



'Moving on' Violence, wellbeing and questions about violence in antenatal care encounters. A qualitative study with Somali-born refugees in Sweden

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ARTICLE INFO

Article history:

Received 25 August 2015

Received in revised form

10 May 2016

Accepted 15 May 2016

Keywords:

Somali women

Maternity care

Migrants

Qualitative

Thematic analysis

Violence

Wellbeing

Sweden

ABSTRACT

Background: Somali-born women constitute one of the largest groups of childbearing refugee women in Sweden after more than two decades of political violence in Somalia. In Sweden, these women encounter antenatal care that includes routine questions about violence being asked. The aim of the study was to explore how Somali-born women understand and relate to violence and wellbeing during their migration transition and their views on being approached with questions about violence in Swedish antenatal care.

Method: Qualitative interviews (22) with Somali-born women (17) living in Sweden were conducted and analysed using thematic analysis.

Findings: A balancing act between keeping private life private and the new welfare system was identified, where the midwife's questions about violence were met with hesitance. The midwife was, however, considered a resource for access to support services in the new society. A focus on pragmatic strategies to move on in life, rather than dwelling on potential experiences of violence and related traumas, was prominent. Social networks, spiritual faith and motherhood were crucial for regaining coherence in the aftermath of war. Dialogue and mutual adjustments were identified as strategies used to overcome power tensions in intimate relationships undergoing transition.

Conclusions: If confidentiality and links between violence and health are explained and clarified during the care encounter, screening for violence can be more beneficial in relation to Somali-born women. The focus on "moving on" and rationality indicates strength and access to alternative resources, but needs to be balanced against risks for hidden needs in care encounters. A care environment with continuity of care and trustful relationships enhances possibilities for the midwife to balance these dual perspectives and identify potential needs. Collaborations between Somali communities, maternity care and social service providers can contribute with support to families in transition and bridge gaps to formal social and care services.

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Introduction

Somali-born women constitute one of the largest groups of childbearing refugee women in Sweden (SCB, 2014). After leaving Somalia, a country torn by more than two decades of political unrest and violence, they encounter a maternity health care system in Sweden that is assigned the task of identifying and preventing exposure to violence (Swedish Society of Obstetrics and

Gynecology, 2008). To undertake this task, midwives need knowledge of how Somali-born refugee women understand and relate to violence and wellbeing, as well as their views on being approached with questions about violence.

Violence against women includes a wide array of manifestations and in this paper the focus is set on war-related political violence at a collective level, and on non-partner sexual violence (NPSV) and intimate partner violence (IPV) at the inter-personal level, in line with definitions made by the World Health Organization (Krug et al., 2002). Migrants' health and health care encounters in receiving countries are influenced by factors both in the sending and receiving countries, and by transnational practices between these contexts

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(Zimmerman et al., 2011; Acevedo-Garcia et al., 2012). Transition theory is applied to situate and deepen the understanding of strategies related to migration and violence among Somali-born women in this paper (Meleis et al., 2000). Transition theory, originating from social psychology, is useful for framing processes of change during migration (Meleis et al., 2000; Baird, 2012; Ramsay et al., 2014) with attention paid to complex interplays of factors at personal, community and societal levels that can facilitate or inhibit healthy outcomes. In migration transition the objective is seldom to leave the old for a completely new set of norms, knowledge and strategies, but rather, to achieve a dynamic integration of new and old resources (Meleis et al., 2000) in a process that takes place over time. In states of successively increased stability, critical points may highlight changes, induce uncertainty and necessitate action. As this process includes elements of both positive development and heightened vulnerability, it may affect people's health (Meleis et al., 2000; Messias, 2002; Baird, 2012).

A link has been suggested between elevated levels of preterm birth among refugee women and refugee stress, based on theories of stress-induced hormonal changes (Shapiro et al., 2013; Liu et al., 2014; Sorbye et al., 2014; Urquia et al., 2015). Potential stressors are likely to be found before, during and after migration in up-rooted life situations, violence exposure, separations or acculturation processes (Lindencrona et al., 2008; Bollini et al., 2009; Byrskog et al., 2014). Increased risks of adverse maternal and perinatal outcomes have been reported, particularly among Somali migrant women (Essén et al., 2000; Malin and Gissler, 2009; Villadsen et al., 2009; Råssjö et al., 2013); but levels of preterm births in these women do not seem to comply with the same high risk pattern (Small et al., 2008; Råssjö et al., 2013; Liu et al., 2014; Urquia et al., 2015). In a recent qualitative study, Swedish midwives did not describe Somali-born women specifically as victims of violence or post-traumatic stress, despite their background of war, migration and adverse birth outcomes (Byrskog et al., 2015). These findings raise questions about how Somali-born women perceive past and present violence, what strategies they apply to cope with these issues and in what ways the midwife might be a resource in these processes.

The midwife has a range of responsibilities within the field of women's health, including violence prevention and identification (Swedish Society of Obstetrics and Gynecology, 2008; The National Board of Health and Welfare, 2012). Midwifery care that is responsive to women's needs, provided by professionals with intercultural skills and clinical knowledge contributes to good quality care and increased incentives for women to access services during pregnancy and childbirth (Renfrew et al., 2014). Vulnerability due to war and migration and unsatisfactory maternity health care encounters after migration has been highlighted among refugee women (Hill et al., 2012; Fernbrant et al., 2013; Benza and Liamputong, 2014), with less attention given to strengthening factors, strategies and resources. As primary caregivers during pregnancy and birth, midwives are expected to provide quality care to pregnant Somali migrant women with lives shaped by war, including asking questions about violence in their care encounters. To accomplish this task, a deeper understanding of Somali-born women's ways of dealing with violence and changes encountered during migration is needed. The aim of this study is to explore how Somali-born women understand and relate to violence and wellbeing during their migration transition and their views on being approached with questions about violence in Swedish antenatal care.

Methodology

An explorative qualitative approach with individual semi-structured interviews was chosen (Green and Thorogood, 2014). In this way we aimed to capture a variety of experiences and

perceptions.

Data collection was carried out from December 2011 to December 2012 in mid-Sweden; where the number of Somali refugees had increased fourfold over the previous six years. In total, 22 interviews were conducted with 17 Somali-born women purposively recruited through maternal and child health (MCH) clinics and key members of local Somali networks. Inclusion criteria were: 1) of fertile age, and 2) brought up in Somalia and migrated to Sweden as adults. To capture a variety of perspectives and yet place an emphasis on the views of women who had arrived in Sweden recently, informants of varying age and parity were recruited. The majority of informants, however, had been in Sweden for four years or less (Table 1). Eight of the women had given birth in Somalia and eleven in Sweden, including five who had given birth in both countries. Five informants had left biological children, or children for whom they were guardians, behind in Africa. Nine were married but not co-habiting due to migration and three were divorced. Five informants were pregnant at the time of the first interview and three of these had husbands living abroad. Three informants had experienced the deaths of their own children in Somalia, and one had recently had a stillbirth in Sweden. All participating women had encountered war-related violence and its consequences directly or indirectly but they did not share own experiences of non-partner sexual violence (NPSV) or intimate partner violence (IPV). All informants had permanent residence permits in Sweden. See Table 1 for background characteristics.

Before recruitment, oral and written information on the study was given in Somali, either by MCH professionals with the use of interpreters or in Somali by key persons. Potential informants were given time to consider participation. Information on the study was repeated orally in Swedish and Somali before each interview started and oral and written consent was obtained. A thematic topic guide was developed and pilot tested, covering family relations, childbearing, IPV and NPSV, war, strategies enabling survival and wellbeing before, during and after migration to Sweden as well as Swedish midwifery care. Data collection was carried out in two steps. Firstly, twelve newly arrived informants were asked to freely talk about their lives, starting from living in Somalia up to the present. They were supported by semi-structured questions based on the topic guide when needed. The interviews varied in depth regarding the more sensitive aspects of migration, relationships and violence, thus, as a second step, a vignette was developed that described a fictional Somali-born woman named Asma and her flight to Sweden (Appendix 1). The use of vignettes is a method seen in different disciplines and is used to explore social and sensitive issues in a deeper way by

Table 1
Informant characteristics at first interview ($n=17$).

Age		Current occupation	
18–24	6	Language studies	6
25–34	8	Parental leave	7
35–45	3	Preparation programme	1
Education (years)		Paid employment	3
0 or Quran-school*	5	Parity	
Primary school	6	0	3
Middle/Secondary School	1	1–3	11
High School	4		
University	1	4–7	1
Residence Sweden (years)		> 7	2
0–1	2	Pregnant	5
1–4	12	Marital status	
4–10	1	Cohabiting	2
10–20	2	Married of whom not cohabiting	9
		Single	2

* Includes recitation, reading and writing Quran-Arabic.

placing the phenomena outside the interviewee's own personal experience (Bradbury-Jones et al., 2014). The vignette was based on preliminary findings from the first interviews and was pilot tested with two Somali interpreters after which minor revisions were made. The vignette was used in subsequent interviews, in which informants were asked to reflect upon the experiences of Asma. Probing questions were used when needed and based on initial topics. The second step included interviews with five additional 'new' informants as well as follow-up interviews with five women who had given birth after the first interview and had agreed to participate in a follow-up interview after the postpartum period. Interviews in this second round yielded more in-depth data. The first author (UB) conducted all interviews with the assistance of one or two Somali interpreters who specialised in health care and were employed within the health care system in Sweden. Three of the interviews were conducted in Swedish. All interviews were digitally recorded with the permission of the informants and lasted between 50 and 90 minutes. After each interview, the first author and the interpreter reflected on content, interaction and nuances together. Field notes on non-verbal communication and reflections were made during and after interviews.

Data consisted of a total of 26 hours of recorded material, and all Swedish parts were transcribed verbatim. To verify translation accuracy, parts of all interviews in Somali were transcribed in Somali, crosschecked and back-translated by independent translators. Thematic analysis (Braun and Clarke, 2006) was applied to categorize and describe patterns in the data. For overall understanding, the first author listened to all digitally recorded data and read each transcript several times. In the text, data relating to critical points associated with past and present violence and related midwifery encounters were identified and labelled with initial codes close to the text. Initial codes were refined and categorized together with all related text segments to crosscheck accuracy and ensure inclusion of all relevant data. Codes were mapped and organised into subthemes and themes and critically discussed and revised among all authors. Repeated comparisons were made between original transcripts and evolving subthemes and themes to safeguard accuracy.

Several ethical considerations were made and the study was conducted in adherence to the WHO's ethical and safety recommendations for research on violence (World Health Organization, 2001). An overall neutral public title of the study was launched due to the potential risks of involvement in violence-related research. Informants were informed orally and in writing about content, procedures, confidentiality and voluntariness, and all interviews were held in privacy. Contact addresses were provided in case questions or emotional concerns were to occur afterwards. Ethical approval was granted from the Regional Ethical Review Board of Uppsala, Sweden (2008/226).

Findings

The analysis resulted in four themes that display four aspects within the process of migration transition, which are directly or indirectly related to violence in the past or present. *Responding to midwives' questions about violence with hesitance* illuminates the encounter with a midwife assigned to ask questions on violence in Swedish ANC. In *Leaving past violence behind* and *Regaining coherence for wellbeing*, strategies to deal with memories and consequences of violent pasts and being able to move on in life after migration are delineated. *Balancing power shifts in partner relationships* elucidates ways to relate to changed gender relations and IPV in the new society.

Responding to midwives' questions about violence with hesitance

The maternity health care provided in Sweden was appreciated and was predominantly associated with medical issues relating to pregnancy and birth. The inclusion of questions from the antenatal care midwife about the women's exposure to violence did not seem self-evident to informants and they were considered too personal to be answered honestly in most cases:

This is something personal for us...But asking me about my health is something normal. (W5).

However, justifications for the midwife asking about violence were also found, and were based on health reasons, particularly when links between violence and mother and infant health were explained during interviews. Associations were not made between anxiety over a forthcoming childbirth and possible experiences of violence. Instead, anxiety was connected with the loss of family or unfamiliar maternity care interventions in the Swedish maternity health care system, but these anxieties were not always shared with health providers.

If a woman had decided to take action against IPV, reliance on her own capability and family/social networks emerged as her main sources of support, while informing the midwife was not highly prioritised.

...I don't believe a Somali woman would go and tell her (the midwife) if she is having problems or anything like that...if it has gone far enough that a woman has decided to report the man, then she knows she can call the police, or that she can get help from friends instead (W16).

In cases where a woman subjected to NPSV broke the silence, speaking to the family was the main option and the women thought the probable outcome was that it would stay there. The health care system, including the midwife, was, however, considered to be a resource for physical care after rape, but less awareness was evident regarding where to turn for emotional support outside the family.

Informants who had resided in Sweden for a longer period considered midwives to be a valuable source of information, particularly for recently migrated women, because sometimes a woman might need knowledge about where to turn for help in difficult situations such as when experiencing violence. By clarifying links to the new society's support systems and explaining in depth the concept of confidentiality within the health care system, the midwife could help Somali-born women to express their needs without the fear of social authorities interfering with their families against their will. It was suggested that information about support systems should be given whether needs were verbalized or not:

...asking straight out (about violence)...that is more difficult, but informing women where they can turn for help...that is good, I think. (W15).

Building strong relationships throughout pregnancy was suggested as a strategy to enhance trustworthiness and mutuality. One woman described how this could be a way to gradually grasp the whole situation of a woman exposed to violence. To exemplify this she placed herself in the midwives' position:

If a woman tells me (about being raped), maybe I would start with the easy parts, such as: 'Have you taken tests?' Because, by telling me, she might be indicating that she wants help with a number of things that she isn't telling me about. But then I might need to find out more a little bit at a time (W17).

Leaving past violence behind

A general wish to leave past difficulties, including violence, in the past and to think positively about the future was prominent in the women's narratives and was described as a key to wellbeing in the migration process. Endurance, derived from inner strength and shaped by war and an upbringing that emphasized capability were outlined as resources that enabled this process. Being able to look forward and not dwell on the past was seen as both a naturally occurring skill and an active choice. Consequently, the usefulness of dealing with traumatic memories through counselling was questioned. One informant exemplified this by describing an encounter between a psychologist and a group of Somali asylum seekers:

She thought it to be a burden on the soul if one were to be quiet, and not talk about it or cry about it, but rather let it go. We, however, thought otherwise: why should one burden the soul by crying and feeling sad when one can say that things will go as well as possible... Thank-fully, we survived and are doing well and we pray that our families will also do well...(W15).

Practical assistance from Swedish society such as organising residence permits and providing housing and maternity care contributed to feelings of stability, and, pragmatically, it was stated that it was more appealing to solve a situation than to talk about it:

For instance... your children are missing. You don't have your children, your husband, any of them. So how can a conversation you have (with a counsellor or midwife), change you? (W11).

Unfamiliarity with psychological symptoms and care from the pre-migration setting was mentioned as a possible inhibiting factor for women to share their needs. Physiotherapy was suggested as a method to release tensions when inner distress was difficult to verbalise. Phone calls to the family back in Somalia or elsewhere and spending time with friends or praying were other strategies. If occasionally a wish to share difficulties emerged, speaking to someone who had had similar experiences was preferred to confiding in a midwife.

Women raised the difficulty in knowing whether NPSV was a common experience among Somali migrant women or not, due to their tendency towards non-disclosure. Their explanations for this non-disclosure included the wish to move on from former difficulties, being unfamiliar with formal societal support and the risk of shame and 'community-talk' added. Nevertheless, access to legal rights and health care in Sweden was mentioned as a new resource for Somali migrant women exposed to violence. It was also stated that there might be situations when women needed counselling, but that the initiative had to come from the woman herself:

But what do you do if that person doesn't tell anyone about it (their exposure to violence)? It stops. (W15).

Regaining coherence for wellbeing

Despite the desire to leave the past behind, some consequences of the political violence that had shaped the pre-migration setting made themselves felt after arriving in Sweden. Continuing violence and instability in Somalia and separation from family and friends, particularly the women's own children, continued to be underlying factors of distress. Furthermore, the focus before flight was more on leaving the violent circumstances in Somalia than on what actually could be waiting after flight, and this resulted in there being little opportunity to prepare for life in Sweden. Thus, the women described how the initial period in Sweden was characterised not only by feelings of relief but also by feelings of

emptiness, alienation and confusion. To be able to move on, obtaining coherence in life was central and spiritual faith, social networks, and motherhood all contributed highly to this.

The women described how a *belief in destiny* and the ability to accept that whatever happened was God's will gave comfort in dark moments and was an anchor in up-rootedness. It was a source of patience which provided hope for a brighter future:

Everything is God's will. That's what I believe. I also feel, and I have it programmed in me, that whatever is not God's will, won't happen to me (W4).

Social networks and being connected to others was a main contributor to a sense of coherence. Compatriots were crucial for providing a social context in which a new life could develop. They provided many keys to understanding the new society and in gaining access to support services. If the women did not already know Somali-born people residing in Sweden, occasional meetings with unknown compatriots were vital:

I didn't know anyone else except for a girl I met at the train station...She told me where I should register (as an asylum-seeker)... When I registered there they asked me: 'Who do you know here?' And I told them that I knew the girl who brought me here to register... I then was given an address under her. (W4).

New social networks, however, could seldom replace a missing family. Finding someone to trust fully was not always a given. Critical points such as pregnancy and giving birth could provoke heightened despair of missing a scattered family:

For me, I felt that I was scared when I was giving birth, even though I had everything I needed. I had two midwives, I had my husband, I had everything, but despite this, the feeling overtook me: I live alone here, and my mother is not with me. (W15).

'Side effects' of the social coherence which could inhibit access to potential resources in Swedish society were also revealed. Women shared how the risk of 'community talk' could hamper disclosure of NPSV, thereby fuelling earlier habits of keeping such experiences private. Instances of social networks both supporting and disapproving of the spread of information about IPV to social authorities or health care services were conveyed. Ways of relating to these messages varied, and were influenced by time spent in the new setting, by knowledge about Swedish systems and also by women's own confidence and individual upbringings. Stories were told both about women's acquaintances who had been persuaded to stay in violent relationships by social networks and family or who had turned to authorities without social support, but also about women who had gained social support when they looked outside their private spheres for help when IPV was revealed.

Becoming a mother and maintaining motherhood was a third contributor for coherence and future orientation. Motherhood was seen as a natural part of life and an important identity marker. Children provided company, occupation and meaning and positive future prospects for children were part of the drive forward. Family relations were important and when financially possible, family members travelled from Sweden and Somalia to meet in safe countries. This nurtured family relations and pregnancies reinforced the bond between couples otherwise separated by war. The centrality of motherhood often overshadowed practicalities with a geographically scattered family and conveyed an approach of satisfaction in the moment:

We don't think: 'What if he doesn't come', or 'How will I raise a child by myself here' and other such things, we don't think in that way. Instead we think: 'Now I will have a child'. We are happy. (W16).

Balancing power shifts in partner relations

Unification with children and husbands in Sweden was described as a crucial milestone in the process forward, and was associated more with joy than worry. However, with time, tensions between the couple could occur due to shifts in gender power relations. Having less access to the extended family for support and mediation and being unfamiliar with the Swedish official support systems often led to new demands being placed on family life.

The women described how in the Somali tradition, with roots in either religion or a mix of religion and culture, men were the main decision-makers and had overall responsibility for the finances and work outside home while women were responsible for domestic work. Some claimed that it was rooted solely in culture and thereby easier to negotiate:

Culture and religion are two different things, and we cannot erase what is based on religion, wherever we are (W13).

Informants appreciated the laws in Sweden that regulate power relations between men and women and how these contributed to women's freedom and opportunities, in addition to safeguarding from violence. However, the women also expressed concern about how husbands experienced identity loss, which was reinforced by financial support for livelihood and child allowances being issued to mothers in the Swedish system. One woman shared how men in Somalia had overheard messages from men in diaspora saying migration to Sweden would lead to them being caught up in 'prison' while the women have the decision-making power. She described her thoughts regarding how to ease the changes for her husband when he arrived in Sweden, as he was suspicious of her being changed:

I'm still thinking about it, that I have to make him understand ... that he will still be responsible for us, like he was in Somalia... (W5).

In response to gender power tensions, a worst-case and unacceptable scenario was IPV, which, was mostly referred to as physical violence and, with reference to religion, was stated as unacceptable. Contrasting views emerged regarding the reasons for and risks of IPV. One opinion was that IPV had been rare in Somalia, but that it might arise as a final consequence of frustration in the new setting. Conversely, it was stated that an upbringing in a setting where men were allowed power over women had made IPV acceptable, but thanks to laws in Sweden, men needed to re-think, and also often did:

What I am saying is, that even if the man used to do that he has to respect and obey the rules of this place (W6).

Women discussed the different approaches that could be taken and what strategies could be used if IPV occurred. First and foremost, actions should be taken before it happened. A pragmatic strategy to retain traditional roles by giving the man power over the family's income was described. This was motivated both by avoidance of gender power tensions and also by the advantages of clearly knowing each other's responsibilities and with the women remaining powerful within their domains.

...It doesn't work without me, in this life. So why not let him feel like he is still the main person? Instead of showing that he isn't worth anything?... Why change a system that has worked well for so long? (W15).

In contrast, a description was given of women who used freedom after migration to threaten husbands with arrest or divorce if he did not suit her any longer; a behaviour primarily seen as

contra-productive, but also understandable. Dialogue, mutual understanding and gradual adjustments were stressed as solutions. If IPV became a fact, few declared they would have stayed in that relationship:

I would have felt that 'I will not tolerate it' since I already have enough problems... (W1).

At the same time, it was stated that occasional incidences of IPV could be tolerated before a newly arrived husband understood and changed his behaviour. Sharing problems experienced in the intimate partner relationship with outsiders was said not to be easy, as it gave a sense of betrayal:

...She could say that she doesn't want him anymore, without causing any problems, without informing the police, without putting him in jail.... Just tell him 'If you are not willing to stop this I'm going to have to take you to court and inform the police... you have done this to me before and I have been patient with you and now I want to look for a better life so let's just leave each other and let me keep the kids (W 13).

If the women needed help, their first step would be to turn to the extended family for support, advice and mediation. If the violence continued, and divorce was not accepted by the man, contacting social authorities and police was a last option; a solution which should be used with caution, as this could cause additional family problems. A contradicting view was that the mediating role of the extended family had decreased due to geographical distance, which made it less shameful for women to contact the police.

Discussion

This interview study with Somali-born women revealed that informants did not naturally associate midwifery encounters and childbirth with discussing experiences of past or ongoing violence. They did not share that they themselves had been exposed to non-partner sexual violence or intimate partner violence, but reflected generally over risks for intimate partner violence and strategies related to power shifts in intimate relationships due to migration with the help of the de-personalised vignette. Strategies that involved not dwelling on difficulties, but rather to hold on to spiritual meaning, motherhood and finding social networks constituted overall facilitators supporting wellbeing in the transition process.

It was not always clear to the women why questions about violence exposure should be asked in the midwifery encounter. However, once violence was associated with health outcomes of infants and mothers, justifications for the questions were found, indicating a need for relevant explanations. This finding reflects a situational transition from a non-functional state to a state with public health responsibilities, with global features of shame and social risks connected to violence disclosure added (Skjelsbaek, 2006; Tankink, 2013; Byrskog et al., 2014). The uncertainty about the state interfering with private matters revealed in this study has also been described by Somali migrants elsewhere, to which components of traditional conflict resolutions further contribute (Abdi, 2014). These findings confirm earlier studies highlighting the need for trust in the woman-midwife relationship if disclosure of violence is to be made possible (LoGiudice, 2015). In the transition of migration the uncertainty in a new society is added to the already existing un-even power distribution between the care giver and care receiver, which in itself risks being more pronounced in encounters across language or cultural barriers (Papadopoulos, 2006). Therefore, striving for a respectful partnership in the

woman-midwife relationship (Papadopoulos, 2006), continuity of care (Meleis et al., 2000; Hildingsson, et al., 2014; Renfrew et al., 2014; LoGiudice, 2015), and flexibility in how and when the questions of violence should be asked are central features. Our findings further highlight that emphasizing the link between violence and the health of the mother and infant can be a key for Somali-born women to view midwives' questions about violence more as a resource than a 'control function'. In addition, if questions about violence are to be beneficial, our present and previous findings underscore that clarifications of confidentiality within the health care system are essential, not the least in relation to Somali born women (Byrskog et al., 2015).

Strategies to leave past trauma and violence behind and focus on moving on were prominent findings. With the move-on approach, questioning the need for counselling followed. Notions made of similar 'moving on' strategies have been shared previously in interviews with Swedish midwives caring for Somali-born women (Byrskog et al., 2015) and among young Somali migrant women in the United Kingdom (Whittaker et al., 2005). The social phenomena of 'forgetting' as a means to cope with adversities is found in varied populations; among Tigrinyan war-victims in Ethiopia (Nordanger, 2007); Sudanese refugees, (Khawaja et al., 2008); and victims of torture from Vietnam and diverse African countries residing in the United States (Isakson and Jurkovic, 2013). Strategies of diverted thinking, distraction and future investment (Nordanger, 2007), correspond well with our informants' strategies and challenge some westernized methods of 'talking through' traumatic events (Summerfield, 1999). Furthermore, social networks were important in the process forward. This highlights the need for midwives to be open to individuality and women's capability to engage alternative strategies for their well-being while being aware of potential unspoken needs in care encounters or barriers to embrace psychological or family support. Preparation, knowledge, and awareness are considered important for a healthy transition process and a lack of these puts individuals at risk of inhibited wellbeing or navigation in the new context (Meleis et al., 2000; Baird, 2012). We found how the backdrop of political violence in Somalia with turmoil, little education, and hasty flights contributed to minimal knowledge about Sweden upon arrival, and about available resources in the new setting. Additionally, low levels of health literacy found among Somali migrants residing in Sweden (Wangdahl et al., 2014) may amplify the reliance on 'informal' sources for support. As an early but continuous link to the new society throughout pregnancy, the midwife can contribute with information about support services and gradually grasp a fuller understanding of women's situations. This also increases their ability to, over time, identify and overcome barriers in situations where psychological support could be needed (Byrskog et al., 2015).

The importance of social networks points to another arena in which the ANC midwife can have a bidirectional bridging role. Because social networks have the potential to contribute both positively and negatively to women's health and choices (Berkman et al., 2000; Lowe and Moore, 2014), collaborations with local Somali communities are important for reaching out and creating awareness about IPV and how it can be prevented. At the same time, the relevance of advice given during pregnancy or parental education to Somali-born women and families can be increased by better awareness of traditions and family changes during migration, with the help of Somali communities and key persons (Pan et al., 2006; Osman et al., 2016).

During war, women's breadwinning function and public responsibilities increase (El-Bushra and Sahl, 2006; Ibrahim, 2004; Byrskog et al., 2014). Continuing along this line, informants in the present study appreciated the freedom for women guaranteed by Swedish law. Simultaneously, they described power shifts in

partner relationships. This multifaceted mix of migration, gender, religion and societies has previously been explored among Somali migrants in Minnesota, concluding that women's independence also includes social risks, which might limit the freedom achieved (Abdi, 2014). Gentle integration of changes and internal communication were suggested as strategies to avoid couple tensions in the present study. Women further described how a lack of extended family made married couples increasingly dependent on each other, with increased risks for tensions. On the other hand, this might open up for easier access to support from the new formal society. The entrance of Somali-Swedish men into the maternity sphere has been described as a way to strengthen couple relationships and also that health care professionals' roles in these processes are important (Binder, 2012; Wiklund et al., 2000).

Definitions of normality, roles within relationships and boundaries for what is considered violence may differ between individuals, communities and cultures (Bradbury-Jones et al., 2014; Muehlenhard and Kimes, 1999). These distinctions influence care providers' norms, the women they care for and their inbound relationship. The women in the present study clearly stated the abnormality of physical violence while more fluid boundaries for definitions and acceptance were found regarding psychological and economic power within marital relationships. Likewise, definitions and acceptance of sexual force within marriage differed, due to varied religious interpretations spanning from sex being a man's right, to sex being a mutual gesture of love and respect excluding force whatsoever. Norms are not static but might be redefined in new contexts over time (Muehlenhard and Kimes, 1999), which is a process visible among the women in the present study. Finding a balance between respecting an individual's integrity and interpretations of violence, and being responsible for discovering situations of potential health threats, can be delicate to manage in midwifery encounters. This further underscores why continuity of care is crucial in encounters across languages and diverse backgrounds. A gradual deepening of the midwife-woman relationship might thus open up opportunities for mutual openness and facilitate more individualised dialogues on violence and coping (Byrskog et al., 2015; Renfrew et al., 2014).

Methodological considerations

Performing research across languages and cultures has challenges. Words and intents might change meaning in translation, data collection might be influenced by divergent conceptualizations and power positions (Squires, 2009). In this study, the main investigator, a Swedish midwife, may have influenced the process and thus the confirmability of the results. To balance these perspectives, to adjust and add further nuances, dialogues were held after each interview with the interpreters of Somali origin and throughout the analysis process with other Somali-born key persons. Two independent professional translators crosschecked both random and more problematic parts of the translations to verify accuracy. Credibility was strengthened by the informants' varied backgrounds which, through both personal experiences and vignette-based reflections, provided different perspectives. Preliminary findings were repeatedly briefed and discussed with research colleagues outside the research group. Continuous and rich field notes during data collection and analysis addressed dependability. Thorough descriptions of informants, analysis process, data and quotes addressed the issue of transferability. To build trust, we chose to include two Somali interpreters in the study who were well-respected in Somali networks and known to some, but not all, informants. This may have entailed both positive and negative effects on the informants' willingness to share sensitive or non-socially acceptable information. While it may have

contributed to the fact that no women disclosed personal experiences of NPSV or IPV, it was seen as a prerequisite for instilling confidence in the women during the interviews.

Conclusions

If confidentiality and links between violence and health are explained and clarified during the care encounter, midwives' questions about violence are more likely to be understood and beneficial for the prevention and identification of violence in relation to Somali-born women. Approaches of rationality and 'moving on', with focus not on violence or adversities, indicate strength and access to alternative resources, but need to be balanced against risks for hidden needs in care encounters. A care environment in which continuity of care and trustful relationships are central enhances opportunities for the midwife to balance these dual perspectives and identify potential needs. Life in the new welfare state challenges traditional structures with subsequent risks of power tensions within couple relationships and increased needs for mutual adjustments and dialogue. Collaborations between Somali communities, maternal health care and social service providers can contribute with support to families in transition and bridge gaps to formal social and care services.

Competing interests

The authors declare that they have no competing interests.

Acknowledgements

Funds were provided from Centre for Clinical Research, Dalarna, The Swedish Crime Victim Compensation and Support Authority and Dalarna University. A special thanks to Fawsiya Bisharo Xajixsan and Hamdi Sheekh Mohammed who assisted with interpretations during interviews.

Appendix 1. - vignette

This is the story of Asma. She is not a real person and the story is not true. Asma is brought up in Somalia. She is married and has four children with her husband Mohammed. The situation in Somalia is difficult due to the war and the family decides that Asma has to escape. The three oldest children remain with their father in Somalia. Together with the youngest daughter, she first travels by land, crossing the border to Ethiopia and then by air to Sweden. She is granted a resident permit after some months. She is worried about her children still staying in Somalia and sometimes she cannot sleep during the night. Mohammed has to hide periodically and then the children are scattered with relatives. After two years, Mohammed and the children are allowed to come to Sweden based on family ties. Now they all live together in an apartment; Asma becomes pregnant and looks forward to having another baby. She starts to visit the antenatal care (ANC) clinic. She has friends who she visits regularly. She has also a preparation position for employment after finishing her Swedish studies. In Somalia, Mohammed was employed outside the family, he is not used to her earning money, and he asks her to let him keep the money so she can ask him for money when needed. He is not secure with her being away from home that much and wants her to stay at home more, to care more for the home, the children and him and tells her to ask him if she is allowed to leave the home or not. Sometimes he forces her to stay at home. When Asma suggests they

can share the housework, as she is working and he has still not started his language studies, he becomes angry and cannot avoid hitting her. Asma is very uncomfortable being near him and starts to stay away from him more and more, even though he wants her to sleep with him every night. She is also worried that Mohammed will hit the children. At the ANC clinic, the midwife tells her that she should ask all patients she meets whether they have experienced violence at any time. Today, she is asking Asma.

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