Sacred Ideals

Diversity and Equality in Swedish Reproductive Healthcare

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Abstract

To promote diversity (mångfald) and equality (jämlikhet) is a key task for a wide range of welfare institutions in Sweden. The two terms appeal to several aspects simultaneously: inclusiveness, moral goodness, awareness and willingness to facilitate a positive social change. Diversity and equality have become, as I suggest in this thesis, two sacred ideals in Swedish society today. In the context of reproductive healthcare, various forms of diversity and equality measures are thought of as solutions to, for instance, inequalities between immigrant groups and others, structural discrimination of minority groups, and difficulties faced by the Swedish healthcare system in caring for patients’ diverse needs and preferences in clinical encounters. In this thesis, diversity and equality are analysed as two important governing mechanisms in the organisation of healthcare in multicultural Sweden. The aim was to explore how these ideals contribute to shape the provision of reproductive healthcare, and its consequences.

Paper I shows that targeted interventions towards immigrant women in contraceptive counselling risk singling out some women from standard routes of care because they are categorised as “immigrants” or “Muslims”. Paper II shows that demands upon healthcare providers to accommodate Muslim patients’ presumed needs have the potential of also creating needs that were not there from the start. Paper III shows that many religious counsellors who are affiliated with Swedish healthcare as spiritual advisers present ideas on abortion that are less progressive than what is stipulated in Swedish abortion law. Paper IV shows that imperatives to promote gender equality in contraceptive counselling were taken seriously by providers in their encounters with non-Western women, at the possible expense of respect for relationship structures that do not conform to the ideals of gender equality.

The findings presented in this thesis show that the interventions and initiatives that sought to presumably help disadvantaged groups of people (i.e. Muslims, immigrant women) could, in fact, be obstacles to solving the problems they were meant to address. I argue that the governance of Swedish reproductive healthcare through diversity and equality ideals must be problematised and balanced with regard to their plausible consequences.

Keywords: diversity, equality, gender equality, religion, reproductive health, migration, multicultural encounters, Scandinavia, Sweden

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To my family
We’re all stuck here for a while, so let’s try to work it out

List of papers

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


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List of related papers

This fifth paper was published within the same project as the above listed papers, but does not immediately contribute to the thesis’s overall conclusion:

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Abbreviations

DO  Diskrimineringsombudsmannen, the Equality Ombudsman
FGD  Focus Group Discussion
ISR  Islamiska samarbetsrådet, the Islamic Cooperation Council
MENA  Middle East and Northern Africa
SCB  Statistiska centralbyrån, Statistics Sweden
SFI  Svenska för invandrare, Swedish for Immigrants
SKL  Sveriges kommuner och landsting, Swedish Association of Local Authorities and Regions
SoS  Socialstyrelsen, the National Board of Health and Welfare
SOU  Statens offentliga utredningar, Swedish Government Official Reports Series
SST  Myndigheten för stöd till trossamfund, the Swedish Agency for Support to Faith Communities
UNFPA  United Nations Populations Fund
WHO  World Health Organization
# Translations

<table>
<thead>
<tr>
<th>English</th>
<th>Swedish</th>
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<tbody>
<tr>
<td>Government Bill</td>
<td>Proposition, <em>i.e. suggestion from the Government to the Parliament</em></td>
</tr>
<tr>
<td>Gynaecological clinic</td>
<td>Kvinnoklinik</td>
</tr>
<tr>
<td>Maternity clinic</td>
<td>Mödrahälsovård</td>
</tr>
<tr>
<td>The Swedish Abortion Act</td>
<td>Abortlag (1974:595)</td>
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<tr>
<td>The Swedish Administrative Act</td>
<td>Förvaltningslag (2017:900)</td>
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<td>Swedish Act Concerning the Ethical Review of Research Involving Humans</td>
<td>Etikprövningslag (2003:460)</td>
</tr>
<tr>
<td>The Swedish Health and Medical Service Act</td>
<td>Hälso- och sjukvårds lag (2017:30)</td>
</tr>
<tr>
<td>The Swedish Patient Act</td>
<td>Patientlag (2014:821)</td>
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Chapter 1: Introduction

About the topic

“Diversity” (mångfald) and “equality” (jämlikhet) are examples of two important discourses that shape political discussions in most countries in the West today (Baehr & Gordon, 2018; Jindra, 2014). Sweden is not an exception. Diversity and equality ideals have become viable components in the structuring of a shared social order, and their popularity is unmistakable: a wide variety of bodies in Sweden — ranging from academia to public welfare institutions to private companies in various sectors — have embraced the idea of diversity and equality as natural components in the setup of services. To give a few examples: municipalities in Linköping, Göteborg, Malmö, Sollefteå, Trelleborg, Falköping och Gislaved frame diversity and equality as core values in the set-up of services, similar to Stockholm University, Uppsala University, and Luleå University of Technology. Labour unions — such as Finansförbundet, The Swedish Association of Health Professionals and IFMetall — have included diversity and equality as part of their declaration of common values. Also private companies, government agencies, and sports clubs — such as Swedbank, Ellos Group, Ramboll, The Agriculture Agency and Hallands FF (Halland’s Football Club) — represent diversity and equality as central components of their activities.

A unifying feature of diversity and equality is the common sense way in which they are used in contemporary public discourse. The linguist Uwe Pörksen (1995) offers an informative account of the processes in which some words manage to enter the realm of the taken-for-granted world. Some words, he suggests, exist in the vernacular, i.e. in ‘the commonly used everyday speech that forms most of public discussions as well as our private conversation’ (Pörksen, 1995, preface xvii). In Sweden today, the terms diversity and equality are so common that they seem to escape deeper reflections on what they mean and the connection (or disconnection) between them (Baehr & Gordon, 2018). With regard to the naturalised quality of some words, Pörksen writes:

They may not be noticed, but they are present everywhere: in the speeches of politicians and on the drawing boards of city planners, at academic conferences, and in the ever more taken-for-granted in-between world of the media. They invade private conversation. When they first appear, they are fashiona-
ble and command attention; but then they merge with the everyday and soon seem common sense (1995, p. 1).

The terms diversity and equality appeal to several aspects simultaneously: inclusiveness, moral goodness, awareness and willingness to facilitate a positive social change. The terms have, what Baehr and Gordon call, ‘a flexible and righteous quality’ (2018, p. 978) in Swedish society. What makes the champion of diversity and equality so special is that the discourses unfold as harmonising and non-conflicting; they have come to resemble each other (Pörksen, 1995). The words do not appear to have become popular because of the material content, but because they both appeal to a liberal and inclusive mindset to people and relations in society. Diversity and equality are, as suggested in this thesis, two of the sacred ideals in Swedish public discourse today.

Migrant reproductive health as field of exploration
This thesis explores how discourses on diversity and equality — as they are represented in various forms of governmental programmes and healthcare policies (Government Bill 1997/98:16; The Swedish Gender Equality Agency 2019a; Government Bill 1975:26; Government Bill 2017/18:249; The Healthcare Handbook, 2018; ICM, 2014; The Swedish Association of Midwives, 2019; SKL, 2019) — are managed in relation to reproductive health and the provision of healthcare in multicultural Sweden. The exploration draws on interviews and focus group discussions (FGDs) with pious Muslim women, healthcare providers in reproductive healthcare settings, and religious counsellors who are affiliated with Swedish healthcare institutions as spiritual advisers. It will become clear that the diversity and equality discourses have become part of the medical discourse in Swedish healthcare today, and that this has had consequences for the provision of care. Although some references will be made to the provision of healthcare more generally, the attention will foremost be directed towards contraceptive use and abortion, as examples of queries that are intertwined with many different, and often politically imbued, ideas about society’s ideal organisation (Palmblad, 2000).

Cultural relativism in the provision of care: a dominant perspective
More precisely, the exploration is positioned in relation to the scientific field that can be defined as “migrant reproductive health”. An important signifier for this field is what appears as a joint struggle among both researchers and policy makers to eradicate what is represented as serious conditions of social and health related inequalities. It is a field where research is closely intertwined with global goals on development (Fehling et al., 2013), with struggles for women’s and ethnic minority groups’ sexual and reproductive health
and rights (Austveg, 2011; Christianson & Eriksson, 2015; UNFPA, 2014) and with the production of politically endorsed policies for health and healthcare provision (Brown et al., 2004; Shaw & Greenhalgh, 2008). Notably, the field reflects a strong desire to produce some sort of change in order to maintain health or seek to prevent negative effects on people’s health (Arah, 2009, p. 54). One more recent example of this broadly accepted imperative to use research as a way to promote social change is exemplified in Verbiest and colleagues’ (2016) commentary Catalyzing a Reproductive Health and Social Justice Movement. ‘The time has come for a revival in our field’, they write (p. 747). The researchers argue that a foundational aspect of public health advocacy includes academic scholars’ and professionals’ ability to address ‘the core issues of our day, including racism, structures of power, gender discrimination, and privilege’ (p. 747). The success of a “new social movement” requires that actors in the field are willing to advocate “relentlessly” for change, and to form “unconventional alliances” with social justice activist groups, faith communities, and professionals in other fields, they propose (Verbiest et al., 2016).

I propose here that the prevalent struggle to combat social and health-related inequalities has served as a compelling argument for making healthcare institutions more vigilant to accommodate the assumed needs among ethnic and religious minority groups in Sweden today (Government Bill 1997/98:16; The Healthcare Handbook, 2018; Sundell Lecerof, 2010). It has become close to common-sense knowledge that the provision of healthcare — where people, voluntarily or involuntarily, move from one part of the world to another — cannot be organised in the same way as it always has been, because it would risk to seriously disfavour people with varying needs (Åkerman et al., 2017; Camphina-Bacote, 2002; The Healthcare Handbook, 2018; Kleinman & Benson, 2006; Kolak et al., 2017; Leininger, 2002; Mladovsky et al., 2012; Renzaho et al., 2013; Smith & Silk, 2011). A kind of “cultural competence industry” has emerged, which seeks ‘to produce more equal health outcomes by eliminating prejudice among health care providers and reducing disparities in patient care across groups’ (Shaw & Armin, 2011, p. 238). For instance, the Healthcare Handbook (Vårdhandboken), which is an online knowledge platform for healthcare providers in Sweden, states that the healthcare system should strive for ‘cultural relativism with transcultural awareness, which means that every unique individual’s needs and wishes are in the focus of attention’ (The Healthcare Handbook, 2018). Others express that a person-centred approach, ‘as a means to counteract stereotypes, misunderstandings, and prejudice’ (Ahrne et al., 2019, p. 113), could improve the quality of migrant maternal healthcare in Sweden.

The trend signifies what Baehr and Gordon describe as an ‘implanting of a more relativist attitude toward our society by instilling an appreciation of other ways of life’ (Baehr & Gordon, 2018, p. 978). This relativist approach encourages actors in the field to appreciate that other realities exist next to
their own, and to be aware that ethnic and religious majority groups that encounter healthcare institutions in Western countries, on average, are more disadvantaged than others. People from these groups become represented as persons who are “at risk” for different forms of injustices (Østergaard Møller & Sommer Harrits, 2013); persons who healthcare institutions would be able to help if the structure would only be prompt enough to adjust the services to the special needs that people from migrant ethnic and religious minority groups are assumed to have brought with them.

What is lacking in this field of research?

My intention in the forthcoming exploration is not to prove wrong these theories about ethnic and religious minority groups’ general disadvantages and vulnerabilities with regard to their health. Neither do I reject the importance of all the reforms that have been made with the ambition to solve important health related problems. Health research of this kind is, as Shaw and Greenhalgh (2008 p. 2506) have remarked, ‘fundamental to development of improved health and healthcare’.

However, I propose that something important is lacking in this field of research; namely, an understanding of how this relativist approach to the provision of care is implemented in practice, and how this relativism is combined with the Swedish welfare ideal about equality and equal treatment for all. When the relativistic diversity discourse first began to gain ground in the field of healthcare, it came to symbolise a tolerant and inclusive mindset towards people’s various needs and preferences. Nevertheless, among social scientists, a more critical review of both diversity and equality ideas has begun to emerge in the past years, where scholars have shown that several tensions exist, both within and between these discursive mentalities (Baehr & Gordon, 2018; Jindra, 2014; Ouis et al., 2013; Stier & Sandström, 2018; Sund, 2015). ‘Reconciling diversity with equality […] may well be among the greatest challenges for the Scandinavian societies in the years to come’, hypotheses anthropologist Hylland Eriksen (2018, preface viii). On the same theme, Thun (2015, p. 16) asks if the ‘Scandinavian citizenship regime is inclusive and women-friendly in a time of diversity’? As another example, Bendixsen and colleagues (2018, p. 22) raise concerns regarding ‘whether cultural difference can be recognized without also weakening social cohesion and the welfare state community’. The relationship between diversity and equality ideals exemplifies what Racine (2009) refers to as the dual element of recognition. On the one hand, diversity ideals encourage a recognition based on difference; a perspective that opens up for a relativist approach and the accommodation of varying lifestyle practices. On the other hand, equality and gender equality ideals favour recognition based on everyone’s equal status and, to some extent, sameness; it encourages a perspective that makes no difference between people. I am certainly glossing over some im-
portant nuances here for the sake of clarity, but what I want to illustrate is that this particular tension leaves open a space for negotiation. Where and how are boundaries drawn to manage the desire to accommodate various cultural and religious needs and preferences without comprising principles of equality and equal treatment for all, and vice versa?

These are perspectives that so far remain largely unnoticed in the field of migrant reproductive health, where research often is directed towards the production of interventions and programmes, rather than a problematization of them (Bacchi, 2016). Consequently, there is a distinct lack of empirical insights about how diversity and equality mentalities contribute to shaping healthcare policies, and what consequences these policies might bring about when they are implemented in practice. In this thesis, I will attempt to address this gap by putting diversity and equality — as signifiers of two often taken-for-granted concepts in Swedish reproductive healthcare today — under empirical and analytical pressure. I acknowledge that the tension between these two policy ideals that I have outlined so far exists on a theoretical level. How these ideals are negotiated, framed, handled and implemented in healthcare practice, and how well they correspond to patients’ various healthcare concerns are, nevertheless, questions that warrant empirical explorations. Notably, to analyse how diversity and equality discourses operate does not, as social psychologist Jonathan Haidt (2012) remarks, imply that I — personally — am against these discourses. However, it can be assumed that an understanding of how they come to function is of importance in order to develop the provision of healthcare in Sweden in desirable directions. Here, I align with scholars such as Bacchi (2016), Haidt (2012), Stern (2016) and Shaw and Greenhalg (2008), when I propose that science presents a key opportunity for exploration, problematization and critique — also of discursive mentalities that are widely endorsed.

Aim and research questions

The aim of this thesis is to explore and analyse how policies on diversity and equality become implemented in Swedish multicultural healthcare today and with what possible consequences. Special attention will be directed towards contraceptive counselling and abortion in reproductive healthcare.

Research questions

• What meanings do various actors ascribe to diversity and equality ideals, and in what specific ways are these policies implemented in everyday practices in reproductive healthcare?
What consequences might arise when policies on diversity and equality are incorporated in the provision of contraceptive counseling, abortion care and in healthcare more generally? Who might benefit from these policies, and who might not?

What possible tensions and difficulties related to the implementation of these ideals in healthcare have so far remained unnoticed? How can they — and the relationship between them — be understood?

Outline of the thesis

The next chapter, Chapter 2, outlines a theoretical perspective on diversity and equality, where it is illustrated how these ideals can be understood as governing techniques with regard to the provision of healthcare. Chapter 3 offers a number of definitions of key concepts that will be referred to throughout the thesis. Chapter 4 presents the methods that have been used in the collection and analysis of the data and reflections on ethical dilemmas that have emerged during the course of study. Chapter 5 presents a summary of the results. In Chapter 6, a discussion is offered about the findings, and their importance for the provision of healthcare in today’s multicultural Sweden is described. Chapter 7 presents strengths and limitations of the study and makes some suggestions for future research. In Chapter 8, the main conclusion is presented and the final chapter, Chapter 9, provides a list of recommendations.
Chapter 2: Diversity and equality as governing tools — a theoretical perspective

I propose here that diversity and equality ideals have laid the foundation for the development of several policies and interventions in the field of healthcare in Sweden today. These ideals are important for several reasons. First of all, they are important on a linguistic level because they — as relatively diffuse but yet broadly accepted concepts — become loaded with positive value, connotations and affirmations in Swedish discourse. Thereby, they have power to influence policy making (Pörksen, 1995). Secondly, they are important because they carry with them divergent, and often simultaneously cherished, mentalities about how society should be organised (Jindra, 2014). Both as positively valued words, and as discourses entailing specific mentalities, I suggest that diversity and equality ideals can be beneficially understood as governing techniques, which seek to direct the healthcare system according to specific logics about what is taken to be the best, and the true, way of organising the provision of care in Sweden. The ambition is to make people willing to be governed and, when successful, these governance ideals manage to become part of people’s taken-for-granted ways of thinking and doing things (Dean, 2010).

It was the French philosopher Michel Foucault who first introduced the concept of governmentality in several lectures and subsequent publications from the beginning of the 1970s and onwards (Dean, 2010). Since then, many scholars have developed, clarified and applied Foucault’s thoughts on governance in various fields of research (Dean, 2010; Lemke, 2012; Olivius, 2014). Government is concerned with what Foucault described as the conduct of conduct: it focuses on how people govern themselves, how people govern each other, and how state institutions seek to govern people in society (Foucault, 1991), with the purpose of ensuring the ‘welfare of the population, the improvements of its condition, the increase of its wealth’ (Foucault, 1991, p. 100). Government entails, in other words, ‘any attempt to shape with some degree of deliberation aspects of our behavior according to particular sets of norms and for a variety of ends’ (Dean, 2010, p. 18).

To approach diversity and equality as governing tools signifies a break with the dominant tradition within the field of migrant reproductive health, in which many scholars have strived to produce policies, partly by aligning with the broader movement circling these ideals, in order to produce social
change. To instead explore how these ideals operate in state governance presents a tool for policy analysis rather than policy making (Bacchi, 2009).

Diversity, equality and mentalities of governance

In Sweden, diversity and equality ideals are made manifest in various ways: in legislation, in government reports, in recommendations issued by government agencies, in clinical guidelines, in professional codes of ethics and in research. Sometimes, the references to diversity and equality are made explicit; other times, the references to these divergent mentalities are more vague and abstract. What I will focus on next is the observation that diversity and equality ideals illuminate what appears to be two divergent perspectives in the provision of healthcare.

Diversity ideals, which have been become manifest in healthcare organisations in Sweden through the nurturing of a more culturally relativist approach to people from ethnic and religious minority groups, reject the idea of “Swedish culture” as superior to any other (Baehr & Gordon, 2018; The Healthcare Handbook, 2018). Through this discourse, it becomes legitimate and relatively uncontroversial to encourage, for instance, improved accommodation of religious minority groups’ healthcare needs and preferences or to increase religious counsellors’ presence in healthcare institutions. Some of the more basic requirements with regard to the accommodation of migrants’ needs are regulated by law. For instance, the state has ensured patients’ rights to interpreter services (The Swedish Administrative Act, §13) and healthcare institutions’ obligation to adjust the information about the provision of healthcare and the patients’ individual health status so that the patient can understand it (The Swedish Patient Act, Chapter 3). However, most of the efforts to promote and protect diversity in healthcare can be found in texts provided by medical associations and professional codes of ethics, which seek to foster a particular mindset related to this discursive mentality. In The Healthcare Handbook (2018), for instance, it is emphasised that ‘encounters in healthcare from a transcultural perspective should […] aim at avoiding ethnocentrism in the sense of letting the majority culture’s values direct the planning of interventions’. Similarly, the ICM International Code of Ethics for Midwives, under which the Swedish midwifery profession also complies, takes a partly culturally relativistic approach to the provision of care. Section II of the Code prescribes that ‘[m]idwives provide care for women and childbearing families with respect for cultural diversity’ (ICM, 2014).

Equality, on the other hand, is closely intertwined with Sweden’s highly valued idea about the development of universal social policies on equal care, equal access to care and of non-discrimination. The idea that patients would qualify for differential treatment, as powerfully claimed from within the diversity discourse, is an unfamiliar one according to mentalities of equality
ideals. In some instances, the relativistic diversity discourse that encourages disparate treatment of migrants is described as a form of “cultural racism” that infuses Swedish healthcare:

People with immigrant backgrounds become culturalized within healthcare and are categorized in accordance with fundamentally divergent “cultural differences”. An abundance of study material that reveals racist ideas exists within healthcare education programs. One example is education material about “multicultural” care that nurtures imaginaries about immigrant patients as cultural objects, who lack the ability to understand the logics within “the Swedish medical mind-set”. This has discriminating consequences for these people, which also inhibits [the provision of] an equal care for everyone regardless of ethnic and religious background (SOU 2006:78, preface).

The Health and Medical Service Act (HSL) — which is the law prescribing and regulating the obligations of Swedish healthcare institutions — is perhaps the most obvious example of a calculated technique that seeks to foster a healthcare system based on principles of equality, solidarity and equal access to services. Equality is here represented as a cornerstone in the organisation of healthcare in Sweden: ‘The aim with the healthcare is a good health and healthcare provision on equal terms for the entire population’ (HSL, Chapter 3, §1). Key arguments in the discourse on equality is that: the population’s health should be as equally distributed as possible (Government Bill 2017/18:249; SOU 2016:55), no one should be discriminated against (DO, 2012), and public health politics should facilitate societal prerequisites for a good health on equal terms (Public Health Agency of Sweden, 2019b). To provide healthcare that ensures good health on equal terms is constructed as ‘an important part of the efforts towards a good welfare and a sustainable Sweden’ (Government Bill 2017/18:249, p. 8).

When equality and diversity are analysed as governing techniques, it helps us to see that solutions, interventions and programmes that are introduced “in the name of” these ideals in Swedish healthcare today entail specific mentalities, as a type of collective thinking activity (Dean, 2010). Clearly, it is no coincidence that these ideals have become part of Swedish healthcare discourse, because they have been key components in the organisation of Swedish welfare for many years. Mentalities of diversity promotion and protection gained serious ground in the 1970s, when multiculturalism slowly became recognised as the political ideal for the management of diversity in Sweden (Borevi, 2014; Tawat, 2019). The introduction of multiculturalism contributed with what Wickström (2015) frames as revolutionary new ways to manage cultural diversity. Swedish immigration policies, which previously had rested upon ideals about ethnic homogeneity and encouraging people to “become Swedes”, now began to insist on the value of recognising ethnic and cultural differences (Borevi, 2014). One of the primary goals set out in the first governmental policy from 1975 was that ‘the immigrants and minorities should be
given the opportunity to themselves decide to what extent they want to adhere to a Swedish cultural identity or keep and develop the original identity’ (Government Bill 1975:26, p. 1). Despite some scepticism against these policies that followed in the years, the new official policies on diversity that were issued in the 1990s were similar to the original ones (Borevi, 2013). Here, the government continued to emphasise that ‘integration must encompass the possibilities to join a greater entity without needing to comprise one’s own cultural and ethnical identity’ (Government Bill 1997/98:16 p. 23), and that the overall goal was to foster ‘a notion of societal community that is based on social diversity’ (Government Bill 1997/98:16 p. 23). Equality ideals have an even longer history in Swedish public discourse, starting in the 1930s and 1940s when the outspoken desire was to create a society with high level of employment and economic growth (Myhre, 2018). The idea about the egalitarian welfare state, based on ambitions about ‘comprehensive, generous and redistributive benefits and welfare services’ (Borevi, 2014, p. 710), and struggles for ‘equality, solidarity, and equal access to welfare benefits’ (Hoffmann Merrild, 2018, p. 181), became an important part of people’s sense of national identity (Lister, 2009; Towns, 2002). Although the mentalities and logics that form the basis of the discourses on diversity and equality seem to differ in many ways, what they have in common is that they are both attached to positive emotional connotations. Few people in Sweden would object to the mentalities of diversity; likewise, few would object to the mentalities of equality. According to Dean (2010), this is how governance works: when there is strong consensus about the benefits of diversity and equality respectively, these discourses can be used to justify the preference for a specific form of state. However, in Sweden, it appears that equality ideals have a more noticeable status in legislative texts and official recommendations than diversity ideals, whose mentalities are foremost made manifest in more implicit ambitions to foster an inclusive mindset.

Four examples of diversity and equality policies in healthcare

This study’s empirical exploration focuses on four specific interventions that all can be grouped under the more general mentalities of equality and diversity, respectively. These policies are described in more detail throughout Papers I-IV, where I also present a reflection on what consequences these policies might generate when they become implemented in practice (see also Chapter 5). Next, I will provide a background for each of these four policies.
1. Targeted interventions towards immigrants

A common line of argument that figures in health research and policies concerns policies regarding targeted interventions towards immigrant groups. The presumption underlying these types of suggestions is that groups who have migrated to Scandinavian countries from non-European countries, on group level, display worse health outcomes than those who are born in the respective countries (Åkerman et al., 2017; Bursell, 2018; DO, 2013; Emtell Iwarsson et al., 2019; Esscher et al., 2013a; Esscher et al., 2013b; Essén et al., 2000; Essén, et al., 2002; Helström et al., 2003; Helström et al., 2006; Omland et al., 2014; Rasch et al., 2007; Rasch et al., 2008; Vangen et al., 2008). Already in 1995, the National Board of Health and Welfare painted a cloudy portrait of immigrants’ health status in Sweden: ‘Regardless if it concerns the prevalence of various physical diseases, psychological well-being, decreased ability to work, or early retirement pension, immigrants are worse off than the native population’ (SoS 1995:5, p. 75). Recent studies indicate that disparities in health outcomes still persist between migrants and Swedish-born people (Esscher et al., 2013a). Related to reproductive health care more specifically, researchers’ recommendations that healthcare providers should cultivate a better understanding of immigrant women’s contraceptive practices and be aware of the influence of cultural and religious norms on contraceptive use (Kolak et al., 2017; Larsson et al., 2016), further exemplify how a desire to achieve equality, or equity, in health outcomes between migrants and non-migrants functions as a governing technique and rationality for action to be taken. Usually, related to this type of targeted interventions, large-scale surveys and statistical analyses have ‘helped determine the forms of laws about society and the character of social facts’ (Hacking, 1991, p. 181). In Hacking’s (1991) line of thought, statistically verified “truths” about inequalities exemplify a technology of power that further justifies interventions towards those groups of patients that are assumed to be most vulnerable with regard to their health.

2. Recognition of people from ethnic and religious minority groups

A second set of policies seek to address the common proposal that the healthcare system — and healthcare providers — so far have lagged behind in acknowledging the various health issues and healthcare needs that exist in Sweden’s multicultural society. A powerful rationality here is that secular countries in Western countries, also Sweden, are thought of as being imprinted with discriminatory structures. Scholars have argued that religious minority groups in the US, particularly Muslims, have been increasingly exposed to discrimination and outspoken racism since 9/11 (Inhorn & Serour, 2011; Laird et al., 2007b; Small et al., 2014). Martin (2015) has, for instance, reported that feelings of being excluded or ignored, discussions related to Muslim clothing, holidays and prayer rituals, as well as insensitive
verbal comments and physical assault, are examples of frequent types of discrimination in US healthcare settings. In a Canadian study about immigrant women’s experiences related to maternity care, it was found that some women felt angry and frustrated when healthcare providers did not ensure to fulfil various religious requests. Other women said that they could “feel” the discriminatory attitudes from care providers by the way they looked at them: ‘You see their faces. You feel it that they think you are stupid and you don’t know anything about this world’ (Reitmanova & Gustafson, 2008, p. 107).

In Sweden, discrimination and negative attitudes toward Muslims in Swedish society in general (Bevelander & Otterbeck, 2010; Botvar & Sjöborg, 2018; Sixtensson, 2009) and in healthcare in particular, have been presented as paramount problems for many years (SOU 2006:78). Recently, through a study of discrimination complaints handled by the Equality Ombudsman (DO), Bursell (2018) has shown that discrimination towards Muslims continues to be of concern within public institutions in Sweden. At the same time, the claims about discrimination illuminate a troublesome dimension for healthcare providers and others to handle; namely, do Muslims feel discriminated against because their religious needs are not addressed, or because they feel uncomfortably singled out by healthcare providers’ attention? (Racine, 2009). Here, governance through the principles of equal treatment for all and different treatment for all (based on a diversity discourse of difference) merge together. This is the tension that actors in Swedish healthcare must navigate.

3. Religious counselling services in healthcare

Another way in which the relativist attitude towards people’s health concerns becomes visible is in the decision to let religious counsellors provide so-called spiritual care in affiliation with hospitals in Sweden. In the beginning, there were foremost various Free Church communities and the Catholic Church that made use of the possibilities to offer services in public healthcare. It was first in the beginning of the 2000s that Muslim, Orthodox and Buddhist faith communities got affiliated to public healthcare institutions in Sweden (SOU 2018:18). The number of religious representatives and leaders from respective faith communities has grown rapidly in the past few years, and still continues to grow (muslimskjukhuskoordinator.se, 2017). In most cases, the counselling activities offered by all faith communities (except the Church of Sweden) are jointly financed by respective faith communities as well as through state funding authorised by the Swedish Agency for Support to Faith Communities, SST.¹

¹ SST, Myndigheten för stöd till trossamfund, is an agency under the government that provides state support for faith communities in Sweden. The state funding is allocated through different types of financial grants on an annual basis. The government decides which faith communities are entitled to funding, and which ones are not. The Agency was previously called, in Swedish, Nämnden för statligt stöd till trossamfund.
The Evangelic-Lutheran Swedish Church — usually referred to as the Swedish Church (Svenska kyrkan) — has provided services as an integral part of Swedish healthcare provision since 1527, when the Protestant Reformation took place. The Swedish Church is part of the Hospital Church. The inclusion of various faith communities into the Swedish healthcare institution over the past few years has been presented as an important step to ensure that the spiritual counselling reflects the religious diversity among people in Sweden (SST, 2017). Backed by the argument that Sweden has become more and more religiously diverse, it appears to have been politically motivated to acknowledge that: ‘pastoral care needs to include representatives from more faith communities’ [apart from the Church of Sweden] (SST, 2019). Moreover, religious counsellors are, in accordance with ideas of holism, considered to complement existing services by offering patients a spiritual dimension that ordinary healthcare services are incapable of giving (SOU 2018:18). It is pointed out that religious counselling in hospitals provides patients and family members the opportunity for individual counselling and existential care (självård), but also to organise worship services and education for healthcare providers (SOU 2018:18). People’s religion – in this holistic version of healthcare provision – supplies with ‘[t]hings that give life meaning; it can contribute with a sense of security, a sense of coherence, and to give people hope, for example; and all these components are vital in times of illness and disease’ (personal communication, SST).

Today, it is known that people across the world in many cases utilise traditional healing practices in the event of illness and disease, sometimes as an alternative to conventional medicine and sometimes as a complement to biomedical routes of care (Alrawi et al., 2012; Johnsdotter et al., 2011). In general, there seems to be much support in research that religious authorities often play an important role in formulating ideas on various health related matters (Ruijs, 2013) — including contraceptive use and abortion (Underwood et al., 2013). Richards has, for example, shown that the Catholic Church in Timor Leste has ‘a significant influence’ on political decision-making about reproductive health and rights, as well as on individual women’s and men’s contraceptive decisions (Richards, 2015, p. 353). In sum, the evidence from international research about the impact of religious counselling on healthcare queries is partly contradictory. In the Netherlands, for instance, Ruijs and colleagues have shown that religious leaders many times opposed the national policies on vaccination, which could hamper the healthcare system’s ability to reach out with evidence-based recommendations in this question. On the contrary, Padela and colleagues have shown that imams in the US can help to encourage healthy behaviours, to assist in events of life and death by performing religious rituals, to advocate on behalf of Muslim community members and provide training in cultural competence for healthcare staff, and to help Muslim patients in their healthcare decisions (Padela et al., 2011). In Sweden, however, research is still lacking with re-
gard to the content of the services that is provided by religious counsellors. The policy initiative of spiritual care in a Swedish context seems to be based on an imaginary picture of the benefits of such services, rather than on knowledge that is derived from systematic scientific analysis (Dean, 2010).

4. Gender mainstreaming

Unlike some of the initiatives outlined above, the gender equality discourse that is the basis of national gender mainstreaming policies reflects a universalist approach to the organisation of care. Here, there is seemingly no space for the accommodation of patients’ diverse ways of planning, for instance, their reproductive paths: the aim is that people should think about gender equality in a specific way — i.e., the way that is outlined in official policies.

The passion for equality that is significant for the Scandinavian welfare states probably provided basis for gender equality to subsequently be recognised as a political welfare priority (Hernes, 1987; Thun, 2015). During the 1960s and 1970s, when the women’s movement gained ground in Sweden, discourses on gender equality began to develop in the Scandinavian countries (Hernes, 1987; Lundqvist, 2019). In 1987, Helga Hernes published a concise and influential collection of essays titled Welfare State and Women Power: Essays in State Feminism. The argument she outlined was that ‘Nordic democracies embody a state form that makes it possible to transform into women-friendly societies’ (Hernes, 1987, p. 15).

The first governmental initiatives to put gender equality on the political agenda in Sweden were taken in the 1970s and the 1980s (Bergqvist et al., 2007). Thereafter, a plethora of initiatives have been taken to facilitate greater equality between women and men (Skr. 2016/17:10). On 1 January 2018, the Swedish Gender Equality Agency (Jämställdhetsmyndigheten) was established, led by Prime Minister Stefan Löfven. The task for the Agency is to ‘systematically highlight and analyse the impacts of various proposals and decisions for women and men, respectively’, and to ensure that this achieved knowledge is used to improve the design and implementation of gender equality perspectives in Sweden (The Swedish Gender Equality Agency, 2019a). The Swedish state, the agency continues, has a responsibility to ensure that gender equality is achieved:

An ambition to increase the gender equality in society is an ambition to give all people an opportunity to shape their own lives without being limited by gender stereotypes. The overarching goal of the gender equality policy is that women and men are to have the same power to shape society and their own lives (The Swedish Gender Equality Agency, 2019a).

Gender mainstreaming commonly refers to ‘the integration of a gender perspective into the preparation, design, implementation, monitoring and evaluation of policies, regulatory measures and spending programs’ (EIGE, 2019;
see also Skr. 2016/17:10). Relevant to the field of reproductive healthcare is The Swedish Association of Midwives’ statement saying that the midwife promotes ‘equality between women and men, as well as solidarity and respect for the individual’ (The Swedish Association of Midwives, 2019). Also, in the Competence Description for Authorised Midwives, attention is paid to women’s rights:

The fundament of the competence description is the midwife’s international code of ethics, that considers women as persons with complete human rights, which seeks justice for all people and equality when it concerns the availability of care and shows respect for each humans’ own value (The Swedish Association of Midwives, 2018, p. 4).

The presumption underlying the efforts of making health and healthcare provision more gender equal seems to be a belief in that women’s (and men’s) health benefits from greater gender equality (Månsdotter & Deogan, 2014). In a *Lancet* publication, Grown, Gupta and Pande (2005, p. 542) state that ‘[l]ong-term and sustained improvements in women’s health require rectification of the inequalities and disadvantages that women and girls face in education and economic opportunity’. A common hypothesis is that a gender equal society, where women and men engage in similar types of lifestyles, living conditions and working conditions, ‘would experience a gender-equal distribution of psychological and physical morbidity, and of the causes and timing of mortality’ (Månsdotter & Deogan, 2014, p. 296). When it comes to gender equality, scientific arguments have to a large extent merged together with those among policy makers. The United Nations Population Fund states, for instance, that:

> Within the context of population and development programs, gender equality is critical because it will enable women and men to make decisions that impact more positively on their own sexual and reproductive health as well as that of their spouses and families. Decision-making with regard to such issues as age at marriage, timing of births, use of contraception […] stands to be improved with the achievement of gender equality (UNFPA, 2019).

The claim that people’s health would improve if ‘gender equality’ enhances is, most likely, difficult to scientifically verify (Månsdotter & Deogan, 2014). In line with Åsa Lundqvist, who have studied ‘opinion-shaping strategies’ with regard to gender equality in Sweden in the 1960s and 1970s (2019, p. 2), I would instead like to propose that the power undergirding gender equality as governing tool comes from its historically ideologically strong status in Swedish society, rather than from research indicating the precise benefits of gender equality on people’s health. This presumption is supported by the fact that gender equality perspectives imbues not only healthcare in Sweden today, but many other private and public sectors as
well. The overarching aim is not to improve “health”, but to create a more gender equal society. When increased gender equality is argued to improve people’s health, it gives the argument a solid credibility that is difficult to question or disrupt (see Loseke, 2003).
Social constructions and discourses: a general perspective

Most broadly, this thesis rests on a social constructionist perspective. What does this mean? It means, for instance, that many concepts that are frequently talked about in the field of migrant reproductive health and which will be referred to in this thesis — such as “immigrants”, “migrants”, “Muslims”, “minority groups”, “diversity”, “equality”, “gender equality”, “health”, etcetera — exemplify terms that become inscribed with various associations. This is not to say that such terms are entirely free-floating and that nothing ever can be defined; rather, it is a perspective that draws attention to how our shared understandings of the world are historically and contextually dependent (Foucault, 1972). All of these words can evoke many different ideas, depending on the context in which they are being used.

Here, the term “discourse” is useful to capture how certain words, concepts and ideas are linked to socially shared meanings. “Discourse” can be defined as ‘relatively bounded, socially produced forms of knowledge that set limits upon what is possible to think, write or speak about’ (Bacchi, 2010, p. 63). I would like to suggest that the field of migrant reproductive health exemplifies a discursive field of meaning-making processes. Snow defines a discursive field as a ‘broader enveloping context in which discussions, decisions, and actions take place’ (Snow, 2008, p. 7). But it also contains an awareness that discourses never exist in singular (Foucault, 1972): the field of reproductive health in Sweden, and globally, is imbued with many different discursive fields — sometimes with loose boundaries and other times more structured (Snow, 2008) — where each of them produce what actors within these fields consider to be real (Bacchi, 2010). Discourses teach us about ‘coming to see something in a particular way’ (Lessig, 1995, p. 960, italics in original).

Discourses are important in this thesis for two main reasons. First, it is important to acknowledge that in some time periods, and in some specific fields of knowledge, some ideas will be more dominant and influential than others. Laclau and Mouffe (2001) call such dominant discourses hegemonic. For example, although many discourses on “gender equality” exist in society today, there is one discursive mentality on gender equality that sets the agenda for public policies in Sweden, namely, the one emphasising women and men’s equal rights and opportunities with regard to, for instance, educa-
tion, labour, income and health. Another example is religious counselling; although many ideas exist about what “religious counselling” is and is not, the hegemonic discourse in Swedish state policies represents religious counselling as an enriching and complementary element to healthcare laws and regulations. In the field of migrant reproductive health, these hegemonic mentalities are important because when they become part of health policies, they will seek to influence both thinking and action in certain directions. The forthcoming exploration will address these hegemonic policy ideals.

Secondly, discursive policy mentalities are important in the thesis because they reveal something about the persons and situations that they intend to address (Bacchi, 2009). Here, it becomes important to understand what assumptions — about people, events, and problems — that underpin existing policies. As Loseke (2003) has pointed out: certain claims manage to enter the realm of health policies because they present compelling and relatively consistent stories about the kinds of people or events that they seek to address. But people are not “kinds of people”: they are real humans who interact with their surrounding in often-unpredictable ways (Bhaskar, 2008; Hacking, 2004). When policies are developed and implemented, they draw on certain assumptions and ideas about the problems they seek to solve, which at the same time leaves many other aspects silenced and unaddressed.

Defining some recurrent terms

I will briefly outline a few key concepts that will appear every now and then throughout the text, and describe how I intend to use them.

**Diversity, equality and gender equality**

The terms “diversity”, “equality” and “gender equality” can mean quite different things (Baehr & Gordon, 2018). For instance, in discussions signified by a sexually liberal attitude, “diversity” in Sweden often refers to a diversity of sexual lifestyle practices and sexual self-identification. Further, in Swedish universities’ policies for inclusion, Adamson (2015) has argued that “diversity” has become a term that foremost implies societal representation: i.e. the number of students and teachers in a university institution of different ethnicity, religion, gender, sexual orientation, etc., should be proportionate to the diversity in society on the whole. In the field of healthcare and migration, “diversity” seems instead closely linked to the idea that the healthcare system should understand and possibly also accommodate for the needs and preferences among various ethnic, cultural and religious minority groups. This is the discourse on diversity that will be given attention in this thesis.

“Equality”, in turn, usually appeals to the imperative of treating everyone the same. In Swedish language, equality would be translated to “jämlikhet”. In English, however, a distinction is often made between “equality” and
“equity”, where equality refers to the same treatment of everyone, and equity to treating everyone according to their needs in order to achieve equality in outcomes (Hoffmann Merrild, 2018). The latter principle has been referred to as ‘proportionate universalism’ (Carey et al., 2015). In this thesis, it will be explored how “equality” operates as a principle about equal treatment for everyone in clinical encounters, i.e. in terms of non-discrimination, and how it is used as an axiom to motivate interventions that seek to reduce inequalities in contraceptive prevalence.

“Gender equality” is also a term that is filled with many various meanings. Clearly, there are many divergent opinions about what it means to live a gender equal life in Sweden and elsewhere today. These opinions are often linked to debates about men and women’s socially constructed versus naturally inscribed roles and responsibilities. Sometimes, the idea of “gender equality” has been criticised for drawing on a traditional hetero-normative assumption about different-sex partnership, thereby excluding individuals who define themselves and their relationships in alternative ways (Månsdotter & Deogan, 2016). In this thesis, I will take “gender equality” as it is formulated in contemporary state policies, as a starting point for the empirical exploration. The Swedish Gender Equality Agency (2019c) states that gender equality ‘means that women and men have the same rights, responsibilities and opportunities in all areas of life’. In the government’s six gender equality policy goals, “gender equality” is intertwined with ideas about ‘gender equal division of power and responsibilities’ (Goal 1), ‘economic gender equality’ (Goal 2), ‘gender equal education’ (Goal 3), ‘gender equal distribution of unpaid housework and provision of care’ (Goal 4), ‘gender equal health’ (Goal 5), and that ‘women and men, girls and boys, must have the same right and access to physical integrity’ (Goal 6) (The Swedish Gender Equality Agency, 2019b). Importantly, this is not the only discourse on gender equality that exists in Sweden today but it is, as I also suggested above, the discourse that appears to have gained hegemonic status in contemporary state policies and in healthcare research, which makes its practical implementation relevant to explore.

Culture and multicultural encounters

“Culture” is another concept that occasionally will be referred to here. Although it does not constitute a significant part of the thesis, I will say a few words about it. I assert that relatively often culture becomes used as a ‘simplistic container model’ (Lentz, 2017, p. 182) in medicine and public health research, i.e. as a concept that has become ‘so all-encompassing that practically everything becomes culture and the term’s analytical value is eroded’ (Lentz, 2017, p. 181). Many times, culture becomes used as a signifier for what other people — immigrants, Muslims, ethnic minority groups — are assumed to have, as, for instance, Johnsdotter (2002) has observed being the case regarding Somalis in Sweden. Recommendations for clinical practice,
then, encourage providers to pay attention to culture or to achieve a higher level of cultural competency, as if culture is something that automatically comes with people’s ethnicity (Kleinman & Benson, 2006). A more dynamic concept of culture would, however, need to take into account that culture is nothing that people automatically “have”, as a type of innate essence. The anthropologist Clifford Geertz (1993) provides a well-known perspective of culture, as encompassing an ensemble of symbolic systems that contribute to giving meaning to people’s actions. Culture, he writes
denotes a historically transmitted pattern of meanings embodied in symbols, a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate, and develop their knowledge about and attitudes toward life (1993, p. 89).

The term “multicultural encounters” and alike (multicultural milieus, multicultural contraceptive counselling) will be used with some frequency. Drawing again on Geertz’ definition of culture as a concept for capturing relativistic bounded meaning-making that guides social action (Geertz, 1984; 1993), the emphasis on multicultural seeks to depict that there are many, simultaneously existing versions of one topic or another. However, it is possible to argue that describing clinical encounters as “multicultural” is unnecessary if we accept the premise that all people are cultural beings. Again, culture is nothing that “belongs” to people from other countries than Sweden — we are all parts of ‘historically transmitted pattern of meanings’ (Geertz 1993, p. 89). That being said, I still use the term “multicultural” because it effectively draws attention to what most people think of when they hear it, i.e., encounters between people from various ethnic or religious backgrounds. Likewise, putting “multicultural…” in a title of an article or as a key word, for instance, makes the research more likely to be found when people use search engines. It might be a less flattering, yet transparent, declaration of my intentions.

**Multicultural society and multiculturalism**

In addition, it is necessary to make a distinction with regard to the use of the terms “multicultural society” and “multiculturalism”. That Sweden is a multicultural society implies that there are numerous systems of symbolic meanings (Geertz, 1993), and that people with differing backgrounds from countries all over the world live in Sweden (Government Bill 1997/98:16). In the past few years, migration to Sweden has reached historically unprecedented numbers (SCB, 2019). That Sweden is a multicultural society is, one could say, an empirical fact. My use of multiculturalism, in turn, refers to ‘a political idea of how an ethno-culturally diverse liberal-democratic polity ought to accommodate and manage diversity’ (Wickström, 2015, p. 513), or, framed differently, a political idea about how society should approach the
integration of diverse lifestyles. Wickström (2015) identifies two core fundamentals that are significant for the political idea of multiculturalism:

1. That cultural diversity in various ways should receive public recognition, and that this should be accomplished for the greater good of the whole society;
2. That minority groups (including both migrants from other countries but also domestic minorities such as the Sami group in Sweden), should be endorsed as minorities. This includes being protected from discrimination and pressure from the majority population to “become Swedes”, i.e. to assimilate. Such assimilatory pressure would exemplify a form of discrimination.

Muslim, Islam and immigrants
The term “Muslim” will be generously referred to. On a basic level, a Muslim can be defined as a person who believes in Islam. Importantly, though, the Muslim group is not homogeneous, but heterogeneous (Ouis & Roald, 2003). Among those persons who believe in Islam, there are a multitude of various ways to relate to religious sources and to incorporate religious ideals into practice; ranging from ultra-conservative groups who make literal interpretations of religious doctrine with no possibilities for adjustments, to followers who work hard to enable that also religious sources become subject for contextual relativising (Svensson, 2010). Following Brubaker, the category “Muslim” is a category that talks to people’s self-identification, a category used among Muslims to identify who is a desirable Muslim and who is not, and a category used by non-Muslims to categorise Muslims (Brubaker, 2013).

“Islam”, in turn, is in this thesis approached as a “discursive tradition” (Asad, 2009). Asad writes: ‘Islam is neither a distinctive social structure nor a heterogeneous collection of beliefs, artifacts, customs, and morals. It is a tradition’ (Asad, 2009, p. 20). I would like to propose that the other religions that are referred to in this thesis could be understood in similar ways. Important is to recognize that “religion” is not a social actor who can have an opinion about anything. Instead, the aim in this thesis becomes to study people’s religious ideas related to certain questions. As Svensson (2010, p. 73) remarks: ‘From this perspective, it becomes clear that ideas and practices within a religious tradition are highly diverse, changeable and often compete with each other’.

Also, the term “immigrant” will reappear throughout the text. In the most general sense, an immigrant can be defined as ‘a person who immigrates’ (The Concience Oxford Dictionary of Current English, 1995, p. 679). However, in Sweden, the terminology has been debated for many years (Ds 2000:43); some argue that the term immigrant is best, whereas others refer
more frequently to people’s ethnicity or “race” (Steer, 2015). Currently, various definitions are used by Swedish authorities and by researchers. In Statistics Sweden’s (SCB) statistics on immigration, everyone ‘who moves to Sweden and becomes a resident (folkbokförda)” (SCB, 2019, my translation added) is defined as an immigrant. In health research, immigrants have often been defined as persons who have migrated to Sweden (or another country), or who have at least one parent who has migrated from another country (Helström et al., 2003; Helström et al., 2006; Larsson et al., 2016). In my exploration, however, I have been more curious to explore how the term immigrant takes form as a discursive construct. This is not to say that immigrants do not exist. Clearly, people migrate all the time, from and to different countries and for varieties of reasons. Migration per se is not a construct — migration happens (Hacking, 1999). From a constructionist perspective, it becomes relevant to explore and try to understand what ideas become discursively linked to the category immigrant (or migrant or ethnic minority), and how these ideas influence the development of policies and possibly also immigrants themselves (Hacking, 2004).

**Reproductive health, contraceptive counselling and abortion care**

In the global health discourse, ‘reproductive health’ is commonly defined as:

…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2019).

The discourse on reproductive health is linked both to discourses about sexual health, and with sexual and reproductive rights (often abbreviated as SRHR). The reproductive right perspective is often described being part of the above definition of reproductive health:

Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (UNFPA, 2014, p. 59).

In Sweden, this global SRHR discourse has emerged alongside historically prominent claims about women’s rights to sexual and reproductive freedom stemming from the women’s rights movement in the 1960s and 1970s. An important factor was that during this time, a new type of family policy began
to emerge as a result of women’s intensified claims for societal recognition (SOU 1983:31). Men and women’s equal responsibilities for home, children and financial burden were emphasised (Liljestöm, 1974). The objective was, as Liljestöm (1974, p. 68) has pointed out, ‘the total integration of women into modern society’; an ideal that required access to both contraception and abortion care. The outspoken support for a liberal sexual and reproductive health politics among both politicians and the general public can thus be seen as characteristic of Sweden (Sydsjö et al., 2012), compared to many other countries in the world (Elgán, 1994; Hilevych, 2015; Hoggart, 2015; Linders, 2004; Shapiro, 2014). Accordingly, in Sweden, the debate about abortion and contraceptive use has been relatively low-voiced and characterised by large consensus about women’s inviolable rights to own reproductive decisions (Linders, 2004).

“Contraceptive counselling” refers to the process in which women and men receive counselling and care with regard to choice and use of contraception. Usually, midwives (and sometimes gynaecologists) provide contraceptive counselling and prescribe contraception, and not general practitioners, as is the case in many countries elsewhere. Almost everywhere in Sweden, certain contraceptives are offered at subsidised costs, and sometimes offered for free to young people (Kopp Kallner et al., 2015). Contraceptive counselling is commonly provided in maternity clinics (mödravårdbcentral), in youth clinics (ungdomsmottagning) and sometimes in gynaecological clinics (kvinnoen). Maternity and gynaecological clinics can either be part of public healthcare institutions, or be run in private regime. Kopp Kallner and colleagues (2015) describe that the current Swedish model has been developed to ensure ready access to contraceptive counselling for everyone in the country.

“Abortion care” refers to the counselling and care that is provided with regard to a woman’s considerations when it comes to pregnancy termination, and the care before, during and after an induced abortion. If a woman wishes to terminate a pregnancy, then she can initiate this process at a gynaecological clinic. While surgical abortion care is provided in hospitals, medical abortions can be performed at home. Nonetheless, the medical abortion must also be initiated at the clinic. Women’s rights to abortion and abortion care are regulated in the Swedish Abortion Act (1974:595). A clarification must be made: in Papers III and IV, the term “abortion clinic” is used to describe the setting where abortion care is provided. This is a somewhat unfortunate translation that can be confusing for readers who are unfamiliar with the Swedish healthcare system. Unlike many other countries in the world, Sweden does not have any dedicated clinics for abortion only. A more suitable vocabulary would be “gynaecological clinics”, as stated above.
Persons who travel across borders continuously become subjects for a critical gaze, and are at the crossing point forced to clearly declare one’s identity, travel route and whom one is planning to meet. If the traveller through his or her identity in addition to this is stubborn enough to claim belonging to several systems of meanings and fields of knowledge, one is often perceived as a jeopardy to the established order (Uggla, 2014, p. 8-9).

Bengt Kristersson Uggla describes himself as a traveller across scientific disciplines. I have found myself being one as well; I have gone from the fields of social work and international law (from where I have my university degrees) into the field of reproductive healthcare. These fields are quite different from each other. While social sciences often make use of qualitative methods and social constructionist perspectives, positivist approaches within medical and public health research has the ability to generate statistically verified data about widespread societal trends. Some years ago, it was more common to talk about the relationship between constructionist approaches and positivist approaches as conflict-ridden and problematic than what appears to be the case today. In the 1990s, Ian Hacking (1999, p. 16), for instance, spoke about the ‘war of sciences’. He described this “war” as signified by positivists’ realization that their so-far relatively undisturbed perspectives about truth and knowledge got challenged by other ways of determining what is true, and what is not (Hacking, 1999). For researchers who were trained in quantitative methods, many qualitative methods for collection of data, analysis, and interpretation might, as Thorne and Darbyshire (2005) have reflected upon, have felt unfamiliar — perhaps even scientifically doubtful. Today, many researchers work in interdisciplinary research projects, which mean that we become increasingly used to navigate between many times divergent research traditions (Uggla, 2014). Here, it is probably worth acknowledging that both quantitative and qualitative research contribute with scientific knowledge to a field of understanding, although in sometimes distinctly different ways (see Small, 2009).

The advantage of doing qualitative research in the field of medicine and public health is that qualitative studies can add something important which cannot be captured through large-scale surveys. Qualitative research, for example conducted through interviews and FGDs, can generate empirically and theoretically rich perspectives about everything from people’s thoughts,
feelings and actions, to the impact of politics and policies on people’s lives — and, of course, anything in between. Yet, in order to get hold of novel qualitative insights, alternative methods for the handling of data must be applied. Instead of relying solely on large-scale data and statistical analyses, in social sciences, it is widely acknowledged that much of what is happening around us must be researched through interviews, interpretations, and with the help of theoretical perspectives. Without these methodological approaches, we would be left with a problematically incomplete idea about what is going on.

The following chapter bears witness to this project’s cross-disciplinary character. It starts off with relatively short descriptions of participants and procedures for data collection, which is then followed by more extensive reports about data analysis and methodological and ethical considerations.

Researching multicultural clinical encounters as a social phenomenon

When I started this project, I did not take the assumed oppression or discrimination against some specific groups as a starting point for the empirical exploration. As Racine (2009) and others (see for instance Loseke, 2003; Patai, 2009) have pointed out, the risk of doing so could be that the analysis gets a too narrow focus, and that certain discourses risk getting uncritically reproduced since other interpretations are not taken into consideration. Instead of this, I attempted to close in on the inquiry of “multicultural clinical encounters” — which was the broadly defined theme of the project in the beginning — as a social phenomenon. Schwarz and Stenaker propose that approaching a topic as a social phenomenon ‘allows for a variety of research paths and outcomes, which may lead to a series of other debates and research opportunities’ (Schwarz & Stensaker, 2014, p. 487). Approaching the field of study as a social phenomenon helped, I believe, to keep the research path open to several interpretations and outcomes. The research process took shape as a pendulum activity between deductive and inductive reasoning, i.e. as both theoretically driven and theoretically generating. This perspective encouraged a constant reflection on theories, empirical data, interpretations and how they all related to each other in the understanding of a particular phenomenon (Lipscomb, 2012). Lipscomb defines this type of approach as abductive reasoning, which encompasses ‘the creative, imaginative or insightful moment in which understanding is grasped – or is thought to be grasped’ (Lipscomb, 2012, p. 244).

Although the study did not take oppression of specific groups as an a priori assumption in the initial exploration (Bhaskar, 2008; Buch-Hansen, 2005; Houston, 2001), the analysis subsequently provided insight about how many
health policies in Sweden today possibly could generate uneven effects on various groups of people in Swedish society (Bacchi, 2016).

Participants and procedure

This thesis draws on empirical material comprising qualitative interviews and focus group discussions (FGD) with informants who self-identified as pious Muslim women, midwives and gynaecologists, and religious counsellors that were immediately or more loosely affiliated with Swedish public healthcare institutions. Interviews and FGDs were conducted between 2013 and 2017.

Pious Muslim women

I interviewed twenty women. Some of the women were interviewed two to three times each. The reason for why I interviewed these women several times was that they provided rich insights to the questions that I wanted to explore. They were “good talkers”, in that they willingly shared deep insights about their lives. All the women who were included in the study had an active relationship to Islam, and they appeared to engage in what Saba Mahmood (2005) has referred to as a pious self-cultivation.

While I knew that I wanted to talk to women for whom Islam was a concern, the recruitment of informants was still very much a stumbling process. When I first began recruiting informants, I found inspiration in Pia Karlsson Minganti’s (2007) ethnography of young Muslim women in the Muslim “revival movement” in Sweden. Similar to what Karlsson Minganti did, I began getting in touch with Islamic organisations and youth groups hosting social and educational events for primarily young Muslims (over 18 but under 30 years old, approximately). I visited a couple of such events in a few medium large and large cities in Sweden.

In most cases, I asked the responsible person leading the event (usually an imam) if I could stand up in front of the group and present my interest to get in touch with interviewees. Thereby, several persons came up to me afterwards and announced their interest in participating. Sometimes, the responsible persons were located in another room, and it was therefore difficult to officially announce my presence. I always ensured that the persons with whom I spoke to knew who I was and what I did there. I often started talking to people sitting next to me in the lecture hall or whom I met during coffee breaks, and was thereby able to invite women to participate in the study.

2 In one lecture that I attended, I was sitting with some fifty other women in a separate room, whereas the men and the imam hosting the lecture were sitting in another. The women and I listened to the imam via a loudspeaker.
When I had conducted some interviews, it turned out that most informants could present ideas about, for instance, contraceptive use and abortion, but had never been in the situation of having to make decisions on contraceptive use or abortion themselves. I therefore extended my recruitment to other settings. To start with, I spent time at three organisations working for migrant women’s integration. The organisations were located in Sweden and Denmark, respectively. In retrospect, I can conclude that some of my efforts in this part of the project were successful, whereas others were less so. The methodological problem that I faced was that not all women in these organisations were very much concerned about Islam, either because they did not self-identify as Muslims at all, or because they generally did not care much about Islamic norms in the way that they organised their lives. In the end, only three interviews with women in Denmark provided insights that were rich enough to be included in the analysis, whereas the organisations in Sweden opened up contacts with a few more informants. While I am aware that Denmark and Sweden are two countries with divergent discourses on both health and health inequalities (Vallgårda, 2007) and on integration of newcomers (Tawat, 2014). I evaluated that including narratives from these three informants did not cause any problems with regard to methodology, interpretation or analytical generalisability. The main reason for this was that the interviews were analysed for discourses, which would enable me to take into account any contextual circumstances that appeared to be of significance for the informants — regardless of which country they lived in.

As the project proceeded, I got in touch with more informants. Some women were recruited via some of the large mosques in Sweden, where they helped to organise Islamic reading groups for women and youths. Other informants were recruited when I visited shops selling Muslim clothes, books, and accessories. In some cases informants were recruited in more unexpected ways. One time, for instance, I began talking to a woman who I asked for directions to a Muslim shop nearby. She expressed interest in the study in a way that enabled me to ask her if she wanted me to interview her, and we decided to meet for an interview some weeks after. Another time, when I was standing in a shopping mall waiting for an appointment to show up, a woman approached me and we began to talk. After a while, she asked if I wanted to interview her, and I accepted her initiative.

The interviews
The interviews usually lasted between one and two hours. In some instances, the conversation lasted longer but then had a more informal character. I was often invited to informants’ homes to conduct the interviews. Usually, we had some food or coffee together before, during or after the interview. But interviews have also been conducted in other places where informants preferred to be, like in the mosque, in an adjacent room to where an Islamic lecture was held, or in cafés.
Who were the women?
It is difficult to describe what the women in the study had in common. In a way, they were all similar in their desires to cultivate their religious faith and to invest in their identity as Muslims. The women reflected what appeared to be a dedicated and active relationship to Islam. When I spoke to them, I could hear that they positioned (at least some) of their reasoning in relation to Islamic discourse; they seemed to make continuous efforts to stay up to date about the content of Islamic discussions, they read books, joined Islamic lectures, watched Arabic television shows about sexual and reproductive health matters given within the context of an Islamic discourse (most women, but not all, spoke Arabic), or other television programme broadcasted locally by Islamic youth organisations in Sweden. Some women regularly visited the mosque for prayers, whereas others prayed at home and “reminded” themselves about Islam’s message through other forums, such as Islamic lectures or Internet sites. In some cases, these descriptions came up as result of me asking about them. Other times, informants brought these reflections up themselves.

All of them also had what best can be described as immigrant background: either they, or their parents, had migrated from countries from outside Europe. One informant had background from Turkey, another from Bosnia, and a third from Albania: all of the remaining women had family backgrounds from countries located in the Middle East or Northern Africa region. All of them had also lived in Sweden or Denmark for at least seven years when the interviews took place.

At the same time, they were all so different: all with unique life experiences, social life, family situation, personal migration experiences and occupation. There was, for instance, Amal from the Northern Africa region who had two children, went to SFI (Swedish for Immigrants), and who wanted to work as a nurse assistant when she had supplemented her grades from high school. Then, there was Lara, who was a medical doctor, and Mariah, who had a Master’s degree in business administration, and who now wanted to start her own company. Aisha had struggled for many years to get her education from her home country accredited in the Swedish education system, but had decided to start from scratch with a new vocational training in nursing — although she would have preferred to just stay home and care for her children. And then, there was Heba who had become a role model for

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3 Though I had the objective to interview Muslim women from the Middle East and Northern Africa region (MENA), this a-priori intention had to be re-evaluated. One occasion when this happened was during one of the Islamic lecturing events that I attended, when I told a group of women that I wanted to interview Muslim women with background in the MENA-region. The women looked at me, surprised, and one of them asked: ‘Why would you only interview us and not her?’ Another women added: ‘There are no differences between us here, we are all the same’. ‘Ethnicity’ was, for these women, not a unifying identification, but their religion was.
younger women in the mosque; a person that they turned to if they wanted help, but who also felt constrained by the heavy demands that older people in the mosque had placed on her. I interviewed her twice, and the second time I met her, she had decided to withdrawal from her tasks in the mosque and instead take supplementary courses that could complement her Master’s degree.

While the scattered demographic profiles of my informants from a positivist research perspective could be criticised for inhibiting the possibility to generate representative description with regard to one group of women in society (Small, 2009), or to downplay the element of “risk” that the most disadvantaged groups of women are assumed to face (Verbiest et al., 2016), it has other advantages. Most crucially, the intra-group differences provided an opportunity for making a problematisation of dominant categorisations of “immigrants”, “Muslims” and “women in minority groups” as they are presented in the field of reproductive health. In my exploration, I do not draw specifically on theories about intersectionality (de los Reyes & Mulinari, 2005). Yet, I would argue that the relatively diverse group of informants has enabled me to “do” intersectionality (Bacchi & Eveline, 2009), if intersectionality is understood as ‘an analytical ambition to explore gender, sexuality, class, and race as complex, intertwined, and mutual reinforcing categories’ (Mattsson, 2014, p. 9).

Healthcare providers

Five individual interviews and five FGDs were conducted. The FGDs comprised 2-8 individuals each. Informants were midwives, gynaecologists or obstetricians by profession. Healthcare providers working in four different clinical units in two Swedish cities were invited to participate in the study. Two of the clinics were located in suburban neighbourhoods, where a large number of immigrant families were living. As explained by the informants, most patients visiting their clinical units came from countries in the Middle East and Northern Africa. The other two clinics were located closer to the respective city centres, where the patient group was more mixed with regard to ethnic and religious backgrounds.

In most cases, I personally went to the clinics and introduced the study and myself to a member of the staff, handed out written information about the study, and got the name and the telephone number to a contact person (i.e. a member of the staff). The persons that I established contact with helped me to inform their colleagues about the study, and thereafter arranged a date and time for FGDs with the persons in the work place who wanted to participate. In some cases, I was asked by the contact person to get in touch with the head of the unit to get final approval for their participation, whereas a few informants and groups of informants did not consider it to be relevant
in the organisation that they were in. Moreover, in some instances, I got the contact information to healthcare providers through my personal contacts.

When I began with the recruitment of informants, I knew that I wanted to get in touch with two “groups” of healthcare providers. On the one hand, I wanted to interview providers that on a daily basis encountered patients with background in non-European countries, of which many would probably be Muslims. On the other hand, I wanted to talk to providers that were less well accustomed to encounters with Muslims from non-European countries. My hypothesis was that the more exposed the healthcare providers had been to encounters with diverse groups of patients, the more reflections they had with regard to how to approach and handle diversity and equality perspectives in clinical practice. This hypothesis was partly influenced by organizational theories about how welfare workers develop strategies, logics and rationalities in order to navigate the often times conflicting policy-demands in encounters with citizens (Sommer Harrits & Østergaard Møller, 2013; Lipsky, 2010), and of previous research showing that welfare workers in Scandinavia often experience encounters with immigrant patients to be difficult (Dellenborg et al., 2012; Erstad, 2018; Larsson et al., 2016).

The interviews
All the FGDs with healthcare providers were conducted at their workplaces, and during lunchtime. This was clearly the preferred choice, since many expressed that their heavy workload made it difficult to dedicate time for an interview during the scheduled working time. To conduct FGDs outside regular working hours was never presented as an alternative by the invited healthcare providers. In most cases, the interviews lasted around one hour. Some interviews could have continued longer because participants still kept the discussion going, whereas other interviews naturally came to an end after approximately one hour. Individual interviews with healthcare providers took place at their offices, except for one, which was conducted at a café. The individual interviews lasted between 1 to 1.5 hours.

Religious counsellors — Muslims and others
In the end of the data collection period, when I interviewed a group of healthcare providers, the informants mentioned that they often consulted the hospital imam when they needed help with special procedures regarding the treatment of, and encounters with, Muslim families. After having read the official information available about Muslim hospital counsellors and having talked to employees at The Swedish Agency for Support to Faith Communities (SST), it became evident that Islamic religious counselling in the past years has become an increasingly present and important part of spiritual care in Swedish hospitals. I was curious to understand what this was all about, and in order to try to figure this out, I decided to invite Muslim hospital
imams and hospital coordinators (in Paper II referred to as religious counsellors) to participate in the study. I contacted all the hospital imams and coordinators that are listed as contact persons on the Muslim spiritual care platform online. The Muslim spiritual care initiative is a financial and organisational cooperation between SST and the Muslim organisations represented in the Islamic Cooperation Council *Islamiska Samarbetsrådet, ISR*. Some of the persons that I contacted replied that they were interested in participating, whereas some of the persons referred me to other persons within their organisations that often are in touch with Muslim patients or healthcare staff in hospitals.

After having conducted a first set of interviews with the four Muslim informants that eventually participated in the study, I presented some preliminary findings at a research seminar at the Faculty of Health and Society at Malmö University. Challenging questions came up with regard to the broader interpretation of the phenomenon of religious counselling in healthcare. Are there no other faith communities that provide spiritual counselling? And why were the services introduced in the first place? Does it have something to do with the role of the Swedish Church? Questions like these hinted about the room for improvements with regard to the empirical focus of the study. Hence, we decided to broaden the recruitment of informants to also include counsellors from other faith communities. More than the four Muslim counsellors that we had interviewed first, the study also came to comprise interviews with one Catholic counsellor, one counsellor from the Swedish Church, and two Buddhist counsellors.⁴ They were recruited in similar way as were the Muslim counsellors, i.e. via the online platforms belonging to respective faith community. In total, eight religious counsellors were interviewed.

**The interviews**

A methodological challenge occurred with regard to the choice of location for the interviews. It turned out that the counsellors that said yes to participate in the study were physically located in county councils all over Sweden — from the Northern to the Southern part. Given that both money and time constraints made it impossible for me to travel around the country to meet the counsellors face-to-face, I had to evaluate whether it would be methodologically justifiable to conduct interviews over the phone instead. Many researchers have found that conducting interviews over the phone could make it easier for informants to disclose information, particularly of the more sensitive nature (Novick, 2008), and that telephone interviews in some cases could be a preferable alternative to face-to-face interviews (Holt, 2010; Irvine et al., 2012). Although I was afraid that it would be difficult to establish a trustful relationship between the informants and me if we could not see

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⁴ A more detailed description of the methods is provided in Paper III.
each other, and that long and elaborative reasoning would be omitted due to this, I decided to go ahead with the interviews. In the end, I conducted telephone interviews with four counsellors, and they all proved to give rich empirical material. I believe that one reason for this was because I conducted many interviews over the phone. It was as if the physical distance made it easy for informants to talk freely; as if it was an advantage rather than a disadvantage that our social positioning, body language, mimics and so on, got tuned down. In addition to this, I did face-to-face interviews with another four counsellors. The face-to-face interviews were conducted at a location decided upon by the informant. I ended up conducting interviews at the religious organisations where they spent time, at their offices, and at a café, respectively. Interviews lasted between 45 minutes and 1.5 hours.

**Sampling, generalisability and saturation**

A purposive sampling strategy has been applied in this study. It means that I have sought to interview people who can help me to answer my questions — both of the empirical and the theoretical type (Small, 2009; Thorne & Darbyshire, 2005). Patton argues that ‘the logic and power in purposeful sampling lies in selecting information-rich cases for in-depth study’ (Patton, 2015, p. 264). Importantly, the study has not sought to generate empirical generalisability, but analytical generalisability. The difference is that in order to achieve empirical generalisability, the population under study must be large enough for statistical analysis to have enough power. If the aim, in contrast, is to reach theoretical generalisability, the material must be rich and deep enough for the researcher to ‘develop conceptualizations of processes and human experiences through in-depth scrutiny and higher-order abstraction’ (Polit & Beck, 2010, p. 1453). Saturation was considered to have been reached when the interviews had provided enough insights for formulating some preliminary hypothesis about what was going on (Thorne et al., 2009, p. 1385).

**Analysis**

In the papers (I-IV), I refer to various modes of handling qualitative data. I will here take the opportunity to describe in more detail the ways in which I have applied the methodological theories that are outlined in the papers.

The interviews that I conducted have been semi-structured. I started out with an overarching set of themes that I have wanted to talk to informants about (see Figure 1). As I have gotten a better sense of what seemed to be going on, these themes have emergently been modified in order to dig deeper into specific areas of interest. I have found Lincoln and Guba’s “naturalistic inquiry” perspective useful to conceptualise how the analysis of the material starts already when the first interview is done. Researchers, that is to say, are
not meant to go out with a pre-defined interview guide, collect data and go home and analyse it, but to revise, define and re-consider interview questions and themes as new insights are gained in the data collection period (Lincoln & Guba, 1985).

The interviews have in most cases been transcribed in full, following an approach of denaturalised transcription. Denaturalised transcription has ‘less to do with depicting accents or involuntary vocalization [but rather] concerns the substance of the interview, that is, the meanings and perceptions created and shared during a conversation’ (Oliver et al., 2005, p. 4). The coding of the material has often been made through both readings of transcripts, and through repeated listening to audio-recordings. The latter method has been referred to as ‘direct analysis method’ (Greenwood et al., 2017, p. 91). When coding is done, including both transcripts and audio-recording, it is has been argued to enhance the validity of interpretations (Davidson, 2009; see also Markle et al., 2011). At the end of the data collection period, when a few complementary interviews were conducted to verify the analytical generalisations, the interviews were coded directly from the audio-recordings only. While this could be viewed as a threat to the validity of the analysis, this decision was made based on my own and others’ experiences that coding from audio-recordings often is an equally good alternative as from denaturalised transcripts (Greenwood et al., 2017). A small number of interviews were not audio-recorded. Instead, detailed notes were taken during the interviews, which then provided basis for the analysis.

In the most general sense, Braun and Clarke’s often-applied approach to thematic analysis lays the foundation for the coding of the material. I think that their methodology is beneficial in that it seeks to verbalise something that most researchers are doing when trying to make sense of qualitative material, i.e. trying to ‘find some patterned response’ (Braun & Clarke, 2006, p. 82) and, perhaps, adding some interpretative dimensions seeking to ‘examine the underlying ideas, assumptions and conceptualizations’ (p. 84) of the data. The method has been most useful when it comes to ‘familiarising myself’ with the material (p. 87). The analysis of the material has been made consistently and systematically throughout the process, but the codes and themes have not been collected in one document as if the themes could not be changed or re-evaluated. Instead, the coding has been done in a process of ‘jotting down of ideas and potential coding schemes’ (p. 86), and by writing up many versions of immature manuscripts with plausible interpretations (Braun & Clarke, 2006).

This is not to say, however, that these preliminary codes and themes existed objectively, as if they were lying there, waiting for me to find them (Skjott Linneberg & Korsgaard, 2019; Thorne & Darbyshire, 2005). It has been argued that the text which becomes produced, is as much a product of the researcher as it is of the informants (Skjott Linneberg & Korsgaard,
2019). Codes and themes in an interview are selected by the researcher, and it is his or her responsibility to ‘tell the story of the research, to analyse and to interpret in order to seek and convey its significant messages’ (Byrne, 2017, p. 38).

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<tr>
<th>PIOUS MUSLIM WOMEN</th>
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<tbody>
<tr>
<td>Themes</td>
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<tr>
<td>• The role of religion in informants’ lives</td>
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<td>• The acquisition of religious information</td>
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<td>• Views of, and experiences of using, contraception</td>
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<td>• Experiences and expectations of clinical encounters</td>
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<tr>
<td>Examples of questions</td>
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<td>• Do you sometimes consult religious sources when you have questions about, for instance, contraceptives or healthcare encounters? If so, what sources?</td>
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<tr>
<td>• What considerations did you make when deciding for your current use or non-use of contraception?</td>
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<td>• Can you recall something particular from the encounters that you had with healthcare providers in the past years?</td>
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<th>HEALTHCARE PROVIDERS</th>
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<tr>
<td>Themes</td>
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<tr>
<td>• Experiences from encounters with Muslim or migrant women/couples from non-European countries</td>
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<tr>
<td>• Experiences of handling “difficult” and “easy” encounters in contraceptive counselling and more generally with regard to the provision of care</td>
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<tr>
<td>Examples of questions</td>
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<tr>
<td>• Are there any encounters with Muslim or migrant women/couples in contraceptive counselling that you experienced as particularly easy or difficult, and why so?</td>
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<tr>
<td>• Can you recall how you dealt with situations that you experienced as difficult or problematic?</td>
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<td>• What is important to think about in encounters with Muslim or migrant women/couples, in your opinion?</td>
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<th>RELIGIOUS COUNSELLORS</th>
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<tr>
<td>Themes</td>
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<tr>
<td>• Informants’ views and advice on abortion from the perspective of religious discourse</td>
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<td>• Perceived responsibility regarding giving advice</td>
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<td>Examples of questions</td>
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<tr>
<td>• How would you advise a woman who is considering an abortion, or who has already had one?</td>
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<td>• How do you interpret your possibilities to give advice according to Swedish abortion law, instead of according to religious doctrine?</td>
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Figure 1. Semi-structured interview guide
Analysing discourses

In my analysis of the interviews, I have aimed at ‘coding for’ discourses (Skjott Linneberg & Korsgaard, 2019, p. 261). In an attempt to forego any criticism that I am applying “discourse” in a way that makes it mean ‘everything — language, narrative, ideology, framework, and so on — and therefore comes to mean nothing’ (Garrit, 2010, p. 197), I will try to make my utilisation of the concept explicit.

The way that I approach discourses in the papers (I-IV) is inspired by a Foucaultian perspective, in which discourses are defined as ‘relatively bounded, socially produced forms of knowledge that set limits upon what is possible to think, write or speak about’ (Bacchi, 2010, p. 63, see also Foucault, 1972). To pay attention to discourses at all in my analyses necessitates a view that discourses are of importance for how people organise their lives. Discourses present, among other things, the options that are available for us in terms of choices, decisions, aspirations and actions (Bhaskar, 2008). An analysis of discourses means that thoughts and actions must be understood in light of the context in which they come into being:

We must show that they do not come about of themselves, but are always the result of a construction the rules of which must be known, and the justification of which must be scrutinized: we must define in what conditions and in view of which analyses certain of them are legitimate (Foucault, 1972, p. 25).

Both individual interviews and FGDs provided good opportunities to analyse how informants positioned themselves in relation to, and contributed to producing (Hacking, 2004) discursive statements on contraceptives, abortion and clinical encounters. In the individual interviews, it became clear that informants positioned themselves in relation to various discourses, both because I sometimes asked about it, but also because the conversation tapped into areas where discursive positioning became visible. In Paper I, for instance, I paid attention to how Islam, as a discursive tradition (Asad, 2009), provided a framework of ideas that pious women ‘negotiated, contested, reasoned about, and argued for and against’ (Paper I, p. 60) with regard to contraception, but also how informants positioned their reasoning in accordance with other discourses (regarding, for instance, family-work balance and responsible child rearing). In the other papers as well, I located informants’ way of speaking to more or less contoured constructs of, for instance, equality and diversity ideals and discourses on abortion and contraception.

In some cases, I sensed that informants wanted to present somewhat idealised versions of them, i.e. that the interview provided an opportunity to reflect their ability to act as a “good Muslim” or a “good healthcare provider”. For my analysis, however, I did not perceive this as a problem, but rather as an opportunity to get hold of discursive perceptions about desired and
undesired ways of thinking and acting. In the individual interviews, informants also spoke about feelings more than was the case in FGDs. According to Lemke, feelings signal how we make sense of something. Feelings cannot be separated from the meaning that we attach to a representation of a condition, a person or an event (Lemke, 2014); hence, when healthcare providers, for instance, expressed anger or frustration about some women’s subordinate positions in relation to their husbands, the feelings can be interpreted as emerging from the informants’ positioning in relation to liberal discourses on gender equality.

FGDs provided fewer insights about informants’ feelings and positioning in relation to me as an interviewer, but more insights about how informants positioned themselves in relation to others. Healthcare providers, which were the only group that participated in FGDs, used the group to argue against each other, to agree with each other and to challenge each other’s perspectives. With the aim to get a hold of discursive formations, both hegemonic and others less pronounced, the FGDs provided good insights. The greatest benefit gained from the FGDs was the awareness of the sometimes-tangible surveillance that the focus group participants engaged in, both with regard to their own self-conduct but also related to how the milieu was patterned by the conduct of others. The FGDs provided what Shaw and Armin (2011) have referred to as a “laboratory” for the studying of the discursive formations.

Carol Bacchi’s WPR approach to policy analysis

Carol Bacchi’s approach to policy analysis, ‘What’s the Problem Represented to be’ (Bacchi, 2009), has provided useful perspectives in various parts of this study. The WPR approach is outlined in more detail in Paper IV. Bacchi suggests that health policies exemplify solutions to various conditions that are perceived as being problematic (Bacchi, 2016). When solutions are presented, they contain within them certain ideas about what, or whom, is considered to be the “problem”:

This proposition relies upon a simple idea: That what we propose to do about something indicates what we think needs to change and hence what we think is problematic — that is, what the “problem” is represented or constituted to be (Bacchi, 2016, p. 8).

The WPR approach helps to recognise that policies are not in any ways neutral, but imbued with presumptions, ideas, and aspirations with regard to the organisation of healthcare institutions and the people within (Shaw & Greenhalgh, 2008). From this perspective, policies are socially, politically and historically dependent. Importantly, it also shows how policies tend to limit our thinking by leaving reflections about certain conditions, people, and circumstances silenced, and what consequences that might arise thereof.
Methodological considerations

Why did the informants say what they did?

Why did the informants tell me what they did? Was it something related to my position in society and in relation to them — such as my gender, skin colour, or religious beliefs that influenced their narratives? Was it something in our sometimes-shared experiences — of pregnancy, work-life balance and childrearing — that made them compelled to talk? Or did information-rich interviews just indicate that the informants and I were a “good match”? It is common that researchers in various fields of research “divulge” aspects of themselves and their positionality in society, as if this is thought to impact the outcomes of the interviews (Thorne & Darbyshire, 2005). While I acknowledge that all people, myself included, are ‘products of our cultures, societies, families, education, genetics, biology, experiences and choices’ (Thorne & Darbyshire, 2005, p. 1106), it is difficult — probably even impossible — to determine how all these various discourses, thoughts, emotions and concerns overlap in conversations between people, and what impact they have on what is being said and done. About my own influence on the interview, I can only speculate.

When I interviewed Muslim women, for instance, I could sense that our conversations came to flow smoothly, perhaps because we had many things in common, in terms of gender, age and experiences with regard to family planning, pregnancy and children. I became a female counterpart. Other times, it was as if the women spoke to me as if I came to represent “Swedishness” and that they positioned themselves in relation to what they thought of as typical imaginaries about Muslims in Sweden. One woman, for instance, asked: ‘Why did you choose this topic in the first place?’ I spent some time trying to clarify my thoughts about Islam and Muslims and religiousness in general before she trusted me enough to open up about her experiences. Others expressed that they often went around feeling that they were looked upon strangely by non-Muslims out on the streets, as if they, as they explained, carried the entire responsibility of defending Islam as a loving religion on their shoulders. They spoke both against discourses about terrorism, and against what they perceived as discourses portraying Muslim women as asexual beings that only obeyed their husbands’ sexual demands:

I would really like to know… You probably have much better contact with the Swedish society than I have, as well as what I have regarding how Swedes, or non-believers generally, at all think. What I would really like to experience, although it is probably never going to happen, is that someone approaches me and asks me upfront, is that how they actually look upon a Muslim woman and her sex life? (Female informant in her late twenties, Sweden)
In some cases, I became aware that female informants were compelled to give me their version of what they perceived as being desired pious behaviour, and to educate me about the rightfulness of religious interpretations and practices – divergent as they could be. Their ambitions were not ultimately to downplay the significance of religious conformity, but to truly make me understand how important it was for them to live a pious life. Here, their ambition to practice Islamic *dawa* appeared to be linked to their wish to invite a non-Muslim person to Islam. The religious counsellors, in turn, surprised me with their openness and determination in their messages on abortion. I had expected that they would be more careful to openly declare their views, assuming they knew about the generally liberal attitudes towards abortion and that they felt inclined not to express too divergent opinions (see also Sorhabi & Farquharson 2015, for a more lengthy discussion about "normalization discourses" among Muslim leaders). Similar to what Åsa Aretun (2007) experienced in her study on Islamic free schools in Sweden, it is possible that the counsellors saw me as a spokesperson for putting what they perceived as important Islamic questions on the agenda, since we spoke about more things than the question of abortion. When we spoke about religious counselling in healthcare more generally, they seemed to apply a form of strategic essentialism, which in Gayatri Spivak’s vocabulary would ‘indicate a political and temporary use of essentialism for the subversive ends of creating or understanding a group self-consciousness’ (McHugh, 2007, p. 39; see also Spivak, 2010). The counsellors made, perhaps, use of my position as a researcher in order to get various types of religiously inscribed messages across, and to emphasise their importance for healthcare in Sweden. This makes quite good sense. When it comes to the question of abortion, then, it is possible that the logic undergirding informants’ transparent accounts could be found in their wish to be truthful to Islamic dictates. Although they knew that their opinions could unfold as controversial from the perspective of Swedish liberal abortion discourse, they saw no other possibility than being truthful to what they considered to be right from the perspective of Islamic discourse.

That being said, I am not convinced that any of these circumstances had an immediate impact on precisely what the informants told me. I cannot

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5 In the starting phase of the interview period, the great interest women showed in my research project often surprised me. Many announced their willingness in participating in the study when I visited Islamic lectures; women gave me books and folders about “women in Islam”, and I was always warmly welcomed by one or several women when visiting mosques. I later came to understand this as being part of practicing Islamic *dawa*, i.e. to “invite to Islam”. One woman laughed when I asked her about it, saying: ‘Yes, we get plus points from God when talking about these things with non-Muslims’.
exclude that the informants would have revealed similar information if they had spoken to another researcher than me. In other words, it is quite possible that there are conditions that informants experience to be real which go somewhat beyond what was allowed to be revealed in my conversations with them (see Bhaskar, 2008).

Ethical reflections

While it was not required to apply for ethical approval to conduct interviews in Denmark, in Sweden an ethical committee shall approve all studies that involve human subjects. The Regional Ethical Review Board in Uppsala (Dnr. 2013/346) approved the study upon which this thesis draws.

Contextualisation, confidentiality and informants’ wishes

The study has been conducted in accordance with ethical principles as established in the Swedish Act Concerning the Ethical Review of Research Involving Humans (Etikprövningslagen), in the ethical principles for research in social sciences and humanities (VR, 2019), and The Declaration of Helsinki. This has encompassed, for instance, obtaining informed consent, emphasis on the voluntary nature of the participation and informants’ right to withdraw from the study at any time, information about how the results are intended to be published, and explaining that various measures will be taken to safeguard confidentiality. However, during the course of the study, I have encountered situations and questions that have required additional ethical reflections from my side.

A typical dilemma, which to some extent lies at the heart of many qualitative studies, is how to ensure informants confidentiality while at the same time give a reasonable contextualisation of their views. I made various decisions with regard to this dilemma. For instance, all groups of informants have been interviewed in different cities, and I have decided to make only sparse references to the locations where the interviews have been conducted. While this decision involves a possible cutback on the contextual understanding, it was important in order to respect principles of confidentiality. Many women that I interviewed, and certainly also the religious counsellors, were active in relatively small types of religious and organisational communities where it would be too easy to pinpoint informants’ statements to individual persons if too much information is given. Hence, all informants have been given pseudonyms. Also, in some cases, very specific information — such as number of children, precise country of origin, or occupation — have been left out or slightly changed, in order to minimise the risk for identification. While it has a limiting impact on rich descriptions, long quotations and
narrations have sometimes been shortened in order to not reveal personal details that people in the informant’s surrounding could refer to him or her.

Some informants did not want the interview to be recorded. This happened a few times. The reason was that informants felt uncomfortable or embarrassed to have their voices recorded. Instead, I made brief and mental notes throughout the interview, followed by thorough summaries shortly thereafter.

**Relationships and interpretations**

I think of an interview study as a process of building relationships with people. If the study should be able to reveal anything that could qualify as an empathetic understanding of informants’ perspectives (Small, 2009), they must to some extent trust that I, as a researcher, will take good care of the insights that they give me.

In most cases, the balance between my role as researcher and my role as female counterpart was easy to maintain, probably because both the informants and I were clear about our respective roles. Yet, one of the most ethically troublesome dilemmas occurred precisely because of the trustful relationships that I built with some of the informants. I remember particularly one informant whom I interviewed several times, and where I, from her side, sensed a wish to become friends. In the encounter with this informant, it felt important that I in various ways made clear that I was there as a researcher and not as a friend. I did this in various ways. I, for instance, repeated that what we spoke about would be analysed in my research project and that I was grateful for her help with completing the interviews. Moreover, I came to use the audio recorder as a type of boundary-maker to indicate the beginning and end of the interview. I sensed that bringing this type of formality into the situation helped to reflect to the informant that our conversation was held for research purposes.

Another ethical reflection emerged when I began to analyse the collection of interviews, and I had to confront the realisation that informants might not agree with my interpretations and conclusions. The dilemma felt troublesome. If healthcare providers have taken time to share with me their concerns, how could I legitimately impose interpretations that risked portraying them in a non-favourable light, seen from their perspective? Similarly, if women or religious counsellors have spoken to me with the expectations that I can be a spokesperson for their views of religious ideals, perhaps to counteract what they perceive to be wrong imaginaries of their religion in Sweden, how could I critically balance various interpretations against each other? While getting access to informants’ experiences is often crucial for knowledge advancements, Jansson has, for instance, argued that only giving voice to informants could ‘risk stabilizing — instead of deconstructing or challenging — existing identities’ (Jansson et al., 2008, p. 229). I have come to conclude that the question does not cause any real dilemmas when it
comes to methodology — although it sometimes has felt ethically troublesome. Science, as pointed out by Thorne and Darbyshire, should not compete with journalism or art in telling the ‘the most heart-wrenching tales’ (Thorne & Darbyshire, 2005, p. 1110), or strive to be spokesperson for various groups’ political interests. The telling and retelling of informants’ experiences must not end up in a ‘naturalization of “the way things are”’ (Jansson et al., 2008, p. 229), but involve an element of distance and critical interpretation (Uggla, 2014). My task as a researcher is not to simply recap what informants are saying, but to put the puzzle together and make visible certain structures or tendencies that have been less thought about before (Agar, 1996).

Further, in proximity to the interviews, I informed the participants that they could ask to gain access to the material that they have provided in the study at any time, and also that they were welcome to read the papers and the thesis after publication. Among the people I interviewed, one informant asked to read the quotations from his/her interview, which I intended to include in one of the papers. After having had read the material, the person approved it for publication.

Preconceptions and categorizations

Sometimes, researchers’ preconceptions are described as undesirable parts of a research study. According to some often-posed arguments in post-colonial scholarships (Anderson, 2012; Berg, 2008; Fricker, 2007), for instance, one such bias that could have influenced my understanding of the topic could be that I — as a White woman — am unconsciously ruled by prejudices about non-White or religious people and that such perceptions will influence my analysis in troublesome ways. The claim is almost too solid to disrupt; what could one say to make critics think the opposite? It lies at the heart of the argument that my prejudices are so deeply imbedded in my so called “White privilege” that I cannot fully be aware of them, let alone set them aside when analysing interview material. I find this approach to be problematic, especially because it sometimes means that researchers risk becoming evaluated according to gender, ethnicity, skin colour, religion, or other ascribed characteristics, and not based on what empirical data or analyses they provide. Daphne Patai argues that these tendencies of making connections between persons’ ethnicity and their views involve a form of “ideological policing”. She writes:

If people found what I said sympathetic or useful to blacks, I must be black.
If minority women were frustrated or disappointed by an administrative decision I made, I, in my white skin, must be racist (2008, p. 16).
I would like to suggest that all people, myself as a researcher included, use stereotypes and preconceptions to make sense of people, problems and events. As Foucault points out, our ways of seeing the world are always products of our own historical time and the discourses that are available to us to make sense of what is going on (Foucault, 1972). Where my own preconceptions come from is probably difficult to say for certain, but I would strongly assume that they have more to do with many other things than my skin colour per se. The point is that preconceptions, or, put differently, a hypothesis about what is happening, provide research studies with a good starting point for exploration. The advantage with doing research is that such preconceptions can be put under scientific scrutiny, and thereby getting a chance to become challenged and re-evaluated. This necessitates, of course, that researchers are both curious and vigilant to maintain openness for the possibility that things might not always be as they are thought to be. Moreover, to base empirical inquiries on categorisations — of people, events, and so on — are not undesirable, but probably necessary for the conduction of a scientific analysis (Sommer Harrits & Østergaard Møller, 2011). For example, to find out something about “religious people” or “healthcare providers”, we must categorize them and give them labels. This is fine, as long as such categories are used in a reflective way as to never assume that they are forever fixed (see Foucault, 1972).

I can recall several occasions in which my preconceptions have been challenged by insights from the study. One such occasion was when I visited a mosque lecture to invite women from the Middle East and Northern Africa Region (MENA) to participate in the study, based on the presumption that the Arabic speaking group of Muslims in Sweden has been one of the most vocal groups in putting Muslims’ concerns on the political agenda (Roald, 2002). When I mentioned this to the women at the lecture, however, they did not understand why: in the mosque, they said, ‘all of us Muslims are the same regardless of which country we come from’. As a consequence of this lesson, a few women from Muslim majority countries outside the MENA-region were also included as informants in the study. A second reconsideration was made in the process of interviewing religious counsellors. Since I had acquired most information from literature on Islam and Muslims’ encounters with healthcare institutions in the West, I had a preconception that counselling on abortion from an Islamic discourse would be more imbued with tensions with regard to the Swedish Abortion Law than would perspectives from many of the other faith communities affiliated with Swedish healthcare. This was a preconception that existed due to my lack of knowledge about how people of various faiths might reason about abortion, and which became re-evaluated during the course of the study (Paper III). A third critical point occurred when I first began to analyse my transcribed interviews. Here, I reflect in hindsight that I was too preoccupied getting the codes and themes correct — as if there was a once and for all given formula
on how to do it correctly — that I missed out on analysing informants’ narratives in light of their life circumstances more broadly. As a result, I first ended up with what I now perceive were too simplified and shallow interpretations that could have risked re-enforcing already established “truths” in the research field. I continued working with the material, however, and gained more depth in my analysis with time.

A last comment should be added with regard to my own positioning in relation to ideals on equality, diversity and gender equality. These questions are reasonable to address, and perhaps even more so when a research topic circles questions that are loaded with political tensions, polarised ideas about integration and values about society’s ideal organisation. So let me be clear about my naïve perception here. Like most other people in Sweden, I have been raised with ideas of equality, gender equality and diversity. I think equality in society is good; I am dedicated to gender equality specifically, and I am very much in favour of cultural and religious diversity. I am part of these discourses (Winther Jørgensen & Philips, 2000). When working in this project, I have had to struggle to not fall into preconceived ideas about how things are or — even more — ought to be, and instead trained myself to maintain a critical, reflective and analytical gaze when studying these ideals. One of the largest challenges here has been to overcome what I best can describe as a fear of being understood as intolerant to various lifestyle practices, and especially those ideals that from within a liberal and progressive viewpoint may unfold as illiberal and conservative. Discussions about immigration, integration and Muslims have been quite heated in Sweden throughout the years when this study has taken place. Both in academic gatherings and in media debates more generally, it has felt as if people sometimes have been extra vigilant to discover — and quickly politicise — any arguments or research results that run the risk of being used by others to give fuel to xenophobic tendencies in society.

Consequences of my own discursive production

Many times throughout the course of the project, I have had reasons to consider my choice of study subject and the results that I present. Two considerations have been of greater significance than others.

First of all, this thesis sheds light on conditions that in contemporary Swedish society may unfold as controversial. I mostly think about both Paper III (about religious counselling on abortion) and Paper IV (about “gender mainstreaming”) that may contribute to generating heated discussions about Muslims (or other religious groups) as being backwards, illiberal, and upholding conservative gender values. The concern has been most pressing with regard to the fact that focusing on “the Other” (Said, 1978) could risk reproducing images of Muslims or other religious minority groups as subordinate to what some would call a White oppressive hegemony — at least this
is what many critics say (de los Reyes, 2016; Martinsson et al., 2016; Muliniari, 2008). The dilemma that I have faced is similar to the one presented by Rochelle Terman in her study on violence against women in a Muslim context. Can we, and should we, name and publicise acts that may ‘provide ideological fuel for orientalism and Islamophobia?’ (Terman, 2016, p. 78). The question is warranted, given that it is possible that the results that I present can be used by various actors and for various purposes to push through their own political agendas, now or in the future (Aretun, 2007). It brings to the fore the in part uncomfortable realisation that when this thesis is out on the market, I lack control over the text and the interpretations thereof — the story will get its own life (Ricoeur, 2011).

Now, if Muslims would be excluded as potential study subjects in research in Sweden because it is considered to be ethically problematic to direct attention to Muslims (or any other cultural or religious minority group), it could generate what Anderson refers to as “hermeneutical injustice” (Anderson, 2012, p. 166), meaning that some people or groups of people become ‘prejudicially marginalized in meaning-making activities’ (Anderson, 2012, p. 166, see also Fricker, 2007). Here, I have been inspired by scholars who have encouraged to ‘take seriously the meanings and workings of religious devotion in women’s lives’ (Bilge, 2010, p. 22). I have listened carefully to what informants have told me, regardless of what they have said, and I have asked myself: How can we make sense of Muslims’ lived experiences, struggles, aspirations and hindrances — although their narratives are not always easily reconcilable with liberal and progressive views? (Terman, 2016). Exploring religious conformity and piousness is not a poorly hidden attempt to reproduce stereotypes, but rather reflects an awareness that there may be other lived realities existing next to one’s own (Foucault, 1972; Geertz, 1984). As I still contemplate publishing the results, I do this with belief that the conditions that I have studied have existed — and will continue to exist — regardless if I name them or not. Religious counsellors will give advice and healthcare providers will continue to feel troubled by gender inequalities in contraceptive counselling; these are somehow real existing conditions and not solely effects of researchers’ study thereof (Bhaskar, 2008). To privilege a critique of “Western imperialism” over and above everything else, and downplay the variety of ways in which people manage their lives, risks flattening a better understanding of what people experience to be real (Terman, 2016).

The second dilemma is related to the consequences that my exploration might come to have for the development of policies in the field of reproduc-

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6 At a research seminar, I presented a very early draft of Paper I in this thesis. After the presentation, a person in the audience made an emotionally imbued comment on my work. I do not remember the words exactly, but it was argued that my interpretations were ultimate examples of the re-enforcement of a “White hegemonic power structure that legitimised oppression”.

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tive health and healthcare in Sweden more generally. Loseke has remarked that even though research often is nuanced and illustrative of the often complex dimensions of human life, research results might always run the risk of becoming reduced to easy-to-grasp messages, and solutions, when entering the realm of policy-making (Loseke, 2003). This is particularly relevant in the scientific and practical field that is thirsty for solutions and practical recommendations (Bacchi, 2016). Most broadly, it makes sense; policies must reduce the complexity of what is going on in the world in order to be effective. The risk, however, is that results are taken out of context and provide platform for the development of new solutions — which also will be inherently incomplete and generate new, perhaps severe, dilemmas if not initiated in a reflective way. I have tried to address these issues in the best way possible: first, to provide an analysis that is nuanced enough to resist the temptation among various actors to use the research results to design simplified solutions and, second, to outline a few policy areas that I hope to describe distinctly enough to encourage a reflective discussion about warranted issues (see Chapter 9).
Chapter 5: Results

Diversity and equality in practice

Thus far, it has been suggested that constructs of diversity and equality are worth taking seriously, because these ideals have an important impact on how healthcare policies are formulated. In what ways, then, might these policies influence real world conditions in people’s lives? In this chapter, an exploration will be offered with regard to how specific governing policies — drawing on ideals of diversity and equality — interact with people in Swedish healthcare. As Murray Li (2007, p. 279) points out: ‘No space, no person or social configuration is a tabula rasa, a clean state awaiting inscription’. Governance, that is to say, always engages with populations and relations that are to be directed and improved towards specific ends, but with the condition that the people that become targeted — healthcare providers, patients or other service providers — are always in motion (Dean, 2010; Hacking, 2004). In the following, a summary of the four papers is provided, as well as some additional reflections where I have found it warranted.

Paper I

*Are “low socioeconomic status” and “religiousness” barriers to minority women’s use of contraception? A qualitative and critical exploration of a common argument in reproductive health research*

In the first paper, we explored a common framing in reproductive health research, in which women from religious and ethnic minority groups are thought of as facing several barriers to an optimal use of contraception. Often presented arguments are that women’s “low socioeconomic status” and “religiousness” present barriers to their use of contraception, which puts them in a disadvantaged and vulnerable position in society (Emtell Iwarsson et al., 2019; Helström et al., 2003; Helström et al., 2006; Moreau et al., 2013; Rasch et al., 2007). Such results are commonly generated through statistical analyses of data comprising large groups of people. In the field of medicine and public health, this empirical generalisability is desirable because it gives certain assurances about the conclusions’ trustworthiness (Hacking, 1991). Recently, however, scholars have cautioned against too a
vivid and unreflective usage of statistically based results in the formulation of health policies, because such studies are methodologically incapable of capturing the multifaceted contexts in which people are embedded and in light of which reproductive decisions are discussed, negotiated and argued for and against (Aronowitz et al., 2015; Mulinari et al., 2015). We took this recent critique as an encouragement to conduct a qualitative study that could contribute with a better understanding of the social context in which contraceptive decisions are made. In the study, we asked: ‘In what ways did Muslim women with immigrant backgrounds reason about their decisions to use, or not use, contraception, and what aspects did they take into consideration when making their choice?’ (Paper I, p. 60). Semi-structured interviews were conducted with twenty women, living in Denmark or Sweden.

Our results revealed aspects that in several ways posed a challenge to the dominant framing of immigrant women’s vulnerable status with regard to their contraceptive practices. First, we found that for several women that we interviewed, ‘living under financially and socially insecure conditions were not obstacles for using contraception, but instead were strong imperatives for using contraception’ (p. 61). For instance, using contraception was represented as an important precondition for being able to make desired planning with regard to education, work and other things that the informants wanted to have time to do in life. Also, for some women, decisions not to use contraception represented what can be understood as adaptive route. Sarah, for instance, had low aspirations to join the Swedish labour market, and having many children could thereby enable her to stay home for many years without needing to work. She explained:

Sarah: I removed the IUD without him knowing about it [laughs]. And I thought for myself: ‘No, I don’t tell him anything, he doesn’t want kids.’ He had great expectations of me that I should study, become something good, like that. I didn’t want that! [laughs]. I wanted to have more children, be like other women.

Researcher: So, what did he say when he got to know that you were pregnant?

Sarah: Yeah, like every time we spoke and discussed that I wanted children, he just said no […] And every time I saw a woman with a stroller, I got so sad and [asked myself] why am I not allowed? What is the difference between her and me? So, when I got pregnant, for three months, he didn’t know anything. And then when I told him, I thought: ‘It is a bomb that will explode!’ But no. He was so happy (p. 61).

In addition to this, we found that the women used Islamic discourse on contraception to frame their use of contraception as a desired pious endeavour. Maryam, a woman in her mid-twenties who was unmarried and did not yet have children, recalled a discussion at a lecture that she had attended in the mosque:
It was one story that I’ve heard about the Prophet [Mohammad] when he was in the mosque and was playing with his grand-children. And then, it was a man who approached the Prophet and said that it was strange that he played with them and said, “I have ten children and I don’t even know their names”. The Prophet answered: “It is not my fault that God took away the mercy from your heart. You have gotten ten children and you say you don’t even remember their names: ‘I actually feel sorry for you because this is nothing you should feel proud of’”. So, this quite clearly shows that it is not as easy as just getting a lot of children — one should also be able to give them enough love, attention, give them the food they need, clothes on their bodies, roof over their heads. So, therefore, it is more common now that people plan their family. To plan your life, actually, just as one should do (p. 62).

Most informants saw Islamic doctrine as encouraging use of contraception because this would allow couples to take responsibility for raising children under financially and emotionally stable conditions. Islamic doctrine functioned, in this respect, as a liberalisation strategy rather than a barrier to the use of contraception. Layla, also a woman in her mid-twenties, described how she previously had thought of contraception as being prohibited. But then something changed; she got married into a more religiously devout family, and got to learn that contraceptive use is encouraged in much of the Islamic doctrine. Her change of opinion was thus a result of her intensified religious readings, which gave her legitimate arguments that she could use to object to other family members’ sometimes-negative attitudes towards contraceptives:

For me, it is allowed. I always have that Qur’an verse in my head: “God never gives you a greater burden than you can manage”. And it should really be a great burden to have a new child every year. So, I usually try to think logically about it […]. One has to give the child love and one also needs to raise them; it is not only about having many children (p. 62).

Our argument here is that common proposals calling for special interventions directed towards immigrant women in contraceptive counselling — which are presented as solutions to some women’s low prevalence of contraceptive use — must be problematised. These solutions draw on a single-dimensioned representation of immigrant Muslim women as facing several barriers for use of contraception, effectively excluding alternative ways of reasoning to come forward. With relevance for the overarching theme of the thesis, the paper shows how the public health research community’s desire to “equalise health outcomes” between groups in society becomes a catalyst for differential treatment of some women (from religious and ethnic minority groups) in contraceptive counselling. Although disparate treatment in some cases may be medically motivated, the consequence of such procedures can be that some individuals risk becoming inappropriately excluded from re-
ceiving the same type of treatment as everyone else and which is less appropriate with regard to their individual needs.

Paper II

*Modes of governing: A Foucaultian perspective on encounters between healthcare providers and Muslims in Swedish healthcare*

In this paper, we sought to contribute with an exploration of how equality and diversity function as governing tools in encounters between healthcare providers and Muslim patients in Sweden, and with what consequences. Today, there are probably few groups of patients that evoke as much attention as do Muslims from the Middle East. Muslims have become a battlefield with diverging views in Swedish society, seemingly influenced by global discourses about “the terrorist threat”, discrimination, stereotyping and Islamic oppression (Brubaker, 2013; Bursell, 2018; Inhorn & Serour, 2011; Laird et al., 2007a; Terman, 2016). Equality and diversity perspectives can, in this context, be understood as offering solutions to various issues in healthcare encounters. While equality measures are claimed to reduce negative stereotyping with the statement ‘we should make no difference between people’ (Paper II, p. 2), diversity ideas function as a framework for differential treatment through the implanting of ‘a more relativist attitude toward our society by instilling an appreciation for other ways of life’ (Baehr & Gordon, 2018, p. 978).

In this paper, we asked: ‘How do healthcare professionals, on the one hand, and pious Muslim women, on the other, argue about the incorporation of equality and diversity policies in clinical encounters? What meanings are these constructs assigned? How do the informants position themselves in relation to these ideals?’ (p. 3). Five semi-structured interviews and five FGDs with healthcare professionals (midwives, obstetricians and gynaecologists), as well as seventeen semi-structured interviews with pious Muslim women, provided empirical basis for the analysis.

We found that although equality and diversity principles are represented as desirable and usually non-conflicting in health policies, they appear to generate tensions and presumably unintended consequences in their practical implementation. First, the ideologically strong connotations attached to equality and diversity ideals seemed to nurture strong convictions among providers that, in turn, appeared to generate tensions between colleagues at the workplace. One informant, Camille, for instance, had decided to leave her old workplace because she experienced that the atmosphere was hostile and racist:
There has been such a rule in the delivery clinic that patients can bring two other persons but no more, and it feels as if that rule backfires against those who need more support. It is such an unnecessary rule. But, it was very strict and it was often people [i.e. colleagues] who said that “now you have to go in there and tell them”. They [the colleagues] were very dominant; I don’t know if this was just my experience, but I definitely experienced that people who didn’t talk so good Swedish could be harshly told off, but that we never told off a thirty-seven year old couple with a law degree... [Such situations] were handled completely different. So, it turned into quite... uncomfortable [situations] (p. 5).

Camille positioned her reasoning in dialogue with a discourse of cultural relativism and the imperative of treating everyone according to their specific cultural and religious needs. Another informant, Eva, on the other hand, was more concerned that too vivid distinctions between Muslim immigrants and native born Swedes would enhance divisions between “us and them” in Swedish society:

With everything that happens at the moment… “Yes, I am Muslim”, yes, but I am also Britta or Anna or Soheila. For me as a person, it feels awful that we… That it… just turns into that category (p. 6).

Second, we found that ambitions to treat people differently based on assumed “religious preferences” could generate feelings of exclusion among Muslim patients. For instance, some informants who expected to be encountered in a particular way became disappointed, and in some cases also decided to opt out from medical treatment, when their requests could not be met. Safira, for instance, had learned from a mosque lecture that Muslim women should try to receive treatment from a female doctor in clinical encounters. When she once went to the mammography clinic to examine what she suspected to be a cyst, her encounter with the healthcare system was influenced by this Islamic discourse of “gender congruent care”:

Safira (prior to the mammography): And I said: “Can you please try to make sure that the female doctor is coming?” I knew it already, [that] a man should not be allowed to see me. And I knew that this was not about life or death. Of course, I will try to get a female [doctor] if the opportunity is there.

Researcher: Mmm, and if that hadn’t worked out…

Safira: …then I would probably have left. And tried to get another appointment with a female doctor (p. 7).

Other times, Muslim informants felt that they became negatively stereotyped when healthcare providers made a priori assumptions based on their religious faith. One female informant, Amal, recalled a recent visit at the midwife, where she perceived that the midwife took for granted that she wanted
a copper IUD because she was Muslim and thus preferred to get her monthly bleeding; a representation that Amal did not attain to herself:

Yes, because she thought that I... She said that there are Muslim women who want their monthly period. She told me today that many Muslim women do not want a hormone IUD because they won’t get their bleeding. And then I thought: “no, that is not me”. I don’t think about that at all, I only think that [the copper IUD] is free of charge (p. 8).

Paradoxically, the political ambitions to make healthcare accessible for all through accommodation of religious preferences appeared to have a sometimes-opposite effect.

The findings in this paper reflect that it seems to be an often-present trade-off between discursive ideals on equality and diversity in their practical implementation. As Racine (2009, p. 19) pointed out: ‘Recognition can be described from two opposite viewpoints: the politics of universalism and the politics of difference’. Each perspective can be criticised for not being sensitive enough to people’s individual needs and preferences, which appears to have generated tensions in the provision of care. Importantly, the study shows how ‘discursive ideas about the accommodation of religious preferences can contribute to creating expectations and tensions in the clinical encounter — both with regard to healthcare providers and among patients — that were not necessarily present from the beginning’ (Paper II, p. 19). It is possible that the strong emphasis on equality and diversity considerations in Swedish healthcare can generate both workplace related issues, such as collegial tensions and emotional stress, but also feelings of discrimination among patients who are not encountered in a way they prefer.

Paper III

*Is religious counselling on abortion in compliance with Sweden’s “women-friendly” abortion policies? A qualitative exploration among religious counsellors*

The liberal attitude towards abortion in Sweden, and the generous time limits for pregnancy termination as stipulated in the abortion law, has contributed to nurturing the image of Sweden as one of the most “women-friendly” countries in the world (Liljestrom, 1974). Women in Sweden can legally have an abortion until the end of week 18 of the pregnancy, without needing to have a special permission from anyone else (The Swedish Abortion Act, §1). Yet, policies on integration in Sweden reveal a desire that welfare institutions should enable people to live their lives according to their own cultural or religious beliefs. When multiculturalist policies were adopted in the 1970s, one of the aims was that immigrants should ‘be given the possibility
to choose the extent to which they want to adopt a Swedish cultural identity or maintain and develop the original identity’ (Government Bill 1975:26, p. 1). In order to close in on this aim, religious counsellors from various religious faith communities have in the past forty years gotten increased possibilities to provide spiritual care in affiliation with Swedish hospitals (SOU 2018:18). In this study, we wanted to empirically test the assumption that such religious services help to complement existing psychosocial support given by other groups of professionals, as stated in the preparatory work (SOU 2018:18). We asked: ‘In what ways would religious counsellors in Sweden advise a woman who is considering an abortion, or who has already had one? How do they view their role as “religious advisers” affiliated with Swedish healthcare? And how do their views on abortion consultation comply with the women’s right perspective in Swedish abortion law and policies?’ Semi-structured interviews were conducted with four Muslims, two Buddhists, one Catholic and one counsellor from the Swedish Church, all of whom were affiliated with public healthcare institutions in Sweden.

Through our analysis, we found that it cannot be expected that religious advice on abortion at all times will be in compliance with Swedish abortion law and the women-friendly abortion policy that the Swedish state seeks to impose. Most counsellors, except the counsellor from the Swedish Church, argued for perspectives on abortion that communicated more restrictive time limits and conditions under which pregnancy termination would be morally acceptable than what is stated in the Swedish abortion law. Several of the informants also argued that they had a divine responsibility to inform women that often it is religiously discouraged to have an abortion. The Catholic counsellor Father James, for instance, explained that he could never provide a woman who asked for advice on abortion with anything else but his religious viewpoints:

No, no, no, no. […] Everything is of course possible but, no, it would be wrong. And then I would have to ask for forgiveness for this afterwards [laughs]. And it would be considered as particularly serious, especially for me [as a counsellor].

Other informants expressed harder struggles to coincide the women’s right discourse with religious discourse on abortion. One of the Buddhist counsellors, for instance, described that he — in the end — felt obliged to give advice-seeking persons advice based on Buddhist principles, partly because he assumed that this was what people who visited him wanted to have. But he also said that he, at a personal level, felt strongly tuned in to perspectives of women’s rights:

I experience that the idea of women’s rights to decide over their own bodies also is very important. This is at least [the idea] in the Buddhist community where I spend time. Like for me, personally, I cannot imagine a society
where women were not given the possibility to choose. Where they would have to go to a backstreet somewhere in the underworld and get someone’s help with a tin lid or something like that. That doesn’t feel very appealing at all, I’m very happy we live in a country where the state offers the possibility for good healthcare.

The informants also provided suggestions on how women who had already terminated a pregnancy could mitigate the “sin”. Baasim, one of the Muslim counsellors, said:

The first thing is that one has to truly regret that sin, and the second is to ask God for forgiveness. […] But the most important thing is that one really regrets what she has done, and [promises] it will never happen again.

Father James from the Catholic Church described how he was inspired by what Mother Theresa in Calcutta used to say, when he spoke to two young women about their pregnancies:

Father James: I encouraged both [of] them to [keep the child]. They both came from very devout and practising Catholic families. I encouraged them to keep the babies and I tried to be very positive […]

Researcher: So when you spoke to these girls, what sort of arguments did you, from a religious perspective, use to motivate them to keep the babies?

Father James: Yes, so from my perspective, it is in some way naturally given, it is self-evident [not to abort]. I remembered what Mother Theresa in Calcutta used to say. She used to congratulate girls being in that situation, to be very encouraging and [explain that] “we will give you all the help we can” […] It is, of course, very important to see if there are people around them who can give them support. […] In this particular case, I knew the girls very well and also the families, so I knew that there was a lot of support there.

Some informants, however, represented the Swedish abortion law as well balanced, and argued to use their position as counsellors to support women to make autonomous reproductive decisions. Thomas from the Swedish Church said:

Yes. So, it must be about the woman’s own position. Why does she want to have an abortion, for example? The choice must always be hers. Because sometimes one can get pressured from several angles [someone saying], “Yes, but should you not keep the child and should you not…?”, like that. And then, it all comes down to: “What do I want in all this? Do I want to become a parent now, am I ready, or can I imagine to [keep it] although I am not ready?” So, it is about what one’s [personal] starting points are. And this is what will guide the consultation.
Although the study does not increase the knowledge about how religious counsellors’ advice might influence women’s actual decisions on abortion, it provides insights about how multiculturalist policies on spiritual counselling has opened up for a diversity of ideas on abortion to be manifest. In the effects, it appears as if this has generated tensions between religiously imbued discourses, on the one hand, and women’s right discourses, on the other. We suggest that these tensions must be discussed and addressed, in order to find a balance between various actors’ perspectives on abortion and their influence on public healthcare in Sweden.

Paper IV

*Unintended consequences of gender equality promotion in Swedish multicultural contraceptive counselling: A discourse analysis*

In this paper, we explored how healthcare providers implement gender equality perspectives in encounters with patients from non-Western countries, where people on average express less support for gender equality values than what appears to be the case in Sweden (Inglehart & Norris, 2003; Kostenko et al., 2016; SCB, 2019). The study was initiated based on the assumption that healthcare providers in Sweden are positioned in the midst of an ideological tension. On the one hand, they are encouraged to “gender mainstream” the provision of care according to national and global goals of actively promoting greater equality between women and men in society (Public Health Agency of Sweden, 2019a; The Swedish Association of Midwives, 2019; UNWomen, 2019; WHO, 2016). On the other hand, multiculturalist integration policies hold that people should be allowed and encouraged to live their lives as they want, and without having to make compromises with regard to their cultural and ethnical identity (Government Bill 1997/98:16). Of analytical interest is to explore how gender equality is “made” in light of these conflicting demands, and what consequences may arise thereof. Five semi-structured interviews and five FGDs with healthcare professionals (midwives, obstetricians and gynaecologists) were conducted.

In this paper, Bacchi’s (2009) WPR approach helped us to locate informants’ representations of problems and concerns in encounters with non-Western women to a specific discourse gender equality, according to which it was seen as desirable that women and men took equal responsibility for work participation and child rearing, respectively. “Gender equality” became a framework through which healthcare providers tried to compel female patients to make what the providers thought of as appropriate reproductive choices. In other words, an appropriate use of contraception would enable women to integrate into society and become empowered. One informant explained that:
if you have many children, you won’t have time to go to school, you don’t have time to educate yourself. And a lot of good things come with education. It is… proven that women who are educated give birth to less children, for example. Both because she doesn’t have time and also because she is . . . schooled, and then she will know about what sort of rights she has and . . . And plus that she understands [how contraceptives function in the body] (p. 1524).

The healthcare providers used various strategies to compel women to use contraception. Ann-Sofie described how she sometimes tries to involve the husband in the process:

[It is possible that] the woman says that the husband wants it, and then I ask, “Do you want another contraceptive method?” No, they don’t want. And do they want more children? Yes, he wants more children. That is very, very common [that the husband wants more children, but the wife does not]. And if the husband is there, I can tell him that, “It is very important that your wife is allowed to express her view, that she does what she wants”. If she does not want to remove her IUD, she should not be forced to do it (p. 1523).

Another informant, Magdalena, described how she had occasionally asked a colleague from Kurdistan to explain to a patient “how things are” in Sweden:

And I said [to the woman]: “No, but maybe it is best that you don’t get more children right now, you need to learn Swedish” and she just said: “Yes, but my husband knows Swedish”. But we have an assistant nurse who is Kurdish and Muslim herself and she was able to better explain that, “It doesn’t really work like that in Sweden, both need to work” (p. 1523).

It also appeared as if the midwives felt a responsibility to take good care of the women that they met; not necessarily by listening to what the patients were saying but to compel women to make contraceptive choices that the midwives thought would be best for the women in the long run. Here, patients’ incompliance to advice was described as challenging, for example, illustrated by a focus group participant when pointing out that:

so, if a woman comes here, if she is older and already has five, six, seven children and we can see that she is tired and worn-out, yes, then we say: “Yeah, but do you really want more children, maybe we should insert an IUD or something that you really swallow?” but then it comes, the resistance (p. 1523).

The paper suggests that the strategies that the providers used probably can generate different types of consequences. On the one hand, to clearly communicate values on gender equality could be an important prerequisite for a faster adaptation to the new societal context in Sweden. We do not explicitly spell it out in the paper, but I take the opportunity to do so here: for people to
get introduced to arguments from within the gender equality discourse can probably be of great help for some women and men. This is particularly relevant for those who could find it useful to use discourses on women’s rights to argue for their rights to reproductive freedom in relation to, for instance, family members opposing of ambivalent views. On the other hand, however, the paper calls for a critical problematisation of the strategies and the rhetoric through which gender equality norms becomes delivered. For instance, the way that the informants talked through gender equality could probably be interpreted as paternalistic by some patients, thus risks influencing people’s willingness to seek future care. Likewise, healthcare providers’ seemingly single-dimensioned focus on gender equality — which is used both to “diagnose” non-Western women’s low prevalence of contraception as well as providing a solution to increase the contraceptive prevalence — could risk leaving any other aspects of importance unexplored. The focus on gender equality could, in other words, mean that healthcare providers become insensitive to the diversity of reproductive logics — apart from the gender equality one — that may precede patients’ contraceptive decisions.
Chapter 6: Discussion

In this thesis, I wanted to explore and analyse what diversity and equality imply in a context of healthcare provision related to reproductive health in Swedish multicultural society. In what ways are policies on diversity and equality incorporated in the concrete world, and what consequences might arise thereby? The four papers indicate that although diversity and equality take shape as two harmonising ideals in medical and public health discourse and in healthcare policies, they do not always appear to be easily reconcilable in the practical implementation. The findings suggest that in some cases, both these policies appear to generate uneven and unintended consequences that risk disfavouring those groups of individuals that they were meant to help. My central argument is that too superficial a perception of diversity and equality discourses risks inhibiting an in-depth understanding of several dilemmas that exist with regard to the organising of reproductive health services in multicultural Sweden.

In this final chapter, I will develop this argument by elaborating further on the findings presented in Papers I-IV. I intend to focus on the often unnoticed and un-problematised tensions that appear to exist between diversity and equality ideals, and try to make explicit how these reflections are of importance for the ways in which the Swedish welfare state decides to organise the delivery of healthcare.

Policy making versus policy analysis

In healthcare policies and in the medical and public health discourse, diversity and equality ideals have developed side by side as two core values in the organising of welfare services in Sweden. They were both expected to lead to what can best be described as societal harmony and solidarity; while mentalities of diversity would ensure that welfare institutions remain alert enough to respond to people’s divergent healthcare needs and preferences, mentalities of equality would ensure that everyone received the same quality of care and that no one gets discriminated against. It has been the non-conflicting, overall positive, representation of these two ideals that has evoked attention in this thesis. I have sought to make the case that regardless of how ideal these concepts are represented to be, it is from an analytical perspective unproductive to continually align for change through the rhetoric
of these two discourses. Instead of this, it is of scientific value to direct attention towards the modes of incorporation and the possible effects that various interventions — initiated “in the name of” diversity and equality — might have. Following Foucault, equality and diversity can be understood as ideals used to govern people in society (Foucault, 1991). This insight opens up for alternative ways to think about diversity and equality in the field of migrant reproductive health, in which scholars often have engaged in producing social change through policies and interventions, rather than analysing and evaluating the policies that already exist.

Un-problematised tensions

The four papers that this thesis draws on all provide examples of how specific policies — that are being initiated under the umbrella of equality and diversity promotion, respectively — appear to generate consequences that the governing institutions did not originally anticipate. Many tensions seem to exist, both between policies at a theoretical level but also in their practical implementation.

State interventions versus reproductive freedom

One such tension exists with regard to the often-figuring encouragement to specially target “immigrant women” in contraceptive counselling in Sweden (Paper I). While it is a relatively uncontroversial suggestion in Sweden that the state has a responsibility to ensure that all people have access to healthcare and that no one is slacking behind, important questions remain unproblematised when policies on “targeted interventions” are implemented in practice. For instance, how to provide those individuals who are at risk of health deficits with adequate care and treatment, without unjustifiably targeting individuals who are at no risk (Krasnik, 2015)? And further, how to balance the desire for equal contraceptive prevalence between groups in society, with the principles about women’s inviolable rights to make autonomous decisions regarding their reproductive bodies — and to try to reach diverse life goals with regard to reproductive choices? Social anthropologist Michael Jindra has noticed that people across the world are increasingly troubled by the fact that inequalities between social groups in society continue to increase. Even more so, they are frustrated about the difficulties attached to reducing social inequalities while at the same time increasing (lifestyle) diversity (Jindra, 2014, see also Hoffmann Merrild, 2018). Jindra takes the relationship between lifestyle diversity and economic inequality as a case of exploration, but his argument points at a tension that also stretches into the field of reproductive health in Sweden, namely, if society wants to encourage people to live their lives in a wide variety of ways (i.e. in favour of diversity), this will probably result in a certain level of inequality with regard to various societal outcomes. While this awareness clearly should not be
used as an excuse to neglect disparities in health outcomes, or as negligence to the fact that people are affected by the social structures of which they are part (Jindra, 2014), it warrants a greater degree of caution to the ways in which some reproductive outcomes are defined as desirable and undesirable (Kowal, 2008).

**The limits of recognition**

Other times, tensions emerge out of the encouragement to accommodate ethnic and religious minority groups’ assumed needs, wishes and preferences in healthcare encounters. While such interventions often could be fully justifiable in order to provide individuals with the care that they are entitled to, this “politics of recognition” (Taylor, 1994) reveals several challenges.

For one, how are healthcare providers assumed to learn about all the various groups’ needs and preferences? Jhutti-Johal (2013), in her study on Sikh patients’ needs, concludes that interventions that draw on the imperative for providers to learn about, and to accommodate, group specific needs becomes practically impossible if implemented as a general policy. The inter- and intra-group differences among Sikh patients are too large, she argues, and it would be difficult for providers to memorise and practically make use of large amounts of a priori knowledge (Jhutti-Johal, 2013). In the international literature, the critique of any such tendencies of “culturalising” or “essentialising” ethnic and religious minority groups through discourses on cultural competence and cultural sensitivity has been extensive (Carey, 2015; Patai, 2018; Taylor, 2003). Moreover, if implemented as a general policy, it would warrant discussions about demarcations. If Sikhs or Muslims were entitled to divergent treatment and care, would other groups be as well? Who will decide on what grounds some patients could request differing care? It is possible that principles about divergent treatment for some patients based on ideological, religious or other grounds would be practically possible if managed on a small scale, but as a generally applicable principle it would risk making patients subjected to arbitrary treatment and re-production of discriminatory structures (see Paper II). Feelings of being discriminated against could increase peoples’ sense of societal conflicts and tensions, which in the long run could generate a weakened support of basic human rights (Botvar & Sjöborg, 2018).

Secondly, the desire to accommodate a diversity of lifestyles comes with a risk that such attitudes and life patterns, which from a perspective of Swedish health policies and liberal sexual and reproductive health politics are found to be unwanted, are also welcomed to be manifest (Racine, 2009). This tension is immediately related to the findings presented in Paper III of this thesis, where religious counsellors’ views on abortion were explored. Almost all informants argued that abortion was a religiously discouraged action, and that they in most cases would advise a woman not to terminate a pregnancy. The study illustrates a central tension in the Swedish welfare
system between the protection of women’s reproductive rights, on the one hand, and the promotion of diversity policies, on the other. These types of tensions, between collective group rights and individual rights, are well-known phenomena in social science literature, and have been extensively discussed in the past years. Most essentially, the debate circles around the extent to which groups of people — in which individuals define themselves through their culturally or religiously shared convictions — should be able to live in accordance with their own ideals, without running the risk of infringing upon individuals’ rights and freedoms (Appelros, 2006; Okin, 1999; Pfändtner, 2006). In both Sweden and elsewhere, the question also taps into an ongoing discussion about legal pluralism and the dilemmas that might emerge when secular laws of the nation state are set to co-exist with religiously imbued norm systems (Cumper, 2014; Roald, 2010).

From the sum of evidence that exist in the field of health care research, it cannot be excluded that religious counsellors can be of help in the provision of healthcare. For instance, they could offer help-seeking individuals with spiritual copying tools for handling illness and disease, and perhaps also offer practical advice that helps policy-making institutions to reach out with messages to people that otherwise are less likely to get in touch with healthcare services (see Padela et al., 2011, for a reflection about the US context). But the interventions also warrant other reflections. Are religious counsellors expected to deliver advice that is coherent with national health policies? If so, how can this be ensured? And if not, how can various perspectives be balanced against each other? In terms of religious counselling on abortion, an important question would be whose rights are to be protected: the religious counsellors’ right to manifest and practice their religious ideas, or women’s rights to be free from religious influence and to make autonomous reproductive decisions? (Demir Gürsel, 2013; Modée, 2006).

**How to do “gender equality” in a multicultural society?**

While the Swedish official ambitions regarding gender mainstreaming appear to be relatively unambiguous — the struggle for gender equality should ‘inform the design of the planning, implementation, follow-up and development at all levels of public operations’ (The Swedish Gender Equality Agency, 2019a) — the practical implementation of such guidelines seems more indefinite.

Paper IV raises questions about the gender mainstreaming in public institutions in Sweden. Because what are welfare workers in Sweden to do when they encounter people who do not pertain to this hegemonic state ideal of gender equality? Should they through various techniques try to convince people that this specific gender equality perspective is better than others? Should the governing be done explicitly, or should it silently sneak into everyday clinical encounters with patients? Or should providers refrain from talking about such gender equality perspectives if they sense that patients
rely on other ideals about gender relations? This last suggestion opens up for a peculiar outcome: the hegemonic state ideal of gender equality can only be promoted if the receiving person already seems to agree with it.

With an increasingly diverse population, gender equality ‘as a means of controlling the population’s attitudes, norms, and practices’ (Roald, 2013, p. 122) might be difficult to implement in healthcare provision. For instance, in her study on childcare in multicultural contexts in Norway, the political scientist Cecilie Thun (2015, p. 16) presents the argument that the governing of families through gender equality ideals will be directly opposed to the objective of accommodating cultural differences — including more traditional gender roles in ethnic minority families. Previously, policy-makers and researchers in the field of health might have thought of gender equality as a fairly non-controversial tool for governance, encompassing a set of ideas that are endorsed by the general public (Hernes, 1987; Inglehart & Norris, 2003; Siim & Borchhorst, 2008). Based on the presumption that almost everyone in society is in favour of gender equality and women’s reproductive freedoms, any attempts to increase equality or autonomy would probably not receive much else than nodding consensus. But in a pluralist society, where a plethora of norms on gender and gender relations exist side-by-side and should be allowed to do so (Government Bill 1975:26), the general tactics of gender equality as governing mechanism becomes less obvious (Dean, 2010). Several studies continually indicate a low level of support for gender equality and sexual liberation among, for instance, Muslim devotees in the Middle East and African region (Gifford, 2016; Norris & Inglehart, 2012; Underwood et al., 2013), as well as in Sweden (Goldscheider et al., 2014; Röder, 2014) — and particularly among poorly educated men (Kostenko et al., 2016). But it is also likely that people continually change their beliefs and attitudes, not seldom an effect of exposure to other types of gender perceptions from people in the surrounding society (Norris & Inglehart, 2012; Roald, 2013). In some cases, changes towards a greater deal of gender equality can be an effect of directed attempts to transform traditional leaders’ conservative ideas in more liberal directions (Underwood et al., 2013). Other times, liberal gender attitudes can emerge unintentionally, as Anne Sofie Roald (2009) suggested being the case in her study on how the Muslim Brotherhood perceived the Jordanian Convention on the Elimination of All Forms of Discriminations against Women (CEDAW). Roald showed that although Islamists in Jordan formally rejected the CEDAW, they were in favour of certain reforms — such as children’s nationality and women’s rights to dissolve marriages — that could help promote increased gender equality in the long run (Roald, 2009).

In sum, for some women and men, being exposed to the hegemonic gender equality ideal can probably have a liberating effect, in terms of seeing what reproductive options and possibilities are available. Others, however, might be less tempted to adhere to clinical advices that are grounded in a
discourse on gender equality; perhaps, because the gender equality discourse evokes negative associations (see for instance Roald, 2009), or because the governing attempts are perceived as being too insensitive and paternalistic to arouse patients’ willingness to comply with healthcare providers’ advice (Larivaara, 2010; Reitmanova & Gustafson, 2008). Governance through gender equality, that is to say, is not an unproblematic endeavour, but a process that reveals several tensions, which requires further attention.

Why are these kinds of tensions so often ignored?

Despite research from both Sweden and elsewhere being solid enough to give bearing to the assumption that it might be challenging to combine diversity ideals with equality ideals in practical welfare work, these kinds of tensions are often ignored in both healthcare research and in health policies in Sweden. Why is that?

One proposal is that many researchers in the field of migrant reproductive health seem inclined to produce social change through the rhetoric of equality and diversity ideals (Verbiest et al., 2016). Social psychologist Jonathan Haidt refers to this phenomenon as rationalist delusion; when a group of people make something sacred, the members lose the ability to think clearly about it. Morality, Haidt points out, ‘binds and blinds’ (Haidt, 2012, p. 28). Rather than critically analysing political discourses and policies on health, rights, and inequalities, researchers often align with these ‘informal networks on shared beliefs and solidarity which mobilize around conflictual issues and deploy frequent and varying form of protest’ (Brown et al., 2004, p. 52; see also della Porta & Diani, 2006). Academia becomes, in Patai’s words, ‘a political staging ground’ for various types of political concerns (Patai, 2009). An unfortunate effect of this desire could be that otherwise complex social phenomena get simplified by researchers (Loseke, 2003), in order for study findings to effectively get on the political agenda and become transformed into official healthcare policies (Levitsky & Banaszak-Holl, 2010; Lubitow, 2013; Parker & Hackett, 2012). For instance, several studies have shown that categories of ethnicity, religion and race continue to be vaguely handled among researchers in the field (Laird et al., 2007b). In an analysis of biomedical research journal publications, Lee has, for example, shown that when scholars present findings on ethnic or racial disparities in health, in-depth insights about the reasons for those disparities remain unclear. As a consequence, she continues, this has ‘the potential to reify “race” and to limit our thinking about what these biomedical differences suggest about health disparities and inequalities in general’ (Lee, 2009, p. 1183). The surplus of large-scale surveys and statistical analyses in the field makes novel theories about people’s various meaning-making strategies relatively low, whereby the dominant representation of ethnic and religious minority groups’ assumed oppression seldom gets the chance to get disrupted. It is
almost as if the research interest in people’s lifestyle practices and experiences is most vigilant if these can be analysed and understood through the discourse of oppression. The field reflects what Alvesson and Sandberg (2014) refer to as a habitual boxed-in research, focused on disadvantages and vulnerabilities, in which alternative discourses of ethnic and religious minority groups’ preferences, ideas, wishes and aspirations receive less attention.

A second, and related, suggestion is that diversity is often thought of in terms of sameness and harmony. In Swedish public discourse, diversity and equality unfold as reconcilable because they both signify what best can be described as liberal values (Carlbom, 2006). Diversity signals, just as equality does, inclusiveness, openness and respect for differences. Diversity in this liberal discourse does not encompass values that are illiberal or undemocratic, but the promotion of lifestyle plurality in terms of, for instance, sexual orientation, gender identification and lifestyle patterns that do not fundamentally challenge the notion of liberal freedom (Racine, 2009). Practical diversity promotion seems underpinned with a presumption that societal difference would still be ‘complementary to a preexisting organization whose orderly structure is taken for granted’ (Baehr & Gordon, 2018, p. 982). As Baehr and Gordon continue, ‘diversity can never be a threat, from that viewpoint, because, at root, we are all alike’ (Baehr & Gordon, 2018, p. 982).

Esra Demir Gürsel, in her exploration of the scope of freedom of religion as formulated in Article 9 of the European Convention on Human Rights, provides an insightful challenge to this discourse in which diversity is understood in terms of liberal progressive ideas only. The principle of freedom of religion in secular states, she argues, is underpinned with the prerequisite that only such religious practices that are in compliance with secular states’ many times liberal values deserve the freedom to be manifested. Other forms of religious practices can, on the other hand, be banned from public manifestation because they ‘are found incompliant with secular sensibilities’ (Demir Gürsel, 2013, p. 389). At the end of the day, what is thought of as being diverse is not so diverse after all, but is expected, relatively largely, to be in harmony with what most people in a liberal democracy take to be true (Baehr & Gordon, 2018).

A third suggestion is that the positive affirmation that impregnates the understanding of diversity makes labelling and studying of cultural and religious differences difficult. While difference is a precondition for the diversity discourse, the discussions about such differences that illuminate illiberal value structures are often deemed to end on the verge of racism and cultural imperialism (Carlbom, 2003). One of the currently most illustrative examples of this is expressed by some scholars in Sweden and some other Scandinavian countries, who argue that “gender equality” has developed as the “central ethnic signifier of national belonging and the most important boundary between “us” and “them” in Swedish society (Mulinari, 2008, p. 180). Critics mean that gender equality policies in the welfare state ‘build on
problematic notions and norms on gender, sexuality, nation, capitalism and workability’ (Giritli Nygren et al., 2018, p. 2). “Gender equality”, it is claimed, reinforces differences between groups and presents labour participation and the capitalist system as the ultimate standards for life (de los Reyes, 2016). De los Reyes argues that in the post-war period when gender equality policies began to take shape,

gender equality was transformed from an ongoing political project to a distinctive national characteristic. In this way, gender equality became a national (essential) attribute closely connected to the idea of Swedish supremacy (2016, p. 28).

From Martinsson, Griffin and Giritli Nygren’s perspective, ‘the hegemonic norm of gender equality in Sweden builds upon and produces naturalised, nationalist, hetero- and cisnormative and racialised positions in a postcolonial time and space’ (Martinsson et al., 2016, p. 1). Due to the negative connotations attached to the studying of cultural differences, for example, with regard to gender norms, it is understandable if the research topic is avoided by scholars in the field, and so the knowledge about divergent approaches to gender relations becomes limited (Baehr & Gordon, 2018).

Diversity management: The consequence of taking cultural relativism seriously

What makes policies on diversity and equality so important in contemporary Swedish society that it is worth dedicating a whole study to the exploration of them?

Undoubtedly, the Scandinavian welfare states are not culturally and religiously homogenous to the same extent as they were some fifty years ago (Bendixsen et al., 2018). Diversity of lifestyle ideals, wishes, aspirations — as well as difficulties, obstacles and barriers that people are facing — has contributed to re-painting the conditions for the provision of healthcare, in Sweden and its neighbouring countries. In Sweden, the political ideal for integration is no longer assimilation; people should not be forced into certain pre-set standards on what is thought of as the best way of living, but have the possibility to organise their lives according to their own convictions (Wickström, 2015). This will inevitably lead to greater fragmentation in lifestyle choices and life conditions (Jindra, 2014). When I here propose that there often seems to be a trade-off between diversity and equality ideals in their practical incorporation, it draws on an empirical exploration that takes cultural relativism seriously (Geertz, 1984). What this thesis points at is that it is a good idea to listen to people’s aspirations, imperatives and challenges in life. Society will always, and should, probably, be able to fit people with
different opinions — as divergent as they all might be (Ricoeur, 2011). Ricoeur writes, wisely, that:

It is meaningless, perhaps also dangerous, to expect a consensus that once and for all should eradicate the conflicts. The democracy is not a conflict-free political system, but a system where the conflicts are open and negotiable according to recognized divide rules. In a society that become more complex, the conflicts will not be reduced either in number or dignity but, on the contrary, multiply and deepen (2011, p. 174).

Thus, if we acknowledge the basic premise that there will be other attitudes in society than our own, and other ideas beyond the most commonly held ones among people in the majority society, we must probably accept that people will not always agree with each other. Tensions and divergent views in society will exist and continue to exist. This is not least because the alternative — i.e. a society that is homogeneous in terms of values and ideals and where divergences from the mainstream norm are unwelcomed — probably is a less tempting one in a modern democracy.

The more difficult query emerges with regard to the normative question about how this diversity of opinions should be dealt with in welfare policies and practice. A minimum requirement must be that interventions and programmes in healthcare are implemented in accordance with Swedish constitutional law, healthcare laws, and other relevant juridical binding documents. As long as this is ensured, subsequent decisions will be a matter of negotiation and debate. Dean has remarked that when people ask what the best solutions are to specific problems, ‘they are asking […] what is the best way to govern, from what value position and with what objectives’ (Dean, 2010, p. 45). The answers to these questions and alike, argues Dean, usually depend on the values that the answerer holds closest to the heart (see also Haidt, 2012). The discussions about governance in many societies today, Ricoeur argues, ‘give witness about that continually arising problems that in the end requires ethical decisions of political nature’ (2011, p. 167). Anyone who attempts to provide solutions to complex conditions in healthcare will have to negotiate various forms of justice claims, alongside what can be considered to be legitimate, and illegitimate, restrictions of actors’ freedoms (Ricoeur, 2011). Who should policy-makers have in mind when solutions are being suggested? Women? People with poor health outcomes? Religious counsellors? Healthcare providers? Would it be legitimate to introduce interventions that are believed to be of the greater good for many people, despite the fact that it would risk excluding some people in what could be argued to be unjust ways? (Rachels & Rachels, 2007). Ricoeur writes:

The great diversity of aims for the ‘good governing’ implies that the historical realization of a multitude of values only can be achieved at the expense of
another set of values, which, in other words, mean that all values cannot be served equally at the same time (2011, p. 176).

To provide a final answer on how to handle the complexity of questions in reproductive healthcare in Sweden today might in the end become politically imbued, not least because a transformation of modes of governance probably requires money, time and human resource management. The analysis that has been made in this study has sought to uncover some often-unexamined ways of thinking about multicultural encounters in Swedish healthcare. It presents an understanding of how current policies might generate unintended and uneven effects in their practical implementation. The study does not give any evidence with regard to precisely how things should be done, but provides an opportunity to think critically about how policies influence practice and with what potential consequences. I have proposed that many of these effects could, from one perspective or the other, be considered to be unanticipated and as having little in common with claims-makers’ original intentions.
Chapter 7: Strengths, limitations and contributions

In this thesis, I hope to have made two major contributions to the knowledge within the field of migrant reproductive health research. For one, the Foucaultian-inspired analysis has made visible some taken-for-granted ways of thinking and doing things in reproductive healthcare policy and practice (Bacchi, 2009; 2016). This theoretical perspective has outlined a tool for critical and problematising policy analysis, rather than policy making, which can be of methodological importance to push the research in the field of migrant reproductive health into more unknown terrains. Secondly, a major strength of this study is that it provides insights about how people in the field of migrant reproductive health reason about contraceptive use, abortion and the provision of healthcare. The study has made visible how culturally relativist approaches to the provision of care can be difficult to combine with universal ideals based on principles of equality, gender equality and equal treatment for all. Ideally, this study has contributed with an encouragement for future projects in the field of migrant reproductive health to catch a critical eye on policies implemented “in the name of” diversity and equality ideals. Viewed more broadly, the study contributes with empirical examples that could be of interest for already on-going discussions about diversity and equality within social sciences, in Sweden and elsewhere.

One immediate drawback with analyses of discourses in the field of health is that the knowledge they produce can be found to be more applicable for discussions on power and governance, than on the everyday experiences among the people who navigate these discourses. Discourse analyses sometimes unfold as abstract, theoretical and being far from reality. If the study would have adapted a phenomenological approach instead, it could, for instance, have provided more in-depth information about informants’ lived experiences: how they feel, navigate, interact, communicate, etc. in encounters. The balance is delicate. A less appealing outcome of such an approach would be a study that produces much knowledge about subjectively lived realities without thoroughly analysing their relevance for social policies and political structures.

Although this thesis has helped to shed light on aspects of Swedish healthcare policy and healthcare provision that so far have received little attention in research, important aspects remain to be explored. For instance,
knowledge about how pious people of various faith manage religious advice on abortion is important to further understand the possible impact of religious counselling in this particular question. A more detailed mapping of the relationship between the state and religious organisations in healthcare would be of help to further discuss the role and desired impact of religious counselling in healthcare. An analysis of how legally binding documents in Sweden compare to international SRHR amendments, both with regard to the manifestation and accommodation of religious preferences and with regard to gender mainstreaming, could be helpful to clarify the responsibilities of Swedish public health institutions. Moreover, it is probable that the relevance of the study extends beyond the relatively small field of reproductive health, in that it exemplifies several practical and theoretical dilemmas that most likely render interest in other sectors of Swedish society as well.
The findings presented in this thesis show that what was thought of as being good solutions to increase diversity and equality in Swedish healthcare, seem to have generated unanticipated consequences. This leaves us with the perhaps uncomfortable realisation that the interventions and initiatives that sought to help presumably disadvantaged groups of people — such as special interventions in contraceptive counselling, providers’ promptness to address cultural differences, gender mainstreaming and spiritual counselling services in hospitals — cause new dilemmas, and sometimes also could obstruct solving the problems they were set out to handle. A speculative hypothesis is that these interventions will not always reduce disparities in health outcomes, but contribute to reproducing them.

It can be concluded that the dominant discourse on diversity and equality reveals several unexamined ways of thinking that, once they are made visible, call attention to sometimes-tangible tensions. The study contributes with an encouragement to problematise and discuss some of the currently ongoing initiatives and discursive tendencies that characterise Swedish healthcare. There is probably no perfect way in which the provision of healthcare can be organised; regardless of what solutions are implemented, some persons and structures will benefit from these, whereas others will not. Yet, an increased awareness of how diversity and equality ideals operate can help to refine these ideals, with the aim that they should be implemented in accordance with what is found to be desirable.
Chapter 9: Recommendations

- Policy makers, healthcare employers and healthcare providers must, on their respective level in the organisation, ensure that all interventions and programmes that are initiated in Swedish healthcare are in compliance with national and constitutional laws

- At policy-level, evaluate the implementation of gender equality policies in Swedish reproductive healthcare and their consequences

- At policy-level, evaluate the content of religious counselling on abortion across religious counsellors with affiliation with Swedish public healthcare, and whether the advice complies with Swedish abortion law

- At policy-level, make regular follow-ups of the content and consequences of gender mainstreaming and religious counselling in healthcare

- At policy-level, evaluate and determine the responsibility for gender mainstreaming and religious counselling, respectively, to relevant actors in society (healthcare institutions, NGOs, activist groups, faith communities, others)
Viljan att främja mångfald och jämlikhet har med åren blivit centrala delar i många välfärdsinstitutioner i Sverige. Orden ”mångfald” och ”jämlikhet” har en förmåga att tala till människors känslor: de signalerar ideal om inkludering, godhet, medvetenhet, och en vilja att främja en positiv social utveckling. Denna avhandling pekar på att mångfald och jämlikhet har blivit nästan heliga ideal i det svenska samhället idag. Inom reproduktiv hälsa och sjukvård — vilket är det diskursiva fält som avhandlingen främst positionerar sig i förhållande till — presenteras olika former av mångfalds- och jämlikhetsperspektiv som lösningar till olika problem som forskare och beslutsfattare har försökt hantera i många år. Vissa förhållanden, såsom ökade skillnader i hälsa mellan invandrargrupper och svenskfödda personer, strukturell diskriminering av personer i religiösa och kulturella minoritetsgrupper, fortsatt ojämställdhet mellan kvinnor och män i samhället, och den svenska sjukvårdenes svårigheter att bemöta och behandla människor med religiös trossuppfattning, tros kunna hanteras genom att göra vården bättre på att främja både mångfald och jämlikhet.

Det finns, med andra ord, en stark tilltro till att dessa diskurser bidrar med en positiv utveckling i tillhandahållandet av vård och för människors hälsa. Däremot saknas det forskning som undersöker vad som händer när mångfalds- och jämlikhetsperspektiv implementeras i sjukvården. Inom samhällsvetenskapliga discipliner har forskare under senare år visat att det tycks finnas flera spåningar i fråga om hur dessa perspektiv kan implementeras vid sidan av varandra i offentliga välfärdsinstitutioner. Å enaidan uppmanas professionella inom välfärdsyrken att behandla alla människor olika utifrån kulturella och religiösa behov och preferenser, men samtidigt finns det tydliga principer om likabehandling i både lagstiftning och nationella folkhälsomål. Hur denna spänning mellan policyideal hanteras i klinisk verksamhet är en problematik som hittills inte belysts inom det forskningsfält som innefattar migration och reproduktiv hälsa.

Det övergripande syftet med avhandlingen är att undersöka hur mångfaldsideal - vilket kan förstås som en vilja att tillmötesgå en mångfald av livsformer - implementeras i svensk sjukvård, och likväl hur jämlikhetsideal - vilket i avhandlingen innefattar idéer om jämställdhet mellan kvinnor och män och idéer om likabehandling - implementeras. Vad betyder det egentlig-
en att främja mångfald och jämlikhet? Vilka reformer har initierats i mångfaldens namn, och i jämlikhetens namn? Och kanske viktigast av allt: vilka konsekvenser tycks uppstå som ett resultat av att olika mångfalds- och jämlikhetsreformer blivit en del av tillhandahållandet av vård i det mångkulturella Sverige?


Artikel IV utforskade vi hur barnmorskor och gynekologer/obstetriker implementerade jämställdhetsperspektiv i mötet med icke-västerländska kvinnor i preventivmedelsrådgivning. Vi fann att jämställdhetsdiskursen användes som ett styrmedel för att motivera patienter att ta beslut som vårdgivarna menade var korrekt i fråga om kvinnornas relation till sina män och kvinnornas roll i det svenska samhället.

Sammanfattningsvis visar avhandlingen att det som presenterats som goda lösningar för att främja mångfald och jämlikhet i det svenska sjukvårdssystemet i vissa fall tycks ha fått motsatt effekt. Detta är en insikt som lämnar oss med den kanske obekväma insikten att de initiativ som syftade till att hjälpa förfördelade grupper i samhället (muslimer, andra religiösa minoritetsgrupper och invandrarkvinnor mer generellt) - såsom särskilda insatser adresserade till invandrarkvinnor i preventivmedelsrådgivning, vårdgivares ökade uppmärksamhet av kulturella skillnader, jämställdhetsintegrering och religiös rådgivning inom sjukvården - i slutändan inte visade sig vara till hjälp på det sätt som man tänkt sig. Avhandlingen visar att den dominerande diskursen kring mångfald och jämlikhet innefattar många ofta outforskade tankemönster som, när de väl blir tydliga, gör gällande att det finns en hel del spänningar i fråga om hur sjukvård i det mångkulturella Sverige organiseras. Avhandlingen bidrar således med en uppmaning till problematisering och diskussion kring några av de nu igångvarande initiativ och diskursiva tendenser som präglar svensk sjukvård idag. Antagligen finns det inget perfekt sätt att organisera sjukvården på: oavsett insatser kommer vissa personer och strukturer att gynnas medan andra missgynnas. Däremot kan en ökad medvetenhet om hur mångfalds- och jämlikhetsideal verkar hjälpa till att förfinna dessa ideal med mål att de ska implementeras i linje med vad som anses önskvärt.
ملخص

( Summary in Arabic)

على مر السنين، أصبحت الرغبة في تعزيز التنوع والمساواة جزءاً أساسيًا في العديد من مؤسسات الرعاية الاجتماعية في السويد. الكلمات "التنوع" و"المساواة" لديها القدرة على مخاطبة مشاعر الناس؛ إنها تشير إلى المثل العليا للإدماج والخبر والوعي والرغبة في تعزيز التنمية الاجتماعية الإيجابية. هذه الرسالة تشير إلى أن المساواة والتنوع أصبحت من المثل العليا المقدسة لدى المجتمع السويدي اليوم. في مجال الصحة الإيجابية والرعاية الصحية، هو مجال البحث الذي تتناوله هذه الرسالة بشكل رئيسي فيما يتعلق بتقديم لوجيات نظر مختلفة فيما يخص التنوع والمساواة كحلول للمشكلات المتعلقة بالصحة التي حاول الباحثون وصناعة القرارات محتججات سنوات عديدة. هناك حالات محددة، على سبيل المثال زيادة الفرق في الصحة بين مجموعات المهاجرين والأشخاص المنتمون إلى السويدون وال=DBST\، والتمييز الهيكلي للأشخاص المنتمون إلى الأقلية الدينية والثقافية، وإستمرار عدم المساواة بين النساء والرجال في المجتمع. والصعوبات التي تواجه نظام الرعاية الصحية السويدي في الاستجابة والتعامل مع الأشخاص ذوي المعتقدات الدينية. يُعتقد من الممكن معالجة هذه المشاكل بجعل النظام الصحي أفضل بتعزيز الثمان المساواة والتنوع.

وبعبارة أخرى، هناك إعتقاد قوي بأن هذا النهج يسهم في التطور الإيجابي للرعاية الصحية وصحة الإنسان. ومن ناحية أخرى لا يوجد بحث علمي يوضح ماذا يحدث فعلياً عندما يتم تطبيق منظور التنوع والمساواة في الرعاية الصحية. الهدف العام لهذه الرسالة هو البحث عن كيف أن التنوع المناسب الذي يمكن أن يُفهم كرغبة يتم عن طريقها تلبية التنوع الموجود بأشكال الحياة يمكن أن يطبق في نظام الرعاية الصحية السويدي، وأيضا كيفية تطبيق المساواة المطالبة، وذلسي في هذه الرسالة يتضمن أطرحة الأفكار عن المساواة بين الرجل والمرأة والأفكار المتعلقة بالمساواة في المعاملة وكيفية تطبيقها. ماذا يعني حقيقة تعزيز التنوع والمساواة؟ ما هي الإصلاحات التي أجريت باسم التنوع وبدعم المساواة. والأهم من ذلك، ما هي النتائج المحصل عليها من الإصلاحات المختلفة التي طُبقت أخذة في المعتبار منظور التنوع والمساواة كجزء من الرعاية الصحية في السويد المتعددة الثقافات؟
الرسالة تركز على استكشاف كيفية إنشاء وتطبيق أفكار التنوع والمساواة في مجالات البحث العلمية والتعليمية والعملية التي تشمل قضايا الصحة الإنجابية. الرسالة تطرح أسئلة حول وسائل منع الحمل والإجهاض. على الرغم من أن بعض الأجزاء تتناول الرعاية الصحية السويدية بصورة عامة، تحتوي المواد البحثية التجريبية على مقابلات فردية وأيضاً مناقشات جماعية مع النساء المسلمات المؤمنات، ومقدمي الرعاية الصحية العاملين في مجال الرعاية الصحية السويدية، وكذلك المرشدات الدينية من أربع مجتمعات دينية مختلفة تابعة للرعاية الصحية السويدية. هذه الرسالة تبحث عن كيفية التفكير أو الاستدلال المنطقي لهذه الفئات حول وسائل منع الحمل والإجهاض. وتوفر الرعاية الصحية والتوقعات حول مجتمعات الرعاية الصحية.

النتائج المقدمة في أربعة مقالات علمية. المقال (أ) يبحث عن كيفية تكوين أفكار النساء المسلمات المؤمنات حول إجهاض ووسائل منع الحمل. على عكس المعلومات المتوفرة في هذا المجال، فقد وجدنا أن هؤلاء النساء إبذلوا قرارات جيدة ومتوافرة بخصوص الإنجاب. هذا الاكتشاف يثير تساؤلات حول الرأي السائد عن النساء المحتجات سيسجلن إلى عمل موجه فيما يخص إجهاض ووسائل منع الحمل. في المقال (ب)، بحثنا عن كيفية تفكير مقدمي الرعاية حول تطبيق مبدأ المساواة والتنوع عند مقابلة المرضى المسلمين لتوفر الرعاية الصحية. وكيف لهؤلاء النساء المسلمات الإلتزام بالإجتماعات الرعاية الصحية. وجدنا أن العديد من مقدمي الرعاية جاؤوا بشدة حول الحجة إلى الإعتراف بالإحترام الخاص للمسلمين (والمرضي المحتجزين) بل على العكس من شأنه أن يهمض مراعاة أن يتطلب إجهاض إotive الناس المختلفة (باسم التنوع). في حين أوضح أخرون أن مثل هذا الإجراء قد يعزز الصورة التنمائية. يبدو أن مثل هذه المعتقدات القوية في بعض الحالات، تؤدي إلى توترات وصراعات جماعية. بالإضافة إلى ذلك، يشير المقال إلى إن زيادة الفرص للمرضى المسلمين لوضع شروط تخصيص الرعاية الصحية على المدى البعيد يؤدي إلى تعزيز تجربة الاستبقاء إذا لم تتحقق هذه التوقعات. على سبيل المثال، وجدنا أن العديد من المشاركين شعروا بخيبة أمل إذا لم يعطوا بفس الطريقة التي توقعها. الأمر الذي أدي إلى بعض الأحيان لرفض هذه النساء للرعاية المقدمة لهم. في المقال (ج) أرجعتنا إلى كيف أن المرشدات الدينية من الكنيسة السويدية, الكنيسة الكاثوليكية, الطوارئ اليوسية, والطوارئ المسلمة يشتركون في إمكانية إجهاض المرأة في صياغ الختام الذي. جميع المشاركين تزعم أن مخالفات لذين إعطاء النصح بالإجهاض. وتشير إلى أن الحالات يركون المرأة السائدة بعد إجراء الإجهاض. نعتقد أن هذه الدراسة ترس توتر واضح حول نظام تنظيم الأمة السويدية. وكيف بنا أن نتجه في التفوق بين حق المرأة الذي لا يمكن إنهاله في اتخاذ قرارات أنجابية مستقلة مع الرغبة بنفس الوقت في حماية التنوع الدين للمجتمع. في المقال (د) بحثنا عن كيفية تطبيق القبابات وأطابق النساء والتوافد لمنشور المساواة بين الجنسين عند مقابلة النساء غير الغربيات وتقدم المشورة بشأن منع
الحمل. وجدنا أن خطاب المساواة بين الجنسين كان يستخدم كأداة لتحفيز المرضى على إتخاذ القرارات التي يعتقد مقدمو الرعاية الصحية أنها صحيحة فيما يتعلق بإبادة النساء بأروجهن ودور المرأة في المجتمع السويدي.

باختصار، توضح هذه الرسالة أن ما تم تقديمه كحلول جيدة لتعزيز التنوع والمساواة في مجال الرعاية الصحية يبدو أنه كان ذو تأثير عكسي في بعض الحالات. هذه الزراعة تترك لنا إنطباع غير مريح ربما أن المبادرات التي هدفت إلى مساعدة الأقلية المحرمة في المجتمع (المسلمين، الأقلية الأخرى من الطوائف الدينية، النساء المهاجرين بشكل عام) مثل الجهود الخاصة الموجهة إلى النساء المهاجرين في تقديم المشورة حول وسائل منع الحمل، زيادة وعي مقدمي الرعاية الصحية بالفرقو الثقافية، والمساواة بين الجنسين والإرشاد الدينى في الرعاية الصحية - لم يثبت أنها كانت مفيدة كما كان معتقد. توضح الرسالة أن الخطاب السائد حول التنوع والمساواة يتضمن العديد من أنماط التفكير الغير مكتشفه بعد، وأنه حين وضوحها، تشير إلى وجود قدر كبير من التوتر فيما يتعلق بكيفية تنظيم الرعاية الصحية في السويد المتنوعة الثقافيات. بالتالي تشبه هذه الرسالة في الدعوة إلى مناقشة إشكالية بعض المبادرات الجارية الآن والتوجهات الخطابية التي توجه الرعاية الصحية السويدية اليوم. ربما لا توجد طريقة مثالية إلى اليوم لتنظيم الرعاية الصحية:

بعض النظرة من الجهود المبذولة، يستفيد بعض الأشخاص والهياكل بينما سيكون الآخرون محرومون. وعلى الرغم من ذلك، فإن الوعي المتزايد بخطر التنوع والمساواة يساعد في صقل هذه المثل العليا بهدف تبنيها بما يتشابه مع ما هو مرغوب فيه.
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