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# The Maternal Migration Effect

*Exploring Maternal Healthcare in Diaspora  
Using Qualitative Proxies for Medical  
Anthropology*

PAULINE BINDER



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#### **Abstract**

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This project explores the 'maternal migration effect'. Following migration to a high-income country with a low maternal mortality rate, we assume that some immigrant women's reliance upon maternal practices that respond to a low-income, high-mortality context can adversely affect care-seeking and utilization of treatment facilities. At highest risk in the United Kingdom and Sweden are those from Africa's Horn, particularly Somali women who have experienced diasporic migration. By applying constructivist qualitative methods as proxies for medical anthropology, we propose a framework for identifying socio-cultural factors, and then we explore how these can influence the western facility-based maternity care encounter.

Study 1 proposes a conceptual framework to understand why sub-Saharan African immigrants might experience adverse childbirth outcomes in western settings. Analysis was guided by 'naturalistic inquiry method' to explore delay-causing socio-cultural factors to optimal maternity treatment. Delays can result from (a) broken trust underlying women's late-booking or refusal of treatment interventions, and care provider frustration; (b) over-reliance on poorly-functioning interpreter services that deny women's access to medical expertise; and (c) mutual broken trust and miscommunication, and limited development of guidelines for treatment avoidance. Limited coherence exists in the perspectives between women and providers about caesarean section and other interventions, refusal of treatment, and coping strategies following adverse birth outcomes. Care providers' held misconceptions about women's preferences for gender- and ethnic-congruence. Women preferred competent care. Congruent language was identified as the key ingredient for optimal culture-sensitive care.

Study 2 applied 'grounded dimensional analysis' and 'functional narrative analysis' to explore pre-migration socio-cultural factors that influence Somali parents' childbearing in Sweden. Women's delayed care-seeking continues, despite that childbearing is still perceived as life-threatening. Decision-making is shared between the couple. Men more than women trust care providers to fill gaps in their knowledge. The postpartum period showed that fathers play an important role. "Aftercare" concerns include unarticulated sexual aversion combined with loss of traditional kin support. Women's autonomy is enhanced but greater necessity exists for intimate partner communication and reliance upon professional care services.

Medical anthropology can provide a complementary instrument for developing qualitative evidence-based strategies that target prevention of adverse childbirth outcomes in European countries.

*Keywords:* caesarean section; care encounter; constructivist; interpreter use; migration; Somali; African immigrant; socio-cultural factors

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*To Robert, my dad –  
You have made this possible in more ways than one.*



# List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

- I Binder, P., Johnsdotter, S., Essén, B. (2012). Conceptualising the prevention of adverse obstetric outcomes among immigrants using the ‘three delays’ framework in a high-income context. *Social Science & Medicine*, 75(11): 2028-2036.
- II Essén, B., Binder, P., Johnsdotter, S. (2011). An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth. *Journal of Psychosomatic Obstetrics and Gynecology*, 32(1):10-8.
- III Binder, P., Borné, Y., Johnsdotter, S., Essén, B. (2012). Shared language is essential: Communication in a multiethnic obstetric care setting. *Journal of Health Communication: International Perspectives*. Doi: 10.1080/10810730.2012.665421.
- IV Binder, P., Johnsdotter, S., Essén, B. The Maternal Migration Effect and Childbearing in Diaspora among Somali-Swedish Parents. Manuscript.
- V Binder, P., Johnsdotter, S., Essén, B. (2012). More than re-establishing the partner relationship: Intimate aftercare for Somali parents in diaspora. *Midwifery*.  
Doi: <http://dx.doi.org/10.1016/j.midw.2012.09.002>.

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# List of Abbreviations

CEMACH	Confidential Enquiry into Maternal and Child Health
CMACE	Centre for Maternal and Child Enquiries
CS	Caesarean section
EBM	Evidence-based medicine
FGD	Focus group discussions
GDP	Growth national product
GP	General practitioner
IUD	Intrauterine device
MDG	Millennium development goal
NHS	National Health Service
RQ	Research question
SFOG	Swedish Society Of Obstetrics And Gynecology
WHO	World Health Organization



# Preface

In 2006, I was teamed up for project work with an obstetrician during a course on qualitative methods. Annette was soon finished with her PhD. One Friday afternoon in April 2008, I got a phone call from her: “You absolutely must send your CV to Birgitta Essén!” Late that night, I pressed the ‘send’ button. The reply was almost immediate, with cc to Sara Johnsdotter: How quickly could I meet them? I began the project at the end of 2008.

The project plan was funded by the time I came on board. Although convenient, this aspect placed immediate pressure to complete the work in a timely way. I have expanded Birgitta’s initial ideas for a modified ‘three delays’ model, and implemented Sara’s advice for hermeneutic constructivist methodology. I have contributed with the concept, maternal migration effect. For Study 1, I performed the analyses and led the write-up of all three papers. For Study 2, I independently orchestrated the data collection, analyses, and write-ups, and led the discussions about interpretation of the findings. As a foreign-born woman who has given birth in Sweden, I have brought personal interest to my work with immigrant parents. I had had a difficult pregnancy and a labor that failed to progress for over 36 hours (even after an induction attempt). I stayed two weeks at the clinical ward for ‘problem maternity cases’ (where caesarean sections are the usual mode of delivery). I shared a room with a lady from Mombasa, who advised about what she would do to relieve painful contractions if we were in Kenya. Over one night, the normal contractions had progressed until about 04:30, when the on-call obstetrician abruptly gave the order from her sleeping quarters to shut them down by an injection in my leg. As a pre-eclamptic patient, that decision made me furious – I was told earlier by the midwives: the only way to cure pre-eclampsia is to have the baby.

This experience from a Swedish maternity ward defines the reflexive perspective I bring to this research project. Whenever a participant has asked me why I am interested in a project about their obstetric experiences, I have openly explained as I have done here. I would always add, “And because I am curious about how it has gone for other immigrant mothers here in Europe.” In retrospect, I do believe that my openness about this private matter has allowed for a deeper degree of trust to be established with the study participants.



# Introduction

In 1990, the United Nations created Millennium Development Goal 5 (MDG-5) to prioritize the health and well-being of all women. Its intention was to reduce the global maternal mortality and morbidity rate by 75% by the year 2015.<sup>138,145</sup> The majority of adverse maternity outcomes occur in low-income settings, while maternal death is by comparison rare in western countries.<sup>27,65</sup> Nevertheless, some immigrant women from non-western countries who give birth in Europe die from direct childbirth-related causes.<sup>92,107,119,120</sup> Others show elevated risk for perinatal death<sup>40,50,140</sup> or severe maternal morbidities.<sup>78,139,148,150</sup> These studies have mainly focused on underlying medical causes, such as hemorrhage, obstructed labor, and sepsis, or on their correlation to socioeconomic factors.<sup>16</sup> Far less attention has been given to potentially explanatory socio-cultural factors that may underlie women's elevated risk.

Following migration from a high-mortality to a low-mortality setting, first generation immigrant women of reproductive age might remain influenced by childbearing experiences or hearsay about others' experiences from their homeland. Such influences could pose negative consequences to maternity outcomes in the host setting, even if women have easy access to well-equipped care facilities. We call this phenomenon the *maternal migration effect*, and emphasize that knowledge about which pre-migration factors can impact a woman's post-migration experience could be crucial to providing effective maternity care in a western setting.<sup>45,46</sup>

Many mothers who have died or suffered severe morbidity in western countries are from low-income settings in sub-Saharan Africa – primarily Africa's Horn. These women have faced limitations to care-seeking and regular utilization of available maternity services.<sup>27,99</sup> This thesis thereby attempts to conceptualize socio-cultural influences that might underlie maternal care-seeking and utilization, especially those related to the western clinical care encounter. A multidisciplinary approach is applied and bridges the disciplines of medical anthropology and international maternal health. The findings of this project may help to support future research, local maternity care guidelines, national enquiries into adverse birth outcomes, and European policy on maternal health. The overall focus is on childbearing in two European settings among immigrant African mothers and fathers

from sub-Saharan countries, mainly Somalia. Study 1 conceptualizes a migration-based antenatal and intrapartum care encounter in the United Kingdom (UK). Study 2 explores women's pre-migration influences on post-migration childbearing in Sweden during the pre-pregnancy, antenatal, childbirth, and postpartum periods.

## International maternal ill-health

In 1987, the World Health Organization (WHO) launched its Safe Motherhood Initiative to promote women's well-being as an essential global priority.<sup>111,127</sup> Its key objective was to reduce maternal mortality rates in low- and middle-income countries.<sup>8</sup> These goals are mirrored in MDG-5. Since the inception of these initiatives, the determinants of maternal mortality have been systematically identified and measured across various income settings.<sup>54,88</sup> Strategies meant to prevent death have also been introduced for all aspects of childbearing: family planning initiatives attempt to lower risks resulting from multiple pregnancies; the provision of skilled care during the antenatal, intrapartum and postpartum periods aims to ensure consistent risk screening; the availability of emergency intrapartum treatment is now considered paramount to appropriate care; and safe abortion programs have been implemented.<sup>21,24,105</sup>

Most maternal deaths are considered avoidable as long as optimal maternity care is available and provided in a timely way.<sup>21</sup> However, Maine and Rosenfield<sup>94</sup> question whether the prevention of all deaths is possible, especially when having to contend with such unanticipated causes as hemorrhage and obstructed labor. According to these authors, the focus of care should be averting intrapartum complications that lead to emergencies. Their "Averting Maternal Death and Disability" program in the US has joined forces with African-based initiatives to improve obstetrics care in the absence of medical doctors by relying on trained mid-level providers that perform skilled emergency obstetrics procedures, such as caesarean sections.<sup>9,49</sup>

The availability of adequate emergency and non-emergency, i.e., preventive, care varies by region, which is reflected by the differences in causative medical factors. Khan et al.<sup>71</sup> conducted a systematic review from 1997 to 2002 and identified hemorrhage as the leading cause of maternal death in Africa (34%) and Asia (31%), while in Latin America and the Caribbean, 26% of such deaths resulted from hypertensive disorders, with hemorrhage as the second leading cause (21%).<sup>71</sup> In high-income, high-resource countries, however, most maternal deaths resulted from "other direct causes" (21%), such as complications during labor interventions. These were related to caesarean delivery and anesthesia. This classification was followed by hypertensive disorders (16%), embolism (15%), and hemorrhage (13%). The

least cause of maternal death was sepsis (2%). According to Berer,<sup>7</sup> deaths from abortion-related causes are virtually unknown where women have access to safe, legal pregnancy termination services. Nevertheless, Khan et al.<sup>71</sup> found that over 8% of maternal deaths in high-resource countries occurred from abortions.

## Adverse maternal outcomes in the West

Women who have migrated from low-income countries in sub-Saharan Africa are reported as more vulnerable than European-born women for death from direct childbirth-related causes. For example, the maternal mortality rate among sub-Saharan women in the Netherlands was three times that of native Dutch women between 1993 and 2005 for underlying factors that include pre-eclampsia as the most cited cause.<sup>106</sup> In France, between 1996 and 2001, postpartum risk for maternal death was twice as high for foreign-born women after taking individual characteristics into account, while the risk for hypertension disorders and infections was four times higher among foreign-born mothers.<sup>107</sup> Nevertheless, these cases are considered rare, partly because it takes years to collect the necessary systematic data for an audit to demonstrate conclusions about mortality risk.<sup>88,94</sup> For this reason, maternal mortality per se is no longer considered the single-most standard indicator of maternity care quality, except when comparing outcomes across regions.<sup>145</sup> Additional concerns for the use of maternal mortality as a quality indicator result from the increasing number of audit-based reports identifying misclassified maternal deaths.<sup>39,43</sup>

Maternal ‘near-miss’ – also known as ‘severe maternal morbidity’ – currently represents the best quality indicator for maternity care.<sup>87,113,149</sup> However, auditing perinatal death is another complementary evaluative mechanism, since these data can assess the effectiveness of emergency obstetrical care.<sup>44,49</sup> Reports of perinatal death identify the same groups of immigrant mothers as those having elevated risk for death and near-miss outcomes. In Sweden, for example, the occurrence of perinatal death among women from Africa’s Horn was substantially higher than Swedish-born mothers; this was especially true among Somali mothers.<sup>44</sup> The provision of quality emergency care to Somali mothers was also reported as suboptimal in relation to the established Swedish care standards.<sup>46</sup> The conclusion of these studies was that the Somali women’s pregnancy care strategies appeared inconsistent with those supporting western-oriented maternity care.

## Childbearing Somalis in western settings

The maternity care needs of Somali women have become a focus of interest to western researchers since the late 1980s, after masses of women of reproductive age began migrating in response to civil war and political unrest in their homeland. According to estimates, nearly 240,000 Somali refugees currently reside in western countries.<sup>136</sup> Research findings, which have benefitted from the women's willingness to share perspectives and accounts of their experiences, suggest that these women have strong opinions about western biomedical treatment strategies. Qualitative investigations have, for example, explored women's perspectives about caesarean section, and report consistently that women hold very negative attitudes toward caesarean delivery. In Scandinavia, such attitudes are said to arise from fears about dying or about concerns for complications to future pregnancies that might result from the operation.<sup>45</sup> The topic of caesarean birth has also been described by Somali women living in the US in association with apprehension about surgical delivery.<sup>64</sup> Women in Norway expressed not only fear of the procedure, but also general dissatisfaction and skepticism with what they saw as an unwarranted operation that was performed too frequently.<sup>68</sup> Findings from another US location show Somali women as preferring maternal care from obstetricians who are 'conservative' regarding the use of this procedure.<sup>6</sup> Moreover, a Canadian study indicated that, despite not being wanted or asked for, caesarean section was performed most often among their Somali participants.<sup>26</sup> Other epidemiological studies show that caesarean rates are elevated for Somali women in western countries, after adjusting for background variables, and are well above figures for country-born mothers.<sup>62,95,125,140</sup> One of these studies evaluated emergency CS, and demonstrated a three-fold increased risk for having the procedure among Somali women compared to ethnic Norwegian women, after adjusting for maternal age and parity.<sup>140</sup>

When this project was conceived, Somali women were among those mothers from Africa's Horn represented in western confidential maternal death enquiries. In the UK between 2003 and 2005, for example, sub-Saharan mothers, mostly from Somalia and Eritrea, were identified as having a maternal mortality rate nearly six times higher than white British women.<sup>87</sup> This figure was double the number of deaths reported for 2000 to 2002.<sup>25</sup> Somali women's experience with diasporic migration may provide a contextualized image about how certain socio-cultural factors, especially those that are related to adverse childbearing outcomes, might be maintained after arrival in a western host setting.

## Migration context in diaspora

The usage of “diasporic” or “diaspora” in this project refers to a subcomponent of the greater African diaspora. Our definition, as applied to the Somalis, meets that of Bulcha,<sup>20</sup> who wrote:

Generally, the concept implies geographical dispersal and social displacement of individuals and groups from a homeland, and the experiences that such dispersal and displacement entails. Since displacement implies both victimization and alienation, the diasporic experience is usually a negative one. Nevertheless, the sense of loss felt by those in the diaspora is intertwined with hope. The memory of and aspiration for a return to the homeland makes life in exile tolerable, even if that means dreaming about a reunion and a joy that may never come. ...It suffices to conclude here that, in addition to the physical fact of displacement, diaspora also involves a cognitive process of reconstruction, imagining, and sustenance of identity in exile.

This description diverges from other common uses of the term, understood as the experience of the Jewish people, which is expressed as “the Diaspora”. Nevertheless, both epitomize the properties of uprooting and uprootedness in exile.<sup>20</sup> Our usage of “diasporic migration” is further contextualized for the first-generation migration of childbearing adults who are uprooted from one income level to another. We therefore mean uprootedness to a setting in stark contrast to the one of origin, involving exposure to unfamiliar social, cultural, and economic conditions,<sup>142</sup> where spontaneous assimilation is assumed to be less profound among those migrating as adults.<sup>91,124</sup>

# Rationale for the Project

Given the substantial effort taken in western countries toward the provision of evidence-based maternity care during the antenatal, intrapartum, and postpartum periods, exploring how immigrant African women seek and utilize these maternity services in western settings appears essential. Midwives, maternity nurses, gynecologists, and obstetricians in both the UK and Sweden strive to manage the needs of all new parents, and yet immigrant groups from sub-Saharan countries are overrepresented in reports detailing adverse childbirth outcomes<sup>27</sup> but underrepresented in maternity care recommendations.<sup>121</sup> We suggest that identifying whether or not socio-cultural influences – which were developed before migration and in response to a specific contextual setting – can influence maternity care encounters in another context may help clinicians anchor their care practice with a migration perspective.<sup>143</sup> When this study commenced, the UK and Sweden had respective first and third highest numbers of immigrant women giving birth in Europe.<sup>126</sup> One methodology well-suited for identifying socio-cultural factors in a clinical setting is medical anthropology.<sup>61,62</sup> However, in both the UK and Sweden, medical anthropologists and their findings are currently absent from advisory panels reviewing nationwide confidential enquiries into maternal death and morbidity.<sup>27,87</sup>



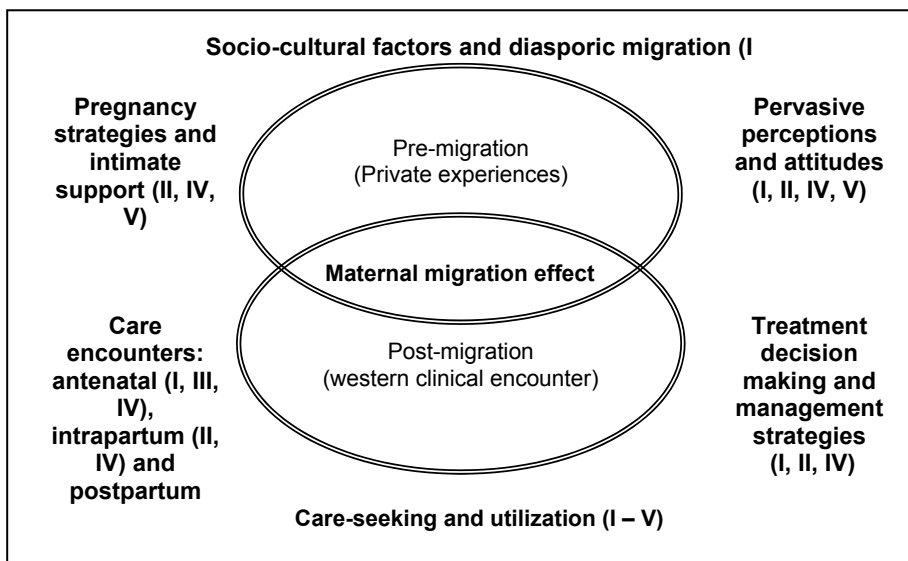
# Aims and Objectives

We intend to propose qualitative methods that can act as a proxy for medical anthropology. The analytic procedures used in this project should therefore be able to emulate anthropology's holistic approach to medical research questions. Our agenda is to magnify the "shared voice" in a clinical care encounter. The findings of this research effort should also be able to lend evidentiary insight into the 'maternal migration effect'. The primary aim is to generate explanatory hypotheses about the childbearing experiences of African parents after they have migrated from a high-mortality to a low-mortality setting in order to: a) improve maternal and reproductive care for these immigrants; and b) better understand the elevated occurrence of adverse maternal outcomes among first-generation immigrants who now live in European countries.

## Objectives:

- 1) to propose a theoretical migration framework that helps maternity care providers identify the underlying socio-cultural aspects of immigrant African women's pregnancy strategies, in regard to: a) care-seeking behavior, b) perception of obstetric risk, c) access to western maternity care providers and services, and d) receipt of optimal obstetric care in a high-resource setting (Paper I);
- 2) to explore how socio-cultural factors among immigrant African women and western obstetric care providers may influence the utilization of antenatal and labor interventions (Paper II, III);
- 3) to explore an explanatory hypothesis about the pervasiveness of pre-migration perceptions on post-migration childbearing among African women and their partners (Paper IV);
- 4) to explore postpartum sexual health and intimate communication among African couples who have experienced diasporic migration to a European setting (Paper V).

Figure 1 illustrates the themes of the maternal migration effect as addressed by Study 1 (Papers I, II, and III) and Study 2 (Papers IV and V). The themes reflecting women’s private circumstances are: socio-cultural factors and diasporic migration; pervasive perceptions and attitudes; and pregnancy strategies and intimate support. Those reflecting the clinical care encounter are: treatment decision making and management strategies; care-seeking and utilization; and antenatal and intrapartum care and postpartum aftercare. The phenomenon we call the maternal migration effect occurs when women’s private, pre-migration experiences overlap with maternity care providers’ western biomedical-trained expectations during the post-migration clinical encounter. It is during the care encounter that these factors have the potential to exert unfavorable influence on the pregnancy outcome.



*Figure 1.* Overview of themes comprising the maternal migration effect. Roman numerals represent the papers in which these themes are addressed.

# Ethics Considerations

Study 1 was approved by the Research Ethics Committee of the National Health Service, UK (reference 06/Q1401/15). Study 2 was approved by the Swedish Regional Ethics Review Board in Uppsala, Sweden (reference Dnr 2010/423). All participants were verbally informed according to their preferred language (Somali, Swedish, or English) about the study and given information in writing. They were given the opportunity to ask questions before signing individual informed consent, as well as the opportunity to decline involvement at any point without need of explanation. Participants were provided with additional contact information for this purpose.

The majority of immigrants involved in this project have legal status as permanent residents or as European citizens. We accepted a participant's self-identified country of origin as their national ethnic identification, and we confirmed their migration as coming from a low-income setting via the relevant World Bank GDP Index, 2005 for Study 1 and 2010 for Study 2.<sup>147</sup> Often an 'ethnic minority' label or a similar, cryptic signature, such as 'Black African', is used as an official identifier in the UK<sup>29</sup>. Six of our participants were still considered as newcomers, refugees or asylum seekers, and thereby, as foreign citizens.

# Methods

The qualitative methods used in this project should be able to act as proxies for medical anthropology. By “proxy” it is meant to say that the procedures should mimic anthropology’s naturalistic approach to medical research questions. The proxies should also be able to support evidence-based practice for maternity clinicians, and their findings should create a conceptual platform for future anthropological exploration of the maternal migration effect.

## Medical anthropology and qualitative research

Anthropology was founded on studies in which an understanding of the customs and behaviors of people were interpreted using naturalistic methods, such as observing, participating in daily activities, and immersing in in-depth dialog with members of the group being studied.<sup>61</sup> In the modern context, these naturalistic strategies are used alike by medical anthropologists and some qualitative health researchers to study, e.g., the interaction between doctors and patients in various healthcare settings. One shared goal is the development of conceptual meanings, so that the experiences and perspectives of those under study can be understood as phenomena that occur in a natural (rather than experimental) setting.<sup>61,89</sup> Both methodologies also offer a possibility to explore research questions (RQs) meant to answer “What is X and how does X vary in different circumstances, and why?”<sup>108</sup>

For our purposes, we assume that qualitative proxies can help to build a bridge between medical anthropology and international maternal health. Generally, research that is conducted in the latter is met with the expectation to inform evidence-based maternity practice.<sup>109,134</sup> The goals of evidence-based medicine (EBM) are

that doctors will use the best available evidence to provide medical care of proven effectiveness; [that the] explicit use of evidence can bring greater openness into clinical decision-making; [to create] the potential to enhance patient autonomy by providing evidence about the benefits and harms of different treatments to inform patients’ choices.<sup>110</sup>

Engelke,<sup>42</sup> however, has suggested that anthropology puts forth neither an explicit definition of “evidence” nor how to use it in actual practice. Our

response is to find affinity with Lambert, who has suggested that many of the priorities of EBM are inconsistent with anthropological approaches, i.e., with the philosophical theories underlying anthropological methods, validity, and scope.<sup>84</sup> Ours is an anthropological project that strives, for example, to explore the pre-migration socio-cultural influences on the emergency obstetric experiences of immigrant women. Such an aim makes improbable the “golden standard EBM-Level 1” randomized controlled trials,<sup>114</sup> since these emergencies occur without advanced warning.<sup>128</sup> Conducting “EBM-Level 2” systematic literature reviews on such rarely studied topics as socio-cultural risk factors in African women’s childbearing is also incongruent with our scope to acquire meaning-rich data from human participants.<sup>53</sup> Statistical meta-analyses (also EBM-Level 2) on childbearing phenomena would further limit our means to interpret what our participants actually experience about those phenomena.<sup>86</sup>

Nevertheless, as medical anthropologists, we do rely on care providers’ formal experience with clinical decision making, which situates at EBM-Level 4.<sup>115</sup> It therefore becomes relevant for us, as Lambert<sup>84</sup> points out, that procedures likely to elaborate what patients say and how their healthcare providers respond implies “that it is the methods used to collect ‘evidence’, rather than the nature of evidence per se, that define whether or not data are potentially applicable to evidence-based practice”. This includes the ethnographic narrative and other forms of non-quantitative data that could “in an expanded representation, be construed as ‘evidence’”.<sup>84</sup>

Justifying qualitative proxies for medical anthropology is thus to propose that our findings from medical anthropological exploration do have, in the least, a possibility to rise to the equivalent ranking for EBM-Level 4 ‘evidence’ as those proposed for qualitative research findings.<sup>30</sup> Noted, however, is that these findings are unlikely to rise above Level 3 (out of 4) on the current EBM scale,<sup>110</sup> unless EBM is revised.<sup>84</sup> At present, any allowance for producing qualitative findings is to perform Cochrane meta-reviews: and yet, these qualitative findings are still “not intended to contribute to the measures of effect in interventions”.<sup>100</sup>

## Qualitative proxies for medical anthropology

Implied in the previous section is an apparent tension that exists in our project about the nature of knowledge. This tension may curtail maternal health professionals from utilizing medical anthropological findings as “medical knowledge”, despite the global effort to improve the effectiveness of health services through both cultural competence and evidence-based practice.<sup>74</sup> It also exists despite reservations expressed in the literature about

the capacity of MDG-5 initiatives to avert maternal death and morbidity. The success of these programs is said to depend not only on the availability of services and women's rate of utilization, but also on discovering *why* utilization might be low. This can be accomplished, for example, by "talking with people in the community and in facilities and by observing the provision of care".<sup>94</sup> Nevertheless, if the highest "ranked" forms of EBM evidence are supported by the scientific underpinnings of positivist, quantitative methods, such as clinical epidemiology,<sup>74,114</sup> then we assume a similar standard of fitness for interpretivist, qualitative methods. Taken further, if the findings from our chosen qualitative proxies are able to remain anchored to their scientific underpinnings, then, by proxy, confidence in our medical anthropological findings should also improve.

A wide body of approaches in medical anthropology conceptualize the scientific underpinnings of a "meaning centered" discourse, which supports "the phenomenological appearance of illness" shaped by culture but rejects the "'disease-centered' empiricist" appearance of disease shaped by biomedicine.<sup>55</sup> This entire body of work – which includes the ethnographic strategies of ethnomedicine, as well as the critical discourse of applied/critical medical anthropology – comprises the interpretivist end of the positivist-interpretivist continuum illustrated in Figure 2. Further imposed upon this interpretivist continuum is the idea that cultural knowledge about human illness can represent three levels of the "mindful body".<sup>118</sup> The first body level, the *individual body*, is "understood in the phenomenological sense of the lived experience of the body-self [where the] parts of the body – mind, matter, psyche, soul, self, etc." are highly variable in relationship to the ways in which the body is received and experienced in health and sickness.<sup>118</sup> The second body level refers to the *social body*, which is represented as "a natural symbol with which to think about nature, society, and culture. Epistemologically, [this allows] social, symbolic and structuralist anthropologists [to] elaborate a continuous exchange of meanings "between the 'natural' and social worlds".<sup>118</sup> The third body level is the *body politic*, which is considered an agent of regulation, surveillance, and control – both individually and collectively – in various aspects of human life: reproduction, sexuality, work, leisure, sickness, etc." In all available forms of polity (chieftains, monarchies, oligarchies, democracies, and totalitarian states), the "stability of the body politic rests on its ability to regulate populations and to discipline individual bodies".<sup>118</sup>

Figure 2A illustrates how we have visualized a qualitative equivalent to these three levels of "mindful body". Interpretivist (ethnomedical), "bottom-up" approaches can use such methods as phenomenology and medical discourse analysis to explore the individual body. Constructivist approaches include naturalistic inquiry method, functional narrative analysis, or an interpretivist method can perhaps be modified (we chose grounded

dimensional analysis) to find a shared voice. We assume this to be the best place to account for the tension that exists in our project about the nature of knowledge. These three constructivist methods and their processes are elaborated below.

Finally, critical medical anthropology, i.e., “top-down” approaches support the body politic. Such methods include critical discourse analysis and critical grounded theory. Proxy equivalents should hold as long as the methods that are engaged are chosen based on the RQ, and the processes of data collection, analysis, and interpretation remain internally consistent to the equivalent underlying approach.<sup>34,89</sup>

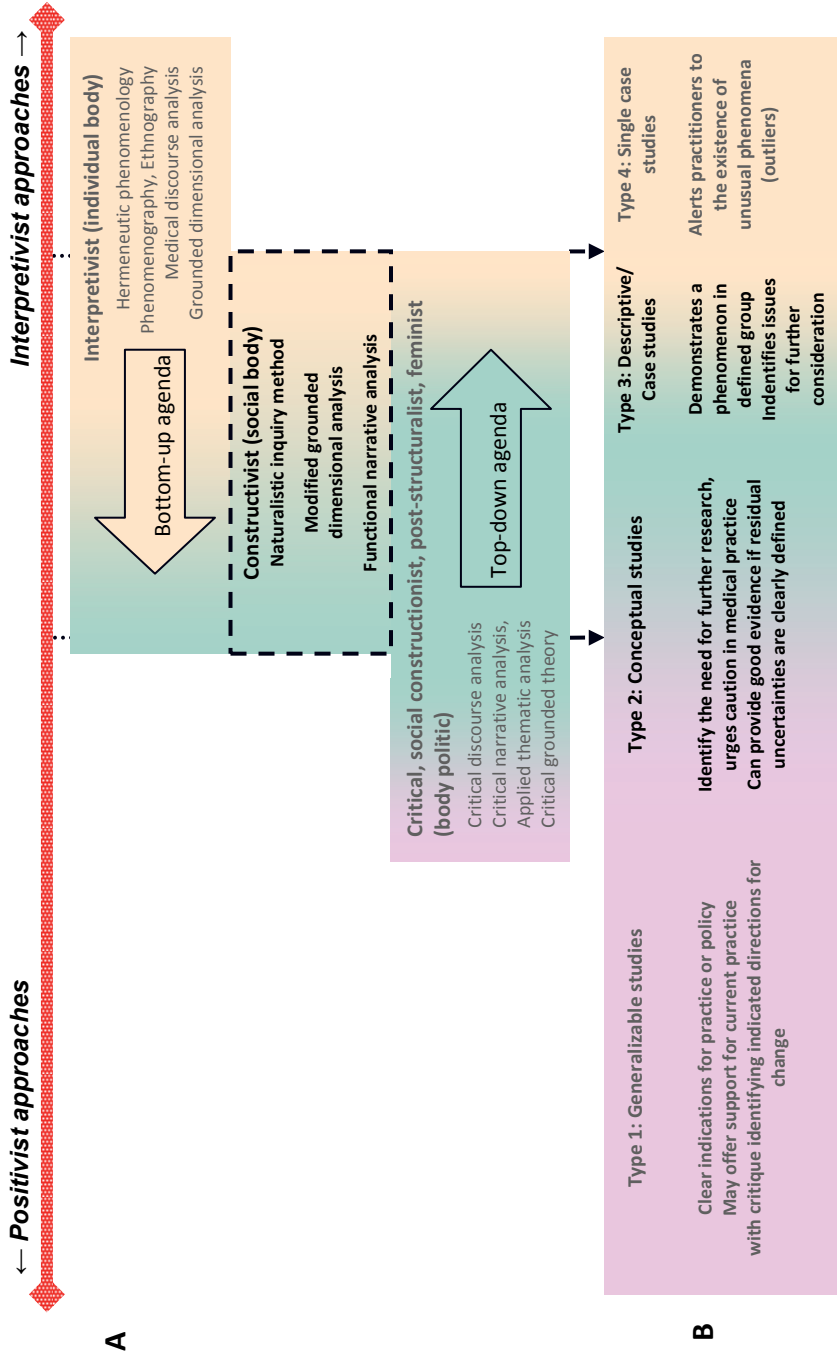


Figure 2. A. Qualitative proxies for medical anthropology. B. Evidence-to-practice, adapted from ranking by Daly et al.<sup>30</sup>



## Constructivist methods

Constructivist proxies mimic medical anthropology because they support the collection of hermeneutic, “thick description” data<sup>53</sup> that develops into relative, subjective realities for not only a study participant, but also for the researcher. The concept of truth for hermeneutic approaches is also subjective and transactional, i.e., co-created through the research process.<sup>34,57,89</sup> Constructivist researchers will thus interact with their study participants throughout the research process to gain access to the multiple views of reality that may exist. Reflexive analysis embraces the idea that a participant’s perspective of reality is different from that of the researcher.<sup>135</sup> The entire process, referred to as the ‘hermeneutic-dialectical’, is not simply about identifying interactions, but is instead using a process of constant comparison to gain a deeper grasp of the naturalistic meanings available to each actor in the study.<sup>89</sup> According to the founders of this constructivist approach,<sup>57,89</sup> hermeneutics is the process of creating the interpretation of “dialectical truth”, i.e. the creation of synergy between two or more colliding ideas.

Constant comparison analysis of categorized data facilitates the relationship between hermeneutics and dialectics.<sup>89</sup> The dialectic process can occur in a number of different ways. First, during an interview when inquirers seek to clarify their understanding of what has been said and then alternative explanations are explored with the respondents. Second, dialectics can influence sampling when alternate views are purposively sought during the data collection. This comparison is at the level of convergent and divergent intuitions (expressed as categories), and allows the researcher to seek explanations for the discrepancies. In both ways, a case report including quoted vignettes is developed and represented as discoveries of the study. These findings may then be judged for coherence, as novel phenomena or they can be evaluated in relation to similar study contexts.<sup>57</sup> The quality and trustworthiness of the study is tested according to the four naturalistic tenets of rigor: credibility, transferability, dependability, and confirmability.<sup>57</sup>

Between 1985 and 1989, Lincoln and Guba changed the name from “naturalistic paradigm”<sup>89</sup> to “constructivist paradigm”<sup>57</sup> in response to confusion among users about the term ‘naturalistic’, which was misunderstood as comprising all interpretivist forms of research.<sup>56</sup> A second caveat is to inform that “constructivist”, as it is used here, is not the ‘cultural constructivist medical anthropology’ ascribed to Gaines.<sup>51</sup> By his own description, Gaines’ constructivist method falls under the “social constructionism” approach, which is concerned with the production of critical knowledge and its reproduction in human societies.<sup>123</sup> Unlike the constructivism of Guba and Lincoln,<sup>57</sup> the methods supporting social constructionism have the agenda to shape a collective understanding of social processes, as they relate knowledge to human social background and group alliances.<sup>2</sup>

## Criteria for evidence-to-practice

The constructivist approach to evaluating evidence-to-practice is to say that qualitative research can help to bridge gaps between theory and practice as long as a method's underlying standards of rigor and quality are maintained.<sup>57</sup> Other means exist for evaluating qualitative evidence-to-practice. For example, Daly et al.<sup>30</sup> have created a hierarchical set of four criteria for judging qualitative studies in the medical and health literature. They were inspired to do this because available quality guidelines were inconsistent, and often conceived all qualitative research as one single type of method. Nonetheless, the proposed structure of Daly et al. is still based on positivist lexicon, as “Level 1, Level 2...” beginning with “Level 1: Generalizable studies”.<sup>30</sup> Inserting this hierarchy into our proxy framework (Figure 2B) shows that Level 1 is consistent with qualitative methods that support positivist or post-positivist approaches (commonly referred to as “mixed methods research”). These would be judged as “the most comprehensive and clear”.<sup>30</sup> Our illustration suggests that constructivist methods would overlap between Level 2: Conceptual studies and Level 3: Descriptive/case studies. We prefer to modify this lexicon according to typology and thus replace “Level 2” with “Type 2”, and so on. Thereby, depending upon RQ and type of study design (conceptual or descriptive), the findings of a constructivist inquiry – i.e., a medical anthropological inquiry – can provide evidence that identifies the need for further research or clinical action, urges caution in medical practice, and demonstrates a health phenomenon in a defined group.

## Naturalistic study context

Our naturalistic study context is figuratively represented as the clinical care encounter. Participants in Study 1 were asked to recall their experiences in relation to childbirth, but also to an antenatal and intrapartum consultation in London, UK. In study 2, participants were asked to recall their experiences during: a) childbirth; b) an antenatal, intrapartum, and postpartum care consultation with a Swedish maternity care provider; and c) during their time spent with their partner while pregnant and after giving birth in Sweden.

*Study 1:* Out of Greater London's approximately 8.1 million inhabitants<sup>14</sup>, just over 84,000 are Somalis.<sup>13</sup> At the time of Study 1, London's population of non-native English speakers was just over 2%.<sup>28</sup> The initial diasporic inflow of Somali asylum seekers began in mid-1990s after the outburst of the civil war in Somalia.<sup>5</sup> Another large immigrant African group in London is the Ghanaians, who (like a smaller population of Somalis from the Somaliland region) have been migrating into the UK in search of jobs and education since the 1960s. The National Health Service (NHS) in London hosts many Ghanaian health providers, while health providers of Somali origin are relatively few: during the 1990s, more than 20,000 Ghanaian health providers entered the UK, and Ghana has been among the top 10 sending countries of health providers to the

country.<sup>29</sup> Official data on Somali health providers were not available at the time of this study.

Because the NHS offered socialized access to well-equipped facilities and pharmaceuticals at the time of this study,<sup>35</sup> we have assumed emphasis in this setting on care provider skill, expertise and expectations during the care encounter. Provider competence is personified by the health system standards for medical training and care guidelines as a matter of course. A contemporary problem of limited availability of maternal care providers was identified in the literature, as a problem of centralization of services, and some authors suggest that this aspect has severely restricted British women's choice and free access to different levels of care.<sup>3</sup> Study 1 involved 5 of approximately 33 maternity hospitals in greater London that were open during the study period. In 2005, there were nearly 645,000 live births in the UK, but only 639,000 recorded maternities.<sup>12</sup> Antenatal care began with a self-referral or one from a general practitioner at 10-12 weeks gestation. Monthly visits were advised until gestation week 30, then fortnightly to week 36, and then weekly until delivery.<sup>99</sup> Problem intrapartum cases were referred by a local general practitioner, midwifery clinic, or were taken straightaway to hospital by ambulance.

*Study 2:* Swedish society can be best described as multi-ethnic, having a higher proportion of registered foreign-born inhabitants than the United Kingdom and USA.<sup>66</sup> According to the 2007 population statistics, 17% of all women of reproductive age were foreign born.<sup>130</sup> In general, most births are facility-based at 46 hospitals with 49 delivery wards for a population of just over 9 million people.<sup>47</sup> In 2011, when the study took place, the Swedish care model operated with the goal to provide evidence-based maternity care practice, and ensured free maternity care for all women since the socialized health insurance is paid by tax in accordance with the Social Security Act.<sup>121</sup> Antenatal care included 9-11 control visits to an antenatal midwife, follow-up antenatal screening as necessary, and 1-2 ultrasound scans as normal procedure (ideally the first occurring between gestation weeks 12- 18). Parental education was available 72-90 hours per pregnancy in a variety of forms (from small groups to auditorium lectures, depending on location in the country).<sup>121</sup> Childbirth is managed by midwives through the primary care system, but for women with complications, the care is provided via hospitals.<sup>121</sup> Additionally, midwives refer to obstetricians and auxiliary clinicians to manage emergency complications, but continue to tend to the client through the delivery.

The national guidelines for discharge from hospital include immediate home-based aftercare.<sup>121</sup> Midwife-led surveillance is considered to be well supported<sup>106</sup> and well utilized<sup>40</sup> during the period immediately following discharge, i.e., when a planned visit occurs up to 3 to 5 days after delivery.

However, the responsibility for late aftercare, defined as up to 12 weeks following delivery, is left voluntary as a cost-effective measure.<sup>41</sup> To better cope with these aspects, strategies such as videoconferencing have been initiated.<sup>90</sup> The recommendations encourage midwives to monitor the recovery status of the mother, the progress of breastfeeding, and to initiate discussions with mothers about contraceptive use and lifestyle factors, such as smoking, diet, and exercise. Late aftercare also encourages indirect surveillance of whether a couple has been “re-establishing the partner relationship”.<sup>121</sup> For indirect observation, however, parents must first seek help on another matter.

## Data collection and sampling

The main supervisor of this project, B Essén, organized the study design, sampling method, and data collection for Study 1. Snowball<sup>10</sup> and purposive sampling<sup>104</sup> were used to recruit participants, which were sought between 2005 and 2006 around Greater London, UK. These included 39 immigrant Somali women, 20 immigrant women representing other ethnic groups from other low-resource settings in the Caribbean or Africa (Ghana, Nigeria, Senegal and Eritrea), and 10 white British women. The age range for all women was 18 – 48 years and time spent in the UK ranged between > 1 year and < 20 years. Range of parity was 1 to 10 children. Inclusion criteria were women who were currently pregnant or who had had at least one child within the British healthcare system, and who lived within the study area at the time of data collection. Also interviewed were 62 obstetric care providers (doctors or midwives) at five hospitals within the study area. Providers represented multiple ethnic profiles (4 Somali, 34 other African or Caribbean, 21 White British and 3 Asian), and had extensive experience in caring for women of British and non-British ethnic backgrounds. For all participants, we define ethnicity as country of origin. Each tape-recorded interview took approximately 30-90 minutes. Data on number of dropouts or reasons for declining participation were not recorded by the culture brokers.

Study 2 was initiated by anthropological fieldwork using Wolcott’s<sup>146</sup> ‘hang around method’ (see below). The observation was conducted between October 2011 and October 2012. Participants were sought for formal data collection between January and October 2011 in nine urban and semi-urban centers across Sweden. Recruitment methods followed Bernard,<sup>10</sup> where snowball sampling was used to recruit Somali facilitators, but only one facilitator per location was used. These facilitators then purposively recruited the participants, as based on our stated inclusion criterion. The inclusion criterion was having had (mothers) or witnessed (fathers) at least one childbirth in Sweden. The data are comprised of 30 individual, in-depth interviews and three focus group discussions (FGDs) with 16 Somali fathers. Nine FGDs were

conducted among 38 immigrant Somali mothers, but this thesis will only report seven FGDs with 27 mothers. The two additional FGDs were the first two and were used for validating the study questions. All participants had arrived to Sweden at varying points in their lives, which ranged from adolescence to late-50s years. The length of time in the country ranged from at least 6 months to at least 19 years. Range of children was 1 to 14. Some of the participants had had children earlier in Somalia. Individual interviews took approximately 20-90 minutes, and were restricted to time as defined by the man's willingness to be interviewed. The FGDs with men lasted 4-5 hours, and FGDs with women lasted between 90 minutes to 4 hours. For each FGD, the flow of discussion dictated the length of time. Refreshments were served. Four fathers declined participation after being approached, and three fathers had agreed to participate but left early because the start-up process took too long. Three mothers declined, and three mothers left before the process began due to sudden commitments elsewhere. The main reason cited for declining participation was dissatisfaction with previous research outcomes about Somalis living in western countries.

## Culture brokers

Study 1 utilized culture brokers to gain access to the Somali community in central London. Culture brokers are persons well known within a community or who are familiar with the culture and habits of the study population.<sup>75</sup> Prior to enlisting the assistance of the culture brokers, the researchers clarified the broker's background, expertise, and possible relationship to a proposed participant, and also explained the goals and priorities of the interviews.<sup>97</sup> Ten female Somali culture brokers initiated the snowball referral and were later commissioned as advocates and interpreters. These women acted on behalf of the researchers to set up the first contacts and focus groups in the homes of Somali women throughout the study area, and assisted the researchers to follow-up on individual interviews around different neighborhoods.

## Hang around observation

Study 2 began with participant observation. Participant observation during fieldwork "involves going out and staying out",<sup>10</sup> and allows for anthropologists to immerse into a culture and learn to remove reflexive reactions from the observation. Rapid assessment observation, on the other hand (referred to by some as non-participant observation<sup>96</sup>) involves ethnographic observation that is done in just a few weeks.<sup>10</sup> This project involved a length of observation situated in between these two extremes: using Wolcott's hang around method.<sup>146</sup>

Wolcott<sup>146</sup> described a utility for "hanging out" during fieldwork, at least during the initial stages "when the researcher may be unsure about how to proceed". Bernard<sup>10</sup> elaborated hang around observation as "hanging out is a

skill, and until you learn it you can't do your best work as a participant observer.” The author of this thesis engaged two Somali communities for 4-5 days per month for nearly a year. One community was in mid-eastern Sweden, the other was in the far south of the country. Hanging around in these two communities was performed contiguously to the in-depth interviews and FGDs. I allowed the people to describe their own culture to me, and purposefully tried not to learn very much on my own. Immersion in the community involved being invited home for dinner to watch family wedding videos from Somalia. (And I learned to eat a banana with my supper during these occasions). It was also possible to attend community meetings, sitting in the middle of a group of unknown women, who accepted my presence because of familiarity in the environment. This level of participation helped to refine certain structural aspects of the culture-specific narrative used in Paper V, which would not have been possible without the help of people I encountered.

### Semi-structured interviews and focus group discussions

Study 1 used semi-structured,<sup>83</sup> in-depth individual and focus-group interviews. These were performed together with an interpreter by an obstetrician (main supervisor, B Essén), and sometimes with a social anthropologist (co-supervisor, S Johndotter). Study 2 used semi-structured, in-depth individual interviews and FGD. Both studies involved open-ended questions. During the FGD sessions of Study 2, a narrative was used to collect data, which were analyzed separately (Paper V).

The term “semi-structured” is used to describe interviews that attempt to gain access to the individuals own experiences and perspectives: open-ended questions are used to avoid leading the participant with the research agenda, and probing occurs based on the saturation of the topic under discussion. FGDs are commonly used to collect data about community perceptions, attitudes, and beliefs because the respondents have the opportunity to respond from each other's answers. Internal checks and balances occur during the dialog.<sup>76</sup> FGDs can also help facilitate open discussions about sensitive topics when more forthcoming members of the group lead the way for those participants who are reticent to speak up.<sup>82</sup> The optimal group size is 4 to 12 participants. The moderator (usually the researchers) is responsible for initiating the discussion and keeping it going during silent spaces. In the case of our project, this was coordinated with the language interpreter.

### Interpreter use

Use of an interpreter in this project was considered essential. We viewed the researcher and interpreter as one entity during the data collection and analysis. Training the interpreter took place about the expectations for the data collection, its agenda, and the anticipated flow of dialog was combined with constant debriefing during the sessions. This strategy intended to define the

boundaries for blending the interpretation (the interpreter's role) with the mediation (the researcher's role), and avoided the pitfalls associated with an interpretation that may omit or add information.<sup>137</sup> Random back-translation was performed on four of the translations from Study 2.

### Open-ended questions

Study 1: Questions posed to the women focused on themes such as general healthcare experience within the British system, value judgments or notions of belief around western medical care procedures and routines, their own pregnancy and post-pregnancy care strategies, perceptions of accessibility to antenatal care and interaction with providers. Probing follow-up questions in response to women's statements explored their incentives or disincentives to seeking care in this setting. Questions posed to providers focused on the provision of care to immigrant and non-immigrant women and aimed to identify perceptions about women's patterns of care-seeking behavior, as well as to describe care experiences with women during the antenatal or labor period. Elaboration was elicited from providers in response to any negative statements about their experiences in caring for immigrant women.

Study 2: Questions posed to women focused on themes such as expectations for maternity care, their attitudes about antenatal and labor interventions, as well as the use of pain relief during labor, their perceptions about how willing they were toward independent decision-making about obstetric procedures, and whether they utilized any traditional pregnancy strategies or "special" forms of maternity care that were not specified by their midwife. Questions posed to men focused on how they respond to Swedish antenatal and labor care services, how they responded to their wives giving birth in a Swedish labor ward, how they experienced the birth and how they coped as a support person during the labor, and whether they sought to engage their wives in conversations regarding the pregnancy and birth, and especially with regard to care interventions. In both cases, with mothers and fathers, discussions relied upon a theme about historical experiences in Somalia, and how these might compare to the antenatal and labor experiences in Sweden.

### Narrative

Data collection for the constructivist narrative analysis used in Paper V is based on constructivism's central premise that hermeneutic "reality and meaning making" is essentially a constructed analysis.<sup>57</sup> However, this analytical tool considers meaning-making as "a function of the mind to construct our life experiences and then tell them as stories".<sup>19</sup> The stories we tell do not simply "happen" and then get recanted verbatim in the real world but, rather, they are reconstructed, contextualized, and processed inside

people's heads.<sup>19</sup> During all FGDs used in Study 2, a culture-specific life story was read aloud or paraphrased aloud.

## Conceptual Frameworks

### 'Three-delays' framework

To model women's pre-migration socio-cultural experiences in Paper I, we applied the 'three delays' framework.<sup>133</sup> This framework was initially developed in response to the low intrinsic value of women's wellbeing represented in contemporary maternal and child health initiatives. Its authors aimed to better understand the challenges faced by maternal mortality intervention initiatives in low-income, high-mortality African settings. The three phases are posited by the authors as viable across all income contexts. However, to our knowledge, before we began our analysis, applicability to the high-income setting was only hypothetical.

The original framework assumed a lack of timely and adequate care as the foundation of maternal death. The three phases focused the potential for delay on the timeframe between a woman's first suspicion of an obstetric problem and its outcome. Their chronological order was emphasized: the decision to seek care (Phase 1), where delays mainly result from either *perceived* or actual barriers that create disincentives to act; the infrastructure involved in reaching a medical facility (Phase 2), where delays can result from the *actual* barriers of cost, and transportation in the form of adequate ambulance and road systems; and finally, the receipt of appropriate and adequate treatment (Phase 3), where delays result from *actual* barriers at the care facility, such as lack of skilled birth attendants, technological equipment and medical supplies.

Avoiding delays in the African context relies on overcoming both perceived and actual barriers. Disincentives in Phase 1 might result from having to negotiate with a partner involved in decision making, or from a woman's low social status. These may influence her ability to judge the severity of a complication in relation to whether an appropriate care facility is accessible. Perceived barriers from negative expectations rely on a woman's prior experience or those of others close to her. The actual barriers in the African setting are obvious for each phase: 1) the local economic environment can hinder a woman's ability to act; 2) long geographic distances and poor infrastructure make it improbable to reach a health facility; and 3) resources for optimal care may be limited or non-existent.



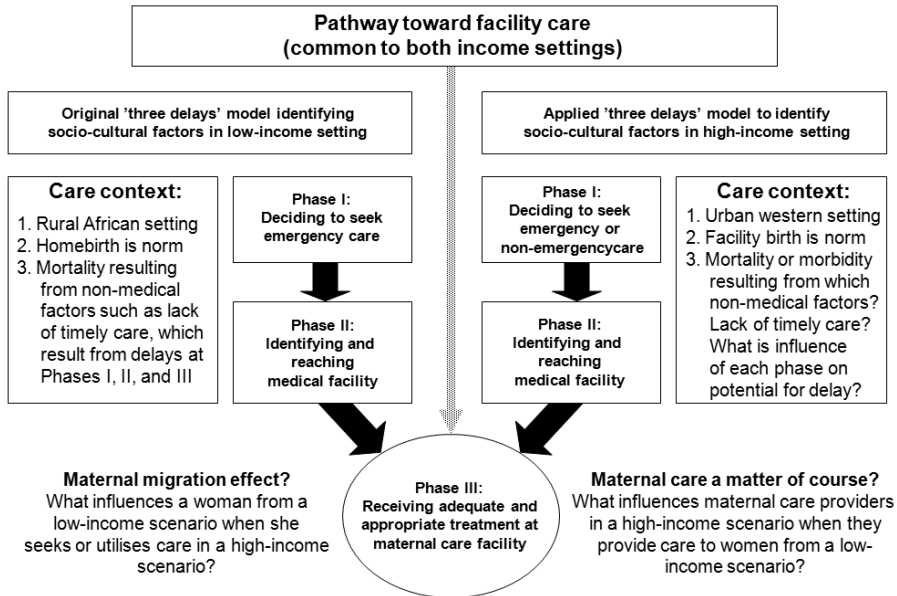


Figure 3. Pathway towards facility care for obstetric emergencies in low-income, rural and high-income, urban contexts.

Figure 3 illustrates our proposed interest to modify the original three delays framework. The need to gain timely access to facility-based care is represented by the central arrow as implicit in the first and second phases. Overcoming an adverse complication therefore presumes a facility-based solution, which appears to be the component referred by Thaddeus and Maine<sup>133</sup> as the most applicable across income settings. In the original, low-income scenario, access to a healthcare facility means overcoming delays to timely care for an obstetric emergency, within a rural setting where homebirth is the norm. We conceptualize overcoming a complication in an urban scenario, where facility-based care and childbirth are universal norms, and where the type of facility sought depends upon the type of maternal care required (emergency or non-emergency).

### Emic/etic model

According to Lincoln and Guba,<sup>89</sup> the *emic* perspective is a cornerstone of hermeneutic-dialectic interpretation. In anthropology, the position of *emic* and *etic* is simultaneously possible. We follow the presentation by Barnard and Spencer,<sup>4</sup> "...an emic model is one which explains the ideology or behavior of members of a culture according to indigenous definitions. An etic model is one which is based on criteria from outside of a particular culture." *Emic* models are thus considered culture-specific, while *etic* models are universal, i.e., they are applicable across a variety of settings and for use on a multitude of anthropological phenomena. The terms have their roots in linguistics, from

which the American linguist, anthropologist and theologian, Victor Pike, intended to develop a grand theory of language and culture.<sup>60</sup> Pike's terms were "phonemic" and "phonetic", and represented the raw data of a language or other system of behavior. However, it was the American cultural anthropologist, Marvin Harris,<sup>59</sup> who first cultivated *emic* and *etic* for use in anthropology. What people "say and think and do" are our main "objects of scientific inquiry".<sup>59</sup>

### Explanatory models for the care encounter

In Papers I-IV, we use the anthropological concept of explanatory models<sup>89</sup> or explanatory hypotheses to explore how immigrant women make sense of their pregnancy and their experiences with care-seeking and utilization of facility-based care. Interpreting our findings accordingly helped us to characterize women's pregnancy strategies in response to the prevailing expectations of maternity care providers during the care encounter.<sup>117</sup> By including women's own explanations about their decisions to seek and utilize care, we could compare and contrast these to the explanations of care providers, who are trained in preventive medicine as a matter of course.<sup>35</sup> Our open-ended questions were designed to elicit explanations about the motivations underlying women's pregnancy experiences so that we could better understand their care-seeking behavior.<sup>93</sup> Our research agenda attempted to give equal voice to women and maternity providers, which is essential for constructivist research strategies.

### Interpretivist interactionism

In Paper IV, we needed to modify 'grounded dimensional analysis',<sup>102</sup> which is an interpretivist form of grounded theory. Accordingly, we created a slight paradigm shift toward the critical position (recall from Figure 2). We did this by replacing symbolic interactionism,<sup>15</sup> which is a mainstay of most grounded theory methods, to interpretivist interactionism,<sup>33</sup> so that we could encourage dialectical shaping. We thus added an interactive, dialectical potential to the dialog without having to take a critical stance as researchers. In short:

[Both symbolic and interpretivist] interactionists approach their materials from a narrative, textual position [and have the] understanding that their texts create the subject matter they write about. ...They believe that persons, not history, make history [and] they understand that the histories that individuals make are not always of their own making. [This] means that interactionist narratives often convey pathos, sentimentalism, and a romantic identification [among] people who struggle to make sense of themselves and their life experiences. ...[One difference between symbolic and interpretivist interactionism is that the latter] takes up the problematics of sexuality, desire, language, gendered selves and identities, and the cultural narratives which work to create the worlds of gendered emotional experience in contemporary society. [Sexuality] and gender are situated in and interactional accomplishments are shaped by a surrounding patriarchal culture.<sup>33</sup>

## Conceptual constructions

In Paper V, we treated the participants' responses to the narratives as narrative vignettes, since we assumed them to be rich with constructed meaning according to Bruner<sup>18</sup>. Conceptual constructions, according to Tetley et al.<sup>132</sup> were applied because they assume the same constructivist hermeneutic-dialectic as the reflexive circle of meaning identified by Guba and Lincoln.<sup>57</sup> The reflexive circle spirals around one constructed reality to another, much like the constant comparative method.

# Analysis, Findings, and Interpretation

Early analysis for each method involved a process of emergent design and content sorting (sometimes referred to as content analysis, which should not be confused with that quantitative method).<sup>89</sup> Emergent design develops the data collection according to knowledge learned at each session: the objective is to develop additional open-ended questions and deepen the inquiry. These emerging aspects are then incorporated into subsequent interviews. Following multiple reads, the text material was then separated into manageable units, according to the specific RQ. Relevant components were extracted and placed into a separate file. It was essential to maintain the emergent design throughout the study process, a process of keeping the data in chronological order of collection so that the emergent design transition can be retraced.<sup>57</sup>

## Paper I

*RQ: How might the ‘three delays’ framework be modified for immigrant African women who give birth in a high-income context? How do women from sub-Saharan Africa experience facility-based maternity care after migrating to a western setting? How might pre-migration socio-cultural factors influence women’s post-migration maternal care-seeking and utilization? Do barriers exist, and if so, why?*

The participants from the Study 1 data collection that were analyzed for Paper I included 54 immigrant women from sub-Saharan Africa (39 Somali women and 15 women from other sub-Saharan countries) and 62 London-based maternal care providers.

## Analysis

The overall similarities, patterns, and differences between the participants’ responses were identified, discussed among the researchers, and then interpreted into intuitive categories. The intuitions were validated for internal consistency by multiple readings and constant comparison across the interviews. The primary analysis was the development of intuitions, which formed the basis of the *etic* insight into the participants’ *emic* perceptions, beliefs, and attitudes, as used in anthropology and elsewhere (Paper II, III).<sup>59</sup> The secondary analysis consisted of a triangulation of the findings: from the

primary analysis, the intuitions from the women were applied to the original three delays framework, and the intuitions from the providers were applied to relevant aspects of the NHS context.<sup>27,35,99</sup> This triangulation allowed us to generate explanatory models, as guided by Kleinman,<sup>77</sup> about the reason for delays experienced during care-seeking and the maternal care encounter.

## Findings

Figure 4A illustrates Thaddeus and Maine's<sup>133</sup> 'three delays' framework, which is contextualized for a low-income African context. The potential for delayed decision-making culminates in Phase 1, when a pregnant woman in a rural environment is anticipating a homebirth and perceives disincentives to seeking facility-based care for an obstetric problem. Delays contributing to her decision making are influenced by her perceptions about actual infrastructure barriers in Phase 2 and of care quality in Phase 3 (identified by blue arrows).

Figure 4B conceptualizes our main findings as the 'migration three delays' framework and represents the factors most likely to influence the receipt of emergency and non-emergency care in greater London, i.e., an urban European high-income setting, where facility-based care is the norm. The given constant is the potential for delays culminating in Phase 3. When a care-seeking pregnant woman enters the scenario, whether or not she receives optimal treatment is critically influenced by her perceptions about decision making in Phase 1 and infrastructure in Phase 2 (indicated by solid red arrows). Actual accessibility delays (e.g., those related to infrastructure and transportation) in Phase 2 are greatly minimized in this high-income context (indicated by dashed red arrow).

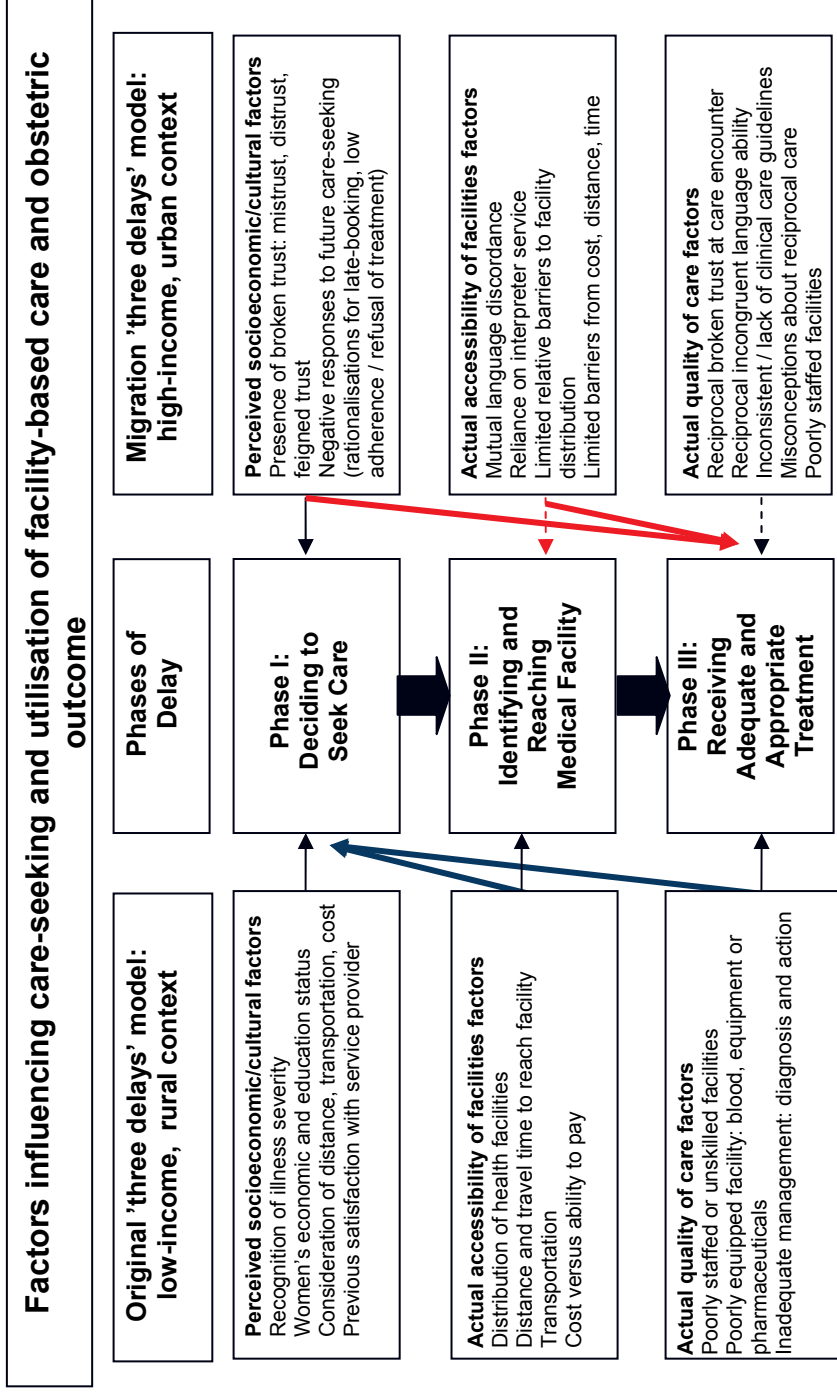


Figure 4: Comparison of factors influencing women's maternal care-seeking and utilization in two contexts. Arrows indicate influence of factors. Broken arrow indicates reduced influence.

### **Phase 1: The decision to seek care**

For those who experienced their maternity care encounters as satisfying, *trust* was intuited as the factor most likely to facilitate optimal future care-seeking. Among those who experienced less than satisfactory encounters, our analysis identified broken trust as the main factor leading to delays in care-seeking. Broken trust was displayed among both women and care providers as mistrust, distrust, and feigned trust. *Mistrust* reinforced negative expectations about care quality or about the ability to provide quality care. The women expressed their lack of confidence in certain hospital policies, procedures, or providers. For example, “I preferred to be in control of my own body because of what I had heard from other women. ...Some of them, when they had the gas, [the clinicians] didn’t know what they were doing. I’ve also heard that epidural can easily go to the spine. You know all this sort of stuff that women talk about (Somali woman 16, 20 years in UK, three children). The care providers’ exhibited mistrust through negative responses, e.g., frustrations, over unmet expectations. One sub-Saharan doctor tried to make sense of the women’s experiences:

Maybe some Somali women do go late [to the care encounter]. Or if the woman came late, then she was late and in labor at the hospital, but they don’t have her background... Some women go from one hospital to another hospital. They are booked for example at [one hospital] and they go and have their baby somewhere else. I know about women who do it on purpose – to go late – because they are afraid of having caesarean section. So, they say, let the labor progress itself and they go late... It is very difficult (Other sub-Saharan provider, doctor 14)

Mistrust manifested early in the pregnancy, during non-emergency care-seeking. As early as the first ultrasound scan, an active choice was made by some women not to adhere to a provider’s recommendations. Some women even travelled great distances for a second opinion from a provider with ‘an acceptable reputation’ (as far away as Germany, Italy, Luxembourg, or Sweden).

When negative expectations combined with misconceptions about care procedures, then *distrust* became manifest as low adherence, delayed care-seeking, late-booking, or outright refusal of preventive interventions. As an extension of mistrust, attitudes of distrust became evident primarily during emergency care-seeking. For example, “I told them that I still wanted to deliver naturally [vaginally]. In Somalia, they do that even if it is a breech...” (Somali woman 9, eight years in UK, six children) The providers elaborated considerable frustration towards women who had refused care that resulted in an adverse outcome: “[Her refusal of emergency caesarean section] was very difficult. I get really cross about how selfish Somali behavior is. She hadn’t any idea what effect she had on us” (Asian doctor 1).

Women's adherence to advice or recommended protocols was not perceived by providers as a guarantee of sincere trust or autonomous care-seeking. The concept of *feigned trust* is implied. For example, most of the Ghanaian women stated ready acceptance of care providers' recommendations. However, this impression was not articulated by most providers. For example, "And some African ladies sometimes seem to be so disinterested. I don't think they are disinterested. Some Ghanaian women, they just come to antenatal clinic and you can't even hear them talking ... they are whispering" (white British doctor 1).

### **Phase 2: Identifying and reaching the medical facility**

All women had appropriate knowledge about the NHS emergency call number, expressed as "Easily dialing the number '999'" (Somali woman 1, seven years in UK, four children). No women described being turned away due to lack of available space. Providers confirmed this perception.

Factors related to communication, such limited ability to articulate either care needs or care advice, were interpreted as the main accessibility barrier for women in the high-income context. One woman illustrated her needs as "When I visit the GP, I do not need an interpreter. Here, in hospital, yes" (Senegalese woman 1, one year in UK, one child). Overall, Somali women had the most difficulties with language and they articulated concerns about becoming a problem to the provider, "Everyone will be fed up with you if you can't understand what they are saying – if you can't talk to them... If you can't speak you will be ignored" (Somali woman 17, 16 years in the UK, two children).

The interpretation service available to most of the providers was described as complicated and either unavailable or unutilized. One care provider remarked: "During labor? In cases where the person speaks a little English, we don't call for interpretation. But when the person doesn't speak at all, that is normally where the interpreters come in" (Other sub-Saharan provider, midwife 15). Sometimes the limited insight of women into NHS procedures was attributed by providers as an arbitrary cultural factor or to the impossibility of the situation. "There are a lot of problems with cultural things because they cannot really understand or appraise what needs to be done or is being done. I think some of them don't give the consent because they don't understand the information" (Other sub-Saharan provider, midwife 18).

### **Phase 3: Adequate and appropriate facility-based maternal care**

Unlike the original three delays framework, all the women in our study reached a maternal care facility, although some described being late or as



having refused treatment once they were in the care encounter. Additionally, no participants indicated delays resulting from lack of essential medical supplies. Instead, several other potentially delay-causing factors were identified. The inability to manage reciprocal trust (influence from Phase 1) was intuited through comments, such as:

And even if it's her third or fourth baby ... if we say: "You should be induced" she just vanishes the whole time and the midwives go and find her and she says she is coming the next day. But we can't force them in. ...we know that our duties end with making sure that they fully understand. ...You keep talking and keep talking and...we see them discharging themselves from hospital with preeclampsia (white British doctor 9).

Incongruent communication (influence from Phase 2) during the care encounter appeared to have serious consequences. One provider lamented: "We could have easily prevented this three hour delay... the woman arrived late and then she was not able to understand what we were talking about, and by the time we called for an interpreter it was too late" (Asian doctor 2).

Inconsistency of available clinical care guidelines presented potential delays for provider decision making. One example includes:

Oh yes, the guidelines on consent are based on the experiences that women refuse treatment, but no guidelines [exist] about how to manage her refusal. It is very difficult for doctors to stand by while the baby dies but you can't do anything about it if the woman is competent" (white British doctor 11).

As a socio-cultural influence, incongruent conceptualizations of care posed a substantial barrier to a reciprocal encounter in this setting. Some providers appeared to assume that gender congruence would influence the outcome of care. For example:

I am female, so it is not a problem. I have been asked to cover for male colleagues, but I do try to be clear with patients that their health is a greater priority. ...Making that point is not always successful, but I feel it my duty to point it out (white British doctor 7).

However, the women did not support this assumption. One woman pointedly addressed this inconsistency:

Even in my own country ... we are exposed to doctors from other cultures and of different sex. I don't see this as any problem. As far as I am concerned, if you know your job and you are very professional about it, that's what matters (Nigerian woman 1, eight years in UK, three children).

Our participants' divergent conceptualizations about the preventive nature of maternal healthcare were evident. On one hand, for example:

These women haven't conformed because they haven't attended their antenatal appointments and now they are ill and we have to look after them... But if they would have done what we said then everything would be okay... I actually look after a number of immigrant women who don't always conform to how we think they should. (white British midwife 5)

Some of the women, on the other hand, described their concerns about attending antenatal screening. One Somali woman explained, "I warn everyone that they will tell you your baby has no head when you have that scan. And, later, if it takes too long, they will just operate. No questions or anything." (Somali woman 22, 14 years in UK, three children)

The pressures on care staff became obvious from providers' elaborations about their duties when caring for immigrant African women. The implications for delay are likely to result from inadequately staffed care facilities. For example: "The actual care that you gave in the past was midwifery, now you are becoming a social worker, their auntie, their uncle, their mother, you know, everything, because their support network has broken down as a whole." (white British midwife 4)

## Interpretation

The triangulation of the primary data analysis (described in Paper II), the original framework,<sup>133</sup> and the health system context in the UK<sup>87,27,35</sup> helped us to modify the 'three delays' framework with a migration perspective in a high-income setting. The authors of the original framework reflected in the title of their paper that it was "Too far to walk..." for many pregnant women to reach optimal care for a suspected obstetric emergency while living in high-mortality settings in sub-Saharan Africa<sup>133</sup>. Our migration three delays framework suggests that it is 'still too far to walk' for some immigrant African women to obtain optimal facility-based care after they have migrated to a high-income, low-mortality setting. To understand this continued vulnerability, we interpret two explanatory models:<sup>77</sup>

- 1) Mutual broken trust between women and maternal care providers may result in delays at the facility level, expressed as women's choice for late booking, non-adherence, or inappropriate decision-making, and as provider frustration resulting from the inability to impart optimal treatment.
- 2) Unmet expectations among providers are worsened by a lack of consistent clinical guidelines, insufficient staff, and poor interpreter services, which are among factors of infrastructure management that

can hinder medical providers from delivering optimal maternal healthcare.

The outcome of the modification suggests that accessibility, per se, is not the main barrier experienced by immigrant African women living in greater London. However, once women arrive at a maternal care facility, they may encounter problems that lead to delays in the receipt of treatment. These explanatory models highlight the links between mutual broken trust, inconsistent expectations and care strategies, and the increased probability for facility-level delays due to incongruent conceptualizations about preventive care. Incongruent conceptualizations likely result from pre-migration experiences and should be explored (Paper IV). Lack of trust among immigrant Somali women in response to acute and non-acute labor interventions has been described in other high-income contexts.<sup>23,64,129</sup> Likewise, the findings also identify that some women have emergency responses to non-emergency care, especially in relation to such labor interventions as caesarean section. No clinical guidelines currently exist in the UK on these aspects of our findings, which suggests a gap between the emergency care women receive and the care that providers are able to give (Paper II).

Several assumptions were identified among the care provider group, including the idea that women prefer gender and ethnically congruent care. As in Beine et al.<sup>6</sup> and Carroll et al.<sup>23</sup> this idea appeared to form the basis for the providers' definition of culture-sensitive care.<sup>80</sup> Given that our main findings included poor language capacity, as well as care providers' underutilization of and caution about the medical interpretation system, the impact of language on the provision of culture-sensitive care appeared to be a critical aspect in this migration-based care encounter (Paper III).

## Paper II

*RQ: What are the conceptualizations of obstetrics care among immigrant Somali women and their obstetric providers in a western clinical context? How do these compare in relation to such labor interventions as caesarean section? If perceptions are contrasting, why might these lead to adverse obstetric outcomes? How can our observation of a triangulated paradox be explained: immigrant Somali women hold negative attitudes about caesarean birth, but they still experience caesarean section very often in western countries, and also represent the one of the highest at-risk immigrant groups for adverse maternity outcomes?*

The participants from Study 1 that were analyzed for Paper II included 39 immigrant Somali women and 62 London-based maternal care providers.

### Analysis

The transcripts were read multiple times to identify the overall similarities, patterns, and differences across respondents. The units of analysis comprised the answers to questions related to caesarean delivery as well as any additional follow-up or proffered remarks. These were interpreted for intuitive categories and then analysed by constant comparison across the dataset. Discussions between the researchers took place at different times and settings throughout the analysis to confirm the intuitive categories generated within the findings. These discussions were conducted during the interview process and also during the analysis period, which allowed for a picture of individual lived experience. We analyzed for first-hand accounts, and any hearsay remarks were either ignored or identified as such in the findings.<sup>85</sup> The resulting intuitions (Figure 5) were defined as perspectives that support the theoretical underpinnings of the *emic/etic* model.<sup>59</sup> This study design is intended to avoid separating the study method from the conceptual theory supporting the research themes.<sup>85</sup>

### Findings

#### **Avoiding death versus preventing death**

The Somali women believed that CS delivery could result in maternal death, while the providers identified CS as preventive care – intended for saving the life of mother and infant. Both groups related it to direct knowledge or hearsay about someone who had not survived the procedure in Somalia. For example:

In Somalia...women die all the time. I was really very worried during my pregnancy ... if you are pregnant in Somalia you are on the 'curse' between

life and death. You don't know what is going to happen to you. That is what the old, like my grandmother, say. These are common words in Somalia" (Somali woman 5, 3 children).

Negative attitudes included denying the care provider's assessment and recommendation, and some women made the decision not to return to the same clinic for future care while others simply chose not to follow the provider's advice. However, while the perceptions expressed by women emphasized avoidance under most circumstances, some of the women who had experienced CS had, in retrospect, a reserved openness for the procedure in relation to their relief at having had a healthy baby. However, these women still believed that the surgery was unnecessary. Complaints were made about having to manage recovery time against family life, and such women also had rather clear complaints about their post-operative care.

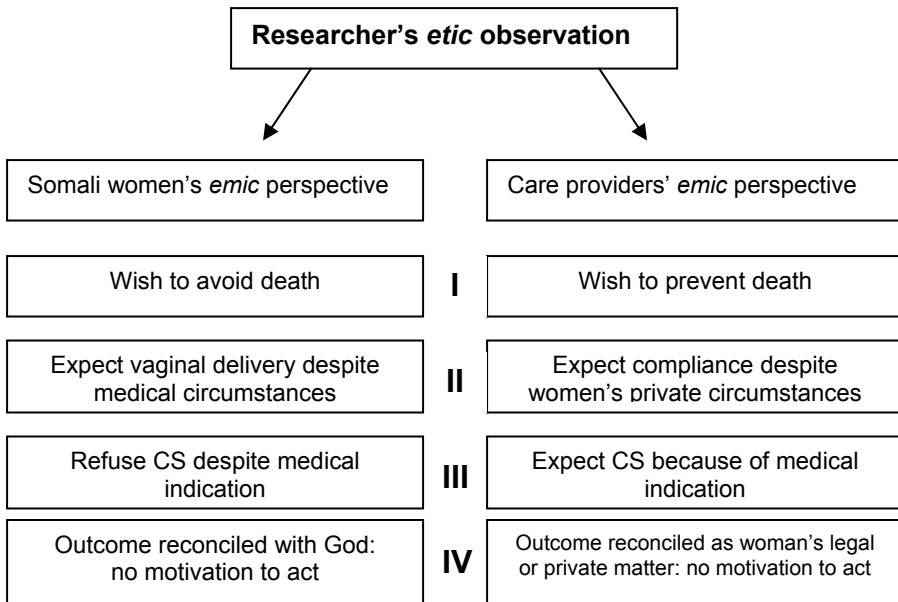


Figure 5. The emic perspectives of Somali women and their obstetric providers, as identified from the etic position of the researchers. Roman numerals and arrows represent progressive barriers to open interaction during the care encounter.

Most care providers identified awareness of the negative attitudes held by Somali women in relation to caesarean delivery, and they based this on personal encounters with Somali patients or from knowing colleagues who had presented cases during clinical review. "I've met many Somali women and men who are very afraid of caesarean section" (white British doctor). Stress as well as frustration was expressed by some providers as a

generalized negative attitude toward this patient group. However, the providers who had direct experience with the issue of CS articulated situations of stress for the healthcare staff attending the case:

Somalis don't like caesarean sections even in direct emergencies. That's a very difficult situation because it is a very demanding emergency where the delivery has to occur within a few minutes, and if there is a lot of resistance on the part of either the patient or the relatives it puts the team who is managing under a lot of pressure. ...It is still in my memory and it is really traumatizing" (Asian doctor).

### **Ensuring vaginal delivery versus expectations of compliance**

At onset of labor, a number of women described an intention to postpone going to hospital. Many women reported that recommendations about waiting to go to hospital came from other women in the Somali community. Hearsay information among the women was specific toward avoiding CS.

A few providers articulated that they were aware of the Somali pregnancy strategy to avoid hospital if there was a risk for CS. Their remarks were in line with this statement:

There was a Somali patient who was booked first for a section and she asked them if she could go home to collect her stuff and she never came back. ...I went to see her at home and she said 'I am going to have a vaginal delivery. I am not having caesarean. I know I have lost two babies, but never mind, this one is going to be normal. [Eventually she waited to go to hospital until she was dilated] 9 centimeters...and she had a vaginal delivery. She came out and said, 'I told you' (Other African midwife).

### **Refusal of caesarean section versus medical indication**

"I refused and just kept pushing and pushing. All the Somalis, at least the ones I know, hate the caesarean. ...I didn't want caesarean" (Somali woman 5, 3 children).

Some providers explained that because consent for CS is required, they must oblige whatever decision is made even if it means loss of life. Complications were described as not knowing the moment when the problem began, and thus, not being able to assess the severity of fetal compromise. Unnecessary barriers such as time delays were also a target of providers' frustrations. Those who were already aware of Somali women's pregnancy strategies in relation to avoiding CS described care encounters where the mother rejected care outright after being advised to undergo CS. "It doesn't matter what we tell them, whatever the consequences are, it's the work of Allah. We don't have any influence at all" (Other African midwife).

### **Reconciliation versus motivation to act**

If the birth outcome ended in perinatal death, coping was described by the woman (for herself and her family) as relying on religious belief. While considered absolutely tragic and undesirable, that death of an infant was considered to be out of the women's hands. A number of women expressed contentment at having their religious beliefs to rely upon. Conversely, the providers rarely expressed any form of understanding over the loss of the child, but still tried to come to terms with the situation.

The providers' coping perspective was expressed toward the family, as a private matter. No providers could remember any resulting guidelines on how to prevent such situations. "I don't know if something is brought up in meetings or whether there are guidelines on how to handle different expectations. ...Refusal itself doesn't get talked about. Providers are disappointed and so on, but they just go ahead in the end." (Caribbean midwife)

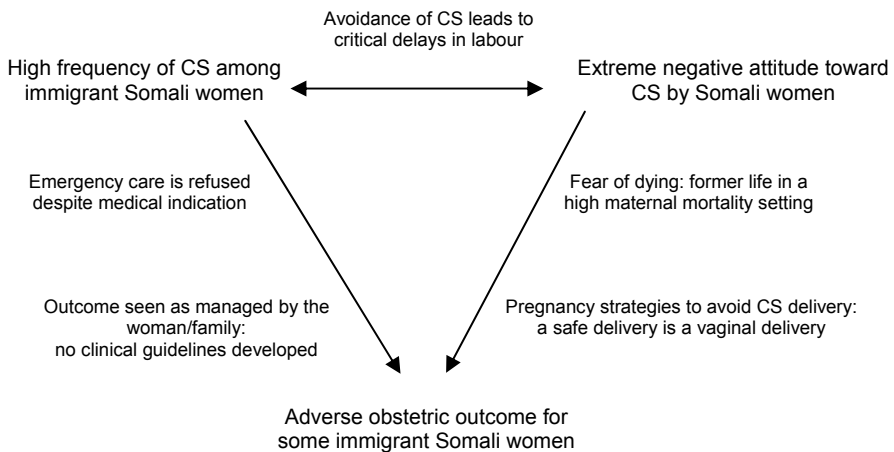
### **Interpretation**

For the women who supported a strong association between caesarean birth and death, their *emic* perspectives<sup>59</sup> seemed to support fear and apprehension as a rational fear of dying. Such fears have been characterized for this group in relation to caesarean birth.<sup>45,141</sup> The maternal care providers were generally aware of Somali women's fears, but their own perspectives did not seem to include considering the woman's position within a post-migration context. Care providers appeared to view adverse outcomes to be the result of a decision made by the woman, which is based on the legal aspects surrounding consent. For them, coping seemed to be a private, family issue. On the other hand, the women coped by relying upon their personal belief system. These distinct strategies strongly suggest that motivation for the development of preventive action is missing from both groups in relation to the severity of the obstetric outcome. Overall, Somali women's perspectives of required care and treatment in relation to CS do not correspond to maternal care provider's medical expectations, and vice versa.

The gap presented here caused us to question how providers would convey to their Somali patients about the need for seeking help if something in the pregnancy seemed questionable or problematic, or about being open to receiving appropriate obstetric interventions. We concluded a strong potential for unanticipated complications in this western care setting, which provided a platform for further investigation into the socio-cultural factors behind them (Paper IV). Other studies have investigated the high incidence of unnecessary CS births among Somali immigrants, and related the occurrence to the clinicians concerns about how to deal with FGM.<sup>26</sup> For the women in our study, fear of dying remained a significant point of discussion,

despite now living in a high-resource setting and irrespective of the time spent out of Somalia. This gives pause since the majority of women in Chalmers and Omer Hashi<sup>26</sup> had no prior discussion with clinicians about the procedure. Furthermore, a large number of our participants also described participation in the local Somali social network with regard to their pregnancy care, and indicated that they perceived as important the hearsay information circulating among women about CS and the caesarean experience. Reliance upon an active social network also addressed decision-making for Somali women, and suggested that, with regard to this mode of birth, the final decision may likely take place beyond the women. Influence of the partner was also an interesting question. These aspects were explored in Paper IV.

The paucity of advice available to practitioners might be due to the fact that anthropology-driven qualitative research in this area is in need of much attention. We have presented here several factors that can help to explain how a procedure that normally produces optimal outcomes can result in adverse conditions among this immigrant group. The elevated rate of caesareans among this group of women<sup>44,95,140</sup> is in paradoxical relation to their open refusal of the procedure. Optimal maternal care requires early identification of potentially high-risk cases, given especially the increased likelihood for complications and mortality<sup>87,27</sup> (Figure 6).



*Figure 6.* The CS paradox. caesareans are being performed too often and too late in Somali mothers who are known to be negative toward the procedure and who show high risk for adverse obstetric outcome.



## Paper III

*RQ: How do immigrant African women and maternal care providers experience incongruent language capacity during a culture-sensitive care encounter? Do women prefer ethnic and gender congruent care while living in a western setting, and if so, why?*

Paper III analyzed Study 1 data involving 39 immigrant Somali and 11 immigrant Ghanaian women, 10 white British women, and 62 London-based maternal care providers.

### Analysis

The data were analyzed and discussed among the researchers as described for the primary analysis in Paper I and the full analysis for Paper II to capture a more complete picture of individual lived experience rather than a narrow perspective of generalizations.<sup>89</sup> The unit of analysis was comprised of all answers and follow-up to the interview dialog on topics such as one's own ethnic profile, ease with language or difficulty with language, being cared for by a male or female clinician, having a male or female interpreter, or caring for an African woman (any ethnicity that was mentioned was included).

### Findings

#### **Language capacity**

Across the participants, language was cited as the main problem against establishing adequate communication between women and their providers. The Somali women, especially, reported having the most communication problems based on language. To nearly all providers, women coming from East Africa were considered as the most challenging to communicate with due to the lack of common language. West Africans on the other hand, were perceived as having more exposure to either English or French, and were considered easier because the providers believed there to be enough hospital staff members to bridge the language gap. Among the white British women, nearly half the participants commented on the importance of being able to understand their provider, with two native English-speaking women offering complaints when the provider was not proficient enough in English for them to understand. No care providers commented, however, on deficiencies in their own language abilities when asked about communication problems with their patients.

A focus group of West African providers discussed that women coming from the same ethnic origin had placed more trust in them and their encounters because they spoke the same language: "Especially when you speak the same language. It puts a smile on their face and they relax...and talk to you

and share more than maybe they would have done if we had spoken English” (Ghanaian midwife, participant 86).

### **Interpreter as communication tool**

The idea of using interpreters during the care encounter was well-received and most of the care providers expressed a positive impression about being able to communicate by using these services. However, many were critical toward whether the interpreters were familiar enough with the medical vocabulary in both languages, and providers had limited knowledge about the training undertaken by professional interpreters. The providers thus felt unable to accurately judge whether the interpreters were performing with competence. Trusting the interpreters was seen as a great leap of faith. One provider expressed this as: “But I don’t always know what the interpreters are saying; how can I trust them? It’s really a challenging assumption” (white British doctor, participant 37). Accessibility, time, and consistency of use were also cited as barriers. The problem was described for acute situations as “You need to have more time. If you want to use an interpreter, everything takes two or three times as long” (white British midwife, participant 106).

It was suggested that some women do not accurately identify their need for the interpreter service, and “claim better English skills than what they actually have” (Asian doctor, participant 57). Other providers pointed-out the irony that poor language skills might leave women unaware of their rights to have an interpreter.

Somali women had the greatest need for an interpreter, and some spoke about their experiences of interpreting for other Somali women when they were already under hospital care for their own needs. This was not recollected among the other groups of women. Family members or friends were often used when availability of a professional interpreter was lacking, or because of personal preference. According to one woman, “interpreters are there on hand, but my children speak very well English so they used to translate for me” (Somali woman, participant 29). This strategy seemed to work well from the women’s point of view, except in cases where bad news had to be relayed during routine consultations. Additionally, not all Somali women expressed willingness to share their personal health matters with an interpreter, despite whether the interpreter was a stranger or someone from within their own social community. Such reservations seemed to be based on distrust.

Providers were more concerned about the too-close ties between the woman and her interpreter, whether it was family or an unfamiliar person. For example:

The other issue that you can have if you use interpreters is that if you have only a small group representing an atypical language, then the local interpreter may also be a part of that local culture and you are asking very personal questions where their culture can interfere with the translation of the woman's needs" (white British midwife, participant 116).

### **Cultural influences on communication**

In general, all women found professionalism and a respectful encounter important during their care. One woman remarked that "it did not matter if he was Somali or British, or anything else, as long as I had a kind midwife or doctor" (Somali woman, 27). This notion was considered to be much more important than meeting providers who share the same ethnic profile (defined according to country of origin), and the women tended not to impose limitations on their preferences. The white women seemed to agree. "It doesn't really bother me, to be honest. Actually, the best midwives are black. I would rather meet an African midwife than a white one" (white British woman, participant 85).

Providers articulated feeling restricted by cultural features. Frustration at not being able to overcome the strong religious beliefs among some of the women was identified by those who had attempted to convince and persuade women about preventive or emergency treatment. A substantial number of women, however, were of the opinion that it is natural to "automatically involve God" (Ghanaian woman, participant 46), since they are religious believers. While for other women, the issue of religion was also about trust:

People have been through a lot of trauma. Many have seen people being killed and they have been raped, vandalized. ...Most Somali people simply don't trust other people. We believe everything happens because of God – that it is meant to be (Somali woman, participant 4).

Across the providers, several participants recalled their encounters with Somali women. In their collective opinion, efforts made at communicating, even if an interpreter was used, went no where. One provider was apt to find explanation:

You see, if a Somali woman perceives herself as treated badly ... she won't get into a big argument. She will just smile gently and go away and won't come back. So, Somali women can avoid the whole of their antenatal care and appear for the first time in labor (white British doctor, participant 88).

For the Ghanaian women, their communication style was identified as docility. One Ghanaian provider explained during a focus group interview, "So, it's just to go ahead and do whatever, to accept whatever... No questions asked" (Ghanaian midwife, participant 87). Among the white British women, adherence to care recommendations appeared to require

understanding of the treatment procedure, and the women complained if they had to ask for too much clarification. They further complained about providers not making a clear effort to explain the treatment.

Communicating with male interpreters during a care encounter was described by most providers as hindering their dialog with the women. They also believed that the women themselves expressed a gender preference for using a female interpreter. Moreover, in the perception of many care providers, women were described as preferring to seek care from providers who are female: it was assumed that women were able to communicate more easily with same-sex providers. The women themselves, however, relayed no such preferences, and judged provider selection to be about competence and personal choice.

### Interpretation

Language, as a means of communication, was the main barrier identified among all ethnic groups represented. Somalis experienced the most language difficulties. This finding is consistent with at least one other European study.<sup>32</sup> The native English-speaking women had fewer language problems as a whole, but did indicate that barriers existed when their providers could not manage well enough in English. A concern expressed among the Somali women was the perception of being a ‘problem patient’, and that their language difficulties lead to providers feeling “fed-up”. This perception is consistent with at least one earlier reporting<sup>31</sup> and might constitute an immediate vulnerability at the onset of the pregnancy or labor care encounter.<sup>38</sup> Limited language proficiency over the course of a pregnancy might actually serve to reinforce any misconceptions between care providers and women about certain antenatal or labor interventions (Paper II), and might also pose an eventual risk for negative obstetric outcome (Paper I).

As a whole, language compatibility was stressed more often among the women as being essential than was a desire to meet a provider of the same ethnic profile. Keeping in mind that we defined ethnicity in this study as self-ascribed country of origin, we did not assume that language concordance naturally followed. While providers held a misconception about women’s desires on this issue, they did share recognition of the significance for a common language. The weight of responsibility for a failed encounter thus appeared not to be placed entirely onto the women, as has been described in other studies.<sup>48,81</sup> These findings lent weight to the need for balanced linguistic communication as a prerequisite to the provision of optimal care.<sup>73</sup> Moreover, a few of the native English-speaking women expressed frustration over providers that could not speak English well enough to provide a clear explanation of various care routines. The possible

negative impact of provider-based language barriers on the care encounter could pose an interesting area for future investigation.

These findings support that, while achieving culture-sensitive care is the optimal goal,<sup>80</sup> it is difficult to do without a basic premise of mutual linguistic comprehension. Language therefore becomes the root, and not simply a component, of the culture-sensitive approach. Moreover, teaching effective care-seeking communication skills to women,<sup>73,64,23,36</sup> and simultaneously preparing providers to sensitively embrace women's enhanced participation, may only be possible once the needs of language concordance are met.

Interpreter use remains the key default option for creating adequate patient-provider interaction with language discordant immigrant and newly arrived women.<sup>52,27,87</sup> However, use of interpreter services in this setting could be understood from our findings as sub-optimal: both providers and women had well-founded reservations about using this service. Somali women's concerns about using strangers or unskilled interpreters was reported earlier.<sup>31</sup> For providers, concerns were raised about placing blind trust in the ability of the interpreters, in their skill-level as an objective conveyer of information, and in the interpreter's ability to manage medical terms in both languages. Such lack of trust might strongly suggest that standardized training for medical interpreters is an important issue in the minds of care providers. Furthermore, where sensitive dialog between a language discordant woman and her provider is concerned, creating necessary sensitivity between the woman and provider simultaneously creates the need to ensure sensitivity by and through the interpreter. Whether sensitivity training about private obstetric concerns is available and properly utilized among interpreters – equivalent to that expected of a care provider – is presently unexplored.

For a variety of additional reasons, the providers in our study tended not to use professionally trained interpreters. It was considered as time-consuming when too many interpreters were required over the same day.<sup>79</sup> Availability of trained interpreters was further considered to be very limited, while some providers complained about the extra pressures added to the acute situation when the need for an interpreter had not been previously identified. This is consistent with the literature.<sup>58</sup> International guidelines on interpreter use are limited. A migration-based perspective is also missing from these guidelines despite appearances of a widespread, anecdotal awareness about interpreter necessity. The medical interpreter service thus appears to be a local or national issue, and the standardization of regulations for interpreter training appears to have limited global merit.

Conceptual barriers that are based on presumed socio-cultural factors, such as the influence of gender on a woman's choice of provider and the role of a woman's religious belief in her obstetric care decision-making,<sup>6,23</sup> and the women's attitudes toward adherence,<sup>72</sup> appear to result from misunderstandings in communication. Widespread assumptions about women's care preferences may serve to limit women's free choices because they are being inadvertently ignored, and not conceptualized as their desire or expectation for quality care. Barriers relating to social marginalization, as presented through such provider perceptions, therefore require further analysis. As does examining the role that such misconceptions might play in health-seeking behavior.

## Paper IV

*RQ: What are the pre-migration childbearing experiences of Somali-Swedish parents? Which pre-migration factors remain relevant in the post-migration context? Why might these factors influence maternity care in diaspora?*

Study 2 recruited 46 Somali fathers and 27 mothers. The data collected from these participants were analyzed for Paper IV and applied to the pre-migration factors we identified from a literature review. Those factors having the greatest potential to influence the post-migration maternal care encounter are described below.

### Analysis

From the data collection and literature review we identified dimensional criteria, i.e., factors on which to base the grounded dimensional analysis<sup>116</sup> of pre- and post-migration contexts. The factors were used to assign relative meaning<sup>17</sup> so that we could infer relevance to the childbearing situations faced by our study participants in both the original and host settings.<sup>89,116</sup> Since dimensional analysis is a form of grounded theory that avoids the use of constant comparison until a late stage of the analysis,<sup>17</sup> we first used constant comparison after the literature review and early sorting of the data were complete.<sup>17,116</sup> We read and reread the text, but also simultaneously listened multiple times to the audiotapes.<sup>22</sup> This aspect was important to capture the non-verbal expressions that signify agreement or dissatisfaction (most commonly a quick, sucking noise made on one side of the back teeth).

## Findings

Childbearing was classified into four areas: pre-pregnancy, antenatal, childbirth, and postpartum.

### Pre-pregnancy factors

Table 1 shows pre-pregnancy factors, characterized as the social process of childbearing for our participants.

*Table 1:* Transition of pre-pregnancy socio-cultural factors among diasporic Somalis. Arrows indicate that a factor was maintained after migration.

<b>Pre-migration factors</b>		<b>Post-migration factors</b>
Oral information about pregnancy from kin		Hearsay from community vs. own experience
Community expectation for marriage	→	Community expectation for marriage
Early-to-late in life childbearing		?
Quick pregnancy increases couple's social status		Pregnancy affords no increase of social status
Forbidden anti-conception vs. contraceptive use	→	Forbidden anti-conception vs. limited contraceptive use
Motivation toward female circumcision		No motivation toward female circumcision
Lack of intimate partner communication		Improved intimate partner communication
Community pressure for yearly pregnancy	→	Community pressure for yearly pregnancy
Desire for large family		Limited desire for large family

### **Pregnancy information via kin, hearsay or own experience**

Omar<sup>103</sup> elaborated the influence of women's kin networks when she found that traditional beliefs about childbearing and maternal practices were transmitted orally from one generation to the next. Similarly, Wiklund et al.<sup>144</sup> reported that myths and traditions were conveyed orally by elder female relatives to young girls at an early age. When our participants were probed about childbearing, either in Somalia or in Sweden, the most common response was that they had learned about what to do from older women. When asked about the possibility for missed information, the women generally replied, "If our mothers forgot to tell us something, then by the time we have 14 children, we will anyway have become experts. If we do not know the first or second time, then by the third, we will" (FGD Mother, 6 children, 1 born in Sweden).

### **Earl-to-late in life pregnancy**

Pregnancy for a young, newly married woman and having multiple pregnancies over the long course of her reproductive life is discussed by Omar,<sup>103</sup> who applies a critical feminist stance to interpret traditional

childbearing as “the treadmill of reproduction”. In Omar’s study, the rural women had married less than 10 months after their first menstruation and became pregnant about 2 years after marriage; thereafter, these women had been “either pregnant or nursing up to 40 years of age.” However, Beine et al.<sup>6</sup> interviewed women from urban Somalia who knew of women bearing children well past the age of 50 years. Among our participants, none of the participants specifically commented on pregnancy at a young or advanced age, but the women could not appreciate why western doctors were so concerned about screening for congenital birth defects when a woman was only in her 40s.

### **Forbidden anti-conception versus increasing use of contraception**

According to Hernandez,<sup>63</sup> the use of birth control was, by tradition, limited to ‘coitus interruptus’ as written in the Qur’an. However, her study participants stated that this method was considered detrimental to the health of the woman in traditional Somali society. Newly migrating couples were more likely to use modern methods of contraception. This may be an artefact of the civil war, at least among those who migrated from Somalia’s urban centers. In rural areas, however, large families are still considered the norm.<sup>64</sup> Beine et al.<sup>6</sup> described newly arrived refugee women as ambivalent: although they used birth control to space the births, they continued to view preventing conception as forbidden by religious law.

None of the participants in our study told of seeking birth control to prevent a first child. The soonest parents sought contraceptives was after the birth of their second child, and in each case it was by use of an intrauterine device (IUD). When asked about the contraceptive pill, many participants responded that they did not like to take medicine. The IUD was considered easier to use and also easier to obtain from the clinic. However, a number of participants described having problems when they tried to have it removed.

The mothers appeared to have low levels of trust when they went to a clinic in Sweden to have an IUD removed.

The midwife asked me to come back so that we could take out the spiral. She was trying to avoid doing it for me. ...They claimed to remove it, and I was expected just to trust her. I did not. I wanted to see if she had actually taken it out and if she had it in her hands. You have to watch them. They don’t want you to have so many children in Sweden (FGD mother, 3 children born in Sweden).

Fathers’ attitudes included using the phrase ‘family planning’ interchangeably with ‘contraception’, as verified by the interpreter. Men



were also generally dissatisfied with being left out of decisions to use birth control.

### **Female circumcision and Intimate partner communication**

Female circumcision was examined by Johnsdotter,<sup>69</sup> who voiced the perspectives of diasporic Somali mothers about female kin who maintained this traditional practice in Somalia in order to ensure social inclusion, chastity, and marriageability of girls. Dirie and Lindmark<sup>37</sup> had reported earlier that women's motivations for practicing circumcision included virginity and marriageability, but also religion. The latter survey was conducted with women in Somalia 10 years after circumcision was made illegal. These authors also reported that the most common type – performed on 98% of girls before age 10 – was infibulation (excision of clitoris, labia minora and majora, and suturing of the remaining vulva to form a small opening for the passage of urine and menstrual blood). Defibulation occurred at marriage (sexual debut) and birth,<sup>67</sup> and a man's bravery was considered enhanced if he could defibulate his wife with his own penis or by some other means, such as a knife or razor blade.<sup>131</sup>

The global discussion on female circumcision has spotlighted limited open communication between Somali men and women on the topics of sexuality and the body.<sup>69,101</sup> Our participants suggest that taboos around these topics are in transition, both in Somalia and in the diaspora. For example, a focus group of mothers erupted in cries of “We are not our genitals!” when the researcher brought up the topic of female circumcision. One woman summed up the group's sentiment:

Why can't they just leave it alone? Our situation is so much more important than whether or not western doctors can handle the view of our genitalia! Nobody wants to do cutting anymore, because it is no longer the fashion in Somalia. Nowadays, girls who have been cut get teased, and so that has already changed! ...I can tell you that there is no one in [our city] who will open us up. ...Many women need that service!” (FGD mother, 4 children, 2 born in Sweden).

A swift, private dialog with the interpreter, accompanied by the sounds of dissatisfactory teeth sucking, ensued before the topic was dropped. However, the researcher queried about why no local clinicians were available to “open up” the women. The answer was, “There likely are, but we don't know them. There used to be one here, but she's moved” (FGD women, 5 children, 4 born in Sweden).

Fathers were generally less vehement about the topic of female circumcision, and some considered that the public attention given to it has allowed men and women to discuss private matters more openly. Similarly, men and

women also appear to have a wider public profile than what was considered traditionally acceptable, which seemed to allow for more discussion at home.

**Social pressure for pregnancy and Reduction in desire for large families**

The topic of starting a family or having additional children launched a discussion about the influence of other women. One father remarked, “Those authorities in Sweden think it is we who are pressuring our women to have children, that we are blindly driven by the Qur’an to do so. No, no, no!” (FGD father, 2 children born in Sweden). Another father added, “You have a point. It is the neighboring women and the pressure my wife gets from them to have a child every year. Every year! Can you imagine it? [Side-sucking of the teeth among other participants] How would we manage that in Sweden, with no family support, the cold weather, and these tiny apartments?” (FGD father, 3 children born in Sweden).

**Antenatal factors**

Table 2 compares the pre- and post-migration factors for the antenatal period.

*Table 2:* Transition of antenatal socio-cultural factors among Somalis in the diaspora. Arrow indicates that a factor was maintained after migration.

<b>Pre-migration factors</b>		<b>Post-migration factors</b>
Care-seeking out of necessity	→	Care-seeking out of necessity
Forbidden abortion, pre-marital sex and illegitimate birth	→	Forbidden abortion, pre-marital sex and illegitimate birth
Taboos and restrictions		Insight into preventive biomedical care
Superstitions about pregnancy		Insight into preventive biomedical care
Lack of practical preparation for birth and parenting		Practical preparation for birth and parenting
Women’s delayed care-seeking	→	Delayed care-seeking vs. timely care-seeking
Reliance on kin-based care networks		Limited reliance on kin-based care networks

**Antenatal care-seeking out of necessity**

According to Hernandez<sup>63</sup> and Moen Flynn,<sup>98</sup> before migration, Somali women attended antenatal care only when they felt it was necessary and because of a suspected problem, if they felt something was wrong with their pregnancy. By contrast, Beine et al.<sup>6</sup> described prenatal practices among urban Somalis as similar before and after migration. In the latter case, the urban women accepted antenatal screening, such as ultrasound, but most wished not to know the sex of their unborn child and few believed that learning of the fetus’s sex was even possible.

When our study participants were asked how antenatal care-seeking had changed for them since moving to Sweden, a few women said they were already familiar with technological surveillance from Somalia. However, when questioned further, all of these women described that they went to private facilities, some of which no longer existed because of the war. In agreement with the studies cited above, antenatal care was not sought by a few of the women unless they believed there was a problem. One mother remarked,

I think it is good to have the appointments with the midwife so that she can listen to the baby's heartbeat and make sure that I am okay. But I still do not see why there should be so many scans. ...For the first baby, the midwife explained that they needed to make sure the baby was healthy. I still wonder, what would they do if it is not? They are not God! (FGD mother, 3 children born in Sweden).

One father described how his wife's antenatal behaviors had changed over time since living in Sweden:

With the first child, my wife did not go [to antenatal care] at all before the birth. She was supposed to go to many checkups, but she was not sure because she believed they would make up problems to keep her coming back. Neither of us understood the purpose. Now, after the last child was born here, we both understand. From my perspective, since I am the father, it is good for me to know how the checkups are going (FGD father, 5 children, 3 born in Sweden).

Men described being excluded in Somalia from antenatal knowledge or from approaching the midwife or hospital about witnessing the birth. In the case of exceptions, the men were friends with the doctors in charge of the women's clinic.

### **Forbidden abortion, Pre-marital sex, and Illegitimate birth**

Traditionally, abortion was strictly forbidden in Somalia.<sup>6</sup> Pre-marital sex was considered immoral and illegitimate children were shunned: having no father, there was no possibility for a clan affiliation or place in society after the birth.<sup>11</sup> The topic of abortion came up in only one interview when a man, who expressed himself in English, lamented that "all Somali parents need to be observant and make sure that the liberal laws about abortion in Sweden do not ruin their children's opportunities for marriage and having children of their own" (Father's interview, 5 children, 3 born in Sweden). When asked what he meant, he added:

Absolutely no sex before marriage! That is *haram* (forbidden). I do not discuss this as a Muslim man. I discuss this as a father. When a teenager—a boy or a girl—makes choices that lead to consequences like abortion, then

that is very bad. For the boy, because he is a Muslim, he will have to pay a very high price. For a girl, because if she has more than three [abortions], she will not be able to have any more children. And then she will also have to pay the high price as a Muslim, too. That is two strikes against the girl. I could say the same for adult Somalians. This is not ‘women’s liberation’!

None of the participants openly discussed their views on pre-marital sex or illegitimate birth. However, they did speak about how quickly marital relationships can change in Sweden. “In Somalia, we could all find a way to live together and care for each other when we are pregnant and have children running around. But he loves making children so much so leaving me was his option here in Sweden. Now, I am alone with my children” (FGD mother, 3 children born in Sweden).

When asked about polygamy, which is illegal in Sweden, the majority of men stated that they enjoyed a satisfying and loving relationship with one wife. Sharing in the childbearing experience seemed to accentuate that feeling. “I have always wanted only one woman, and my wife is my best friend. ...I am a changed man since I saw my children being born. ...It is because I love her – and not only because I am a Muslim and that is what I am supposed to do (FGD father, 3 children born in Sweden).

### **Timing of antenatal care-seeking**

Choosing to delay going to hospital was not discussed among any of the mothers, but a number of fathers spoke of lingering at home with contractions as the traditional way many Somali women anticipated childbirth. One father remarked that, “Women in Somalia used to wait a long time with their labor pains before doing something about them. With my wife, even if it was 15 days, she did not complain so much and she never said that it was time to go [to the hospital]” (FGD father, 4 children, 3 born in Sweden). Over one-third of the men in our study told of having to deliver a baby themselves because a woman had waited too long before seeking help. One man even described helping his own mother deliver his sibling, although after the birth he was not allowed to cut the umbilical cord because it went against tradition for a male to be involved. Another two men delivered their neighbor’s wives in their own cars on the way to the hospital in Mogadishu. Yet another said that his eight children came so quickly that one of them was half-way delivered by the time he returned to the house with a female neighbor. One father described that his wife gave birth in the car of their Swedish neighbor while on the way to a hospital one hour away.

### **Reliance on community networks**

Some of the men described “gentleman’s agreements” that took place during discussions with male relatives and close friends about topics such as

circumcision and naming the child. According to one father, “Men have always discussed who would be the best to perform the circumcision on the boys, but it is only recently in Somalia that we have also agreed not to allow our wives to circumcise our daughters. We do the same here in Sweden” (FGD father, 6 children, 3 born in Sweden). Male circumcision was traditionally organized by the fathers within 7 days of the birth, but could be delayed for 7 years or longer in the rural countryside until a family-approved man could make it to the village to perform the task. The fathers also seemed amazed at how women kept abreast of each other’s pregnancies. “I can only wonder what it must have been like at home! Even here, they are talking to each other all the time. I overhear my wife, and they are comparing everything! How many vitamins they are taking, how many times they have thrown up, if they feel the baby move, and what the doctors have told them” (FGD father, 1 child born in Sweden).

### Childbirth factors

Table 3 compares the pre- and post-migration factors for the childbirth, i.e., intrapartum, period.

*Table 3:* Transition of childbirth socio-cultural factors among Somalis in the diaspora. Arrow indicates that a factor was maintained after migration.

<b>Pre-migration factors</b>		<b>Post-migration factors</b>
Results in increased social status for woman		Results in limited social status for woman
Continuous support from female kin		Continuous support from husband, available kin, and professional care providers
Childbearing threatens life	→	Childbearing threatens life
Women’s exclusive process		Couple’s shared process
Homebirth vs. facility delivery	→	Mainly facility delivery
Natural process vs. overt preventive process	→	Natural process vs. overt preventive process
Patriarchal decision making about preventive and emergency care		Shared decision making about preventive and emergency care
?		Emergency birth priorities and mother’s survival
?		Men’s role in childbirth has religious priority

### **Constant support from female companion and Exclusive processes**

Wiklund et al.<sup>144</sup> found it very common for Somali women close to delivery to have a constant female companion. The parents in our study agreed that, traditionally, childbearing was women’s business and women were rarely left alone, if possible. Men were not allowed to take part. “I was very worried. Of course I had to follow her to the clinic; it is obligatory. In

Somalia, you do not need to follow your woman to the clinic. The nurses will reject you and they will say, ‘No, this is where your border is, you don’t have any business here, so go and wait in the waiting room’” (Father’s interview, 1 child born in Sweden).

### **Childbearing perceived as threatening to life**

Childbearing is described in the literature as a threat to women’s lives – one so common that a Somali proverb speaks of the open grave that awaits every pregnant woman until 40 days after she delivers her child.<sup>103</sup> A number of mothers cited this proverb almost verbatim. When asked about whether they still believe this is true in Sweden, most mothers acknowledged that childbearing conditions here are much better and safer. However, during the postpartum period, some women found it strange to be expected to leave the house so soon after birth to go to the clinic for a postpartum check-up. One woman remarked, “I’ll need to wait and see. So far, I’m not convinced. It might be good in Sweden, but I know in other European countries, it’s not so good” (FGD mother, 5 children, 1 born in Sweden).

### **Homebirth versus facility delivery**

The rural women in Omar’s<sup>103</sup> study preferred homebirth, either in their own home or in the home of their mother or mother-in-law. There they were assisted by birth attendants having no formal training except from life-long service to local pregnant women in their local area. Only 4% of the women in Omar’s study delivered at hospital. In our study, one FGD session with mothers led to a debate about which was better, homebirth or hospital delivery. The conversation centered on the increased access to professional help one has at the hospital. However, a number of women supported the counter-argument to say, “If you cannot bring all of your women kin into the clinic, what kind of support would you have?” (FGD mother, 6 children, 2 born in Sweden). In Sweden, our participants never discussed homebirth as an option. One mother turned the question back to the researcher: “Why would we opt for homebirth when we are steered toward the clinic every time we see the midwife?” (FGD mother, 5 children, 2 born in Sweden).

### **Natural processes versus preventive strategies**

According to Hernandez,<sup>63</sup> Somali women only claimed to need a hospital when they were ill, and they did not consider pregnancy an illness. Thus, pregnancy and childbirth required no medical scrutiny as they were only considered as natural processes. However, the urban woman Beine et al.<sup>6</sup> interviewed had diligently attended prenatal care and delivered in either government or private hospitals, depending on their economic resources. Such women were convinced about the need for proactive medical care.

All the women in our study claimed they used proactive preventive strategies, even if they refused medical interventions. “Our idea is not to disrupt life or the ability to care for our children or have more children the future. If God says it is time for death, then there is nothing we can do about it. western doctors play God too much. They only want to prevent death and don’t care about what happens after the treatment is over” (FGD mother, 9 children, 2 born in Sweden).

In rural settings, the birth most commonly took place while sitting on an upside-down mortar-type block and holding ropes attached to the ceiling (for this purpose). A female relative, preferably the mother, supported the woman’s back.<sup>103</sup> In Sweden, one man voiced his wife’s objections, recalling, “She did not like lying on her back and felt very exposed. She could not even see who was looking at her private areas. She asked me to stand down there at her feet to make sure everything was okay. But once the baby started coming, I almost fell to the floor! The doctors advised me to go back and stand by her head [group laughter]” (FGD father, 3 children in Sweden). By contrast, one mother in another group commented, “I’m glad we have options to try different types of birth positions in Sweden. I want to try underwater birth next time” (FGD mother, 1 child born in Sweden).

Massage and traditional medicines also helped ease women’s labor pains when giving birth in Somalia.<sup>63</sup> In Sweden, however, not all mothers were eager to use assisted pain relief. As one woman stated, “They kept asking me if I need any pain relief. I’m glad my husband was there because I asked him to tell them to stop bothering me with that question. No means no!” (FGD mother, 4 children, 2 born in Sweden).

Surgical or assisted delivery generally provoked anxiety among parents in both urban and rural settings, especially with regard to such interventions as induction and caesarean section.<sup>6,45,63,64</sup> One woman in Sweden remarked, “If they try to make the baby come, it will just hurt for a longer time and it already hurt too much. For that reason, I didn’t want them to force me!” (FGD mother, 2 children in Sweden).

One participant father became anxious when his wife did not respond well after delivery: “When they took her to the intensive care section, I was really afraid. ...People die when they go to that area. I was really afraid and could not sleep for three days and three nights” (Father’s interview, 3 children born in Sweden). Men generally placed their trust in what they described as the expertise of the medical professionals. They blamed their own lack of knowledge about childbearing for their inability to remain calm. One father admitted, “She should have delivered the baby three days earlier, but she was late. They started to say that she should have a caesarean section. What

would I have done if something went wrong? I had no idea what was going on. I was very afraid! Finally, after 5 days, the baby came, and I was relieved!” (FGD father, 3 children born in Sweden).

### **Decision making**

In Somalia, consent for any type of medical treatment should have been given by a male relative, and caesarean section was often refused.<sup>122</sup> When we asked participants about who makes the decisions during birth, nearly everyone responded that it was the woman who decided because the birth was taking place within her own body.

Sometimes they asked my wife what she had decided, and sometimes she asked me what I thought. I understand that this had to do with her body, and so all of the decisions are hers. But she sometimes asked me for advice, especially when the situation had to do with our child. Then it became my decision also. We are used to giving each other advice, so this time was no different. Sometimes I also advised my wife not to exaggerate her pain and such things. I told her just to explain to the Swedish doctors what was happening to her. But what will happen is also God’s will (FGD father, 2 children, 1 born in Sweden).

One man explained having to stand up for his wife’s decision. He recalled, “The workers were actually trying to push us to allow them to give her pain relief in the lower spine. They were really pushing, and I was really insisting. She could not speak any Swedish but had told me the day before what she wanted” (Father’s interview, 2 children born in Sweden). In some situations a husband had to decide because his wife was unable to do so.

She could not decide anything. She was too ill and was barely able to open her eyes. Actually, as I saw it, she and the doctor had the same goal – that both she and the baby make it okay. So, I left the decision up to the doctors and I just agreed with everything they said. They are the one’s who know what they are doing, and I did not know anything. This was how it came about that I agreed with them, but it looked as if it were my decision. ...I saw the operation and that it served a purpose (Father’s interview, 13 children, 1 born in Somalia).

### **Priorities at birth**

A recurring factor that came up during the data collection was how Somali parents cope with the choice between saving the mother or saving the baby. For example, “In Sweden, they only care about saving the child. They will do anything to save the child. But if they cripple the mother and she cannot take care of her other children, it is apparently not their business” (FGD mother, 6 children, 3 born in Sweden). Discussions among the fathers carried this idea further. One man, whose wife had already dilated a few centimeters before they arrived at the hospital, told the following story:



She was too small for the size of the baby. The child’s heart was still beating and the doctors thought a caesarean section should be performed. All the time I was thinking that when they do the operation, they would only be concerned with saving the child. She and I talked about this on the way to the hospital. If an operation was necessary, we wanted them to save both her and the child, and we should listen to the doctor. We would listen to the doctor, but if it came down to one of them having to die so the other could be saved, we both preferred that she remain alive. ...If the child dies, God will allow another, and hopefully then with a good childbirth. But, still, we agreed to listen to the doctor because he is the one who knows things (Father’s interview, 2 children born in Sweden).

One priority at childbirth had religious significance: “Directly after she was born, I was able to whisper the ‘Adhan’ [Islamic prayer] into her tiny ear, as I should do. But, I did not have anything sweet to put on her lips as I have done with my other children in Somalia” (Father’s interview, 13 children in Somalia, 1 child born in Sweden). About the prayer, to be able to perform this immediately and before the child heard too many other sounds was discussed in two men’s focus groups as a benefit to witnessing the childbirth. “Every Somali man should consider this fortunate circumstance as an advantage to his role as a father!” (FGD father, 4 children born in Sweden). One man remarked that he had seen his own father performing this rite with siblings held directly against his father’s bare chest. He summarized his thoughts by saying, “For Adhan, we have practiced skin-to-skin routines for centuries!” (Father’s interview, 1 child born in Sweden).

### Postpartum factors

Table 4 compares the pre- and post-migration factors for the postpartum period.

*Table 4:* Transition of postpartum socio-cultural factors among Somalis in the diaspora. Arrow indicates that a factor was maintained after migration.

<b>Pre-migration factors</b>	<b>Post-migration factors</b>
Support network from female kin	Support from husband and professional care
40-day period of seclusion	Reduction or no period of seclusion
Breastfeeding (exclusive?)	?
Plans for circumcision of female child	No plans for circumcision of female child
?	Couple’s private and community discussion about circumcision of male and female children

### Postpartum support and Breastfeeding and 40 days of seclusion

The majority of women in Omar’s<sup>103</sup> study were supported during the postpartum period by the same close female family members who also gave

them emotional and practical support during the childbirth. This finding is also described by Beine et al., Hernandez, and Wiklund et al.<sup>6,63,141</sup> The length of time depended on the availability of the helpers. The majority of Omar's participants stayed resting for at least 14 days and the other half through the first 40 days. According to the women interviewed,<sup>63</sup> this time allowed women to focus on breastfeeding the infant. Among pastoralist Somalis, this tradition was much observed, but among urban dwellers the necessities of daily life have made the 40-day tradition difficult to maintain.<sup>1</sup> However, it nevertheless appeared to be the 'golden rule' even among most urban Somalis.<sup>6,144</sup>

When we asked the women in our study how they experienced the postpartum period in Sweden, most of them said they missed the help from their close female kin but were making the best of their new situation. Some had mixed feelings about the change, while others said they have experienced exhaustion at their new roles. However, those who appreciated support from their husbands suggested that they enjoyed having the upper hand and were able to teach their partners about the support they needed during this period. Fathers mostly described their pleasure at being given an inclusive role in their new family.

I cannot say that I did everything, but we cannot do like we did in Somalia. The family is not here. We have to do our best. We have different needs at this time, but I could cook and buy food and wash the clothes. That gave my wife more energy for breastfeeding. So for three weeks I was free from work and I could help her to do all of these things. I might say that I helped her 80% (FGD father, 3 children, 2 born in Sweden).

One father was quick to point out that he was not trying to diminish his wife by explaining how he helped her: "I am not telling you this because you are a white woman. I want you to know that I think my wife is very strong, and she is the one who takes care of everything. But I have helped her anyway although it does not mean she is incapable. I did everything she asked me to do because she is the strong one between the two of us." (Father's interview, 6 children, 3 born in Sweden). Other fathers wholeheartedly embraced their new roles in the diapsora: "Since the birth of my son, I am now the one who is cooking at home. I never saw that done in Somalia – never! So, when you come to another country or culture, everyone has one eye [sic]. When we came here, we left our culture there. Here, everyone is equal and must help equally, too" (Father's interview, 12 children, 3 born in Sweden).

Many of Omar's<sup>103</sup> rural participants referred to the first 40 days as the only opportunity in their lives to get some rest. These women considered themselves and were also considered by others as impure if their body was

“open” and bleeding. The latter was perceived as a threat to men. A woman in the postpartum period was also not supposed to comb her hair, look at herself in the mirror, and remained in a separate room from their husbands.<sup>6</sup> Thus, during this period of seclusion sex was strictly prohibited.<sup>1,103</sup> A ceremony was devoted to the end of the 40-day period, attended only by women. In some areas,<sup>103</sup> the child itself was not taken outside the house for the first year of life.

Most mothers are reported to have understood the importance of hygiene and nutritious food for keeping themselves and their children healthy.<sup>6</sup> None of the parents in our study described these “heat rituals”. Most women expressed being keen to breastfeed, which seemed to include exclusive breastfeeding (although this topic was not expressly sought during the study). Many women complained about gaining a substantial amount of weight during the months of breastfeeding, which suggests they enjoyed a generous diet at that time.

### **Planning for circumcision**

According to our participants, Somali men and women have traditionally relied upon an oral tradition of passing down information from elders about topics such as circumcision. However, in Sweden and in the absence of this kin support system, not all men automatically identified having to organize the circumcision of their sons during the postpartum period. A number of men recalled instead that it was their wives who either reminded them to do it, or their wives simply took care of it themselves, since they had more contact with maternity care providers. The difference was made apparent by the older men’s remarks:

In Somalia, many boys had to wait more than 7 years before their father’s organized the circumcision. Only the fathers organized it and only men performed it. It all had to do with the availability of the traditional attendant. Many boys became frustrated with the delay and performed the circumcision themselves, using a knife or a razor blade. Many have nearly bled to death because of this. Of course, this is not the case in the cities, but was a problem in rural villages (Father’s interview, 9 children, 1 in Sweden).

### **Interpretation**

The maternal migration effect influences childbearing among Somalis in the diaspora. Several pre-migration factors remain relevant after migration for the pre-pregnancy, antenatal, childbirth, and postpartum experience. Four main influences are implied for the pre-pregnancy, antenatal, intrapartum, and postpartum care encounters.

### **Pre-pregnancy counseling**

Somali fathers appear to express a pragmatic perspective and seem aware of the limitations imposed on bearing numerous children in the diaspora: extended family support is most likely absent, housing may be too cramped, and children can be confined to the indoors because of the climate during much of the year. For these reasons, fathers were overtly frustrated over three factors: 1) they wished to avoid the negative influence of some of the oral traditions among Somali women in general, which continue to promote expectations for yearly pregnancy; 2) they were dissatisfied that Swedish maternity providers have not acknowledged that they are already cutting back on the size of their families and therefore do not wish to have family planning counseling; and 3) they were dissatisfied about being excluded from discussions about anti-conception, which took place during the pre-pregnancy and postpartum periods. Western maternity care providers might thus consider strategies that do not deny Somali fathers their role in these childbearing processes.

### **Antenatal care**

The Somali pre-migration antenatal experience typically involved not visiting a professional clinic unless the woman deemed it necessary in response to a suspected problem. This finding supports the original ‘three delays’ framework<sup>133</sup> we utilized in Paper I. The post-migration experience identified in Paper IV offers some similarity. A number of the men described how their wives had waited so long to seek late-stage care in both Somalia and Sweden, and that many of these fathers ended up delivering their baby themselves. Our post-migration analysis in Paper I identified ‘broken trust’ as a likely reason to cause delays in the western care context. Similarly, the findings from Paper IV suggest that these women trusted their maternity care providers less than their husbands, whose lack of experience promoted a trust-based reliance on care providers. The findings from Paper IV adds to this understanding, but further suggest that women’s choices for care-seeking also result of being able to detect an obstetric problem. If a pregnant woman considers a problem as low-risk, she may not seek immediate help.<sup>45,141</sup> This factor may become evident to women only after the complication has advanced to an obvious state, which may be too late for an optimal care response.<sup>49</sup>

The findings also suggest that fathers have reservations about the potential for caesarean delivery until they learn from the care providers about its purpose. It is known that Somali women might delay going to hospital for delivery if they perceive or are told by the clinician that caesarean section is a possibility (Paper II). Such delayed care-seeking is likely to be rooted in broken trust (Paper I) and maintained by communication problems in the care encounter (Paper III). The implication is for maternity care

professionals to be observant and to encourage mothers who exhibit tendencies toward low adherence or over-concern about this mode of delivery. Those parents who attended parenting classes did describe having learned about different birthing strategies, but only during those classes. None of the parents who discussed antenatal care described that their midwives provided this information without first being asked. Those participants expressed dissatisfaction. A proactive strategy to relay this information appears to be lacking among some antenatal care providers. Client-informed choice in the post-migration context is thus unlikely in such cases.

### **Intrapartum care**

In the pre-migration context, the consent of a male relative was apparently required for any obstetric procedure to be undertaken on a woman.<sup>122</sup> Obstetric interventions such as caesarean section were often refused. Our finding suggests that such refusal may be thought to save the mother – as a pragmatic approach to decision making: refusal was identified as a desire to save the mother from physical incapacity, which might affect her ability to carry out other family and household responsibilities. Such pragmatic considerations were also described by the participants in Study 1; however, they also cited a rational concern about dying. Fear of death, according to Study 2 participants, appears to be atypical in Islam. However, some of the parents from rural settings did react with fear in when asked specifically about caesarean delivery. Men, especially, who are no longer asked after migration to make exclusive decisions for their wives, seemed willing to defer their fears to the judgment of the medical professional when faced with this mode of childbirth. Fathers gave up their fear of caesarean section when they better understood the medical justification. With regard to this procedure, fathers in the diaspora might thus become instrumental in helping to support their wives toward trusting the utility of this treatment. Fathers who place their trust in maternity care providers might also help women to gain confidence in the clinical strategies promoted during maternal care encounters. The mother's autonomy is not replaced in this scenario, but the father is given a role during the care encounter. Maternity care clinicians may thus benefit from identifying pragmatic attitudes in clients who utilize this level of decision making.

### **Postpartum care**

The absence of traditional knowledge and intimate kin support during the postpartum period is replaced by the opportunity for women to learn by their own experience in the diaspora. However, heavy reliance on women's support groups apparently continues to take place – even if made up of non-kin members – if the father's role remains ambiguous toward childbearing. Nevertheless, life in the new setting affords fathers, who were once

disconnected from the process, the opportunity to demonstrate their support and to have their efforts validated by their wives. Implicit within the father's new role as postpartum support-giver is his own transition.

While postpartum support is necessary to women who have had a difficult delivery and recovery period,<sup>121</sup> not every childbearing experience that Somali women have is problematic. Therefore, it is unlikely that all Somali mothers would require the extensive postpartum support they had become used to in Somalia. In the pre-migration context, women would have received ample care from female kin for approximately 40 days, and they would have remained secluded whether they had had a difficult delivery or not. Certain mothers in the diaspora will thus learn by experience that they can manage well with only their husband's support, while others who do require more vigilant maternity care can access professional care services.

The author of this thesis became curious about references to postpartum sexual aversion among Somali fathers during the fieldwork component of this study. The impact of childbirth on the sexual relationship was also mentioned by one father during the interviews with individual men. We have explored this aspect of the intimate partner relationship in Paper V.

## Paper V

*RQ: How do diasporic Somali parents living in Sweden experience late postpartum aftercare when the care is contextualized for the Swedish context? How do they provide intimate postpartum support to each other in the new setting? Do these couples experience sexual problems following the birth of a child, as new Swedish parents are reported to experience? If so, why?*

The participants included in Paper V are the 16 Somali fathers and 27 mothers who took part in the FGDs. Units for analysis comprised the responses given to the reading or paraphrasing of a culture-specific narrative. The order of participant responses was considered significant.

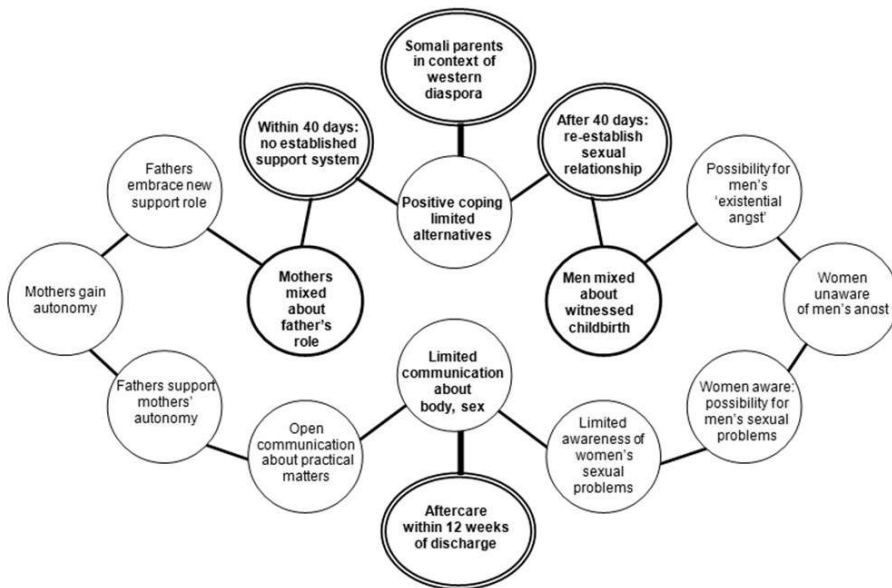
## Analysis

Early member checking<sup>57</sup> occurred as the FGD data collection progressed from city to city and during interviews that were carried out for Paper IV. Findings were discussed among all co-authors. We applied 'functional narrative analysis'<sup>18</sup> as the main analysis to capture participants' reflexive connection to a particular character in the narrative. The analysis began after the audiotapes were listened to multiple times, and the transcribed text was reread and sorted for relevant discussions about a specific character's name.

Such “intuitively convincing accounts” are chosen for their functionality, i.e. their ability to provide rhetorical meaning to both the narrative and the experiences that participants considered to be most significant.<sup>18</sup> We ignored hearsay accounts or specifically noted them during the write up.<sup>85</sup> Meaning was further interpreted according to the order of participant responses. Primary responses, i.e. first spontaneous responses, were considered as most significant because they ultimately directed the flow of subsequent discussion. Secondary responses were analyzed according to consistency with a primary response or as the introduction of a novel concept. Interpretive concepts were constructed as inspired by Tetley et al.<sup>132</sup>

## Findings

Figure 7 conceptualizes the late postpartum aftercare needs of these Somali parents living in the Swedish context. Two important areas were identified. Within 40 days, parents must renegotiate their support strategies in absence of traditional social networks. After the first 40 days, some couples might experience problems with reestablishing the sexual relationship. Traditionally, this postpartum date was anticipated with celebration and sexual reunion, which some couples also tried to emulate in this setting. However, most couples chose a ‘no choice but to cope’ attitude. By coping with the changes of the new setting, some parents rejected all the traditional ways so that new norms could be created.



*Figure 7.* Two important areas during the postpartum period for Somali parents living in a western, diasporic context: renegotiating care for the mother in absence of traditional support systems and re-introducing the sexual relationship. Articulating any sexual problems might only occur after 40 days from hospital discharge.

The narrative hosted three main characters, Abdullatif, Asha and Zahra. 'Abdullatif' represented a father who has reservations about sexual intimacy after the birth of his son but relies on subtlety to avoid expressing it. 'Asha' reflects the idealized life-giver to a child whose name embraces comforting and care. The sense of irony brought out in the narrative is that, a mother, who is providing care to both her children and husband, remains uncertain about her husband's disposition toward her based only on unspoken avoidance of her sexual advances. She perceives the impact of Abdullatif's unspoken reservations as negative, but avoids taking up the issue directly with her husband. Finally, 'Zahra' represents the loss of experienced and trustworthy female kin, who traditionally played a role in providing insight into the childbearing process as well as exclusive care to the new mother for the first 40 days postpartum.

### **Abdullatif: unspoken angst**

Only the men responded to the character 'Abdullatif' and related their discussion about sexual aversion to having witnessed the childbirth. For example:

To be honest, I did not feel comfortable with all of the births of my children. ...After the birth of our first child, especially, I could not go to my wife. So, men have to understand that it is okay for them to go to therapy, to go for help. There is some research done in Norway that says, seeing the birth of a child can damage a sexual relationship. It's true. To see my wife in pain, and all the blood, and to know there is nothing I can do to make it better for her. I accept her suffering as my own, because this is a child we created together, but it is not enough. It really affected me in a serious way for a long time, having seen that. ... We went to a family therapist to discuss the problem and to seek guidance on how to overcome the difficulties (father of four children, born in Sweden by vaginal delivery).

Men who shared opposing, secondary views waited patiently for their turn to express them. Late in one discussion, a father provided a response, which directed the group's attention toward accepting responsibility for the suffering of the wife: "...it cannot only be about waiting to hear, 'It's a boy!' we have to suffer because she is suffering. It is important to be there for her because we are alone in Sweden and it is our obligation!" (father of one child, born in Sweden by cesarean section). Another added:

About obligation, we are in Sweden now. I threw my mother-in-law out of the room, because she was expecting to be there with my wife. But, we are here now and have to face whatever we find, and it is my responsibility to be there for my wife! (father of six children, three born in Sweden, two by vaginal delivery and one by cesarean section).



In the third FGD, the first father to speak linked his memory to his own responsibility:

I saw that my wife was in the worst pain possible, and she was screaming and there was nothing I could do. ...My child was so big that he could not fit through. I felt so miserable and so responsible. If I had not made my wife pregnant, then she would not have had to be cut open like that! (father of two children, born in Sweden by vaginal delivery).

**Asha: idealized life-giver**

Before the interpreter was finished relaying the narrative, one mother interrupted by saying, “I can understand this story perfectly. I did not want my husband there during the birth of my children. For such reasons, I do not want him to ever see me like that” (seven children, two born in Sweden by vaginal delivery). Another woman agreed:

I delivered both of my children in Sweden and my husband was with me both times. I did not want him to see me like that, there have been some problems, so I do not want him to see me if there will be more [children]. (two children, born in Sweden by vaginal delivery).

The first secondary response to this comment was from a mother who described herself and her husband as thriving and as firmly established in Sweden. She explained:

My husband helped me a lot with the pregnancy and birth and he is very kind. He is very good at changing diapers. But, there were sex problems that began after our first child came. ...I have never had an orgasm. I have children but I have never had an orgasm” (mother of four, each born in Sweden by vaginal delivery).

Participants of one women’s FGD had no direct response to the characters, but to its implications. For example, one secondary response included: “This is like a double sword, because it is good that the men are there and can see the pain we go through. But they might be so shocked that they don’t find their way again after it’s over” (three children, born in Sweden by vaginal delivery).

Among those women who remained silent during the primary and secondary discussions, when probed for their experiences, they shared unoptimistic views. One mother offered, “Directly after the baby came, my husband seemed not to notice that anything was going on. We talked a lot about what to do with the baby and how to care for it, and he was good at that. Later, he was talking all the time about coming after me for sex. I just kept telling that I was so tired and did not want to have him again for a long time.” From

there, it followed, “Yes, these are times when we really need our own mothers” (two children, born in Sweden by vaginal delivery).

**Zahra: experience of trusted elder**

Only one focus group offered an initial, primary response for the character, ‘Zahra’:

I was completely alone in Sweden when delivering my children. At that time, there was no one for me to rely on, like that woman, Zahra, in the story. I lost my mother and my sisters, and my husband was, for the birth of one child, still in Africa and for the other, he was too busy with his studies. He came to the hospital, but then realized there would be a lot of blood, so he went out from there (three children, two born in Sweden, one by vaginal delivery and one by cesarean section).

Across the other focus groups, for both sexes, the implicit importance of this character led to reflective discussions about the juxtaposition of supportive roles between the husband and wife. From one mother,

My husband was really supporting me, wiping my brow. In Somalia, it is that you have your mother and sisters right with you, before, during and after the birth, and your husband is not allowed to see you for 40 days. He waits for you at the hospital, takes you home afterward, and that’s it. Here in Sweden, you don’t have your mothers or sisters or aunts or anybody, and your husband has nothing to keep him from seeing you when he is not supposed to. And, nothing to stop him from wanting you in ‘that way’ once you’re back at home. Maybe in Sweden, it is true that he would see you and see you sweating when the baby comes, and when he is with you, he can see the process in a proper way. But also here in Sweden, we don’t have 40 days to make ourselves beautiful again” (mother of six children born in Somalia and one child, born in Sweden by vaginal delivery).

Another mother explained, “For me, it was no problem. My husband never looked [where the baby came out] for any of the births. But, I am glad for the 40 days because a man cannot see you healing for that time!” (mother of seven born in Somalia and one in Sweden, born by cesarean section). One father commented,

When the baby comes, it is the worst period for a woman. She gets so many wounds in different ways when the baby comes out. In Somalia, men have no idea about this, and they just buy a goat for all this trouble. But, here in Sweden, how can I help? All of the attention she deserves from her mother and sister are not here. Is it enough to cook for her, to shop for her? There is nothing to do to make her wounds heal faster and to take away her pain. When our first child came, it was hard for me to see those wounds and to imagine how I could help her (four children, born in Sweden by vaginal delivery).

Conversely, some men had already made up their minds about women's perspectives, "My wife, she wants a female to be there with her. This is a woman's process, so what could I do? It is better to buy her things and to support her during the 40 days" (three children, born in Sweden by vaginal delivery). Among both fathers and mothers, some gave a very practical account of the 40-day period. One father articulated,

We are now living in Sweden, and we should not expect anything on this matter. I believe that, here, some women don't ask for this 40-day period because they want to be independent, and I believe that my wife wants to show herself that she can manage. But, I understand, for other women, they don't believe they can do anything themselves, and they long for that care (two children, born in Sweden by vaginal delivery).

The sexual reunion at the end of the 40-day period was emphasized by both sexes. Some of the fathers, for example, who had experience in both Somalia and in Sweden, lamented the loss of the traditional celebration on day 41. Still others explained that it was up to them to create that moment again for their wife, to keep her happy without the extra attention she'd missed. Similarly, one mother shared,

Oh, when that time comes and he comes home from work, you know, I have already made the house prepared and have put on something sexy under my clothes. While he's just sitting there, watching TV, then I touch my foot to his leg [demonstrates]. Then, he knows, it's time! Forty days or not, we manage here in Sweden! (three children, born in Sweden by vaginal delivery).

Exemplified in one father's comment is the mystique and anticipation of this time of sexual reunion:

Oh, when a baby comes, we must do everything to keep her happy! During the birth, I hold her hand and focus on her. I do not like blood, so I do not watch the baby come out. But, during the 40 days, I buy her gifts and clothes and new furniture, whatever she wants! When she is done, she is so sweet and her body has returned to normal, just as a young girl's body (eleven children, one born in Sweden by vaginal delivery).

## Interpretation

The men's aversion to sexual activity might have related to "existential angst", especially if a man simultaneously perceived a) being exposed for his uprootedness during the childbirth, b) felt responsible for his wife's pain by impregnating her, and c) if he felt strongly about being singularly responsible to uphold a moral and ethical obligation to support his wife (see Appendix Paper 5 for elaboration). In general, women appeared unaware of men's potential to experience this angst. The women also did not comment

directly on whether or not their husband's experienced sexual problems, but they nevertheless did independently exhibit awareness of the possibility for these to occur after witnessing childbirth. In general, women did not directly discuss their own sexual problems, if they existed, except if they were approached by their husbands for sex during the first 40 days postpartum, which coincides with the traditional period of rest. This finding is consistent with a Canadian study, which showed that two-thirds of the cohort of Somali immigrants re-introduced sexual intercourse only after postpartum day 40.<sup>26</sup>

Mothers linked the breadth of their experiences to the characters, 'Asha' and 'Zahra', and to the loss of traditional female support networks. This might correspond to being situated between the loss of traditional support systems and newly gained autonomy. Both parents related to the latter, which is consistent with Wiklund et al.<sup>144</sup> However, our findings suggest that the loss of the traditional support opened the requirement for better articulation of needs between the partners, and for fathers to become open to learning from their partners about maternal processes. By this, men's recognition and willingness to embrace their new role in childbearing seemed to open a window of opportunity for women's enhanced sense of autonomy and independence.

Despite these gains, parents did show signs of a measured acceptance of typical Swedish norms related to maternal aftercare.<sup>121</sup> For example, while some mothers wished to avoid being seen by partners during either the birth or the healing period, most of the fathers were already becoming reflective about the great distance they still needed to travel to be able to provide adequate support to their wives. Yet, both parents might be hesitant to seek help for sexual intimacy problems, even if they know that help is available during the first 12 weeks postpartum. This finding suggests a missed opportunity for midwives who engage aftercare counseling strategies that encourage waiting to discuss sexual problems until asked by the couple.<sup>102</sup> One could anticipate instead that a couple's hesitation might prove to be a window of opportunity for postpartum care providers to make a concerted, proactive effort to explore this aspect of care.

# Discussion

## Major findings

The previous section identified our interpretations for each paper presented in this thesis. The major findings identified below support our exploration of the maternal migration effect. We first proposed a theoretical framework – the migration three delays model. This was modified from the original three delays model,<sup>133</sup> which was developed for the low-income, high-mortality African context, so that we could apply it to our high-income, low-mortality context in the UK. Both models theorize women’s care-seeking and utilization of facility-based treatment. However, women’s decision making in the original framework situated in the rural African home setting, in anticipation of a homebirth. In the urban UK context, decision making was found to situate in the clinical care encounter. This finding implies a familiar reference point from which western maternity care providers can identify underlying socio-cultural aspects of immigrant African women’s pregnancy strategies. Once socio-cultural factors are identified, they can potentially be used to help guide audit enquiries into maternal and perinatal mortality and severe morbidity.

The model identifies delays in timely emergency and non-emergency, i.e., preventive, care-seeking and utilization. These appear to result from:

- individual broken trust of the immigrant women and care providers. Broken trust influences women’s late-booking or refusal of treatment interventions and is exhibited as care provider frustration;
- miscommunication, which limits women’s access to the western clinician’s maternity care expertise and facility-based services. This factor can be magnified by over-reliance on poorly-functioning interpreter services;
- mutual broken trust and incongruent language capacity during the care encounter, as well as limited motivation and means to develop appropriate system-level guidelines for treatment refusal.

We also problematized a paradox which suggested that, despite immigrant Somali women’s very negative attitudes toward caesarean birth, there is an

elevated tendency for caesarean sections to be performed on these women relative to western, country-born women. This paradox is also at odds with these women's increased potential for adverse obstetric outcomes in western settings. The possibility for limited coherence between women's and maternal care providers' perspectives about caesarean section was identified, which can theoretically explain women's refusal of this emergency treatment but also incongruent coping strategies following adverse birth outcomes. Both women and care providers appear vulnerable to experiencing potentially avoidable emergency caesarean section.

Several presumptive socio-cultural factors were problematized from the dataset of Study 1, including the notion that immigrant African women prefer a gender- and ethnic-congruent care encounter. Maternity care providers also over-emphasized the concept of "culture" in their attempt to understand women's decision making and choice for late booking, treatment avoidance, or lack of adherence to care recommendations. Our findings suggest that women are more interested in receiving competent care. Additionally, if the care provider's focus relies too much on presumed cultural factors, then the appropriate management of a woman's obstetric needs might be obscured. Emphasizing too much the culture behind a health issue might ultimately hand the problem over to the patient as a private matter. Additionally, shared language was found to be a key ingredient in the care encounter. However, the response to this demand among the western medical community has been to promote the formal use of interpreter services. Our findings strongly suggest that such services are used in a suboptimal way. This problem can be magnified by the few existing regulations for defining and promoting medical interpreter service standardization.

The findings from Study 2 may help maternity care providers to better understand the pervasiveness of pre-migration socio-cultural influences on post-migration childbearing among Somali parents. Mothers appear to maintain an attitude for seeking antenatal care only out of necessity, if they suspect a problem. These mothers anyway mostly attended regular antenatal care during pregnancy. The fathers in our study mostly co-attend antenatal visits. Information gleaned from antenatal checkups and parenting classes appeared to replace superstitious beliefs and taboos about pregnancy. Participants recalled learning about birth procedures during parenting classes but not during antenatal care, which was perceived as inconsistent. Marriage remains a crucial prerequisite to pregnancy. Blocking conception is still considered forbidden, although parents have begun to use contraception for spacing births. Traditional social pressure from other women about yearly pregnancy appears to continue, but fathers in diaspora have come to view it as a negative influence on their private circumstances. Delayed care-seeking

at birth remains an issue, despite that birth is also still perceived as life-threatening. Mothers in the diaspora have facility-based childbirth but some wish to forgo screening or other preventive interventions. Decision-making in diaspora is egalitarian, especially in relation to the circumcision of sons. All of these parents are against the circumcision of daughters. The men remained inhibited by the lack of traditional exposure to birth processes, and trusted care providers to fill the gap. Women appeared to trust care providers less than their partners. For pragmatic reasons, priorities at birth emphasize keeping the mother alive. The postpartum period affords fathers a role in childbearing and women an increased independence. These findings suggest that multiple factors are likely to adversely influence childbearing in diaspora, but they nevertheless accentuate heightened reliance on professional maternal care services.

Somali couples' postpartum "aftercare" needs (postpartum to 12 weeks) include aversion of sexual activity among the men, which may result from a combined angst and sense of responsibility about having caused their wives so much pain during the childbirth process (by simply having made the wife pregnant in the first place). Women's loss of traditional kin support systems characterizes their postpartum needs. Mothers appear mixed about wanting exclusive assistance from their husbands, but fathers embrace their new roles and learn to care for their newborns to help the mothers. These women were unaware about their husband's anguish-related aversion to sexual intimacy. Women's autonomy appears enhanced in this setting but there is great need for intimate communication between the couple as well as increased reliance upon professional care services.

## Methodological considerations

We identified constructivist proxies for medical anthropology: naturalistic inquiry method alone or in conjunction with (modified) grounded dimensional analysis or functional narrative analysis. These methods allowed us to avoid limitations usually confronting qualitative analyses that miss identifying "how" and "why" differences in qualitative datasets.<sup>30</sup> All are supported by either theoretical explanatory models<sup>77</sup> or conceptual constructions.<sup>132</sup>

To ensure credibility of the findings,<sup>57</sup> we ensured that the analyses and interpretations occurred through our familiarity with the dataset. Mostly this involved returning to the original data sources to develop an intuitive grasp of their meanings.<sup>89</sup> For this reason, and because the constructivist procedure is not a step-by-step recipe, it is considered important to keep the samples well chosen.<sup>2</sup> For this, we used a combination of snowball and purposive

sampling. However, one potential limitation might arise from our reliance on snowball sampling because our main participant group tends to support a strong oral culture.<sup>6,129</sup> Therefore, shared knowledge among this group might have a tendency to spread quickly and bias the sample. To overcome this challenge, we made every attempt to ensure that information relayed about experiences in the study settings was conveyed reflexively from the individual's own point of view.<sup>85</sup> Second-hand or descriptive hearsay about others' experiences was kept distinct. However, we clearly noted when hearsay information was included. In Study 2, we additionally limited the snowball sample of study facilitators to one per study site<sup>10</sup>. This was done to build an exhaustive sampling frame among this relatively small sample of people who may have had previous contact with one another.

The project purposefully operated within the criteria for dependability, confirmability, and authenticity.<sup>57</sup> These required an audit trail of the fieldwork, data collection, and analysis, as well as "member checking" and transferability. A field notebook and journal of all encounters was kept for accountability purposes. Continuous member checking occurred each time a new data collection session began. Additionally, regular feedback was sought from informal sources in the fieldwork communities. We are not able to directly transfer these findings to other western settings. However, the hermeneutic process is designed for topical saturation, which adds to our ability to interpret rich meaning from the data collection. We also identified all assumptions at the beginning of both studies and addressed them within the findings and discussion of each paper. This created internal consistency for the project. The findings identified here nevertheless provide a platform for coherence to similar settings. Where relevant, we have attempted to find coherence to prior studies conducted with these groups.

We attempted to show goodness of fit between the research product and the methods supporting the study design by having kept the context viable throughout the study process and by maintaining the "voice" of the *emic* perspectives. These aspects are absolutely essential for claiming adherence to the constructivist (i.e., naturalistic inquiry) methodology proposed by Lincoln and Guba<sup>56,57,89</sup>. To avoid the risk of lost or misinterpreted *emic* meaning by the use of an interpreter, informants were asked to elaborate first-hand responses during follow up, which posed questions on the same topic from different angles.



# Conclusions

Medical anthropologists are currently missing from maternal health advisory and national level policy networks. Our findings suggest that the addition of this expertise could complement efforts to understand why adverse childbirth outcomes occur in western, high-income settings. Additionally, the notion 'maternal migration effect' may allow for theorizing delay-causing socio-cultural factors as well as their potential to influence a migration-based maternity care encounter. Both can have broad implications for global maternal health initiatives, including Millennium Development Goal-5.

The use of constructivist proxies for medical anthropology allowed for an equal representation of both immigrant women and their maternity care providers during a clinical care encounter. Mutual broken trust between women and care providers appeared to result in delays at the health facility level. Various aspects of broken trust appeared to negatively influence women's choice to seek care, but also their utilization of it. Broken trust also helped to facilitate frustrations among the care providers. The potential for imposing delays on the shared care clinical encounter is thus mutual, and suggests a strong potential for less than optimal maternity outcomes. The unmet expectations among these providers were worsened by the lack of consistent, problem-specific clinical guidelines, especially about refusal of emergency treatment. However, these care providers were also faced with insufficient staff occurring at the time of the study, and over-reliance upon less than optimal interpreter services.

Miscommunication was identified as the strongest negative influence on infrastructure management. This has important implications for both immigrant women and their care providers. Many of the women were unable to gain access to the provider's expertise or to a sound understanding of the preventive strategies on offer. Limited informed consent is implied. Miscommunication seemed to hinder medical providers from delivering their medical expertise according to their training, and from understanding the needs of their clients at a deeper level. Our findings suggest that some maternity clinicians might also rely too much on presumed cultural factors, insomuch as the appropriate management of an immigrant woman's obstetric needs might be obscured by the interjection of culture-based misconceptions. Becoming informed about women's socio-cultural factors may help to

facilitate more open and trusting dialog during the care encounter, which might also benefit women's perceptions about receiving competent care. Shared language was found to be an underlying component of the culture-sensitive model, and not simply an instrument for implementing it. The demand for shared language capacity and reliance upon medical interpreters having an unregulated training background thus magnifies the need for defining standardization of medical interpreter education.

To date, the western medical community has yet to completely understand the influence of women's pre-migration experiences on their post-migration maternity choices. One of the participant groups in this project has been migrating into European countries for over two decades due to reasons of civic uprootedness in their homelands. The implication of diasporic migration is that migrating adults are motivated by choices other than a simple lifestyle change. Understanding these parents' childbearing needs thus likely involves incorporating their past experiences before arriving in the host country. Preventive treatment strategies may thereby remain limited on the essential topics of caesarean refusal unless reasons for women's avoidance of it become incorporated into their standard maternity care.

This project sought to conceptualise the maternal migration effect for Somalis who have experienced diasporic migration and who now live in a western European country. By this, we have identified a number of pre-migration factors related to childbearing that remain relevant in the post-migration context. Mothers appear to maintain an attitude about seeking care out of necessity for a suspected problem. This finding implies that an unanticipated emergency may go undetected if the mother's insight into the potential risks is limited. Nevertheless, the findings suggest that transitions related to childbearing are underway. The reputation of the African father, from what was once considered a disconnected figure to the processes of pregnancy and childbirth, may be strengthened by our findings. Many men in the diaspora act as the sole private support system for their wives and newborn children. These Somali fathers actively embraced this opportunity. The Somali mothers also appeared to be gaining new experiences and independence away from the traditional female kin-based support systems that afforded them a passive role – whether it was required or not. However, trust was confirmed throughout the entire project as an issue of concern. Additionally, certain aspects of the intimate postpartum experience are paving the way toward more open, intimate dialog between the couple, at least for the parents involved in this project. Private dialog about matters of the body may have positive implications for approaching western care providers, as well as the care encounter, with increased insight and confidence. From the viewpoint of care providers, these socio-cultural

processes of childbearing can inform the depth of care required for this group.

Western maternity clinicians strive to provide best care to all new parents as a matter of course. However, our findings suggest that the needs of immigrant clients are underrepresented and anecdotally linked to recommendations derived from evidence on western clients in western settings. Guidelines targeting an evidentiary platform might better include specific-needs for these parents, bearing in mind their own pace toward progress, as well as the potential for lingering pre-migration influences that might not meet the western standard for preventive care. The increased insight offered by these findings, which were derived by qualitative proxies that mimic medical anthropological research procedures, can lend a glimpse into the provision of evidence-based western maternal healthcare for immigrant African women and their partners.

# Clinical Recommendations

The following recommendations should be used to optimize the shared care encounter between immigrant women and men from low-income countries and their European healthcare providers. The advice is based on results from our medical anthropological studies, which has had the goal to situate the care consultation as an arena having two experts: the caregiver and the client.

## Women from low-income countries

- Improve your awareness of the new local language and be aware of your rights to use a medical interpreter service
- Become informed about the healthcare system in the new setting, especially its emphasis on prevention
- Seemingly appropriate habits in the country of origin may not always be appropriate in the new country. Discuss your ideas with the clinician about how to make motherhood safer for you
- Participate regularly during pregnancy with your willing partner in patient education groups

## Maternity care providers

### Antenatal and postpartum care

- Inform the women from low-income countries about the advantages of regular ANC-controls and about seeking immediate treatment if severe symptoms appear. Confirm your definition of medical concepts, such as symptom severity, with those of the woman
- Inform the women from low-income countries about the reasons for CS and the safety of this procedure in Europe.
- If you have several pregnant Somali women, it could be worthwhile to form a specific parents' education group – thereby creating an interactive focus group to share and identify concerns
- Midwives should encourage Somali couples toward open dialog about their needs for shared postpartum intimacy, including the sexual relationship and communication about the body, and not only anti-conception

## Intrapartum care

- Discuss your own conceptions about obstetric interventions, such as CS and induction, with the patient and her partner *before* an unexpected emergency situation arises
- Develop guidelines on how to best manage refusal of treatment interventions, such as CS and induction of labor

## General recommendations

- Do not let your own opinions about cultural mechanisms guide your medical risk assessment
- Ensure a good dialogue with the foreign-born women, using interpreter services when needed. Demand that such services be optimized if needed

## Clinical researchers

- Clinical research questions, which are driven by evidence-based practice, could be more deeply investigated using medical anthropological expertise
- Qualitative health methods that are inspired by medical anthropology can be useful for understanding the complexity of clinical phenomena
- The anthropological concepts *emic* and *etic* can become part of the clinical research design when the goal is to explore a migration-based clinical care encounter

## Health policy makers

- Revise European national health service requirements for medical interpreter services as a component of the Millennium Development Goal 5
- Anthropological expertise can benefit medical quality and patient assurance for safety
- Quality controls should include questions related to migration, integration, and communication
- Support and further co-ordinate migration-related investigations and interventions at the national level

# Clinical Recommendations in Swedish (Kliniska Rekommendationer)

Nedan följer råd och rekommendationer för att optimera mötet mellan invandrade kvinnor och män från låginkomstländer och vårdgivare inom den europeiska mödra- och förlossningsvården. Råden baseras på resultat från våra medicinsk-antropologiska studier och syftar till att göra konsultationen till en arena med två experter på förlossningsrummet, kvinnan och doktorn/barnmorskan.

## Kvinnor från låginkomstländer

- Förbättra dina språkkunskaper i det nya hemlandet och värna om din lagstadgade rätt till tolkservice
- Förbättra dina kunskaper om hälso-och sjukvården, speciellt den preventiva delen
- Goda vanor och seder i hemlandet faller inte alltid väl ut i det nya hemlandet. Diskutera dina föreställningar om hur man bäst uppnår en okomplicerad graviditet, förlossning och eftervård med din barnmorska och läkare
- Deltag regelbundet, gärna tillsammans med din partner, i föräldrautbildningen

## Mödravården

- Informera kvinnor från låginkomstländer om fördelarna med regelbundna MVC-besök, även vid besvärsfrihet, samt att söka akut vid allvarliga symptom. Uppllys kvinnan om vad du menar med allvarliga symptom
- Informera kvinnor från låginkomstländer och deras partner om medicinska indikationer till kejsarsnitt och om säkerheten omkring ingreppet i Sverige
- Om Du har flera gravida patienter från låginkomstländer, kan det vara av värde att bilda en egen föräldrautbildningsgrupp. En interaktiv fokusgrupp bildas därmed

- Barnmorskor rekommenderas att befrämja en öppen dialog om sexuell hälsa med somaliska par vid efterkontrollerna på MVC, utöver sedvanlig preventivmedelsrådgivning

## Förlossningsvården

- Diskutera dina, patientens och partnerns föreställningar om obstetriska interventioner som kejsarsnitt och induktion *innan* en eventuell akut situation uppstår
- Utforma PM för handläggning av kvinnor som vägrar interventioner så som kejsarsnitt eller induktion

## Generella råd för mödra- och förlossningsvården

- Försäkra dig om en bra dialog med patienter och använd alltid tolk när det behövs
- Kulturrelaterade fenomen är dynamiska och ändras inte sällan i samband med migration, detta inkluderar även synen på djupt rotade traditioner som kvinnlig omskärelse

## Kliniska forskare

- Kliniska forskningsfrågor med evidensbaserad ansats har en potential att bli förstådda på ett djupare sätt med hjälp av antropologisk expertis
- Kvalitativa metoder inspirerade av medicinsk antropologi har visat sig vara ett användbart tillvägagångsätt för att förstå komplexa kliniska frågeställningar
- Antropologiska begrepp som 'emic' och 'etic' kan med fördel bli en del av studiedesignen när mötet mellan vårdgivare och invandrade patienter ska utforskas

## Beslutsfattare inom Hälso- och Sjukvården

- Antropologisk expertis kan med fördel användas vid det medicinska kvalitets- och patientsäkerhetsarbetet
- Kvalitetskontroller bör även omfatta frågorna som rör migration, integration och kommunikation
- Se över sjukvårdens rutiner för tolkservice, på nationell nivå, som en del av Millieniummål 5
- Stöd fortsatt migrationsrelaterad forskning och utformning av åtgärdsprogram på nationell nivå

# Summary

In 1990, the United Nations created Millennium Development Goal 5 (MDG-5) to prioritize the health and well-being of all women and to reduce the global maternal mortality and morbidity rate by 75% by the year 2015. The majority of maternal deaths and morbidities occur in low-income settings, but maternal death is considered rare in the western world. Nevertheless, some immigrant women from non-western countries, who give birth in Europe, die from childbirth-related causes. Others have greater risk for the death of their infants or severe illness resulting from childbirth. Little attention has been given to socio-cultural factors that may explain women's elevated risk. This lack of interest exists even though the global effort to improve the effectiveness of health services includes both cultural competence and evidence-based practice. Additionally, the capacity of the MDG-5 initiative to avert maternal death and morbidity is said to depend not only on the availability of services and women's rate of utilization, but also on discovering from the women themselves why utilization might be low.

Following migration from a high-mortality to a low-mortality setting, first generation immigrant women of reproductive age may likely remain influenced by childbearing experiences or hearsay about others' experiences from their country of origin. Such influences may pose negative consequences to maternity outcomes, even if women have easy access to well-equipped care facilities in western settings. We call this phenomenon the *maternal migration effect* and emphasize that knowledge about which pre-migration factors can impact a woman's post-migration experience is crucial to providing effective maternity care.

Many mothers represented in the literature on maternal death and morbidity in the western world are from low-income settings in sub-Saharan Africa – primarily from Africa's Horn. These women are reported to have difficulties related to care-seeking and utilization of available maternity care services. This thesis conceptualizes socio-cultural influences that affect maternal care-seeking and utilization, and on the clinical care encounter itself. Its findings may help to support future research, maternity care guidelines, and national and global enquiries into adverse childbirth outcomes in western countries. A multidisciplinary approach bridges the disciplines of medical anthropology and international maternal health. The overall focus is on childbearing in two European settings among immigrant African mothers



and fathers from sub-Saharan countries, mainly Somalia. Study 1 conceptualizes the post-migration antenatal and birth care encounter in the United Kingdom (UK). Study 2 explores pre-migration influences on post-migration childbearing in Sweden during the pre-pregnancy, antenatal, childbirth, and postpartum periods.

In Study 1, we modified a popular conceptual framework used in the low-income African context – the ‘three delays’ model – for the high-income context of urban London, UK. Our modified framework proposes why some women from sub-Saharan Africa experience adverse childbirth outcomes in western settings. For the first publication, we analyzed data collected by in-depth and focus group interviews with 54 immigrant African women and 62 London-based maternity care providers. The analysis identified several factors that might cause delays at each of the three phases: women’s care-seeking, their accessibility to available maternity care facilities, and their receipt of optimal maternity care. Delays can result from: a) individual broken trust during the care encounter, which can lead to women’s late-booking or refusal of treatment interventions, and can be expressed as in frustration for care providers; b) over-reliance on poorly-functioning interpreter services, which can delay women’s access to the care provider’s medical expertise; and c) mutual broken trust and language barriers, as well as limited motivation or means to develop appropriate system-level guidelines for women’s avoidance of treatment.

In a second paper, we analyzed the interviews with 39 Somali women and 62 maternity care providers. Findings suggest limited coherence between women’s and care providers’ conceptualizations about preventive treatment, caesarean section, refusal of emergency treatment, and coping strategies following adverse birth outcomes. The third publication included the interview data from all African women and care providers plus data from in-depth interviews with 10 white British women collected over the same study period. We problematized the care providers’ assumptions about immigrant women’s maternity care preferences. We found that women prefer provider competence over the presumed gender- and ethnic-congruence. However, congruent language was found to be the key ingredient in the provision of culture-sensitive care.

In Study 2, we recruited Somali women and men who had experienced diasporic migration and who had borne at least one child in Sweden. Data were collected from 30 in-depth interviews with fathers, and from three focus group discussions with 16 fathers and seven focus group discussions with 27 mothers. We were able to identify pre-migration socio-cultural factors from a literature review that could be applied to our dataset, and then we analyzed for their potential influence on the parents’ post-migration experience. After migration, mothers feel encouraged toward facility-based

childbirth, although some forgo antenatal screening during the first pregnancy after migration. Some maintained an attitude that antenatal care-seeking is required only when necessary, although they attended regular check-ups. While considered forbidden, women have begun to use contraception for spacing births. Fathers expressed concerns about being neglected by midwives from contraception-planning encounters. Fathers viewed the traditional social pressure from other women about yearly pregnancy as a negative influence on their private circumstances. There is potential for women's delayed care-seeking at birth, despite that childbearing is still perceived as life-threatening. Fathers strive to understand preventive interventions to replace fears of maternal death or illness. Decision-making is shared, especially in relation to the circumcision of children. All parents were against the circumcision of daughters. Men trusted maternity clinicians to fill their gaps in knowledge. Women appeared to trust care providers less than their partners. The postpartum period affords fathers a role in childbearing and women increased independence.

A second publication involved the focus groups and a short, fictional narrative about a Somali couple's postpartum sexual problems. This narrative was constructed during the anthropological fieldwork, and was based on an anecdotal story told by the study interpreter. We explored the postpartum "aftercare" needs (for the period postpartum to 12 weeks). Men's aversion to sexual activity may have resulted from angst about causing their wives pain during childbirth, which did not meet their conceptions as a responsible support provider. Women adjusted to the loss of traditional kin support systems, but were mixed about receiving exclusive support from their husbands. Fathers embraced their new supportive roles. Women were unaware about their partner's sexual anguish. Women's autonomy appears enhanced in this setting but there is great need for intimate communication with the partner and reliance upon professional care services.

The results of this dissertation imply the need for European maternity care professionals to incorporate socio-cultural evidence into the provision of care to immigrant African parents. It may also benefit local and national level maternal health policy makers to include advice from medical anthropologists, as well as the results of studies that explore socio-cultural factors. In the United Kingdom, the possibility among first-generation immigrants for avoiding or refusing emergency treatment interventions, such as caesarean section, could be developed into official care guidelines. In Sweden, the current available advice for providing optimal care during the antenatal, intrapartum, and postpartum periods is presently limited to evidence obtained mostly from non-immigrant groups. Maternity care guidelines tailored to the specific needs of immigrant African couples, especially Somali, may respond well to these parents' willingness to share childbearing experiences following diasporic migration.

## Summary in Swedish (Sammanfattning på Svenska)

Det femte millenniemålet (MDG-5) skapades 1990 av FN för att prioritera alla kvinnors hälsa och välmående samt minska den globala mödradödligheten och morbiditeten med 75 % fram till år 2015. Majoriteten av alla mödradödsfall och fall av svår mödrasjuklighet inträffar i låginkomstländer och mödradödlighet är ovanligt i västvärlden. Inte desto mindre händer det att invandrarkvinnor från låginkomstländer avlider i Europa på grund av graviditetsrelaterade komplikationer. Dessa kvinnor löper även en högre risk för perinatal död och svår mödrasjuklighet. Uppmärksamheten på de ökade riskerna har främst riktats mot underliggande medicinska orsaker, såsom blödning, bäckenförträngning, och sepsis, eller sambandet med socioekonomiska riskfaktorer. Mycket mindre uppmärksamhet har riktats mot underliggande sociokulturella faktorer som kan förklara den ökade risken. Trots att de globala ansträngningarna för att förbättra sjukvårdens kvalitet omfattar både kulturkompetens och evidensbaserad praxis föreligger det ett ointresse för sociokulturella faktorer. Dessutom hävdas det ofta att möjligheterna att uppnå det femte millenniemålet att avvärja mödradödlighet och sjuklighet inte bara är beroende av vårdens tillgänglighet och i vilken grad kvinnorna utnyttjar den, utan också av att man kommer underfund med varför kvinnorna kanske inte utnyttjar vården.

Efter migration fortsätter den första generationens invandrarkvinnor i reproduktiv ålder förmodligen att påverkas av sina egna eller andras berättelser om erfarenheter av barnafödande i hemlandet. Konsekvenserna av denna påverkan kan vara ett negativt förlossningsutfall, även om kvinnan har god tillgång till välutrustad sjukvård. Vi kallar detta fenomen *the maternal migration effect* (på svenska ungefär 'Migrationseffekt på mödraskapet') och betonar att kunskap om vilka faktorer som härrör från tiden före migration och som kan påverka en kvinnas erfarenheter efter migration är nödvändiga för att erbjuda en mödra- och förlossningsvård av hög kvalitet i västvärlden.

Många av de invandrarkvinnor som förekommer i litteraturen om mödradöd och mödrasjuklighet i västvärlden kommer från låginkomstländer i Afrika söder om Sahara, främst från Afrikas horn. Dessa kvinnor beskrivs mer

sällan söka vård och till en lägre grad utnyttja tillgänglig mödrahälsovård. Denna avhandling begreppsliggör de sociokulturella influenser som påverkar kvinnors vårdsökande och utnyttjande av vården, samt av själva konsultationen. Fynden kan användas som stöd i utformande av riktlinjer och i utredningar av negativa förlossningsutfall på nationell nivå. En flervetenskaplig ansats med utgångspunkt i både medicinsk antropologi och internationell mödrahälsa har använts. I fokus står barnafödande bland afrikanska, främst somaliska, kvinnor och män i två europeiska länder. I den första studien undersöks barnafödande och vårdmöten efter migration till Storbritannien. Studie 2 utforskar influenser från tiden före migration på barnafödande (tiden före graviditet, under graviditet, förlossning och barnsängstid) efter migration till Sverige.

I Studie 1 anpassade vi ett konceptuellt ramverk som ofta använts i afrikanska sammanhang med små ekonomiska resurser, 'the three delays model', till en miljö med större ekonomiska resurser i London, Storbritannien. Vår modifierade modell föreslår orsaker till varför en del kvinnor från Afrika söder om Sahara drabbas av negativa förlossningsutfall i västvärlden. I den första artikeln analyserade vi fokusgrupp- och djupintervjuer med 54 afrikanska invandrarkvinnor och 62 vårdgivare inom mödra- och förlossningsvården i London. Flera faktorer som kan orsaka fördröjningar i var och en av de tre faserna beskrivna i modellen kunde identifieras: kvinnors sätt att söka vård, deras tillgång till tillgängliga sjukvården, samt mottagandet av optimal vård. Fördröjningar kan orsakas av (a) ett ömsesidigt brustet förtroende mellan patient och vårdgivare, vilket kan leda både till att kvinnor skriver in sig sent i mödrahälsovården eller att de vägrar behandling, och att vårdgivarna blir frustrerade, (b) en alltför stor tilltro till dåligt fungerande tolktjänster, vilket kan fördröja kvinnors tillgång till vårdgivarens medicinska expertis, och (c) bristande motivation eller resurser till att utveckla ändamålsenliga riktlinjer på systemnivå för hur man handskas med kvinnor som undviker erbjuden behandling.

I den andra artikeln analyserade vi 39 intervjuer med somalier och med vårdgivare från mödra- och förlossningsvården. Resultaten visar att kvinnornas och vårdgivarnas konceptualisering av preventiv hälsovård, kejsarsnitt, vägran att ta emot akut sjukvård, samt strategier för hur man handskas med följderna av förlossningskomplikationer stämmer dåligt överens. Den tredje artikeln i denna studie inkluderade data från alla de afrikanska kvinnorna och vårdgivarna samt data vi samlade genom djupintervjuer med 10 vita brittiska kvinnor. Vi problematiserade risken för att vårdgivarna har förutfattade idéer som inte stämmer överens med vad invandrarkvinnorna faktiskt förväntar sig av mödra- och förlossningsvården. Vi fann att kvinnorna anser att vårdgivarens kompetens har större betydelse

än deras kön och etniska bakgrund. Kommunikation på ett gemensamt språk fann vi dock vara en nyckelingrediens i kultursensitiv vård.

I Studie 2 rekryterade vi somaliska män och kvinnor som hade migrerat från hemlandet och därefter fött minst ett barn i Sverige. Fäderna skulle ha varit närvarande vid minst en förlossning. Vi samlade data från 30 djupintervjuer med fäder, tre fokusgruppintervjuer med 16 fäder och sju fokusgruppintervjuer med 27 mödrar. Genom en litteraturgenomgång efter datainsamlingen kunde vi identifiera sociokulturella faktorer relaterade till graviditet och förlossning som var relevanta för denna grupp före migration. Vi applicerade dessa faktorer på våra kvalitativa data och analyserade deras potentiella påverkan på föräldrarnas erfarenheter efter migration. Vi upptäckte att kvinnorna efter migration uppmuntrades att söka förlossningsvård på sjukhus, en del avstod dock från mödrahälsovård under den första graviditeten efter migration. Vissa kvinnor behöll inställningen att man enbart behöver söka vård under graviditeten om man måste, men de gick likväl på sina planerade besök. Kvinnor hade börjat använda preventivmedel för att glesa ut graviditeterna, även om detta inte ansågs vara religiöst tillåtetsansågs tillåtet. Fäderna var bekymrade över att bli negligerade av barnmorskor vid preventivmedelsrådgivning. Männerna ansåg att det sociala trycket på deras fruar från andra kvinnor att genomgå en graviditet varje år pågrund av traditionella värderingar. Det finns en risk att kvinnor dröjer med att söka vård under graviditet och förlossning, trots att man uppfattar tillstånden som livshotande. Fäderna strävar efter att förstå att förebyggande åtgärder kan ersätta rädslan för mödradöd och sjukdom. Föräldrarna tar beslut gemensamt, särskilt när det gäller omskärelse av barnen. Det minskade sociala trycket bidrar till att alla föräldrarna var emot omskärelse av döttrarna. Männerna litade på vårdgivarnas förmåga att överbrygga deras egen okunskap om barnafödande. Kvinnorna föreföll lita mindre på vårdgivarna än deras partner. Under tiden efter förlossning fick männen en viktig roll och kvinnorna en ökad självständighet.

En andra artikel utgick från fokusgruppdiskussioner i vilka en kort fiktiv berättelse om ett somaliskt pars sexuella problem efter förlossning lästes högt eller återberättades. Denna berättelse konstruerades under det antropologiska fältarbetet och baserades på en anekdot berättad av projektets tolk. På detta sätt utforskade vi vilka behov som somaliska par har av eftervård under postpartumtiden (upp till 12 veckor efter förlossning). Bland män som avstod från sex efter förlossning fann vi en kombination av oro och ansvarstagande för den starka smärta som de orsakat sina hustrur under förlossningen, enbart genom att befrukta henne. Kvinnors förlust av traditionella stödstrukturer karakteriserade deras behov efter förlossning. Mödrarna hade skilda åsikter om de önskade få stöd av enbart sina män, medan fäderna åtog sig sina nya roller och lärde sig att ta hand om sina

nyfödda barn för att hjälpa mödrarna. Kvinnorna var omedvetna om sina mäns ångestfyllda motvilja mot sexuell intimitet. Kvinnors autonomi förbättrades i detta sammanhang men det fanns ett stort behov av en nära kommunikation mellan parterna, liksom en hög tilltro till professionell vård.

Resultaten av denna avhandling visar att den europeiska mödra- och förlossningsvården behöver införliva sociokulturell evidens i vården av invandrade afrikanska föräldrar. Beslutsfattare på lokal och nationell nivå kan dra nytta av råd från medicinska antropologer, liksom resultat från studier som utforskar sociokulturella faktorer, när man utvecklar sjukvårdspolicy för att hantera ökad risk för mödradödlighet och svår morbiditet i respektive land. I Storbritannien finns det en möjlighet att utveckla officiella riktlinjer för hur man bemöter första generationens invandrarkvinnor som vägrar akuta interventioner, såsom kejsarsnitt. I Sverige bygger de nuvarande riktlinjerna för optimal vård under graviditet, förlossning och barnsängstid främst på evidens från studier av grupper som ej migrerat. Att anpassa riktlinjer för mödra- och förlossningsvård för de specifika behov som de afrikanska invandrade paren har kan ge positiva effekter, då dessa föräldrar har visat sig beredvilliga att dela med sig av sina erfarenheter av barnafödande efter migration.

## Summary in Somali (Dulmar Af Soomaali ah)

1990 kii, ayaa Qaramadda Midoobay abuurtay 5 Haddaf Horumarineed ee Qarniga (MDG-5) oo muhim looga dhigayo caafimaadka iyo fayo-qabka dumarka oo dhan; oo lagu dhimayo heerka umul-raaca iyo jirooyinka dhalmada ee caalamka ilaa iyo 75% marka la gaaro 2015. Intabadan dhimashooyinka umul-raaca iyo dhaawacyada dhalmada waxay ka dhacdaa meelaha dhaqaalahu hooseeyo, laakiin umul-raaca wadamada reer Galbeedka waxaa loo arkaa mid aad u yar. Si kastaba ha ahaatee, qaar haweenka ka soo guuray wadama aan Galbeedka ahayn, oo ku dhala gudaha Yurub, ayaa u dhinta dhibaato xaga dhalmada ugu timaada. Kuwa kalana waxay khatar ugu jirraan in ilmahoodu ka dhintaan ama jirooyin daran oo kasoo gaaray dhalmada. Markii dhibaatooyinkan la eegay, waxaa muhiimadda koobaad la siiyay sababaha caafimaad, sida dhiig-baxa, ilmaha oo soo bixi waaya iyo sepsis (jirkoo iska difaaci waaya dhaawac ku yimaada), ama sida ay ula xariiraan sababo dhaqaalo-bulsheedka. Muhiimad aad u hoosaysa ayaa la siiyay sababaha dhaqan-bulsheedka, taas oo sabab u noqon karta khatarta dumarka oo kor u kacday. In aan muhiimad la siin sababaha dhaqan-bulsheedka waa mid jirta, inkastoo dadaalka caalamiga ah ee lagu horumarinayo waxtarka adeegyada caafimaadka ay tilmaamayso in la tixgaliyo cadaymaha caafimaad iyo dhaqankaba. Waxaa intaas dheer, awoodda hadafka MDG-5 ay ku joojinayso umul-raaca iyo jirooyinka dhalmada la sheegay in uu ku xirnayn oo kaliya helitaanka adeegyada iyo heerka ay dumarku uga faa'iidaystaan, balse ay sidoo kale ku xirantahay in dumarka la waydiiyo sababta uu u yaryahay isticmaalkoodu.

Marka la eego, ka guuritaanka degaan dhimashada umuleed badan tahay oo loo guuro meel ay dhimashada umuleed yar tahay, jiilka ugu horeeya ee ka soo jeeda dadka dalka u soo guuray ee wakhti ay dhali karaan ku jira, waxay u badan tahay in ay saamayn ku yeelatay sheekooyinka iyo kutiri-ku-teenka dhalmada ee wadankoodii ka jirtay. Saamaynta noocaas ah waxay yeelan kartaa saamayn xun, xataa hadii ay awoodaan goobo adeeg caafimaad oo aad u qalabaysan. Dhacdadaan waxaan u naqaan, *maternal migration effect (saamaynta guuritaanka uu dhalmada ku leeyahay)*, waxayna cadaynaysaa in ay muhiim tahay ogaanshaha in sababo soo guuritaanka qofka ka hor ay saamayn ku yeelan karaan waxa ay la kulmayso qofka dumar ah marka ay wadan cusub timaado, si adeeg waxtar leh looga helo wadamada reer Galbeedka.

Hooyooyin badan oo ku jira qoraalada umul-raaca iyo dhaawacyada umusha ee wadamada reer Galbeedka ayaa ka yimid degaanno dhaqaale hooseeya ee Afrikada Saxaaraha ka hoosaysa – oo ay ugu badan yahiiin Geeska Afrika. Dumarkan waxaa la soo tabiyay in ay la kulmeen dhibaatooyin ay ka mid yahiiin in aanay raadsan daryeel iyo iyaga oo aan si joogto ah uga faa’iidaysan adeegyada lagu daryeelayo umulaha. Teesahan waxuu figrad ka dhiibayaa oo baaritaan ku samaynayaa saamaynta dhaqan-bulsheedku uu ku leeyahay raadsiga daryeelka dhalimada iyo isticmaalka adeegyada dhalimada, iyo la kulanka daryeelka caafimaad laftiisa. Helitaanada qoraalku waxuu gacan ka gaysan karaa in uu taageero nidaamka loo caawiyo umusha iyo baaritaanka qaranka ee lagu ogaanayo dhalitaanada waxyeelada leh ee wadamada reer Galbeedka. Qaab dhinacyo badan leh ayaa la isticmaalay, waxuuna isu keenayaa qaybaha aqoonta daawaynta dadka iyo caafimaadka dhalimada ee caalamiga ah. Waxaa si gaar ah loo eegayaa uur-qaadida laba meelood oo Yurub ah oo la darsayo aabayaasha iyo hooyooyinka ka yimaada Afrikada Saxaaraha ka hoosaysa, khaasatan Soomaaliya. Daraasadda 1 waxay baaraysaa dhalimada marka dibadda loo soo guuro iyo sida adeegga-caafimaad ee wadanka Boqortooyada Biritishka (UK) loo isticmaalay. Daraasadda 2 waxay baaraysaa saamaynta inta aan dalka la imaanin ay ku leedahay ilmo qaaditaanka marka loo soo guuro Sweden, inta lagu jiro uuraysiga ka hor, wakhtiga uurka, dhalimada iyo wakhtiyada umusha lagu jiro.

Daraasadda 1, waxaan wax ka badalnay qaab fakareedka loo adeegsado qoysaska dhaqaalaha-hooseeya ee Afrikaanka ah – qaabka “saddexda dib-dhigid” - oo loo badalay habka qoysaska-dhaqaalaha sare ee magaalada London, UK. Nidaamkeenii la badalay waxuu markaas soo jeedinayaa sababta ay dumar badan oo ka yimid Koonfurta Saxaaraha Afrika umaraan dhalitaan waxyeelo leh marka ay Galbeedka yimaadaan. Daabacaaddii ugu horaysay, waxaan si qotodheer ugu qaadaa-dhignay warbixinta la aruuriyay, waxaana si gaar ah u eegnay waraysiyada lala yeeshay 54 dumar dalka u soo guuray oo Afrikaanka ah iyo 62 bixiya adeegyada caafimaad oo London kuyaal. Baaritaanka waxuu cadeeyay sababo dhowr ah oo keeni karaa dib u dhac ku yimaada mid walba oo ka mid ah saddexdan weerood: doonashada daryeelka ee haweenka, sida ay ku tagi karaan adeegyada daryeelka umulaha, iyo helitaankooda daryeel caafimaad oo sare. Daahitaanadu waxay keeni karaan (a) qofka oo ka aamin baxa marka uu daryeelka caafimaad la kulmo, taas oo keeni karta in qofka dumarka ah ay wakhti danbe tagto ama ay diiddo in la daaweeyo, taas oo lagu tilmaami karo in ay wareer ku tahay bixiyayaasha daryeelka caafimaad; (b) in aad loogu xirnaado adeegyo turjumaad oo aan si wanaagsan u shaqaynayn, kuwaas oo daahin kara in dumarku tagaan bixiyayaal daryeel caafimaad oo khibrad leh; iyo (c) in aanay jirin is-aaminid, xiriirka luuqadeed adag, iyo in sidoo kale ay jirto



dhiirigalin hoosaysa ama in la sameeyo qaab nidaam ah oo lagu horumariyo habka looga hortagayo in dumarku daawaynta diidaan.

Warqadda labaad, waxaan ku baarnay 39 Soomaali la waraystay iyo 62 kuwa bixiya dareylka caafimaad. Waxa la ogaaday in aan isku-xirnaan wanaagsan ka dhexayn isfahanka dumarka iyo bixiyayaashada daryeelka qaabka daaweynta ka hortagga ah, qaliinka dhalmada, diiditaanka daaweynta deg-degga ah, nidaamka loo wajahi karo dhalitaanka dhalmada ee dhibta leh. Daabacaadda saddexaad waxaa ku jira warbixino laga qoray dhamaan dumarka Afrikaanka ah iyo bixiyayaasha daryeelka caafimaad ee aanu waraysanay, oo lagu daray waraysiyo dheer oo aan la yeelanay 10 dumar cadaan Biritish ah. Waxaan baarnay in ay dhici karto in bixiyayaasha daryeelku ay khalad ka fahan sanyahiin rabitaanada daryeelka dhalmada ee dumarka dibadda ka yimid. Waxaan ogaanay in dumarku ay jinsiga iyo isku mid ahaanshaha asalka qofka daaweynaya ay uga muhiimsan tahay in ay helaan daaweyn waxtar leh. Hase ahaatee, luuqad la isla fahmo waxaa la ogaaday in ay tahay mid saldhig u ah in la bixiyo daryeel caafimaad oo tixgalin siiya dhaqanka.

Daraasadda 2-aad, waxaan qoranay dad isugu jira, rag iy dumar kuwaas oo waayo-aragnimo u leh qurbaha, ugu yaraanna hal cunug ku dhalay dalka Sweden. Aabayaashu waa inay ugu yaraan dhalmadooda hal cunug ka qaybgaleen. Warbixino ayaa laga aruuriyay waraysiyo qotodheer oo 30 gaaraya oo aabayaasha lala yeshay, iyo waraysiyo laga soo aruuriyay saddex koox doodeed ay ku jiraan 16 aabe iyo waraysiyo laga soo aruuriyay todoba koox doodeed ay ku jiraan 27 hooyo. Markaan si cilmiyaysan u baarnay natiijada warbixinada la aruuriyay, waxaa noo suurtagashay in aan ogaano sababo dhaqan-bulsheed oo soo guuritaanka ka horeeyay oo aan ku isticmaali karno warbixinteenaa, oo aan ka dib baari karno saamayntooda ay ku yeelan karaan nololsha waalidka marka ay dalka u soo guuraan. Waxaan ogaanay in soo guuritaanka ka dib, in hooyooyinku ku dhiiradaan nidaamka dhalmada ee loo sahlay, in kasta oo qaarkood aysan aadin baaritaanada wakhtiga uurka ugu horeeya marka ay dalka yimaadaan. Hooyooyinka qaar ayaa aaminsan in raadinta daryeelka mudada uurka ay muhiim tahay oo kaliya markii loo baahdo, inkastoo ay aadaan baaritaano joogto ah. Iyagoo u arka in ay mamnuuc tahay ayaa dumarku waxaay bilaabeen inay isticmaalaan qalabka lagu xadido dhalmada si aay u kala fogeeyaan dhalmada. Aabayaasha ayaa walaac ka muujiyay in aanay umulisu doonaan kala tashan kulanada qorshaynta waxyaabaha xadididda dhalmada.

Aabayaashu waxay u arkaan in culees dhaqameedka bulshada ee dumarka kale ku saarayaan in sanad walba la dhalo ay tahay mid xun. Waxaa wali suurto ah in dumarku daahiyaan in ay daryeel-caafimaad doonaan, in kasta oo wali la fahansan yahay in dhalmadu khatar noqon karto.

Aabayaasha waxaay isku dayaan inay fahmaan in marka talaabooyin ka hortag ah la isticmaalo ay keeni karto in hooyada laga badbaadiyo dhimasho ama dhaawac halis ah. Go'aanka waa la wada wadaagaa, khaasatan kuwa la xariira gudniinka caruurta. Waalidka way u dhanyihiin kasoo horjeedka gudniinka gabdhaha taas oo ay keentay in culayska bulshadu saarto uu yaraaday. Raggu waxay aamineen bixiyayaasha daryeelka caafimaad in ay u buuxiyaan aqoontooda dhalmada ee yar. Dumarku waxay u egtahay in ay daryeel bixiyayaasha aaminsan yahiin in ka yar nimankooda. Wakhtiga umusha waxay aabayaasha awoodsiiinaysaa in ay qayb ka qaataan ilmo-dhalitaanka, waxayna hooyada siinaysaa xoriyad.

Daabacaad 2-aad waxay ka koobnayd warbixinta kooxda oo kaliya. Sheeko gaaban oo khiyaali ah oo ku saabsan dhibaatooyinka galmada ee qoysaska Soomaalida dhalmada ka dib, ayaa loogu akhriyay ka-soo-qaybgalayaasha. Sheekadaan waxaa la isagu duway qaabka cilmi-bulsheedka, waxaana lagu saleeyay sheeko-maaweelo ah oo ay sheegtay turjumaanka daraasadda. Waxaan sidaas darteed baarnay baahida qoyska/lamaanaha Soomaaliyeed xiliga dhalmada kadib (Mudo 12 isbuuc dhalmada kadib). Waxaan kaloo ogaanay in raggu iska dhowraan galmada iyaga oo cabsi iyo masuuliyad ka dareemaya in ay sababaan xanuunka dumarkoodu maraan wakhtiga dhalmada (maadaama uu uureeyay). In aanay dumarku helin dumarkii sida caadada ahayd daryeeli jiray wakhtiga umusha astaan u noqotay baahidooda wakhtiga umusha. Waxay dumarka waxay ka walaacsanaayeen in ay adeeg khaas ah ka helayaan nimankooda, laakiin ragii aayaa waxaay bardeen sida loo xanaaneeyo ubadka dhashay si ay u caawiyaan hooyooyinka ku jira xiliga umusha. Dumar badan ayaa ogayn dhibaataada nimankooda ka haysata galmada iyo xanuunka dhalmada. Xubnaha dumarku waa isbadalaan, laakiin aad ayaa loogu baahan yahay in dadka isqaba ay isu soo dhawaadaan, sida loogu baahan yahay in lagu xirnaado daryeel caafimaad bixiyayaal khibrad leh.

Natiijada teesahaan waxay aad u dhiirigalinaysaa in daryeelka umulaha ee Yurub u baahantahay in ay xirfadda daryeelka ku darto dhaqan-bulsheedka waaliddiinta Afrikaanka ah ee soo haajiray. Waxuu kale oo anfaci karaa dajiyayaasha siyaasadda caafimaadka dhalmada ee dalka iyo caalamkaba, in ay ku daraan talooyinka aqoonyahanada daaweynta dadka, iyo sidoo kale natiijada daraasadaha baaraya saameynta dhaqan-bulsheedka. Boqortooyada Biritishka, in dadka dalka u soo guuray ay diidaan ama ka dhowrsan karaan in daaweyn dag-dag ah lagu sameeyo, sida qaliinka dhalmada, waxaa laga dhigi karaa hab nidaamsan la aqoonsan yahay. Sweden dhexdeeda, talada hadda jirta oo lagu bixiyo daryeel wanaagsan ee dumarka uurka leh, wakhtiga dhalmada, iyo wakhtiga umusha waxuu hadda ku kooban yahay cadaymaha laga qaado dadka dalka hore u daganaa. Nidaamka daryeelka umulaha oo si gaar ah loogu sameeyo baahida gaarka ah ee qoysaska ka soo

guuray Afrika, khaasatan Soomaaliya, waxay si gaar ah u anfici kartaa rabitaanka waaliddiintan ay ugu gudbiyaan waaya-aragnimadooda dhalitaanka dadka dalka imaanaya ee iyaga ka sii danbeeya.

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Sida aan u sheegay ka soo qaybgalayaasha daraasaddayda, ujeedaddaydu waxay ahayd inaan u sheego daryeel bixiyayaasha baahidaada daryeel iyada oo sida aad u rabto laga eegayo. Walina, marka aan sidan u fiirino, sida aad wax u rabto waxay la mid noqonaysaa tan bixiyayaasha daryeelka caafimaadka iyo ujeedadeena haddii aan nahay waxbaarayaasha. Sidaas darteed waxaan isku dayay inaan gudbiyo oon shaaca ka qaado codadkiina si aad u heshaan caawimaad. Waxaan baaritaankaygan uga warbixinayaa in baahida umuleed ee soomaalida Galbeed aanay ku ekeen gudniin oo kaliya, taas oo ah sida laga aaminsanyahay Boqortooyada Biritish-ka (UK) iyo Sweden. Waraysiyada aan la yeelanay qoysaska (Soomaaliyeed) waxaa ku cad in aabayaasha iyo hooyooyinka – oo wada shaqaynaya – waxay leeyahiin cod xooggan oo ka taageeraya walaacyada arimaha uurqaadka iyo dhalmada-caruurta. Booska aabaha cusub kuma eka sidii hore dhaqanku u haan jiray. Dumarku waxaay haystaan fursad ay ku muujiyaan dhiiranaan iyo awood, maadaama ay barten qaabka loola qabsado nolol qurbaha, iyaga oo aan u baahnayn in ay caawiso qof dumar ah oo ay qaraabo yahiin. Dhabar-adayga iyo kartida waalidka Soomaaliyeed waxay u tahay tusaale iyo dhiira-galin aduunkoo dhan, waxaana rajaynayaa in aan fariintaan ku gudbiyay qoraalkan.

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