multiple overlapping and mutually reinforcing power hierarchies" that "constrain their ability to access health care and pursue healthy lifestyles" (Bourgois et al., 2017, p. 300). Besides, Brown et al. (2014, pp. 267–268) argue, when individual literacy is not adequately addressed in public health initiatives, this may reinforce their vulnerable status in society.

Moreover, in a broad study of migrant populations' health literacy in Norway, Le et al. (2021, p. 97) have argued that the migrant status itself is a relative factor of being vulnerable to poor health, sometimes correlating with low socioeconomic status, inaccessibility of services, and susceptibility to viruses and infection (such as COVID-19). Meanwhile, a review of organizational health literacy has shown that "limited health literacy is viewed as a vulnerability that coexists and interacts with other social vulnerabilities" (Farmanova et al., 2018, p. 4).

Proficient health literacy, on the flipside, is associated with empowerment in the research literature. According to the health literacy advocate Nutbeam (1998, p. 357), "health literacy means more than being able to read pamphlets and make appointments." Proficient health literacy may, moreover, lead to "critical to empowerment" (Nutbeam, 1998, p. 357). Individual empowerment and resilience are often considered prevalent goals in public health initiatives in their own right (see e.g., Ziglio, 2017), but the growing emphasis on individual empowerment is influenced by rationality and market-oriented neoliberal ideals (Ylvisaker & Rugkåsa, 2021, p. 2). Vulnerability, meanwhile, is frequently associated with a lack of control and agency (Honkasalo, 2018, p. 1), depicting both vulnerability and empowerment as static phenomena.

The critical theorists Butler, Gambetti, and Sabsay (2016, p. 1) question the "basic assumption that vulnerability and resistance are mutually oppositional." Instead, they seek to unravel discursive binaries of resilience that depict vulnerable subjects as passive and victimized, proposing that resistance encompasses, even hinges on vulnerability (Butler et al., 2016). Accordingly, Butler et al. (2016) argue that vulnerability and resilience are not oppositional, but part of the same continuum as relational qualities emerging *between* people, rather than psychological qualities residing *within* us. This relationality sheds light on "new modes of collective agency that do not deny vulnerability as a resource and that aspire to equality, freedom, and justice" (Butler et al., 2016, p. 7). In the analysis, I explore discourses of structural vulnerability, but also experiences of vulnerability as a source of collective agency in welfare-state spaces.

3 A discursive approach to health literacy

3.1 Normalcy and racialization in health literacy

This article contributes to existing health literacy research by exploring the discursive construction of health literacy at multiple levels in welfare-state spaces – from lived experience to interaction and broader policy. The sociolinguistic scholars Blommaert, Collins, and Slembrouck (2005, p. 2) describe space as "an agentive force in sociolinguistic processes." That is, discourses are not only produced and reproduced by subjects, but also by the spaces that they are (re)produced in, say the welfare system. When discourses of vulnerability are expressed in one context, but refer to another, this is called intertextuality. As explained by Blommaert (2021, p. 379), intertextuality refers to "the meaning effects generated from text-context relationships."

Indeed, "words carry with them histories of use and abuse" which gain and lose value depending on when, where, and how they are expressed (Blommaert, 2007, p. 8). Taking a scalar sociolinguistic approach (Blommaert, 2021), I have explored how discourses of vulnerability in health – or *fractals* – are reproduced at different discursive levels, what we may call *scales* (see Agar, 2005). The anthropological scholar Agar (2005, p. 20) has explained that fractals are iterative when they occur repeatedly, and they follow a recursive logic when these repetitions are used to create new patterns. Agar (2005, p. 20) writes: "The result is that a structure is built up, a structure of patterns at different levels of scale, in which the patterns are produced by repeated applications of a simple algorithm."

When repeated across texts, intertextually, that is, discourses construct and maintain knowledge regimes as taken-for-granted truths (see Valen-Sendstad, 2023, for a discussion on health literacy and doxic truthmaking). The recursive logic leading fractals to create repeated patterns may cause a false sense of normalcy. Through rigorous theoretical and historical research, the medical and linguistic anthropologist Briggs (2024; 2005) has introduced three concepts to provide a deeper understanding of the normalization and, moreover, racialization of health knowledge and communication: *communicability, incommunicability,* and *biocommunicability*. Briggs (2005, pp. 282–283, 287) describes *biocommunicability* as the communicative logic that establishes "categories, subjectivities, and social relations and position people hierarchically within them" – some as producers and experts, others more passively as knowledge receivers.

In recent developments of this theory, Briggs (2024, p. 2) describes communicability as "capable of traveling and invoking a response in others" – communicable disease, yes, but also communication. Referring to the COVID-19 pandemic, Briggs (2024, p. 2) explains that "[t]he promise of communicability is that if health authorities create a sufficiently persuasive, clear, and convincing avalanche of 'messages'" that, if laypeople listen, will mitigate their vulnerability to disease. Processes of communicability, however, do not only hierarchize scientific information over non-expert knowledge, which is often framed as misinformation. Moreover, communicability racializes; Briggs (2005, p. 287) writes: "Persons who assimilate knowledge cognitively and bodily become sanitary or biomedical citizens, whereas those who are judged to fail – often no matter what they say or do – become unsanitary subjects."

3.2 From self-discipline to wiggle room

In other research, I have shown that ideals of clarity in scientific health communication invoked a distinction in migrant subjects that when internalized, in turn rationalizing injustices in welfare systems along gendered and racialized lines (Valen-Sendstad, 2024). According to Foucault (1988), we become subjects through self-discipline. We learn to act in particularized ways, and strive to become more palatable, more 'correct' versions of ourselves in order "to move forward to the future we are supposed to be reaching for (happiness, imagined as what follows living your

life in the right way)" (Ahmed, 2014). Following this social script as a technology, we expect to "transform [ourselves] in order to attain a certain state of happiness" (Foucault, 1988, p. 18).

In the context of health, Foucault (see 2010) invoked the notion of *biopolitics*, namely the disciplinary control, governing, and strategized regulation that the state exercises over subjects' bodies, lives, and wellbeing. To critical theorists, like Foucault, subjective agency is always already regulated by structural conditions. Meanwhile, the micro-ethnographer Erickson (2001) has used the notion of *wiggle room* to show that while interactions are indeed scripted, subjects are not entirely docile: we possess agency to actively work out who we are, and how we want to be seen. In this way, wiggle room as a term may guide us in exploring the complex interplay of subjectification, performance, and agency (Copland & Creese, 2015, p. 3).

The feminist theorist Ahmed (2014) has explored the notion of *wiggle room* to describe microscopic forms of resistance. Ahmed (2014) describes "social categories as rooms" having an agentive force in that they are "giving residence to bodies." The notion of *wiggle room* describes agency in discursive-embodied and spatial terms: the ways that bodies and their movements are constricted by the space with which they have been provided.

Some rooms are tighter than others, limited by norms and overlapping, sociopolitical histories. Some bodies – white, male, able-bodied – fit in seamlessly; borders between their own bodies and their surroundings are barely even visible (Ahmed, 2006, p. 134). Other bodies – gender, racialized, disabled – do not fit into the spaces to which they have been assigned, and are seen as taking up too much space. Every movement is stopped by a wall, that is, seen as non-conforming. Wiggling provides a counter-perspective to Foucauldian theory. Instead of self-correcting to fit in, wiggling is a conscious act *not* to align with the walls of assigned rooms. When we claim "the capacity to deviate … pushing ourselves right out of the room we have been given" (Ahmed, 2014, para. 7), we reach for what Butler et al. (2016, p. 7) call "new forms of embodied political interventions."

Wiggle room permits a deepened exploration of vulnerability as a collective experience that reveals us as "as embodied, social beings who are intimately entangled with various cultural forms" (Pritzker & Perrino 2020, p. 369). Besides, wiggle room provides a framing that moves beyond perspectives of systemic injustice, toward resistance and agency as embodied and affective micro-scale actions in collective spaces. As explained by Wetherell (2012), *affect* is a relational action; it does not emerge internally within us, but interactionally between us. It touches bodies, and it moves them.

Wetherell (2012, p. 52) defines discourse as the "realm of language in action" that is "patterned within the everyday activities of social life." Meanwhile, combining affect and discourse, she proposes *affective practice* as "a moment of recruitment and often synchronous assembling of multimodal resources, including, most crucially, body states" (Wetherell, 2012, p. 159). This article draws on Wetherell's theoretical framing to explore *wiggle room as an affective practice*: a communicative, embodied action of meaning-making that emerge interactionally between people as relationally vulnerable subjects in welfare-state spaces.

4 Methods

This study uses shorter term linguistic ethnography to explore how "macrosocial processes … operate through microsociological encounters or interactions" (Copland & Creese, 2015, p. 17). This approach is informed by discourse analysis, broadly understood as a way of identifying patters of social meaning in speech. The data consists of interactional data, semi-structured interviews, and participant observation generated together with five migrant women on long-term sick leave from work, their caseworkers at the Norwegian Labour and Welfare Administration (from now on referred to as Nav),

and civil servants working with diversity at different levels in Norway's healthcare and welfare system. This study focuses on the data created with three migrant women and two civil servants. The original interviews were conducted in Norwegian, have been transcribed and translated into English.

The linguistic-ethnographic approach is an interpretative process which, through rich description, investigates participants' perspectives on "language as communicative action functioning" in the social context of everyday life (Copland & Creese, 2015, p. 27). As researcher, I sought to tease out how participants (including myself) used language. By way of an emergent thematic approach, I used NVivo to explore the discourses that make up the participants reality in the welfare apparatus, how this reality is shaped by their social and institutional location, and what this can illuminate about the social underpinnings of health literacy.

During the preliminary coding process, I noticed that civil servants described patients with limited linguistic proficiency in Norwegian as "vulnerable" (*sårbare*) – a term that I did not initially go looking for. I began systematically identifying and pulling out sentences where I found this word. I went back to the literature on vulnerability, realizing that vulnerability is often defined as the imposition of risk, causing need for protection, and engendering shame. I noticed that the civil servants described *information* and enhancement of health literacy as means to *protect* vulnerable patients. When reading through the women's data, I noticed that they did not use vulnerability to describe their own lived experience but spoke of shame when experiencing failure to meet expectations in a new linguistic and normative system in Norway.

I began systematically exploring the ways that vulnerability came up in the data, how its definition changed depending on participants' social-institutional positionality. I identified the following nodes: spatial, embodied, hindrance, resource. Through the discourse analysis, I identified the emergence of two forms of vulnerability– *structural vulnerability* and *vulnerability as a resource* – which I give examples of in the results. In the first part of the Analysis section, I analyze how civil servants describe their organization's health literacy, and how organizational health literacy is linked to protection from vulnerability. I show excerpts from conversations with 'Alex', a policy officer, and 'Kim'[1], a civil servant in public healthcare – both of whom are deeply invested in enhancing the accessibility of services for migrant individuals.

In the section part of this section, I show selected excerpts by 'Julia', 'Sara', and 'Laila', including 'Sofia', Laila's boss[2], a woman who herself has migrated to Norway. The second part of the analysis involves more ethnographic richness than the first part, and my own positionality plays a role. I identify as a woman, grew up in a multicultural home in Norway, have lived several years in different countries, learned, and used other languages as part of my everyday life. My background has helped me establish friendships and trust with the participants. However, my privilege as a Norwegian citizen means that I am not in the same position as the participants.

5 Analysis

The analysis compares iterations of vulnerability across different scales of Norway's linguistically diverse public healthcare and welfare system. The analysis is two-pronged, comparing the health literacies of migrants with those of civil servants.

5.1 Organizational health literacies

I begin this section by providing examples of organizational health literacy, and the ways that vulnerability came up in interview when discussing the civil servants' work.

1. Pseudonyms.
2. Pseudonyms.

I hone in on civil servants' enactments of their organization's health literacies to secure the accessibility of public services.

Example 1: Protecting vulnerable patients

Vulnerability was a recurring trope invoked in interviews with civil servants. For example, while discussing the significance of health literacy, Kim explains, "I mean, all patients are vulnerable, but if you in addition have challenges concerning the language or cultural or specific religious considerations…" In this excerpt, Kim recognizes both relational and structural aspects of vulnerability, scaling down from *all* to *particularized* patients, who, through linguistic obstacles are at particular risk. This statement links health literacy to vulnerability. Kim shares,

> Health literacy contains ... that a big part of the Norwegian population might experience problems reading and understanding health information, might experience problems understanding what health personnel are trying to communicate, focus on this idea that one has the right to receive comprehensible information, eh, regardless of, well, health literacy and of course language.

Kim depicts health literacy as a "container" of literacy in the traditional sense of reading and writing abilities, including interactional and language competences. Additionally, this container holds the population's "rights to receive comprehensible information" and implicitly also the organization's legal duties to provide it. Health literacy, according to Kim, entails both individual and organizational efforts. Interestingly, Kim emphasizes not individual competencies but rather the "problem" of lacking information, shedding light on the vitality of the organization's health literacy to provide access. State-provided information plays a crucial role, mentioned 56 times by Kim in our one-hour-long interview.

Similarly, the policy officer Alex mentions information 19 times in our one-hour-long interview. They link health literacy to information, highlighting that during the COVID-19 pandemic, the authorities attempted to "adjust information to different vulnerable groups." Like Kim, Alex proposes lack of linguistic proficiency in the dominant language (Norwegian) – and subsequent lack of access to information – as a central factor, adding to the vulnerability of migrants in Norway's institutional spaces. Meanwhile, Alex explains that during the COVID-19 pandemic, attention was paid to "how information can be adjusted to immigrant populations" as vulnerable groups.

Both Alex and Kim construe health literacies as underpinned by an egalitarian logic of universal rights – a key dimension in models of organizational health literacy (see Farmanova et al., 2018, p. 4), as well as a central aspect of Norway's welfare model. Through iterations of imposed and structural vulnerabilities, Kim and Alex spotlight the urgency of securing the welfare state's egalitarian ideals, which were under severe pressure during the pandemic. Vulnerability as a fractal brings about a recursive logic: the recurring meaning of vulnerability is exposure to external factors of harm, especially concerning contraction of the COVID-19 virus, thus implying vulnerable patients' "need for protection and the strengthening of paternalistic forms of power" (Butler et al., 2016, p. 1).

Alex and Kim are deeply invested in questions of equal access to healthcare services but are discursively constricted. The recurrence of vulnerability here sketches what Peterie et al. (2021, pp. 12–13) refer to as "a sliding doors moment: if the government acted soon enough" vulnerable groups "could be protected." Easy-to-access and readable communication of scientific knowledge is undoubtedly important, not only to reach public health goals and minimize the spread of viruses, but also to offer egalitarian services and to ensure the implementation of democratic principles. However, although state-directed information may protect individuals against health-related risk, prioritizing this form of

information over other forms may imply a biocommunicable logic, which establishes a binary relationship between producers and receivers of legitimate knowledge, as further illustrated in the second example.

Example 2: Reaching vulnerable patients

Kim explains that during the outbreak of the COVID-19 pandemic, "there has been a lot of information-related challenges, right, to reach [people] with information ... and there is also a lot of fear." To solve some of these issues, a "contingency response team … was established for information to the immigrant population", Kim goes on. "I think this has been a massive lesson for the whole of Norway, but, like, for another time too, how to reach [people] out there with information and build this competence." The spatial metaphor of "reaching" echoes what Briggs (2005, p. 283) has called a *bicommunicability chain*: vulnerable bodies are positioned "out there" in the periphery, while experts are "reaching" for them from *in here*. This analogy comes to "draw important distinctions" between people – creating closeness and distance between them – in order to craft an "embodied space (e.g., inside or outside)" – of knowledge centers and peripheries (Pritzker & Perrino, 2021, pp. 366, 381).

The idiom of "reaching" is often used in public discourse to describe communication with a broad audience. Moreover, 'hard-to-reach' groups are known to be particularly inaccessible and at risk for a variety of reasons, including language, health, socioeconomic and political status. The Norwegian idiom *utenforskap* describes the state of being excluded or displaced, i.e., metaphorically existing in the outskirts of society.

Alex too explains that public institutions have collaborated with organizations and professionals "who can act as ambassadors outward, and additionally, one must produce adapted information that can reach [people] out there." "Ambassadors" are situated on the *inside* of the knowledge center, and are "supposed to work here under the tutelage of knowledge producers … [from a] loci of reproduction, translation, popularization, and transmission" (Briggs, 2005, p. 282) in order to reach people "out there." When I ask Kim why it is important to translate information, Kim replies, "I mean, reaching [people] out [there], who do not understand Norwegian, that is important, though ((laughter))." Later in the same conversation, Kim shares,

> It seems that ... there is no understanding of the fact that there are people in this country of ours who do not actually speak … Norwegian well enough to understand information in Norwegian, there are people who can't read Norwegian, and it is just like I think several [people] have had an aha moment, because- also the Directorate of Health, that, 'oh right, we need to reach them, too, and well, how do we do that?', they have almost been so honest that … 'we don't know exactly how we can reach those who do not speak Norwegian' ((laughter)).

Through "rapid shifting between spatiotemporal frames" of "directionality and distance" (Pritzker & Perrino, 2021, pp. 381, 378), Kim situates people who do not "speak Norwegian well," nor "read Norwegian" as "out there" – further away from the knowledge center.

Alex explains: "In Norway, there is maybe a bit of a different situation than in other countries in Europe, m, based on all the conditions that we have adjusted to here in Norway." They then continue, "But you see that it is still very difficult to reach ((laughter)) the population, right, and thinking about this- and it's simply about understanding- and where does one actually find the right information, right?" Here, Alex up-scales by placing the health-political project of health literacy in a broader sociopolitical context. They then leave the position of the expert insider, reflecting on the perspective of the population:

> So, we feel that much has been done from the authorities' side, but then this may be perceived completely differently out there, and it is the way that health messages are

> communicated out which then actually are understood out there, [this] is about health literacy, both at the system level, but also from the population's standpoint.

Alex describes health literacy as a situated interpretation process – one that is "differently scoped and valued" (Blommaert, 2021, p. 379) depending on the "sides" and "standpoints" from which it is practiced – thus further deepening this inside/outside model. In this explanation, state-provided "health messages" are "communicated out" but are themselves ultimately seen as unchanged – "so decontextualized that [they] can travel between texts and countries without losing [their] stability, meaning, transparency, and authority" (Briggs, 2003, p. 282). By establishing an inside and an outside, this model may also pattern a knowledge hierarchy that on the one hand prioritizes the advice of the authorities, on the other hand overlooking the diversity of subjective knowledges.

Blommaert (2021, p. 375) describes this kind of reiteration as a *scope of communicability*, that is a "*value*, distinction, quality in the sociolinguistic field, which is a vertical image of stratification," in which "[e]very difference in scope is likely to be accompanied by a difference in value." Through discursive repetition, the value of information may overshadow the value of the diversity of health knowledges and literacies that exist in these knowledge regimes. Moreover, while discourses of structural vulnerability enable Kim and Alex to shed light on the power structures that marginalize some social groups, such discourses may also provide them with limited wiggle room to describe their work within a more nuanced discursive framework.

5.2 Subjective health literacies

In the second part of this analysis, I explore the ethnographic data that I co-constructed with three women clients at Nav, all of whom have migrant backgrounds and are living with disabilities. Their stories, and our interactions, shed light on the imposition of structural vulnerabilities, through which their health literacies are constricted, but also relational vulnerabilities, enabling new potentialities for agency to create wiggle room in spaces that are otherwise experienced as normalizing and disciplining.

Example 4: Vulnerable bodies

Laila has lived in Norway on and off for a few decades. Her past is affected by war and forced migration, but she describes her current life as happy and stable. Laila talks about family and friends in affectionate terms and pulls up her phone to show me photos from festive occasions. Besides, Laila loves her job and describes her colleagues as a second family. Her boss, Sofia, describes Laila as talented and motivated, but lately things have changed. Laila has started forgetting things. She is tired and easily distracted. Laila's doctor has advised her to take some time off from work, but Laila would prefer to keep her routine and frequent contact with her network, and Sofia agrees.

In our interview, Laila is in disarray. She centers on affective and bodily states to put words on how she is feeling. Over coffee in a private room at her workplace, I return to something that Laila has mentioned earlier,

> Ingvild: Do you think a lot about what happened when you were little?
> Laila: Yeah, I can't forget, never. I try to forget, but it does not go away. Eh, almost my head, when you fill up that cup, it pours up. Yeah, I have become like that. Mhm.
> I: That you feel like it overflows?
> L: Mhm, yeah.
> I: Do you often get sad?
> L: All the time. Now I am laughing, and I talk, but I ((unclear, long pause)) I cry almost every day before I go to bed.
> I: Was it always like that, or=

> L: =it has become like that.
> I: Was it always like that?
> L: Yeah, it is four-five months.
> I: But before that, tho- it was going well?
> L: Yeah, I was be- very well, I had problems with my head and such. Pain and stuff. But it wasn't like that during that period.
> I: Do you talk a lot about your memories with your (health professional)?
> L: Yeah, mhm, I must.
> I: Does that make you sad?
> L: Yeah, when I talk about for instance my family and about war and those things … you know, if one has a lot of problems, because [I] cannot forget, over time, you know.

This sequence has a visceral quality. Laila and I co-construct an embodied trope, in which Laila's head is depicted as a cup, brimming with difficult memories, soon to be "overflowing." In the words of Busch (2021, p. 195), "[w]hat cannot be verbalised can manifest itself as a somatic symptom." This "embodied rhetoric" (Pritzker & Perrino, 2021, p. 381) maps Laila's vulnerable state onto her body. Laila speaks in a soft, smiling voice, and she points out that her emotional expression collides with what she considers to be her authentic emotional state.

In my own fieldnotes, I have jotted the following down: "She talks a lot about this, her brain, which has stopped working, describes it as a brim-full glass. Points to her cup" – which is placed on the table in front of her. What makes this embodied trope so conspicuous, is that it illuminates how Laila's memories occupy space, which can no longer be used anything else. Laila's focus and cognition is constricted by her current health state, threatening to overflow. In my fieldnotes, I observe,

> She struggles with her eyes, says that it hurts, and she can't see. She also shows me a book that she has read, a (diagnosis) book that (health professional) recommended her to read. But she does not find that it helps.

Invoking the Norwegian trope of *slite* – directly translated into English as *wear* or *tear*, but often used to describe a struggle – I reflect on Laila's particular wording as an expression of experienced failure to meet normative expectations in clinical encounters. Her doctor presents her with one possible solution, but she is unable to make use of it. My fieldnotes and our conversations shed light on how health information becomes part and parcel of "[c]ultural models … understood as culturally available (though not necessarily always shared) ideals" in turn "entrenched in bodies" in ways that may produce "stress and suffering when the ideals they uphold are in some way unachievable or when they pull us in too many directions at once" (Pritzker & Perrino, 2021, p. 368). Laila experiences what Blommaert (2007, p. 8–9) has called *intertextual asymmetry* in her encounter with her health professional, in which generalized health intervention through provision of expert health advice proved less subjectively relevant to Laila (see Dutta, 2010, p. 537).

Being unable to comply with her health provider's recommendations may lead Laila to fear being "branded as [an] unsanitary [subject] who lack[s] the capacity to take care of [herself] and understand medical recommendations," thus risking being "placed beyond the reach and responsibility of the state" (Hanell, 2017, p. 235). Laila goes on,

> I read the books I borrow … I get from the library. A dictionary for instance, I have it at home, I read. But I forget right away when I read. Don't know why. So I have asked (the health professional) yesterday. I said, 'maybe I have Alzheimer's?' He said, 'you shouldn't think about that. You have- you are young.' I am- I don't think that. But…

Laila is encouraged to "stick to the script" of health information, which seems to hinder her from "taking [her] somatic knowledge seriously" (Samerski, 2019, p. 7). Indeed, Laila

wishes to read books – a technology to "discipline her own body and exhibit control" (Hanell 2017, p. 242) – even when it does not enable her to take care of her health. Toward the end of this reconstructed conversation, Laila proposes a self-diagnosis, but her suggestion is dismissed, and after this, her voice trails off.

Example 5: vulnerability as an isolating experience

Normativity came up more directly in a conversation with another focal participant in my study, Sara. Sara migrated to Norway about a decade ago. Her life in Norway has been turbulent, and she has endured several periods of severe infirmity. She grew up in a marginalized family in her home country and has frequently felt out of place. Ethnolinguistic difference and language obstacles figure prominently in Sara's stories from childhood onwards into her life in Norway (see Valen-Sendstad, 2024, for a detailed analysis of Sara's narratives). Sara explains,

> some people think that everyone comes as a refugee, they come from very poor, they imagine (unclear) that they come from poor, without a sofa, without a table, without (unclear). Maybe that is just how people imagine it to be when you think about refugees, or others that come here. Because (name) said once, 'do you sit on a sofa in (country)?' I just, 'yes.'

The presumed truism (that all migrants are poor) in the reported interlocutor's question recruits Sara into an affective response. She reiterates, "I just 'okay'. So, what to answer to that? 'Do you use toilet paper?' Okay? It is, like, childish, I don't know, mean? Or like, okay, this is lack of knowledge." Her interlocutor's questions are glued together with a recurring "history that 'sticks,' and which does not need to be declared" (Ahmed, 2004, p. 127). Without anything being spelled out, the interlocutor's question is inadvertently about more than toilet paper; it is about the deemed appropriateness of some hygiene practices over others, which, moreover, stick to racialized fractals, and to conceptions about socioeconomic class. We can gauge the value that Sara assigns to these questions by virtue of the affectivity of her reaction: Sara labels her interlocutor as "childish", even "mean" for asking.

This constructed dialogue indicates fractal recursivity; while using toilet paper may in some places be considered less hygienic than using water (e.g., in much of Asia), it is often considered the normative choice in Norway. This recounted interaction, in other words, illuminates some normative underpinnings of health literacy. Individuals acquire and lose health literacies, and learn to adjust to new ones, when they move from one place to another, an inherent "part of the experience of migration and diaspora" (Blommaert, 2007, p. 2). Sara's response to her interlocutor's question as offensive suggests that the sticky nature of toilet paper produces a *social distinction* (Bourdieu, 1977, p. 659) between Sara as a migrant and her Norwegian interlocutor.

This risks her being cast "into the realm of the unsanitary subject" (Briggs & Mantini-Briggs, 2003, p. 10). There is an "absurdity" to "regulating what is appropriate" in seemingly mundane situations like the one that Sara describes, but mundane details are frequently meaningful, because they demonstrate some of the subtle ways through which practices are "instantly noted and sanctioned vis-à-vis an expected ideal" (Purkarthofer et al., 2021, p. 17). In Sara's story, a question about toilet paper is imposed on Sara's subject position (Wetherell, 2012, p. 83).

We do not know why Sara's interlocutor asked Sara about toilet paper, but in the wake of this question follows a trail of intertextual histories, which in turn stick to Sara and restrict her wiggle room. Sara's affective responses illuminate how her health literacy is patterned by these normative discourses. "Focusing on emotions as mediated rather than immediate reminds us that knowledge cannot be separated from the bodily world of feeling and sensation; knowledge is bound up with what makes us sweat, shudder,

tremble" (Ahmed, 2014, p. 171). Striving to be deemed a 'sanitary' subject, Sara's affective response, of taking offense, becomes a technology through which she can accommodate the health norm, discursively positioning herself as an *obvious* user of toilet paper.

While this technology enables Sara to avoid having her sanitariness drawn into question, it restricts her wiggle room. Ahmed (2014) writes:

> To become accommodating we learn to take up less space; the more accommodating we are, the less space we have to take up. Or we make ourselves smaller because we are given less space; and we are given less space because we are smaller.

Sara's stories show that health practices are underpinned by local moral and politicized norms – a finding that is reciprocated in other sociolinguistic literature (see e.g., Hanell, 2017; Karrebæk, 2012; Milani et al., 2021)

Example 6: vulnerability as a collective experience

In my fieldnotes, I have jotted down what Julia, a migrant woman with a disability, shared with me when we spoke on the phone after her appointment with Nav. In the meeting, it had become clear that it was unlikely that Julia would ever be able to return to work fulltime. She explains that "there is no shame in the fact that I am in pain. But how much pain I am in … I can't deal with people feeling sorry for me." Shame is a social and moral emotion, because "the judgement of others can teach me that I have transgressed some rule or norm" (Dolezal, 2017, p. 423). Expressions of shame may be seen "as a reaction that arises in the rupture of the biopolitical ideologies of health" (Hanell, 2017, p. 234). Julia does not feel ashamed because of her disability, but because she is sanctioned by others as vulnerable.

Sara describes similar sentiments. She has been under treatment for a few years now. With a fragile immune system, she has been required to avoid exposure to viruses and bacteria. During ailment, Sara felt estranged, not only because she at times needed to physically isolate herself, but also because she no longer felt like she was on the same wavelength as her family and friends. Sara felt like she was often perceived as overacting, as being unable to manage her health, as not recovering at an appropriate speed. A lot of the time, Sara felt isolated.

Things changed after the outbreak of the COVID-19 pandemic. Sara explains that "some people think like, 'oh, I am not doing well, but she is doing worse than me, she is not doing well either. He is not so happy either.'" Here, Sara scales her own experiences up by "rhetorically solidifying" (Pritzker & Perrino, 2021, p. 379) a connection between herself and others. "Then one becomes kind of calm. That's how it is- humans. It is not, like, said maliciously. But, eh, yeah. So. I think that then it is not only me ((laughter))." Scaling her experiences up again – lumping herself together with a group of people who are experiencing vulnerability – provides reassurance for Sara. She is no longer all alone.

I ask (somewhat awkwardly rephrasing "not just me" as isolated), "Do you feel less isolated now that it is- that it." Sara interpolates that "yeaah." I finish my question: "that it is generally hard for people around you as well?" Sara continues her story,

> Sara: Yes, because (unclear) the shops, a few months ago, then I was terrified to take unpackaged fruit, like, do you get me?
> Ingvild: Mhm.
> S: Because I felt we used so much detergent, and just bought soap, soap, and just a little, just that, I- so much at home ((laughter)).
> I: Was this before- this was before COVID-19?
> S: Yes, indeed, it was in May last year, when I was receiving (treatment) then I hoarded lots of toilet paper and stuff like that ((laughter)).
> I: ((laughter))

S: ((laughter))
I: Well, that was not at all weird.
S: Yeah, it was not weird. I fought with my husband once, that he was meant to buy toilet paper, and he didn't. And then I was like completely, ah, nuts, and so, then it was on the news that people were hoarding toilet paper and like, buying and ((laughter)), I thought 'God, what is this? Is it kind of a little (unclear) of all of this that I thought about last year, or, what is this? This is sick.'
I: It makes you feel a bit less, eh, different to see=
S: =of course.
I: =others go through the same type of crisis.
S: Yeah, everyone, like, handles, like, there was nothing wrong with me. I was, like, yeah, I remember at a health food store, they sell these kinds of very expensive soaps at health food stores and I go … crying and I say 'yeah, do you know what I need? Real, genuine soap' and she just 'okay, just take the one we have.' 'But is it good for, I mean-' I was going about asking so many dumb questions. So. Oh, I saw that she looked- 'so strange', like, just, 'what is she on about?' ((laughter)) and then I just, 'you know what, I am in (treatment) and I do not know what kind of soap I should use', kind of. Now I see people, kind of, you see it in their eyes, everyone is uncertain, like, you get me, it is, I do not know, it is extra surreal for me, at least, to experience this.

Sara responds to my question by scaling her experiences down again, describing previous experiences when she felt out of place and isolated.

During treatment, Sara exercised stringent hygiene practices; she used a lot of soap, spent a lot of time at home, and "hoarded" toilet paper – all in the name of control and oversight in an otherwise uncertain everyday life. When her husband forgot to buy toilet paper, she went "nuts." Throughout the pandemic, individuals in Norway, other countries in Europe, and the US started stockpiling toilet paper, a tendency that has since been linked to an increased need for control in the face of crisis (Garbe et al., 2020). Sara has seen this on the news. As a response to my question, Sara scales her story up again, presenting her own experiences in tandem with the experiences of those others that she observes around her. This observation is meaningful for Sara, as it enables her to reach the conclusion that "there was nothing wrong with me" in the first place.

In a recount of a previous experience of feeling out of place, Sara scales her experiences down to share an interaction with a salesperson in a health store. In this encounter, Sara felt like she was judged as "strange," lamenting that she asked "so many dumb questions", fearing that she will appear incommunicable. She felt isolated and alone. Her health literacy did not meet the (normative) threshold. In the final turn of her story, Sara scales her experiences back up again, describing the pandemic as providing a unique opportunity for her to recognize that she was not alone in feeling conflicted and unsure about her health decisions when a crisis was looming large. Sara's narratives are frequently marked by laughter, through which she "displays her recognition of the problematic nature of the activity" (Haakana, 2002, pp. 226–227), but also a strong sense of relief.

By upscaling her vulnerable experiences, Sara is able to "recognize how we are bound up with others" (Butler, 2009, p. 52), rather than alone and isolated in our vulnerable experiences. The pandemic creates a space for Sara to start unravelling her experiences, offering wiggle room to acknowledge her "vulnerability as mutuality while still recognizing the limitations of [her] power to disrupt often historically and politically entrenched ideologies" (Pritzker & Perrino, 2021, p. 368). By positioning herself in relation to vulnerable others, Sara establishes what Stroud (2018, p. 22) has dubbed a "*space of vulnerability*" – harbouring possibilities for Sara to engage in "dialogue and reflection on [her] own experiences" (Higgins, 2014, p. 722), as well as to participate

in the "deconstruction of dominant voices" in pursuit of "more equitable linguistic engagement with others."

Sara's story illustrates how vulnerability can be more than a structural phenomenon of oppression. Collective vulnerability enables the rise of novel political agency at the micro-scale, a cautious wiggling to create just a tiny bit of room to enact more relevant, less disciplined, moralized, and normalized health literacies in Norway's stratified spaces.

6 Concluding remarks

This short-term linguistic ethnography inquired into health literacy at the intersection of migration, race, language, disability, and gender in Norway's stratified welfare spaces. I have analyzed the ethnographic data material that I cocreated with subjects operating at different scales of Norway's welfare system, exploring how discourses and experiences of vulnerability impacted health literacies at both subjective and organizational scales. Combining recent theoretical innovations concerning vulnerability (Butler et al., 2016; Pritzker & Perrino, 2021; Fineman, 2010; McAllister, 2024; Virokannas et al., 2020) with scale (Blommaert, 2021; Gal & Irvine, 2019; Agar, 2005), affectivity (Wetherell, 2012), and wiggle room (Ahmed, 2014), I have investigated the iteration and recurrence of discourses of vulnerability to describe exclusion, invisibility, and isolation, but also embodied experiences that engender new forms of agency – wiggle room – in socially stratified spaces.

My analysis has illustrated the duality of vulnerability as, on the one hand, a structural phenomenon imposed on migrant individuals, excluding and isolating, erasing and invisibilizing diverse and experiential ways of life. On the other hand, vulnerability is a deeply human experience that sheds light on our relationality and connectivity. In other words, it does not only discern particularizing forms of marginalization but enables novel forms of micro-agency to enact less normatively charged forms of health literacy.

The first part of the analysis explored the discourses of Kim and Alex, who are both invested in the accessibility of healthcare services. I showed how they relied on a discursive inside/outside model to describe how coalescing social factors – hard-to-read information, limited linguistic competence, science communication – contributed to the vulnerability of migrant subjects, who were emplaced in the periphery of the nation-state. The fractal recursivity of normalizing discourses rendered some subjects structurally vulnerable, while at the same time normalizing biocommunicable knowledge regimes of what (scientific health information) and whose (the state) health practices are expected to enhance health literacy.

By relying on discourses of structural vulnerability, Kim and Alex were able to shed light on power structured inequalities, as well as the urgency to address such inequalities. However, this discursive framework provided them with limited wiggle room to address subjective knowledges. Indeed, while scientific information is undoubtedly important, such biocommunicable regimes may reproduce epistemic inequalities in health and welfare spaces. Julia, Laila, and Sara internalized normalizing discourses about 'appropriate' health literacies, including engagement with expert information. This contributed to their structural vulnerability, constricting their wiggle room to use relevant health knowledges for themselves. However, the COVID-19 pandemic provided Sara with new experiences, in which she saw herself no longer as alone, or as transgressing, but as normal in relation to others: as part of a collective with whom she shared vulnerable experiences during a health crisis. Such experiences provided reassurance and enabled wiggle room to start reinterpreting her health literacy according to her own knowledges, rather than the norms system.

By exploring the duality of vulnerability as exclusionary and inclusionary discourses and experiences, this study contributes to a deeper understanding of migrants' health literacies in relation to institutional knowledge regimes in Norway and beyond, as well

as the unique ways that migrant women's health literacies are regulated – or not – by broader discourses of vulnerability. By combining theoretical concepts such as wiggle room, affect, and scale, this study seeks to offer a theoretical framing to grapple with the complex nuances of vulnerability not only as victimhood and marginalization, but also as the collective agency that emerges affectively between subjects through experiences of vulnerability.

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Endnotes

Transcript conventions

[word]	inserted words or researcher's clarification
(name)	replacement of real names with description/pseudonyms
((*word*))	non-verbal expression
=	overlap
-	incomplete utterance
…	material left out of transcript

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