'Moving On’ and Transitional Bridges

Studies on migration, violence and wellbeing in encounters with Somali-born women and the maternity health care in Sweden

ULRIKA BYRSKOG
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Abstract

During the latest decade Somali-born women with experiences of long-lasting war followed by migration have increasingly encountered Swedish maternity care, where antenatal care midwives are assigned to ask questions about exposure to violence. The overall aim in this thesis was to gain deeper understanding of Somali-born women’s wellbeing and needs during the parallel transitions of migration to Sweden and childbearing, focusing on maternity healthcare encounters and violence. Data were obtained from medical records (paper I), qualitative interviews with Somali-born women (II, III) and Swedish antenatal care midwives (IV). Descriptive statistics and thematic analysis were used. Compared to pregnancies of Swedish-born women, Somali-born women’s pregnancies demonstrated later booking and less visits to antenatal care, more maternal morbidity but less psychiatric treatment, less medical pain relief during delivery and more emergency caesarean sections and small-for-gestational-age infants (I). Political violence with broken societal structures before migration contributed to uprootedness, limited healthcare and absent state-based support to women subjected to violence, which reinforced reliance on social networks, own endurance and faith in Somalia (II). After migration, sources of wellbeing were a pragmatic “moving-on” approach including faith and motherhood, combined with social coherence. Lawful rights for women were appreciated but could concurrently risk creating power tensions in partner relationships. Generally, the Somali-born women associated the midwife more with providing medical care than with overall wellbeing or concerns about violence, but new societal resources were parallel incorporated with known resources (III). Midwives strived for woman-centered approaches beyond ethnicity and culture in care encounters, with language, social gaps and divergent views on violence as potential barriers in violence inquiry. Somali-born women’s strength and contentment were highlighted, and ongoing violence seldom encountered according to the midwives experiences (IV). Pragmatism including “moving on” combined with support from family and social networks, indicate capability to cope with violence and migration-related stress. However, this must be balanced against potential unspoken needs at individual level in care encounters. With trustful relationships, optimized interaction and networking with local Somali communities and across professions, the antenatal midwife can have a “bridging-function” in balancing between dual societies and contribute to healthy transitions in the new society.

Keywords: Somali-born women, violence, transition, migration, childbearing, midwife, maternal health, perinatal health, wellbeing, qualitative, case-control

Ulrika Byrskog, Department of Women’s and Children’s Health, Akademiska sjukhuset, Uppsala University, SE-75185 Uppsala, Sweden.

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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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*Cover: Alindi, a traditional Somali fabric.*
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Abbreviations

ANC    Antenatal Care
CI     Confidence Interval
IPV    Intimate Partner Violence
LGA    Large for Gestational Age
MCH    Mother and Child Health
NPSV   Non-Partner Sexual Violence
OR     Odds Ratio
SGA    Small for Gestational Age
UNHCR  United Nations High Commissioner for Refugees
VAW    Violence Against Women
WHO    World Health Organization
Definitions of central terms

Before migration/pre-migration, after migration/post-migration. There are no fixed boundaries for when a migration process starts and ends and these may vary according to individual experiences. In this thesis these terms refer to life before leaving the home country and to life after arrival in Sweden, respectively.

Forced migration is defined in accordance with the International Organization of Migration as “a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes” (1). Refugees, internal displaced persons, asylum seekers, trafficked persons and other irregular migrants are included.

Refugee is defined according to UNHCR: “Any person who: owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avails himself of the protection of that country” (2).

Violence is defined according to the WHO definitions and typology (3):

Violence against women (VAW): “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

Political violence: an overarching term, based on motive, for collective war-related violence, state violence or violence carried out by large groups for political reasons. It can include physical, sexual, psychological violence and neglect/deprivation towards individuals.

Non-partner sexual violence (NPSV): inter-personal violence including a sexual component and perpetrated by a person other than the intimate partner.

Intimate partner violence (IPV): inter-personal physical, sexual, psychological violence or neglect/deprivation perpetrated by an intimate partner.

Wellbeing refers to a personal and subjective experience of health, life satisfaction and balance, including social, physical, psychological and spiritual components.

Women refers to females aged 18 years and above.
Introduction

This thesis stems from a paradox I had experienced in my midwifery encounters with Somali-born women in Sweden. Motherhood and childbearing parallel to migration can be demanding due to social instability and navigation in unknown maternity healthcare structures (4, 5). The total global number of individuals in forced migration is estimated to be 73 million, with war cited as the major contributing factor (6). War and forced migration are associated with increased risks of direct and indirect violence at collective and inter-personal levels, with negative consequences for women’s health (7), yet many of the Somali-born women I encountered in my clinical work did not conform to these pictures of “vulnerability”. However, communication difficulties retained our encounters on a surface level. We encountered an increasing number of Somali-born women at the delivery and post-partum wards where I work. The first study was thus undertaken in this regional hospital to achieve an overall view of the Somali-born women’s maternal and perinatal health and outcomes. The findings highlighted a need to learn more about background perspectives of the Somali migrants, who had recently arrived in Sweden from a war-torn setting. What experiences from war and migration did the Somali-born women we met bring with them and how did they relate potential violence to their wellbeing and their maternity care encounters after migration? In parallel, the routine asking of questions of violence were being increasingly implemented within antenatal care in Sweden (8). The central role of the midwife became paramount; both for encountering women with a variety of backgrounds, and for asking questions related to violence during care encounters. In what ways could the midwife, assigned to ask questions about violence exposure, be a resource in the care encounter with the Somali-born woman?

Forced migration and health

Health in migration is multifaceted and is influenced by factors at individual, community, societal and global levels in both the sending and receiving countries (9-11). International and national relations, policies, laws and environmental factors shape the health conditions of the individual migrant (9). During the last few decades, globalization, along with improved communications, has changed migration patterns and increased possibilities for main-
taining relationships, transnational movements and economic remittances across borders (9), all of which have also contributed to changed patterns in migration health (10). Examples are; exposure and spread of infectious diseases, changes in family compositions or changes in socio-economic situations when financial support is sent back to families in the country of origin (10). A transnational healthcare-seeking pattern is also described among migrants, in which health resources in both sending and receiving countries are integrated (12, 13). Thus, migration from one context to another is not static and neither are the prerequisites for health. Furthermore, socio-economic factors and exposure to diseases in childhood are shown to influence health later in life (14), which has important implications in migration health.

If life preceding migration was characterized by a low-income setting or armed conflict, the health effects on individuals, based on curtailed public health services, are likely to be more pronounced (15). Migration entails the need to adapt to new societal structures, norms and languages which is a demanding process. If the migration has been forced, sudden or involved disruptions of close social networks, the likelihood of negative health effects such as psychological distress during or after migration is increased (9, 16). Moreover, a continuous situation of instability in the home country can continue to produce stress through bonds to the land of origin and remaining network, further pronounced by desires to provide financial and emotional support for remaining family (17-19). Events in the sending countries and during or after the flight may contain traumatic components, leading to post-traumatic stress (PTS) as a natural response to trauma. In some cases the symptoms can develop into manifest post-traumatic stress disorder (PTSD) (20).

In parallel to the process of migration, motherhood and childbearing are associated with challenges and increased vulnerability (5). Becoming a mother is in itself a process of change and uncertainty with physical and socio-psychological processes including shifts in identity and focus in life (21, 22). Risks of enhanced psychological distress during pregnancy, childbirth and during the post-partum period are reported among migrant women (5, 23). Described challenges are lack of social support, clashing socio-cultural beliefs, communication barriers, unfamiliarity with healthcare systems, weak support from care providers, and broken trust between women and healthcare providers (5, 23-25). Previous traumatic events may add a further burden. Thus, refugee women of childbearing age are a specific group within the migration process who need tailored attention. Somali-born women’s health is of special concern due to their country of origin being a low-income country with long-lasting exposure to war.
Somalia, Somali migration and health

A brief background of the Somalia context

At the end of 2014, Sweden catered for 58,000 Somali-born individuals after more than two decades of political instability in Somalia (26). Somalia is situated on the Horn of Africa and is populated by an estimated 10.4 million citizens. A majority (85%) are described as ethnic Somalis, with smaller ethnic minorities residing mostly in the southern parts of the country (27). Somali, belonging to the Cushitic family of languages, is the main language (27). Sunni Islam and Sufism are practiced alongside small minorities of Shia Muslims, animists and Christians and nomadic pastoralism has been the traditional base for livelihood (27, 28). Trade and business have been a complementary source of livelihood alongside small communities of farmers. During the decade preceding the outbreak of civil war in 1991, increased urbanization took place (27).

Independence from foreign powers was gained for the larger parts of the Somali-speaking areas in 1960. Nine years of establishing democracy followed, where after General Muhammed Siad Barre seized power in a military coup in 1969. Clan-based disputes weakened Siad Barre’s position, and in 1991 he was overthrown. The Somali state collapsed and left the country in civil war (27, 29). Subsequent demolishing of the infrastructure has followed (15). During the latest decade, Islamist militia has increasingly become an active part in the continuous conflicts (29). Somalia is bottom-ranked in the 2015 Mothers’ Index, which includes maternal health, children’s wellbeing, and educational, economic and political status for women (30). The maternity mortality rate in 2013 was estimated at 850 deaths per 100,000 live births, and the infant mortality rate was 90 deaths per 1,000 births (31).

Social life in Somalia is traditionally based on a patriarchal, patrilineal and collective clan-based structure, which, influenced by Islamic teachings, has formed the base for family affairs, protection of women and conflict resolution1 (27). Marriages have been a means to establish bonds between clans and in traditional Somali society, women have played important roles, assuming responsibility for animal husbandry, household chores and child care (28). During the latter years, women’s involvement in business and trade has increased (28). Since 1975, the national Family Code has formed the legal backdrop in which rights for women are regulated with men set as the main decision-makers in families. Women are entitled to custody of children up to the age of 10 years for sons and 15 years for daughters in case of divorce (32, 33). Furthermore, women have the right to seek divorce because of serious disagreement, if incurable illness has made married life impossible or if the husband has been absent for more than four years (33). Rape is pro-

1 Named Xeer and based on elders’ traditional conflict mediation.
hibited by law, but there are no juridical restrictions for IPV (34). Parallel to the national legal system, which has been dys-functioning during the long-lasting political instability, functions of the clan-system and customary law remain (29, 34). In the 2014 report from the Social Institutions and Gender Index, Somalia scored high to very high in gender discrimination against women in social institutions (34).

Somali migration and health

Mobility, due to the nomadic tradition, has been a part of Somali history (35). Transnational migration and practices have furthermore been undertaken because of employment, trade and the need for education since the colonial era up to the present (35). Several waves of refugee movements have followed since the start of the civil war in Somalia in 1991, with high numbers of urban and camp-based refugees settling in the neighboring countries, particularly in Kenya, Ethiopia and Yemen (36). Additionally, diasporic communities of Somali migrants can be found in a number of western countries. The first larger groups from Somalia came to Sweden in the early 1990s (26). Since 2005, this group has increased more than threefold, whereof 50% are female. Out of these, 74% are of fertile age (13-44 years) (26). While the majority of Somali-born refugees in Sweden reside in the two largest metropolitan areas, Stockholm and Gothenburg, a growing number and size of local Somali communities are also found in middle-sized urban areas in other parts of Sweden (26). Of the Somali-born adults living in Sweden, 23% were employed in the labor market in 2010, with women comprising only 18% of these (37). This, despite Swedish Somali-born women’s descriptions of paid work as being a vital part of their identity (38). Establishing contacts though Somali networks has been described as important for initial access to the labor market in Sweden (39). However, those social networks, which previously played vital roles in providing livelihood opportunities in Somalia, have been scattered and fragmented due to war and flight, which has reduced these opportunities for finding paid work (37). The mentoring role of already settled Somali-born persons to newly arrived Somali migrants has been stressed as being important to strengthen their orientation in the new society (40).
Factors associated with resettlement in host countries after migration have been suggested as having greater influence on the health status of Somali migrants than war-related traumas per se (41). Unemployment, unsure asylum status, family separations and challenged gender values have been associated with poor mental health and psychiatric symptoms (41, 42). A study on mental disorders among Somali migrants in the United Kingdom showed higher levels of PTSD than in the general population but lower levels when compared to mental disorders in other refugee groups (43). Meanwhile, a correlation between higher numbers of earlier traumatic events in sending countries or during flight and later elevated levels of PTS has been found (44, 45). However, studies on PTSD among refugee groups report substantial differences in prevalence, and the suggested contributing reasons for these are time since experienced trauma, the kinds of experienced traumas and lack of validated instruments suitable for refugee groups (20, 46). In a cross-cultural perspective, programs for addressing post-traumatic stress and mental health among refugee populations have been criticized for over-emphasizing a westernized bio-medical concept of PTSD (47). The perspective on distress as something pathologic does not necessarily resonate with practices, conceptualizations and enhancement of mental health among refugee groups in clinical encounters (47). In line with this finding, a study focusing on conceptions of mental health among Somali migrant residents in Sweden revealed that traditional religious healing and social support in case of mental illness were preferred over the bio-medical care offered by the healthcare system (48).

Few studies describe general health and wellbeing among Somali migrants in Sweden and those found present varied and sometimes contradictory findings. Somali migrant women and men have shared feelings of alienation and discrimination in Sweden after migration and described how life
after migration is characterized by movements in the mind between the old and the new country (17). When self-rated health was investigated among 120 Somali migrant women, 75% reported it to be on the same level as the Swedish majority population, and that it increased with length of residence in Sweden (38). Mental health was, however, simultaneously reported lower than in the majority population (38). In the same study, low levels of trust towards other people were reported along with lacking knowledge about formal support systems in Swedish society. Low health literacy has further been outlined among Somali-born men and women in Sweden, but these researchers found a higher-scored general health level compared to other immigrant groups (49). These mixed findings indicate a need for increased knowledge regarding factors promoting wellbeing in the aftermath of war and migration. In line with this, a need for a more comprehensive and holistic understanding among healthcare providers about the needs and experiences of Somali migrant women, including prior experiences to traumatic events, has been emphasized in healthcare research (50).

Somali migrant women’s health and outcomes during childbearing

Adverse maternal and perinatal health among migrants in the west is reported but study findings differ depending on integration policies (51) and country of birth, with Somali migrant women demonstrating a pattern of being at highest risk (51-53). Increased risk of perinatal death, low birth weight and infants small for gestational age (SGA) are reported, compared to infants born to native-born women in receiving countries (54-57), as well as increased perinatal morbidity (54, 56, 58). Elevated levels of caesarean sections are found (54-56, 58), despite a described hesitance towards the procedure among Somali migrant women (59). Furthermore, increased complications during pregnancy, such as oligohydramnios and gestational diabetes, are found (58). Several of these findings from different western high-income settings are coherent with Swedish register data (60-62). Regarding length of pregnancies, post-term deliveries seem to be a more common finding among Somali migrant women than pre-term deliveries (55, 58, 63, 64).

The reasons behind these outcomes are multiple, intertwined and not fully understood. Suboptimal health status originating from a low socio-economic situation and insufficient healthcare provision in the pre-migration context (15, 65) are two explanations. Furthermore, female genital cutting has been suggested to contribute (54), but studies have shown contrary results (54, 66, 67) with difficulties in generalizing findings across samples or in determining casual links (68). Miscommunication due to lack of language interpreters appears to have resulted in perinatal deaths among women from the Horn of Africa in Sweden (69) and language barriers have been described in other
studies (70, 71, 72). Strategies based on pre-migration experiences and traditions, such as avoidance of caesarian section, among pregnant women from the Horn of Africa have also been suggested to contribute to suboptimal pregnancy outcomes in the post-migration setting (59, 69). Broken trust between the pregnant Somali migrant patient and the care giver is suggested to add further hesitance towards embracing medical interventions (59). Additionally, navigation in an unfamiliar maternity healthcare system has been outlined as a complicating factor (73, 74). Few studies have explored antenatal care patterns among Somali migrant women (56) and none is found in Swedish settings. Furthermore, war-related stress and violence in connection with maternity healthcare encounters have been sparsely addressed.

Violence against women
Similar to migration, violence against women (VAW) is a multifaceted phenomenon. There has been increased attention paid to VAW as both a human rights violation and a public health concern during the last decades. In 1979, violence against women was acknowledged as being a part of discrimination against women in the Convention on the Elimination of All forms of Discrimination Against Women (75). The United Nations (UN) Declaration on the Elimination of Violence against Women (1993) further stressed its unacceptability (76). During the Fourth World Conference on Women in Beijing in 1995, an expansion was added to stress a life cycle perspective in which infanticide, sexual assault, female genital mutilation/cutting and violence within marriage and against widows and elderly women was included (77). To draw attention to the unacceptability of sexual violence during armed conflicts, Resolution 1820 was adopted in 2008 by the UN Security Council, in which member states were urged to end impunity and to grant protection and juridical rights for victims of sexual violence (78).

Risk factors for violence against women
Risk factors for exposure to violence can be found interlinked on macro and micro levels. Regarding intimate partner violence (IPV), a gender regime supporting male dominance over women and unequal financial and juridical rights for women contributes to higher risks (79-81), which is further exacerbated by poverty (79-82). Levels of IPV correlate with countries’ gross domestic products, however, a recent cross-national study suggests that these links are likely not casual but are instead related to social changes following increased financial development (81). At the family level, income inequality within the relationship is suggested to be a crucial risk factor, not only for those with low income per se (82). Thus, women’s empowerment and education might disrupt power balances and trigger IPV in specific situations (82).
However, women’s empowerment in general and competition of secondary education has been found to be protective against victimization (83, 84). A collective way of living has been linked to increased risks of IPV due to the family’s wellbeing being prioritized over the individual’s (84). High levels of conflicts and tensions between partners furthermore constitute a risk (84). Poverty, alcohol consumption, contexts of pronounced male dominance and sexual entitlement are shared risk factors for non-partner sexual violence (NPSV) and IPV (85). High numbers of sexual partners and having transactional sex are other risk factors associated with perpetration of NPSV (85).

Risks of co-occurrence of exposure to multiple forms of violence from different perpetrators over the lifetime have been demonstrated (86). Having previously been a victim of sexual, physical or emotional abuse increases risks becoming a perpetrator of NPSV or IPV (80, 85, 87); indicating patterns of normalization to violence which can have implications for women from war-torn settings. Studies in Sweden show that foreign-born women have an increased risk of exposure to violence as well as mortality due to violence compared to other women (88). Furthermore, increased risks of being hit during the first year after delivery are found if the woman or the partner was born in a country outside Europe (89). A history of war and forced migration increases the risks of having been exposed to violence, and the violence can occur during different stages (7). During war, a wide range of violent acts, including direct exposure to warfare and incidental community-based violence in turbulent environments, are likely to occur (90-92). One example are the systematic actions of NPSV which have been reported from war settings, referred to as “rape as a weapon of war”, however, NPSV also occurs as unorganized actions (91). The migration per se presents conditions of vulnerability to varied forms of violence exposure as a result of flight and displacement. The subordinate position in which migrants are placed at border-crossings, in uprooted situations in refugee camps or during journeys, depending on route, mode of transport, financial means and timeframe in transit, all constitute risks of violence perpetration (93). Another facet of violence in the context of war and migration is the increased risk of IPV as a result of instability in the war setting, during displacement and transits or in a new host country (94-96). Suggested reasons for the latter are demanding, uncertain asylum processes, economical constraints and powerlessness, with subsequent tension and frustration within families (97).

Prevalence of violence against women

Determining prevalence of the varied forms of violence against women is a delicate matter, due to social norms and the consequences associated with the phenomena. A global underreporting of exposure is generally assumed, affecting prevalence studies. Furthermore, the availability of data and definitions of violence vary between settings. Hence, both numbers and compari-
sons in and between settings must be interpreted with caution. Exposure to IPV is, even if including regions with armed conflict, considered to be the most common form of violence against women globally (95). In a systematic review covering 81 countries worldwide, the prevalence of ever experienced IPV among women above 15 years of age has been estimated at 30%, with substantial variations between regions (98). NPSV globally has recently been estimated at 7% among women, with the highest rates reported in central and southern sub-Saharan Africa (99).

Studies exploring violence among Somali women are limited in number and vary in study designs. A prevalence study among Somali women in Somalia’s capital city, Mogadishu, from 2011 demonstrated that nearly half of the female respondents had been confronted by war-related extreme violence which included witnessing severe injury or murder, closeness to shelling or bombs or being present in combat zones (90). Similarly, studies in the United States and the United Kingdom have reported high levels of reported direct or indirect exposure to war related violence among Somali-born refugee women before migration (44, 50). Regarding IPV, camp-based refugee women in Kenya from surrounding countries, including Somalia, described how it had increased after arrival to the refugee setting which they connected to inactivity among the men (100). This study also found reluctance towards reporting IPV to supporting agencies among the women, due to a fear of alienation from the local informal community if they reported the violence (100). A needs assessment in minority communities in the United States revealed that challenged traditional gender norms in Somali migrant families were thought to contribute to IPV (101).

Violence against women and women’s health

Several maternal and infant health aspects are associated with direct or indirect exposure to violence (102, 103), whereof some are linked to sexual violence, some to physical intimate partner violence, or to both. Causes for these associations can be direct physical force or these can be indirect, through stress reactions and decreased mental health (103-105). Another indirect association between violence exposure and decreased health are the effects of strategies shaped by violent situations, such as decreased social functioning and avoidance of healthcare encounters (106, 107).

During pregnancy, late booking and less visits to antenatal care (ANC) are associated with a history of physical violence exposure among women (107). Increased physical pregnancy-related symptoms alongside elevated levels of antenatal hospitalization due to hyperemesis, bleeding and premature labor are linked to sexual violence (108, 109). During delivery, a link between sexual violence and increased risks of operative deliveries is shown (110-112), particularly among primipara (110, 111) and if the violence was experienced in adulthood (110, 111). Furthermore, prolonged labor has been
found to be linked with sexual violence (110). Operative delivery is also associated with other forms of violence (112, 113), although not consistently throughout the literature (111). Regarding the infant, increased neonatal mortality (114,115) and low birth weight (103, 116-118) have been found to be linked to violence against the mother. An association between preterm birth and violence towards the mother is demonstrated (118), but not consistently reported (119). Furthermore, stress and ill health due to traumatic events such as violence may influence the attachment process (120).

The role of the antenatal care midwife in violence inquiry

The vast health consequences of violence against women affect individuals, communities and societies, and this has increasingly set violence on global and national public health agendas. Calls for increased healthcare sector awareness and response have therefore been raised (121). At the 67th World Health Assembly held in May 2014, the resolution, “Strengthening the role of the health system in addressing violence, in particular against women and girls, and against children”, was launched to further urge member states to actively reinforce efforts made against violence against women (122).

Including routine questions on violence exposure at visits within the healthcare systems has, during the last decade, been implemented in Swedish and various other international settings (123-126). The antenatal care setting has been recommended as a suitable arena for routine questions on violence due to the repeated encounters with women during pregnancy (8, 127). The routine has stepwise been introduced in Swedish antenatal clinics to now cover antenatal care clinics in all counties (126) with an emphasis placed on violence in close relationships (8). However, lack of knowledge and awareness (128, 129), confidence (130) and lack of routines or support, or time for follow-up (131, 132) can risk limiting the pursuit or quality of the task. For effectiveness of routine inquiry, a recent Cochrane review concludes that professional training and functioning follow-up routines are needed (133). Migrant women have been identified by antenatal midwives as being particularly vulnerable to violence exposure (129, 131). Nevertheless, women born outside Europe are asked questions about violence exposure within the maternity healthcare system more seldomly than Swedish-born women (126). Regarding disclosure of violence, language limitations is identified as a barrier (132, 134) and the importance of providing the same opportunities to disclose violence for migrated women as for native-born women has been stressed among professional language interpreters (135). The presence of an interpreter can present a parallel barrier which prevents violence inquiry further (132, 136). A recent report from the Swedish National Board of Health and Welfare highlights additional risk factors for violence related to migrant women: limited social networks, little knowledge of Swedish society, and lack of permanent residence permit (137).
Flexibility and sensitivity among social workers and healthcare professionals are therefore stressed (137). The role of culture and other context-specific factors have been underscored as being highly relevant and in need of further investigation for effective outcomes in violence inquiry (125).
Rationale

Suboptimal maternal and perinatal health and outcomes are found among Somali-born refugee women in research conducted in receiving high-income countries after migration (54, 55). The migration of Somali-born women to Sweden has increased more than threefold during the last decade, generating a need to follow up their maternity healthcare encounters in Sweden during this period. Furthermore, little is known regarding war-related violence and intimate partner violence within this group who have roots in war and migration. Previous research shows links between post-traumatic stress, violence and adverse childbearing health (103, 138). Given migration, long-lasting exposure to war and proposed links between poverty, gender inequity and violence against women (84, 85), Somali-born women might be at risk of exposure to violence. In Sweden, the antenatal care midwife has been identified as a key person in the identification and prevention of violence against women by including questions of violence during care encounters (126). Midwives encounter women and families from varied backgrounds, which require a broad base of knowledge to pursue this task in a relevant way. In order to develop the woman-centred approach in maternal health care there are needs to deepen this knowledge and also to embrace perceptions and knowledge of midwives encountering a group of women exposed to long-lasting war.
Aim

The overall aim of this thesis was to gain a deeper understanding of Somali-born women’s maternal health and needs during the parallel transitions of migration to Sweden and childbearing, focusing on the maternity healthcare encounter and violence.

Objectives:

• To describe how Somali immigrant women in a Swedish county use the antenatal care and health services, their reported and observed health problems and the outcome of their pregnancies (I)

• To explore experiences and perceptions of war, violence and reproductive health before migration among Somali-born women in Sweden (II)

• To explore Somali-born women’s views on being approached with questions on violence in Swedish maternity care and how they understand and relate to violence and wellbeing (III)

• To explore ways ANC midwives in Sweden work with Somali-born women and the questions of exposure to violence (IV)
Methods and research process

Both quantitative and qualitative methods were applied in this thesis. The initial quantitative study provided us with an overview of Somali-born women’s pregnancy outcomes in the region where the main parts of the subsequent qualitative studies were conducted. See table 2 for studies, methods and papers, and figure 2 for the emergent study process and links between the studies and papers.

Table 1. Studies, participants, methods and papers included in the thesis

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<th>Study &amp; design</th>
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<tr>
<td>Study 1, retrospective case-control</td>
<td>258 pregnancies of Somali-born women, 513 pregnancies of Swedish-born women</td>
<td>Retrospect data From medical records, descriptive statistics</td>
<td>Paper I post-migration outcomes</td>
</tr>
<tr>
<td>Study 2, interview study</td>
<td>17 Somali-born women</td>
<td>22 in-depth interviews, thematic analysis</td>
<td>Paper II pre-migration perspectives</td>
</tr>
<tr>
<td>Study 3, Interview study</td>
<td>17 antenatal care midwives</td>
<td>17 in-depth interviews, thematic analysis</td>
<td>Paper IV pre- and post-migration perspectives</td>
</tr>
</tbody>
</table>

Study settings

All studies were undertaken in Sweden, where antenatal care is attended by 99% of all pregnant women and offered free of charge. The antenatal care (ANC) midwife is responsible for providing care during normal pregnancy. General practitioners are involved if a woman presents with general medical problems and an obstetrician if pregnancy- or labour-related problems occur. The Swedish national guidelines for ANC recommend approximately 10
visits for a normal pregnancy and that they start before 12 gestational weeks. More than 99% of deliveries are performed at hospitals and birth centers. Of the female Somali migrants in Sweden, 74% were of fertile age, and, during 2013, 2,062 Somali migrant women gave birth in Sweden (26). The Swedish National Board of Health and Welfare states that the law-granted rights to equal healthcare for all includes the right to language interpretation when needed; a service which should be offered by the healthcare facility (140).

Study 1 was conducted in a middle-sized regional hospital situated in a Swedish county with a population of 250,000 living in rural and small or middle-sized urban areas. The catchment area included approximately 2,800 deliveries annually. A steep increase in Somali migrants had been seen in the county since 2005 (26), and the vast majority of birth-giving Somali migrant women delivered at the hospital included in the study. Study 2 was conducted in middle Sweden, in three urban and semi-urban areas including the catchment area in study 1. The chosen areas had high densities of foreign-born residents in general and, during the latest decade, Somali migrants in particular. Study 3 was conducted in ten medium- to large-sized urban settings in central and northern Sweden at ANC clinics with large numbers of Somali migrant women in the catchment-areas. The sizes of clinics varied, employing from two up to ten ANC midwives.

Recruitment and participants

In study 1, the quantitative study, records of antenatal and obstetric care were identified through a manual search of the labour ward logbooks for the years 2001 to 2009. The records of women with a possibly Arabic or Somali name were checked for information about nationality, which was indicated in the antenatal record. For each pregnancy of a Somali-born woman identified, the two closest control cases with the same parity (para 1, para 2–3, or para 4 and above) were chosen from the logbook. The review of Somali-born women’s pregnancies showed younger age at first ANC visit compared with the Swedish-born group. Six percent in the group of Somali-born women reported age below 20 compared to 2% in the group of the Swedish-born. Being married or cohabiting with the partner was less common in the group of pregnant Somali-born women (75%) compared to the group of Swedish-born (95%). Among primipara Somali-born women, 58% reported that they were married or cohabiting.
Study 1
Do previously suboptimal reproductive health outcomes of Somali-born women persist in the Swedish setting? How is the maternal health care seeking pattern of Somali-born women characterized?

Study 2
How do Somali-born women reflect over war, violence and maternity care before and after migration? How do they relate to wellbeing in the pre- and post-migration settings?

Study 3
What are the perceptions and strategies among Swedish antenatal midwives about caring for Somali born women with possible violence exposure and to ask questions about exposure to violence?

Paper I: To describe how Somali immigrant women in a Swedish county use the antenatal care and health services, their reported and observed health problems and the outcome of their pregnancies.

Paper II: To explore experiences and perceptions on war, violence and reproductive health before migration among Somali born women in Sweden.

Paper III: To explore Somali-born women’s views on being approached with questions on violence in Swedish maternity care and how they understand and relate to violence and wellbeing.

Paper IV: To explore ways ANC midwives in Sweden work with Somali born women and the questions of exposure to violence.

Figure 2. Flow chart of the development of design with studies, research questions, related papers, aims and how the three different studies connect with each other.
In studies 2 and 3, using qualitative methodology, purposive sampling strategies were used. Purposive sampling is a term used for deliberate sampling strategies, in which informative participants carrying particular features useful for the aim and depth of the study are recruited (141).

In study 2, women meeting the two inclusion criteria; 1) of Somali origin, and 2) of fertile age ≥18 years were invited to participate in the study. Contacts with potential informants were carried out by the first author (UB) who contacted and engaged with staff at two MCH clinics, and with three Somali-born key persons, well known in different local Somali networks. Potential informants were initially provided with brief oral and written information in Somali and Swedish. Women who agreed to receive more information were individually contacted and were informed in writing and orally by the first author or by the key persons who later served as interpreters. Seventeen women chose to participate. See table 3 and attached paper II and III for background characteristics of the informants.

In study 3, the first author (UB) informed superintendents or midwives at the actual clinics about the study by telephone and e-mail. Information was spread through the work groups at each clinic that volunteered to take part. Inclusion criteria for the study were being a registered midwife, and having more than two years of work experiences at the actual clinic. The working experiences of the midwives varied between 5 and 20 years. One participant was included in the study despite only being in the position for 1½ years, as her role was being a midwife for asylum seeking and refugee women only, which provided an additional perspective to the study. Three of the clinics approached refrained from participation due to heavy workload.

Study designs and data collection methods

Case-control design – study 1

In study 1, a quantitative case-control design was chosen (142, 143), to examine Somali-born women’s childbearing health and outcomes. The case-control design allowed us to examine a number of varied factors related to pregnancy and delivery. Data were collected retrospectively from antenatal, gynaecological and obstetric records. From 2001–2005, data were available from paper records, and from 2006 onwards, data were available from a computerized database. For each case and control, medical records were identified and reviewed according to a pre-tested protocol. The four authors and a research assistant conducted the data collection in parallel. After excluding twin-pregnancies (n=15), data from 180 Somali-born women and their 258 pregnancies and from 507 Swedish women and their 513 pregnancies remained for analysis.
### Table 2. Study 1: Socio-demographics of Somali- and Swedish-born women as reported at the first ANC visit during each included pregnancy 2001–2009.

<table>
<thead>
<tr>
<th>Socio-demographics</th>
<th>Pregnancies of Somali-born</th>
<th>Pregnancies of Swedish-born</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n = 258 ) (%)</td>
<td>( n = 513 ) (%)</td>
</tr>
<tr>
<td><strong>Maternal age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>16 (6.2)</td>
<td>9 (1.8)</td>
</tr>
<tr>
<td>20-39</td>
<td>235 (91.1)</td>
<td>465 (90.6)</td>
</tr>
<tr>
<td>&gt;39</td>
<td>7 (2.7)</td>
<td>39 (7.6)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>184 (71.3)</td>
<td>485 (94.5)</td>
</tr>
<tr>
<td>Single</td>
<td>22 (8.5)</td>
<td>8 (1.6)</td>
</tr>
<tr>
<td>Other</td>
<td>45 (17.4)</td>
<td>17 (3.3)</td>
</tr>
<tr>
<td>Missing</td>
<td>6 (2.3)</td>
<td>2 (0.4)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No work outside home(^a)</td>
<td>245 (95.0)</td>
<td>152 (29.6)</td>
</tr>
<tr>
<td>Work outside home</td>
<td>7 (2.7)</td>
<td>357 (69.6)</td>
</tr>
<tr>
<td>Missing</td>
<td>6 (2.3)</td>
<td>4 (0.8)</td>
</tr>
</tbody>
</table>

\(^a\)but includes studies

### Table 3. Study 2: Socio-demographics of the Somali-born women at first interview (\( n = 17 \)).

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
<th>Current occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>6</td>
<td>Language studies</td>
</tr>
<tr>
<td>25-34</td>
<td>8</td>
<td>Parental leave</td>
</tr>
<tr>
<td>35-45</td>
<td>3</td>
<td>Preparation program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid employment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 or Quran-school(^a)</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Middle/Secondary School</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>High School</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Residence Sweden (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1-4</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>4-10</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>10-20</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Parity</strong></td>
</tr>
<tr>
<td>0</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>4-7</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>&gt;7</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Pregnant</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Marital status</strong></td>
</tr>
<tr>
<td>Single</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Cohabiting</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>of whom not co-habiting</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\)including recitation, reading and writing Quran-Arabic
Main outcome measures were utilisation of antenatal healthcare, pregnancy complications, mode of birth and infant outcomes. Socio-demographic information included maternal age, parity, marital status, occupation, smoking habits as reported at the first visit to ANC. Information related to the use of maternity healthcare included the number of visits to the ANC midwife, gestational age at the first ANC visit, admissions to the hospital in early or late pregnancy and booked and un-booked visits to an obstetrician. Health status during pregnancy included haemoglobin level at first visit and in late pregnancy (severe anemia, <90g/L, moderate anemia 90-110g/L, and normal Hb-level >110g/L), weight gain at 32 gestational weeks, admittance to hospital due to hyperemesis, vaginal bleeding in early or late pregnancy, threatening premature labour, preeclampsia/hypertensive disorder, gestational diabetes, and urinary tract infection (UTI). Pre-existing medical conditions reported by the women were noted for each woman the first time she was included in the study. Health conditions observed during pregnancy were also noted. Pregnancy outcomes included mode of onset of labour, delivery mode and pain relief. Perinatal outcomes included gestational age, birth weight, SGA and perinatal death.

**Individual interviews – studies 2 and 3**

In studies 2 and 3, inductive qualitative individual interviews were applied. The application of qualitative interviews is suitable when searching for depth and nuances and when the focus is on perceptions and experiences of a particular phenomenon from the participant’s viewpoint (141). Thus the qualitative interview is open in character. An inductive approach allows a variety of perspectives to be derived (144). In study 2 the research design emerged as the study progressed, which provided possibilities for adjustments and changes along the study process and thus was useful when researching this relatively unexplored area (144).

In study 2, the interviews included three varied ways of gathering data. All interviews were conducted by the first author with the assistance of one of two professional Somali interpreters with healthcare professions. Three interviews were held in Swedish without an interpreter. Initially, recently arrived women (n=12) were asked to narrate about their life, starting in Somalia up to the present. A pre-tested interview guide (see appendix), covering family relations, childbearing, war, varied aspects of violence, and strategies enabling survival and wellbeing before, during and after migration to Sweden was used when needed for follow up-questions. Because not all informants were comfortable with freely talking about themselves and instead preferred questions to be asked, *semi-structured questions* based on the interview guide were used to a varied extent during the interviews. A preliminary analysis after the initial 12 interviews revealed interesting perspec-
tives but it was evident that violence and gender relations were only briefly touched upon when the informants focused on themselves. By providing a neutral ground, we hypothesized that informants might be freer to share perceptions and, if they liked, also their own experiences, for further perspectives and depth. Thus, a vignette (141, 145) based on the preliminary analysis was developed, describing the life journey of a Somali migrant woman, Asma (see appendix). The vignette was read aloud at the beginning of the subsequent interviews and constituted an ice-breaker for both both pre- and post-migration perspectives. This second round of interviews (n=10) consisted of follow-up interviews with five informants from the first round and, additionally, five new informants. In total, 22 interviews were held with 17 women. See figure 3 for the data collection process for study II.

Figure 3. Development of design and interview flow for study II.

In study 3, the informants (midwives, n=17) were initially asked to recall and share a caring situation comprising a Somali migrant woman and an aspect of violence. Follow-up questions were open-ended and based on an interview guide (see appendix), including different aspects of violence, the midwifery role in relation to Somali-born patients and violence, barriers and facilitators in counseling violence and wellbeing with Somali-born patients. In interviews where the informant could not recall a situation to share, interviews started with the questions based on the topic guide.

Field notes
Throughout the research process of studies 2 and 3, continuous field notes were taken, during and after the interviews. In study 2, after closing each interview, an informal conversation between the first author and the interpreter was held with reflections on content and nuances which was documented together with the field notes. Additionally, reflective field notes were taken connected to informal gatherings within local Somali communities and during travels to Somaliland parallel to the research process. The field notes served as reminders of thoughts, impressions and points of direction during the data collection and analysis process and also to situate interview findings.
in the greater whole. They provided background perspectives during data analysis but were not formerly included in the analysis.

Data analyses

Descriptive statistics
In study 1, descriptive statistics formed the main basis for analysis, as we aimed to capture an overall picture of the pregnancy outcomes and related health of the Somali-born women. All data were analysed in Statistical Package for Social Sciences (SPSS) for Windows version 19:1. Categorical data were grouped and cross-tabulations with intergroup comparisons between Somali-born women and native Swedish women conducted. Univariate analysis was used to obtain odds ratios (OR) and their 95% confidence intervals (95% CI) (142,143).

Thematic analysis
In studies 2 and 3, inductive thematic analysis according to Braun and Clarke was chosen due to its flexible yet structured approach (146). Thematic analysis is used in various theoretical fields and its feature of binding the data together and thus retain context and meaning, beyond the “what-questions” (146), made it suitable to employ throughout the qualitative studies included in this thesis. Thematic analysis can be applied either on a semantic level; including analysis on a manifest/explicit level and with subsequent interpretations following upon that, or in a latent way, in which the starting point is underlying ideas, beyond the semantic data (146). In both qualitative studies in the present thesis, a semantic analysis was the point of departure and interpretations beyond the text were made from there.

All interviews were digitally recorded and all Swedish parts of the recorded data transcribed verbatim. To verify the accuracy of translations from Somali to Swedish, parts of all interviews were transcribed in Somali and crosschecked by independent translators.

In both studies, the analyses were performed manually. First, all transcripts were read several times and all digital recordings listened to, for familiarization with the data. Initial codes close to the text, with enough data kept for context orientation, were first created and classified to sort data, provide overviews and find common threads. Codes were either printed out and collated on big sheets of paper (for paper II) or sorted into computerized files (for papers III and IV). The codes were revised, reclassified when needed, and thereafter mappings were made where codes were linked together with subthemes and themes. Repeated comparisons were made between original transcripts and evolving subthemes and themes to safeguard accura-

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The processes of coding, mapping and generating subthemes and themes in the different studies were reflexive and dynamic. Table 4 provides a schematic example of the analysis process.

Table 4. Illustration of thematic analysis, study 3.

<table>
<thead>
<tr>
<th>Data extract</th>
<th>Coded for</th>
<th>Subtheme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I mean, my aim is that I want to care for every woman as the woman she is, despite her origin or religion. In that way I try to work with anyone. And then I cannot say that a Somali woman needs more support than an Arabic-speaking woman or a Swedish woman.</td>
<td>Aim to care for every woman as the woman she is</td>
<td>Need of support not associated to ethnicity</td>
<td>See each woman’s uniqueness</td>
</tr>
<tr>
<td>That they… that it is blocked in some way. That they have difficulties in opening up, and to dare open up one’s self. And a little suspicious against … yes, instances here and you have to build that trust up before they dare …</td>
<td>Difficult to open up one’s self</td>
<td>Establishing trustful relationships</td>
<td>Approaching violence in the care encounter</td>
</tr>
<tr>
<td>This with the knowledge about the different traditions, how does the religion work in that particular country, culture and the present situation, the political situation. It is so much that connects to each other. And I feel that, oh, so little knowledge I have about this. That, what do they leave? And what do they come to? What do they seek, what do they want?</td>
<td>Lacking cultural/religious/situational knowledge</td>
<td>Achieving cultural competence</td>
<td></td>
</tr>
</tbody>
</table>

Ethical considerations

Several ethical considerations were made in this thesis and the studies adhered to the WHO’s ethical and safety recommendations for research on violence (147). For study 2 in particular, a thorough risk-benefit analysis was conducted, as involvement in violence-related research may impose a social and safety risk if participation is known or it can poses a psychological inconvenience due to the recollection of emotionally loaded topics (147, 148). The professional interpreters’ reputations were examined and they were carefully informed about confidentiality issues and about the actions to take to safeguard participants’ safety. All informants in study 2 and 3 were in-
formed orally and in writing of the purpose, procedure, confidentiality and voluntary character of participation before their inclusion in the study and this information was repeated before the interview started. Confidentiality was safeguarded to as large an extent as possible. The different geographical locations of the studies are not included in the dissemination of findings. An overall neutral public title of study 2 was launched, to minimize risks in case a woman’s participation was revealed to outsiders; and written information regarding the study was neutralized in case the information was shared with others. Interviews were undertaken in privacy in places of the women/midwives’ choosing, and in an atmosphere of calmness, and the studies included informants living in a variety of areas and belonging to various social networks. During the interviews, all informants were asked to tell about their own experiences, however, allowances were made for those who chose not to. All informants in study 2 were provided with contact details in case questions or emotional concerns might arise afterwards and a dialogue was held between the research group and psychotherapists at the Swedish Red Cross Centre for Victims of Torture, Uppsala and Hedemora. Digital recordings and transcripts were depersonalized and kept in a locked storage cabinet with only the first authors’ access. Ethical approval was granted from the Regional Ethical Review Board of Uppsala, Sweden (2008/226).
A point of departure in this thesis is that the life we live and how it is viewed is, to a great extent, socially constructed. This means that norms, values, knowledge and definitions of normality are context-related constructs, shaped by our own experiences, human relations, social interactions and environmental factors (149). As life evolves and takes new turns, basic assumptions are challenged, influenced and modified in both conscious and unconscious ways. For migrant women and maternity healthcare professionals, the care encounter constitutes an intersection of, often different, socially constructed realities, where divergent world views meet and continuous adjustments are made. These intersections can include, among other things, transitions between norms that value a collective life system versus individuality, different meanings of what health versus ill-health means, definitions of what constitutes violence and how gender relations and the associated power dynamics are played out (149, 150).

**Transition theory**

Originating from social psychology, transition is found in varied settings to describe a process or a period of changing from one state or condition to another. Transition theories have been used to frame and understand processes of change during a wide range of life events, such as health and illness, development stages, and situational changes (22, 151, 152). Migration can be described in terms of a situational transition, both due to the change in place and due to processes over time of life-changing character (153). Three phases have been described within migration transition; separation, followed by liminality and resulting in integration; but boundaries between these stages may be more fluid than fixed (151). Transition, as described by Meleis in a middle-range theory (figure 5), pays attention to the complex interplay of socio-ecological (154) factors on personal, relational/community and societal levels that can facilitate or inhibit healthy outcomes (22), and is thus useful, both when exploring strategies related to transnational migration, and together with consequences of different forms of violence. On a societal level, socio-cultural and religious beliefs and norms in dual societies influence the transition process. On a relational/community level, access and relation to institutional support systems and social or family networks can
facilitate or inhibit a healthy transition. On the personal level; meaning, socioeconomic status, preparation and knowledge, together with cultural beliefs and attitudes, are conditions that shape the individual transition experience (22, 153). Time influences the migration transition but a definite end point may not be experienced. In states of successively increased stability, critical points or situations may highlight changes and differences, induce uncertainty and necessitate action. The destination in migration transition is not to leave the old for a complete new set of norms, knowledge and strategies, but to achieve a dynamic synthesis of new and old resources, described by Meleis as “fluid integrative identities“ (22). As this process includes elements of both positive development and heightened vulnerability, it may affect health (22, 151, 155). Mastery is described as an another outcome indicator (22), but one can question whether it is possible to measure or achieve this in full as life will always be in an evolving process of development. Four “process indicators” for a healthy transition process are identified; feeling connected, interaction, location/being situated, and the development of confidence and coping (22). Included in Meleis’ theory of transition is the role of nursing therapeutics. To contribute to a healthy transition it is important to acknowledge patterns and needs of a care receiver situated in processes of change. Transition theory, as described by Meleis, is used in this thesis to: i) achieve an overall understanding of critical points, changes and balancing acts of Somali-born women undergoing migration transition; and to ii) situate the antenatal care midwife’s role in relation to this.

Figure 4. Meleis’ Middle-Range Transition Theory (22). Reprinted with license from Wolters Kluwer Health Inc.
Summary of findings

Somali-born women’s maternal health and maternity care usage in a Swedish setting (I, II and unpublished data, study 2)

The group of Somali-born women in the case-control study reported a later onset of antenatal care with 21% attending the first visit after 20 weeks of pregnancy compared to 4% in the group of Swedish-born women. In line with this, less ANC visits were found during the Somali-born women’s pregnancies. The group of Somali-born women further demonstrated higher levels of severe hyperemesis; and anemia, in both early and late pregnancy, and also higher admittance to the gynaecology ward and this was mainly due to severe hyperemesis. In contrast, less treatment for psychiatric problems before the pregnancy or psychological complaints was reported, compared to the Swedish-born group. A weight gain of less than 6 kg was more common during Somali born women’s pregnancies. Threatening premature labour, preeclampsia, hypertension, and gestational diabetes appeared with similar prevalence in both groups. See table 5 for maternity healthcare utilization and health conditions during pregnancy.

It was twice as common with delivery without pain relief in the Somali-born group and the use of medical pain relief was lower. Additionally, more emergency caesarean sections, especially before the start of labour were found in this group. There were no differences regarding perineal repair postpartum. Data on female genital cutting were missing in the majority of the records and could not be evaluated. Seven perinatal deaths were found among pregnancies of Somali-born versus one among the Swedish-born. Significantly more children with birth weights below 2,500g were found in the group of Somali-born women and more infants were small for gestational age. Being large for gestational age was more common as an outcome in the group of Swedish-born. An increased proportion of very pre-term deliveries was found in the Somali-born group but no statistically significant difference was seen between the groups with regard pre- or post-term deliveries. Table 6 shows pregnancy and perinatal outcomes.
Table 5. Healthcare utilization and health conditions during pregnancy, based on pregnancies of Somali- and Swedish-born women.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pregnancies Somali-born n=258 (%)</th>
<th>Pregnancies Swedish-born n=513 (%)</th>
<th>Total n=771 (%)</th>
<th>OR*</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of ANC visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4 (1.6)</td>
<td>3 (0.6)</td>
<td>7 (0.9)</td>
<td>2.73</td>
<td>0.61-12.30</td>
</tr>
<tr>
<td>1-3</td>
<td>11 (4.3)</td>
<td>8 (1.6)</td>
<td>19 (2.5)</td>
<td>2.87</td>
<td>1.14-7.23</td>
</tr>
<tr>
<td>4-9</td>
<td>147 (57.0)</td>
<td>265 (51.7)</td>
<td>412 (53.4)</td>
<td>1.30</td>
<td>0.96-1.77</td>
</tr>
<tr>
<td>&gt;10</td>
<td>87 (33.7)</td>
<td>229 (44.6)</td>
<td>316 (41.0)</td>
<td>0.65</td>
<td>0.47-0.89</td>
</tr>
<tr>
<td>Missing</td>
<td>9 (3.5)</td>
<td>8 (1.6)</td>
<td>17 (2.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational week first ANC visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-11</td>
<td>95 (36.8)</td>
<td>367 (71.5)</td>
<td>462 (59.9)</td>
<td>0.22</td>
<td>0.16-0.31</td>
</tr>
<tr>
<td>12-19</td>
<td>94(36.4)</td>
<td>109 (21.2)</td>
<td>203 (26.3)</td>
<td>2.23</td>
<td>1.60-3.11</td>
</tr>
<tr>
<td>20-31</td>
<td>41 (15.9)</td>
<td>15 (2.9)</td>
<td>56 (7.3)</td>
<td>6.49</td>
<td>3.51-11.98</td>
</tr>
<tr>
<td>32-40</td>
<td>13 (5.0)</td>
<td>3 (0.6)</td>
<td>16 (2.1)</td>
<td>9.25</td>
<td>2.61-32.78</td>
</tr>
<tr>
<td>Missing</td>
<td>15 (5.8)</td>
<td>19 (3.7)</td>
<td>34 (4.4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric treatmentb</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (0.8)</td>
<td>30 (5.9)</td>
<td>32 (4.2)</td>
<td>0.13</td>
<td>0.03-0.54</td>
</tr>
<tr>
<td>No</td>
<td>249 (96.5)</td>
<td>481 (93.8)</td>
<td>730 (94.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>7 (2.7)</td>
<td>2 (0.3)</td>
<td>9 (1.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hb first visit ANC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe anemia</td>
<td>7 (2.9)</td>
<td>0 (0.0)</td>
<td>7 (0.9)</td>
<td>9.97</td>
<td>4.73-21.02</td>
</tr>
<tr>
<td>Moderate anemia</td>
<td>37 (14.3)</td>
<td>9 (1.8)</td>
<td>46 (6.0)</td>
<td>0.08</td>
<td>0.08-0.17</td>
</tr>
<tr>
<td>Normal Hb level</td>
<td>198 (76.7)</td>
<td>497 (96.9)</td>
<td>695 (90.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>16 (6.2)</td>
<td>7 (1.4)</td>
<td>23 (3.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted for hyperemesis</td>
<td></td>
<td></td>
<td></td>
<td>7.00</td>
<td>2.53-19.33</td>
</tr>
<tr>
<td>Yes</td>
<td>16 (6.2)</td>
<td>5 (1.0)</td>
<td>21 (2.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>231 (89.5)</td>
<td>505 (98.4)</td>
<td>736 (95.5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>11 (4.3)</td>
<td>3 (0.6)</td>
<td>14 (1.8)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*comparing Somali-born women (case) with Swedish-born women (controls, used as reference group)

b ever experienced, self-reported
### Table 6. Pregnancy and perinatal outcomes of Somali- and Swedish-born women’s pregnancies.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pregnancies Somali-born n=258 (%)</th>
<th>Pregnancies Swedish-born n=513 (%)</th>
<th>Total n=771 (%)</th>
<th>OR*</th>
<th>95% CI*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset of labour</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous</td>
<td>196 (76.0)</td>
<td>396 (77.2)</td>
<td>592 (76.8)</td>
<td>0.95</td>
<td>0.67-1.36</td>
</tr>
<tr>
<td>Induction</td>
<td>39 (15.1)</td>
<td>78 (15.2)</td>
<td>117 (15.2)</td>
<td>0.99</td>
<td>0.65-1.50</td>
</tr>
<tr>
<td>Emergency CSb before labour</td>
<td>12 (4.7)</td>
<td>5 (1.0)</td>
<td>17 (2.2)</td>
<td>4.96</td>
<td>1.73-14.22</td>
</tr>
<tr>
<td>Elective CSb</td>
<td>11 (4.3)</td>
<td>34 (6.6)</td>
<td>45 (5.8)</td>
<td>0.69</td>
<td>0.35-1.35</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-instrumental</td>
<td>194 (75.2)</td>
<td>412 (80.3)</td>
<td>606 (78.6)</td>
<td>0.74</td>
<td>0.52-1.06</td>
</tr>
<tr>
<td>VE</td>
<td>18 (7.0)</td>
<td>29 (5.7)</td>
<td>47 (6.1)</td>
<td>1.25</td>
<td>0.68-2.30</td>
</tr>
<tr>
<td>Emergency CSb</td>
<td>35 (13.6)</td>
<td>38 (7.4)</td>
<td>73 (9.5)</td>
<td>1.90</td>
<td>1.16-3.10</td>
</tr>
<tr>
<td>Elective CSb</td>
<td>11 (4.3)</td>
<td>34 (6.6)</td>
<td>45 (5.8)</td>
<td>0.69</td>
<td>0.35-1.35</td>
</tr>
<tr>
<td><strong>Perinatal outcome</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liveborn total</td>
<td>252 (97.7)</td>
<td>512 (99.8)</td>
<td>764 (99.1)</td>
<td>0.08</td>
<td>0.10-0.69</td>
</tr>
<tr>
<td>died first week</td>
<td>1 (0.4)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stillborn total</td>
<td>6 (2.3)</td>
<td>1 (0.2)</td>
<td>7 (0.9)</td>
<td>12.19</td>
<td>1.46-101.80</td>
</tr>
<tr>
<td>died at labor</td>
<td>1 (0.4)</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gestational age delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very pre-term</td>
<td>8 (3.1)</td>
<td>5 (1.0)</td>
<td>13 (1.7)</td>
<td>3.25</td>
<td>1.05-10.04</td>
</tr>
<tr>
<td>Pre-term</td>
<td>15 (5.8)</td>
<td>35 (6.8)</td>
<td>50 (6.5)</td>
<td>0.84</td>
<td>0.45-1.57</td>
</tr>
<tr>
<td>Term</td>
<td>220 (85.3)</td>
<td>453 (88.3)</td>
<td>673 (87.3)</td>
<td>0.77</td>
<td>0.50-1.19</td>
</tr>
<tr>
<td>Post-term</td>
<td>15 (5.8)</td>
<td>20 (3.9)</td>
<td>35 (4.5)</td>
<td>1.52</td>
<td>0.77-3.02</td>
</tr>
<tr>
<td><strong>Small for gestational age (SGA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21 (8.1)</td>
<td>15 (2.9)</td>
<td>36 (4.7)</td>
<td>2.95</td>
<td>1.49-5.82</td>
</tr>
<tr>
<td>No</td>
<td>236 (91.5)</td>
<td>497 (96.9)</td>
<td>733 (95.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>1 (0.2)</td>
<td>1 (0.4)</td>
<td>2 (0.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain relief during vaginal delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>98 (38.0)</td>
<td>55 (10.7)</td>
<td>153 (19.8)</td>
<td>5.72</td>
<td>3.89-8.41</td>
</tr>
<tr>
<td>Epidural</td>
<td>19 (7.4)</td>
<td>117 (22.8)</td>
<td>136 (17.6)</td>
<td>0.27</td>
<td>0.16-0.46</td>
</tr>
<tr>
<td>Nitrous oxide</td>
<td>98 (38.0)</td>
<td>261 (50.9)</td>
<td>359 (46.6)</td>
<td>0.60</td>
<td>0.43-0.83</td>
</tr>
<tr>
<td>Non-medical</td>
<td>11 (4.3)</td>
<td>32 (6.2)</td>
<td>43 (5.6)</td>
<td>0.69</td>
<td>0.34-1.40</td>
</tr>
<tr>
<td>Missing</td>
<td>32 (12.4)</td>
<td>48 (9.4)</td>
<td>80 (10.4)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a comparing Somali-born women (case) with Swedish-born women (controls, used as reference group)

*b CS refers to caesarean section

*c VE refers to vacuum extraction

In the interviews, the Somali-born women described childbearing before migration as being characterized by limited access to, or low quality of, healthcare facilities (II). Family and social networks were stated as crucial for basic care and financial or practical assistance, such as transportation to neighbouring countries, in case of serious ill-health. Childbearing hardships were both justified as normal parts of women’s life cycles and viewed as fearful. Motherhood was said to constitute an important part of identity and continued child-bearing was not questioned, despite warfare and separations.
After migration, the safety of a stable healthcare system was described as a relief. Kindness in care encounters was praised and benefits of the preventive maternal healthcare were emphasized. At the same time, a side effect of stress related to the regular check-ups was described: what will be discovered and what interventions will it lead to? A balancing act between medical reliance and belief in fate was outlined:

Some things make me happy; that you can see that the infants have all organs … and already in the beginning of pregnancy you can tell that you will give birth at a certain time. That made me happy, too, but I believe that what will happen will happen no matter how many check-ups you go through. This is the role of fate … (W4)

Information from care providers were weighed against messages from their family, social network and tradition, evoking uncertainty in relation to the maternity healthcare when these were inconsistent. Particularly divergent messages regarding unfamiliar interventions and side effects of pain relief were described. Women’s responses varied, and were influenced by their own confidence and experiences within the Swedish maternity healthcare system.

It was not a given that questions or needs should be verbalized in the care encounter. In the women’s accounts, childbearing worries were seen as natural and did not hamper giving birth and thus were not necessary to verbalize. Women who had lived longer in Sweden proposed that the mere satisfaction with access to care, and unfamiliarity of sharing needs in care encounters could inhibit responsiveness, with language barriers added. Key persons of Somali origin or midwives with particular knowledge about Somali-born women were suggested to bridge such gaps in care encounters.

But those who do not know the language, and who are not yet into the (Swedish) society, they only have the rumours they hear … they do not ask much … the midwives believe: ‘they know anyway. They get information from friends or something.’ (W16)

Aspects of violence in the context of war and migration (II, III)

Violence was considered from two view-points in the interviews with the Somali-born women; the pre-migration political violence as a backdrop, and changed power relations within partner relationships due to migration, with potential risks for intimate partner violence. They did not reveal their own experiences of non-partner sexual violence or intimate partner violence and those parts of the interviews were based on their perceptions of the phenomena as such.
The back-drop of pre-migration violence (II)

At the later stages, I felt too much fear and our lives were at risk. As well as you didn’t freely work. I mean gunshot that doesn’t know whom to kill or not to kill, lack of education, children without education, reduction of education due to shootings. You live in fear; will you be hit by explosion? Will you be killed, will you be raped by tonight? … I was injured from explosion in the leg and arm/hand. And later I felt fear for my life, my children and my husband not being safe. This forced me to flee from the country to a country where I don’t know its culture … I swear, my feeling was very difficult … She was 17 days old, when I left my baby. I took with me two children older than her. The circumstance did not allow me to take her with me. (W1)

Varied forms of war-related political violence before migration were revealed; direct and/or indirect, with both structural and individual effects. Upheaval of the juridical system, periodically more intense warfare and limited access to education and healthcare contributed to life on a day-to-day-basis, compromising health and exacerbating underlying fear. Spin-off effects were increased interpersonal violence, fuelled by availability of weapons, drugs, persistent turmoil and lack of laws. A prominent finding was the difficulty of being separated from kin, beginning in Somalia and continuing up to their present situation in Sweden. Losses of family continued to produce distress during the migration transition and hopes for the future were much associated with being reunited with lost family.

Religiously motivated power dynamics were described as increasingly circumscribing women’s lives in local areas. The already limited access to maternity healthcare was reinforced, exemplified by one woman who shared her experience after having been cared for in secret by a male doctor during childbirth:

… they [the militia men] abused me. … They think that if someone happens to see the genital organs of a married woman, the woman has to be stoned – stoned to death. … It was just after the delivery I escaped. I had recently given birth. (W5)

Light was shed on the vicious cycle of non-partner sexual violence in a setting where authorities/societal ruling structures were absent. With no legal consequences, acts of non-partner sexual violence could continue and few benefits to disclosure were seen. There were neither counselling or health services for with victims of violence at hand. Instead, the abused woman would be left at the mercy of other peoples’ arbitrary and persistent stigmatisation; which was described as strong in the community. Awareness or rumours of non-partner sexual violence became a trigger for flight, often before it became a reality in the own family. If sexual violence were disclosed in the family, it would most likely remain a family matter.
In 1986 it happened that a certain girl was raped, and that time was the time when there was law and order. A certain guy she had rejected gathered a few guys to rape her and the 3 guys were arrested … but because there is no law and order now, no one is going to help a woman there. There is no court that can help, so the person is forced to just keep it as a secret. (W11)

Intimate partner violence was pictured as being of minor importance in a setting characterized by political violence and therefore it was reasoned that not much attention had been paid to it in the pre-migration setting. The extent of the phenomenon was therefore difficult to know, and a variety of perceptions were found. Families and mediating elders had major roles in solving marital conflicts; which could have both good and bad outcomes for the woman. Islam was said to view intimate partner violence as abnormal and forbidden by religion, underlined with a traditional saying that conveyed a respectful attitude between men and women in marriage. In contrast, also a view of the home country as a high-risk setting for intimate partner violence emerged. This opinion was motivated by referring to a system in which men were decision-makers over women and in which a lack of juridical rights for women further fuelled their vulnerability.

An illustration of these pre-migration dynamics can be found in the attached paper II.

Gender relations and intimate partner violence in migration transition (III)

...he must forget about that life in Somalia, this is Sweden, it’s another situation… (W13)

After migration, the Somali-born women pointed at shifts in power within relationships as a potential risk factor for intimate partner violence, but opinions differed about the extent in which this led as far as to violence. The women described how their platforms during war had increased in public life, despite militia mobilization, with increased responsibilities for bread-winning and decision-making, informally and for pragmatic reasons. They welcomed the laws protecting them from violence and the formalized juridical rights and financial platforms for women in Swedish society, which contributed to power shifts in favour of women. Financial freedom combined with livelihood support and child allowances being assigned to mothers in the Swedish system made this power change even more apparent. Worries of men losing ground and identity in migration were revealed, which could lead to partnership tensions. The women described various ways of managing the balancing act of dual gender systems. A strategy of using the freedom gained after migration to threaten partners with police or divorce if the man did not suit her any longer was described, but mostly seen as counterproductive; but
also understandable, as women’s will and freedom had sometimes been circumscribed before migration. In contrast, some women preferred retaining traditional roles, which both could reduce power tensions, and provide convenience through clearly defined responsibilities, but with women still being powerful:

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

Dialogue, mutual understanding and stepwise adjustments were stressed. Violence towards others was stated as being unacceptable. Solving situations of intimate partner violence without involving formal authorities was mostly recommended. Few declared they themselves would have stayed in a violent relationship. Parallel to this opinion, it was raised that occasional violence could be accepted until both husband and wife were on equal terms with each other in the new society. If violence continued, and divorce was not accepted by the man, social authorities and police would be a last resort. Ambivalence was found, due to a worry for additional family problems, when formal authorities involved.

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

A paradox was described in how increased distance to extended families influenced women’s vulnerability to IPV. One the one hand, this distance could open up possibilities for women to more easily embrace societal support services in a violent situation, due to a lesser sense of betrayal towards the family. On the other hand, increased distance to the closest collective resulted in less support from the larger family in terms of childcare and daily chores which raised the demands on both husband and wife. Added to this were decreased mediation from elders and extended family in couple tensions. Thus, after migration, couples had to rely more on their own efforts and dialogue. The women pointed out how this could lead to increased risks of IPV if one of the partners lacked wisdom or if the dialogue was weak. See figure 5 for an illustration of these dynamics.
The women referred mostly to physical violence in their accounts. Disentangling definitions and acceptance of psychological and economical violence were more difficult. These concepts touched upon roles and responsibilities for women and men; areas currently undergoing changes. If a newly arrived husband wanted to control the income, for instance, this was not necessarily observed as a bad thing – this might have been his former responsibility and a way of arranging family life, with both pros and cons. Definitions and acceptance of sexual “force” within marriage were also depicted in various ways and were usually supported by religious interpretations. These spanned from a close word-by-word understanding of hadith (Islamic text) to interpretations where religious messages as a whole along with historical gender influences on interpretations were also considered. Thus, statements concerning sex as an unquestionable right of the man as well as sex as a mutual gesture of love and respect, excluding force whatsoever, were both present in the data.

Wellbeing in the new society (III, IV)

Although few options had been available for women subjected to non-partner sexual violence or intimate partner violence in the pre-migration setting, the women described how women’s overall strength had been shaped by the context of war. Crucial factors supporting survival and fostering resilience had been endurance, spiritual belief, social networks and the broadened platforms for women in family decision-making and income generation business (II). After migration, pragmatic and “informal” strategies continued to influence their navigation of the new society, alongside the process of
Coping with adversities in life

Even after migration, non-partner sexual violence was described as something that was not talked about, although it was mentioned that an existing juridical system might convince some women to disclose the violence. In cases where a woman who had been subjected to non-partner sexual violence would break the silence, mainly family would be told, and most likely it would not go further. Thus, the women described difficulties in knowing if a woman was suffering from non-partner sexual violence, if it was common or not, and how it might potentially impact on her life. Reasons for remaining silent were to avoid continuing social risks of shame together with desires to move forward in life.

A prominent strategy for overall wellbeing was to leave difficulties behind, with hopeful future-thinking being a central feature. In regaining stability after flight, the usefulness of verbalizing traumatic memories was thus questioned.

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

Despite the prominent “moving on strategy”, it was brought up that there might be situations in which unfamiliarity with acknowledging psychological distress, and little knowledge about the benefits of such health services, might be a barrier for women to seek help. This had been neither the custom nor accessible in Somalia. An informant with many years of residence in Sweden suggested that, due to their in-between position, midwives or public health nurses could be a valuable resource in providing first-step brief counselling when the gap to requesting a psychologist seemed too large.

An anchor in the instabilities of war and migration was the belief in destiny and finding meaning in whatever happens. This contributed to patience and provided strength to wait out dark moments, resulting in the approach of not burdening yourself in vain. This approach was further apparent in the maintenance of motherhood across distances; where the happiness of giving birth to a child exceeded the worries of not knowing when the father would be able to migrate:
We don’t think, ‘What if he doesn’t come?’ Or, ‘How will I raise a child by myself here?’ and such things, in that way you don’t think. Instead you think, ‘Now I will have a child,’ you are happy. (W16)

The midwives also described these “here-and-now” attitudes which they had experienced in their encounters with Somali migrant women, including a wish to leave the past behind. Whether this was enough after leaving a context of war and how deep a midwife should engage in past experiences was reflected upon. Contentment with offering their services regardless of the response from the woman was expressed but also the importance of overcoming initial distances in the encounter, to ease disclosure, or the sharing of needs over time.

… it has to come out somehow at some point, I think. I mean, of course if you have seen your dad being killed and yourself been subjected to rape, like someone told last week and then she says, ‘I have not told this before, because I don’t want to talk about it.’ Of course, in some way it must … (MW12)

The crucial role of coherence

Local and transnational ties with family and social networks had been important for moving on in violent circumstances before and during flights. After migration, social coherence, or lack of the same, continued to have a vital impact on wellbeing. The period preceding the establishment of new social contacts after migration were described as dark and confusing. In response to the often anecdotal knowledge about the new society upon arrival, social contacts were crucial for navigation:

I didn’t know anyone else except for the girl who I met at the train station … she told me where I should register … When I registered there they asked me, ‘Whom do you know in this place?’ And I told them that ‘I know the girl who brought me here to register.’ … I then was given an address under her. (W4).

Similar to life before migration, extended family and elders were a valued source of support in daily chores and for advice and mediation in case of relational conflicts. However, these informal regulating “buffers” were now described as diminishing in influence due to migration. Being and becoming a mother was another way of finding, or maintaining, coherence, because having children was closely connected to identity and they also provided company and occupation in the new setting.

The antenatal care midwives had recognized a sisterhood among Somali-born women, which was thought to operate as a protective factor, for either
exposure to violence or for coping with adversities in life, together with the women’s own strength and capability.

I perceive the Somali women overall as incredibly strong, secure and content. And you seldom need to go in and help them. They manage very much by themselves. I believe many live in a sisterhood. That they have many relations and many friends. And they talk a lot with each other. I think. (MW10)

At the same time, the midwives described having a lack of knowledge concerning the local Somali communities. This posed difficulties in knowing whether social networks provided enough support in the case of more sensitive areas such as violence exposure. Loneliness and vulnerability were issues of particular concern in relation to newly arrived women.

In line with this, some women shared that they did not attempt to engage deeply in new social networks. New social networks were not a replacement for missing an entire family, and the birth of a child was cited as an example that could highlight the pain of a scattered family. “Side effects” of the influences of social networks were also described, including gossip, and the women described occasional recommendations of not engaging social authorities in family issues, particularly those related to intimate partner violence.

Approaching questions of violence in the care encounter

In the encounters with accessible support systems in the new society, support for housing, family reunification, education and with childbearing was highly valued by the women. Less understanding was found regarding the midwife being involved in violence inquiry:

That story is a personal issue for the person, right? (W10).

In cases of IPV, it was instead a question of deciding to move on with or without the husband and in those cases the extended family or police were more obvious sources of support than a midwife. In parallel, justifications of the midwife asking questions were also found based on health reasons, particularly when links between mother and infant health and violence were clarified. While recently arrived women expressed satisfaction with the access to safe maternal healthcare and expressed few expectations apart from medical care, women with longer residency in Sweden had reflected more on the midwife as a resource in a wider sense. They considered the midwife valuable in providing information about where to turn for help with difficulties such as violence, whether such needs were verbalized or not by the individual woman. Clarifying links to societal support systems and confidentiality could help minimize fear of unnecessary interference of social authorities.
A gradual deepening of the relationship and trust throughout pregnancy was considered to be crucial in finding the right time to inquire about violence.

For the antenatal care midwives, asking questions of violence had increasingly been implemented as a natural part of the work, motivated by concerns for the health of the mother and infant. Their wish to focus on the individual woman beyond ethnicity and cultural differences was central. They had reflected on how they themselves, the women they met and the surrounding society were shaped by norms of normality versus violence, which differed depending on context. This was a particular concern in relation to economic, psychological or sexual violence within marriage. Together with language barriers, this could complicate the conversations about violence with Somali-born women. Despite the use of professional interpreters, either by telephone or on-site, conversations risked being superficial, with nuances lost. As well, the presence of an interpreter was considered to hamper disclosure.

Increased culture-specific knowledge was desired, particularly among midwives who recently had started conversations about violence with Somali-born women. The gaps due to social distances which were sometimes glimpsed in the midwives’ accounts tended to fuel cultural explanations on a group level, despite the desire to have a woman-centred approach.

The interviewed midwives seldom encountered ongoing violence among the Somali women they met and, overall, they did not associate Somali-born women specifically with violence, despite backgrounds of war, migration and adverse childbearing outcomes. Uncertainty was described in relation to what kind of violence one should inquire about, when the healthcare system mostly emphasized violence in intimate relations yet these women came from war zones. Strategies to either embrace wide spectra of violence including former experiences of war and migration, or including questions about intimate partner violence only, were revealed.

When I was about to start asking, also foreign-born, then I felt I had to think another way round, how to formulate it. And then I thought specifically on the Somali group. Because what we should ask for is violence in the close relationship only. Not ask, ‘Have you been exposed to violence in general?’ And then I thought it was a little tricky in relation to this group. Because probably they might have been exposed to very much, outside the close relationship. (BM11)

Similar to findings among the Somali-born women, the midwives considered providing information about rights and support in the new society as important. In this, networking with other healthcare and social actors and Somali communities was valuable, and parental groups were a suggested arena for highlighting relationships and women’s rights beyond childbearing; although this strategy requires persistence. Having patience and establishing trustful relationships were emphasized as key elements for midwives in violence prevention and identification among Somali-born women.
Discussion

Through migration, a new society with other premises, norms and societal structures is encountered. Our findings suggest that multiple pre-migration conditions of Somali-born women are being challenged within the migration transition continuum. In these transitions, balancing acts and the integration of new and well-known resources take place in a process over time. Movement along this continuum is not necessarily always linear, but rather fluid and individual. Examples of conditions, dynamics and balancing acts in the transition of migration of Somali-born women, based on findings in this thesis are provided in figure 6. A socio-ecological perspective (154) helps to visualize the finding that conditions on societal levels have impact on dynamics on community, relational and individual levels (fig 8). Some of these balancing acts will be addressed in this discussion and then related to the encounter between the Somali-born woman and the antenatal care midwife, supported by Meleis’ transition theory (22).
Figure 6. Examples of conditions, dynamics and balancing acts in the migration transition continuum among Somali-born women.

* For a more thorough description of the pre-migration dynamics at these levels see the attached paper II.

** NPSV = non-partner sexual violence, IPV = intimate partner violence
Balancing acts in migration transition

“Moving on” in the new society

Prominent for the process of coping and wellbeing during the transition process of the Somali-born women (III) were wishes to not focus on past or present experiences of hardships and violence, but rather to move on. The factors we found as crucial for wellbeing were all central in this “moving on” approach” (fig 7). Motherhood provided, together with spiritual faith, hopes and drives for the future. Social coherence supported the navigation forward and practical support in the new society was appreciated and preferred in this process. The secular healthcare system in Sweden offering psychological counselling and presuming outspokenness in care encounters stood in contrast to this approach.

Figure 7. Illustration of motherhood, spiritual faith, social coherence and pragmatic solutions as central in the approach of “moving on” among the Somali born women.

The lower levels of reported psychological ill-health and psychiatric treatment among the Somali-born women (I) are interesting in the light of war and the demands of migration and separations. They diverge from some other studies showing increased psychological distress and the use of psychotropic drugs among migrant women of different ethnicities residing in Europe (156-158). However, parallel to these studies have, similar to our findings, own cognitive strategies focusing on the present and the future (159-161), distraction (161) and spirituality (160, 162, 163) been described among other groups subjected to war-related violence, with their origins in both African and Asian settings. Among Tigrinya people in Ethiopia, it was found that indulging in sorrow of the past was thought to lead to vicious circles of passivity. Concrete acts such as focusing on the children’s future were considered to be more positive responses in the aftermath of war (161). One
explanation is that these conceptions in war-affected settings have been shaped by the necessity of pragmatic solutions in a context with little space for emotional responses. Women’s strength in the wake of war, which was highly valued by women in our studies, may be shaped by these circumstances. Interestingly, however, is that even after settling in a peaceful society with access to professional counselling, these attitudes were still considered to be vital for wellbeing, and not only among the recently arrived women (II,III). Together with “moving on”, a contentment, rooted in belief in destiny, was displayed by the Somali-born women, which correspond with accounts from the antenatal care midwives who overall did not associate Somali-born women with high levels of violence or distress. Contentment and the concept of “moving on” with motherhood, faith, social coherence and pragmatism thus appear to operate as a protective factor related to distress and difficulties.

There are, however, additional perspectives which can add some complexity to our findings of “moving on”. Lack of pre-migration experiences with mental health services could be a barrier for women, despite a need of psychological support, as was mentioned by a few women (III). Previously described conceptualizations of mental distress and strategies differing from a westernized bio-medical view (48) may here act both as a barrier and as a resource. We further found unfamiliarity with verbalizing needs in maternity care encounters, which can apply to both emotions and more direct childbearing needs and questions. Concerning intimate partner violence or non-partner sexual violence, social risks connected with disclosure were shared (III), which is a well-known phenomenon (164).

For healthcare professionals, social workers and policy makers, these dualities constitute a balancing act, which might be reinforced by potential social distance (IV). One pitfall is to exoticize the other. Migrant women experiencing pressure from social networks and healthcare professions to show endurance and strength, despite having a need for support, have been described (165). On the other hand, placing a one-sided emphasis on refugee women’s vulnerability risks set aside women’s own capabilities and ways of finding sources of strength or support; which sometimes may be shaped differently than the “new society” expects. Highlighting specific groups as being particularly vulnerable to violence or trauma is needed in order to tailor preventive and supporting measures accordingly (8, 137). If nuances are lacking, there are, however, risks of stereotyping and victimizing women who do not view themselves as such. This might result in a sense of subordination in the process of regaining coherence in a new environment. For midwives encountering Somali refugee women, this double perspective is important to bear in mind in conversations about violence and wellbeing. In interviews with torture survivors of different nationalities, having power over what should be disclosed, and how, was considered central for wellbeing (159). In the same study it was further revealed that wishes to “move on”
could be complemented with institutional support, both practical and psychological in a more easily accessible way if key persons from a similar cultural context were involved (159). This can, however, be a concern in case of processing ongoing violence since belonging to the same social network can imply safety risks. Dialogue starting from the individual woman’s point of view is thus, for several reasons, central in care encounters.

Redefining support systems

Another balancing act revealed in this thesis was between different sources of support in the process of migration transition. This was displayed in how healthcare services were approached and used, in ways to relate to family tensions and violence, and in how knowledge was gained about functions in the new society.

Public health, gender relations and instances dealing with violence

Later bookings and less visits to antenatal care during the pregnancies of the Somali-born women was found (I). We also found that women did not naturally link experiences of violence with midwifery encounters (III). These findings may partly be linked to the discrepancy between the familiarity with a “care-out-of-necessity” approach in Somalia (II), and the overall public health and preventive care offered in Sweden. Family and social networks had been crucial for taking care of many essential parts surrounding childbearing before migration. In addition, regarding violence in the past, war-related violence has been described as a collective burden, beyond individual pain, with common activities and bonds within Somali diaspora communities constituting an arena for processing these experiences (166). Furthermore, in Somalia, family, social networks and/or elders, rooted in the clan-based social structure, were significant in solving relational conflicts and violence between couples (II, III) (167).

Entering a system with juridical rights and a state-based social security system after migration was nevertheless appreciated by the women in paper III. It rendered, however, new challenges that were connected to power in gender relations (III). We found a pattern of both a desire to exercise independence intertwined with a wish to allow men to retain their responsibility as the main decision-makers. Similar patterns have been found in other Somali diaspora communities, with men finding it more difficult to embrace system changes and power shifts which operate in favor of women (19, 168, 169). Furthermore, authority persons, such as midwives, were viewed as a resource but sometimes also as a threat to the individual’s and the family’s welfare (III), which contributed to hesitation regarding questions on violence in care encounters. In correspondence with other studies among Somali migrants, these findings illustrate both the transition between divergent gender
systems and the transition between collective and individualistic life systems that take place in western exile (19, 168, 169). A generational shift has been described among Somali migrants in Minnesota, with more positive attitudes towards embracing state-based support in case of violence among younger Somali migrant women (168). Also in our findings a variety was displayed, with some women considering it natural to incorporate questions about violence from the midwife, or support from social authorities, with more “informal” support strategies. This was particularly, but not exclusively, found among informants who had resided in Sweden for longer periods (III), underscoring the individualized nature of migration transition (22).

Orientation in the new society

Reliance on non-governmental support systems was further displayed regarding orientation in the new society (III). Central for a healthy migration transition is to have preparedness, being oriented in the new situation and connected to others (22). Because the Somali-born women began their journeys to Sweden with little knowledge about the destination and about what was waiting for them upon arrival, social networks were crucial for regaining coherence. This crucial role of social networks is also demonstrated among immigrants in other settings (155, 170, 171). However, some women displayed a more reserved attitude towards engaging in, or relying on, new networks after migration (III). This can indicate both independence and complexities of entering new social spheres (172). Risks of exclusion from the wider society within a refugee community can act as a barrier for gaining access to resources in the new society (170). The findings of later and fewer bookings of maternal healthcare during pregnancy and the sometimes conflicting messages regarding maternal health from social networks versus maternity care providers (I, study 2, unpubl), might partly be a reflection of this. Balancing belonging, protection and loyalty within a well proven collective system and the offer of independence in a new more individualistic system can thus be challenging, but can also create new possibilities. The combination of “internal” social networks for orientation and support, with a wider and more “outbound” social capital, has thus been stressed (170).

Somali-born women’s ways of interpreting and utilizing the support systems offered in Sweden are influenced by navigation between different gender-power structures, strong versus weak state-based structures, individualistic and collective life systems and between different sources of information. Together with contentment and the desire to move on, this navigation has implications for midwives and how they understand the needs of women with post conflict experiences.
The bridging function

Pursuing motherhood and providing a future for the children were important parts of the Somali-born women’s “moving on” approach, which contributed to wellbeing after arrival in Sweden (II,III). Due to the centrality of motherhood, Somali migrant women might encounter Swedish maternity healthcare shortly after their arrival in Sweden, having limited links to Swedish society. This is therefore a situation where the midwife could make positive contributions if she is aware of the transition the woman is going through and has the ability to identify what kind of support is needed to facilitate a healthy transition (22). The Somali-born women did not see the midwife as an obvious resource relating to ongoing or past experiences of violence (III) and displayed access to own resources to deal with this, in ways which not always might be visible to the midwife. However, a pregnancy or the re-union, or lack of union, of family can during the process of transition increase uncertainty or vulnerability (22). Its demands might expand beyond already known and utilized strategies and support systems, particularly when situated in a new environment. The antenatal care midwife relationship can be central to assess whether the woman’s own resources are sufficient in her individual situation and raise awareness of potential needs for bridges to the new society (III,IV). This “bridging function” (fig 8), will be further discussed below, particularly in relation to violence, and can be related to Meleis’ suggested process indicators: coherence, location, interaction and developing confidence/coping.

![The bridging function](image)

*The bridging function*
- **coherence & location**
  - Information: links health-violence, confidentiality, ways to societal support, juridical rights
  - Identify individual needs, mapping existing support/resources
  - Dialogue on family roles / parenthood
  - Arena for coherence and social networking

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Mutual trust</th>
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<tr>
<td>Woman-centered to identify needs</td>
<td>Gradual deepening of relationships</td>
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<td>Minimized language barrier</td>
<td>Continuity of caregiver</td>
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<td>Time</td>
<td>Partnership</td>
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<tr>
<td>Knowledge: based on theory, experience, Somali networks, colleagues</td>
<td>Routines for violence inquiry allow individual adjustments</td>
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<td>Openness and interest for differences</td>
<td>System level support</td>
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*Figure 8.* Interlinked structure of the “bridging function” in the antenatal care midwife - Somali-born woman relationship, inspired by Meleis’ Transition Theory.
Coherence and location in a wider society

The antenatal midwives’ role in health education and information (173) is a central component in the relationship between the midwife and the Somali-born woman. Particularly regarding information about laws, women’s rights, confidentiality issues and available societal support, this role was outlined in our findings as being important for recently migrated women (III, IV). Clarifying links between violence and health aspects of mother and infant were suggested keys to help women make sense of the violence inquiry and encourage disclosure when needed (III). Besides this, the relationship between the Somali-born woman and midwife can per se be important. Being seen and reaffirmed by someone outside the woman’s own sphere, can be strengthening and contribute to coherence within a process of change (22). This need is likely to be even more pronounced if a woman is processing violent experiences in unfamiliar environments (174). Our findings additionally revealed that the maternity care arena can promote connections between Somali-born women who have not yet established social networks (IV).

Changed family patterns with power shifts between men and women (168, 169) and new demands on parenthood (175) might require new strategies. In processing these changes (22), the Somali-born women compared roles and responsibilities for men and women in the two societies while they balanced embracing new opportunities in the new society with upholding traditional roles. The parallel entrance of Somali-born men into the childbearing sphere (176), and women’s insights in the need for partner dialogue (III), poses challenges to the midwifery work, but also opportunities. Reflecting with women or couples about their rights, roles and responsibilities in the old and new societies can help them as they are being positioned in the new society. This could further be a gateway to resources such as parental education and family counselling. A concern is that earlier research demonstrates less attendance at parental classes during pregnancy among women with a native language other than Swedish and among women who display less antenatal care visits (177). Midwives in this thesis described in line with this how parental groups with Somali-born women or couples demanded time and patience, with a risk of high drop-out rates (IV). However, the opposite was also found; particularly when a more holistic perspective was applied with added collaboration across professions. Thus, flexible solutions might be needed. Collaborations with Somali communities and key persons have been highlighted as being important in violence prevention work within Somali communities (101). In such ways, parental education or counselling is more likely rooted in knowledge of tradition and family changes during migration, with increased relevance in relation to Somali-born families.
Interaction

The midwives expressed a wish for an individual approach in their care encounters with sensitivity to the women’s own needs, going beyond stereotypes based on ethnicity or religion (IV). This brings forward the importance of interaction in care encounters. Two findings were particularly interesting regarding interaction in our studies.

A paradox was that the newly arrived women did not focus on interaction and language in midwifery encounters, while this was highlighted by women with longer residency in Sweden (study 2, unpubl) and the midwives (IV). This might be because a deeper interaction with the midwife was not expected when they had recently arrived in Sweden. Interaction with others is central to meaning-making, understanding and development in a transition, and was so for the women we interviewed, but is not necessarily sought in care encounters (22). Informal social networks were vital for the women in this regard (III). However, for access to adequate care, for outlining potential individual needs related to violence and for information about the new society, interaction between care receiver and care giver is central (164, 178). Lacks of the same risks contribute to unequal care (178). Therefore, language interpretation is a law-granted right in Swedish healthcare and considered to be a basic prerequisite in inter-cultural communication (140, 72).

The other finding was that, despite its regular use, the mere presence of a professional interpreter indicates, and contributes to, a loss of nuances in communication which may reduce the extent and quality of conversations, particularly in relation to violence (IV). Thus, additional tools are needed to bridge these gaps in care interactions. Risks of misunderstandings increase when we work across cultural boundaries (179) and the social distance revealed in paper IV is therefore a concern. For optimal interaction, openness for differences and a willingness to learn are needed, together with enough time for communication, reflection with colleagues and knowledge acquisition (180). This implies that commitment and support also from the system level in the health care organization are needed (179). Women in paper III underscored the need for openness and knowledge in their wishes for key persons within the maternity care system with in-depth knowledge and interest in Somali-born women’s lives. Emphasising the individual woman, and notions made about possible impact of the own world-view in care encounters indicates a foundation of cultural awareness among the midwives in paper IV. If complemented with culture-specific knowledge and about the changing nature of “culture” and transition (22, 179), the likelihood is higher that both potential risk factors on group level and individual variations are embraced in the care interaction. Collaborations with local Somali communities could be one way to situate theoretical and experience-based knowledge effectively (III,IV).
Trust

While Meleis’ focus is on the development of a persons’ own inner confidence in a transition process (22); our findings highlight the importance of confidence linked to trust in the other in the care encounter and in the health care system during the transition process. Inquiring about violence in the antenatal care setting adds an additional dimension, since trust is identified as important for disclosure of violence in care encounters in general (8) and this was confirmed by both women and midwives in our studies (III,IV). Important to note for the midwife-woman relationship is that in a refugee perspective, levels of trust in care encounters and -systems can be lower or require a longer establishment period. One factor is the uneven distribution of power in care relationships which can be more pronounced due to language or cultural barriers (179). Thus, striving for an equal partnership in the care provider-patient relationship, built on respect and acceptance is suggested to be crucial (179). Furthermore, experiences related to authorities in contexts of political violence, during flight or in migration processes can influence the trust building process (181, 182), as can uncertainties in relation to social authorities after migration (168, 169, 182). In response, a gradual deepening of the care relationship was suggested by both some of the women and midwives in our studies. Continuity of caregiver, which is highlighted in different midwifery settings and the repeated antenatal care encounters during pregnancy are therefore vital (173, 183, 22). Routine questions about violence at one point during pregnancy, often asked together with the medical and social history taking in the first part of pregnancy might therefore not be enough (125, 132). Moreover, the late bookings revealed in paper I are a concern that needs to be considered when adjusting routines for violence inquiries. Trust in the new societal systems is also linked to the level of understanding of the same (22), which further underscores the midwife’s role in health education.

Feeling connected, to interact, being located and develop confidence in the new situation are identified by Meleis as important indicators for a healthy transitional process (22). The midwife can contribute to this process by optimizing interaction and trust in the care relationship and by acting as a bridge. Awareness and dialogue about changes in gender power relations, about women’s self-assessed resources and needs together with providing information about accessible support systems in the new society are thus central.
Further reflections and suggestions for future research

The main focus on the maternity care encounter in this thesis is related to varied aspects of violence, but several findings and discussion points are also applicable to maternity care encounters in a wider perspective. Many areas in need of further reflections or to be addressed in future research have been found when working on this thesis and some are mentioned below.

The findings related to late antenatal attendance and subsequent fewer visits warrants further investigation and response, as lower levels of attendance can be linked to a risk of adverse pregnancy outcomes (184). Our findings indicate that there are multiple interlinked factors contributing to this pattern, but more knowledge and close collaboration with Somali diaspora communities and key persons are needed to address this with relevance for the target group. We also saw a discrepancy between the Somali-born and Swedish-born women’s use of medical pain relief during delivery, similar to Swedish register-derived data (185). Does this represent unmet needs among the Somali-born patients, indicating gaps in information (186) or are other strategies used to cope with pain (187)? We found that “community talk” regarding side effects was one factor influencing women’s attitudes towards the use of particular epidural anaesthesia. Based on the right to equal care, potential barriers for birth giving Somali-born women in need of medical pain relief have to be further investigated and addressed.

The “Move on” approach as a strategy for wellbeing was a central finding in this thesis. Whether this approach is useful for a healthy transition in the long run, and how far it reaches in the aftermath of personal experiences of non-sexual violence or intimate partner violence, was not within the scope of this thesis. This is however an important question to address among Somali-born women in future research.

Spirituality and religion were central in the Somali-born women’s accounts. To midwives working in a secular society, it may appear paradoxical that while restrictions of women’s rights based on religiously justified power was a reason for flight, religion was, at the same time, an important source of strength on a personal level. It further influenced decision-making regarding family life and reproductive health. An individual’s religious faith is often regarded as being strictly personal in a more secular society, but in Somali society it is voiced prominently and it was found to be an integral part of the Somali-born women’s lives. Thus, it should not be considered taboo to raise questions or initiate dialogue on spiritual matters if needed, as long as it is pursued in a respectful way in the care encounter. The Somali-born women included in this thesis did not delineate the role of religious institutions and leaders for support or for choices made in relation to reproductive health after migration. The engagement of religious leaders’ is, however, essential.
and must be included in work with violence prevention, due to their positions of interpreting and communicating religious messages (188).

When divergent world views meet, a delicate question is: who should define what violence is and what actions need to be taken? The midwives reflected on the issue that definitions of violence might differ depending on contexts; influencing both themselves and the women they encountered (IV). Respecting and having the individual woman’s view and experience as a starting point is highlighted in violence inquiries (189) and this works well with a patient-centred care philosophy (190). Nevertheless, it can be argued that there might be situations of internalized justifications of violence (150), with harmful consequences, regardless of the victim’s label (128). In response to this, the “bridge-function” with the midwife transferring information is central, because even if direct questions about violence are not easily answered, or definitions are not shared, the midwife contributes with awareness, providing means for informed choices to women striving to balance the best of the two worlds in their own lives.

Methodological considerations
Strengths
The case-control design in study 1 allowed the investigation of multiple outcomes (143). To safeguard the internal validity in study 1, the study protocol was pilot tested and further adjusted repeatedly before the onset of the data collection. During the data collection process, potential risks of inconsistency were reduced with repeated meetings in the research group where comparisons were made between protocols and uncertainties could be discussed. The design in study 1 provided an overview over challenges within the area of maternal health among Somali-born childbearing women residing in the same region as where a substantial part of the later qualitative data collection was performed. The combination of quantitative and qualitative designs allowed the emergence of nuances in the data. Data collection from medical records and from the views of both care providers (antenatal midwives) and potential care receivers (Somali-born women) gave varied perspectives. The use of qualitative open interviews contributed by providing depth, and with this, some of the limitations of using structured questionnaires across languages were avoided (191). Due to the flexibility in the design and the conversational style of the interviews in both studies 2 and 3 we were able to approach the topics from different angles and to solve unclear issues along the way.

In the qualitative studies (2 and 3), common strengths addressing consistency were that I, as the main investigator, conducted all interviews and kept thorough and rich field notes throughout the process, which were regu-
larly checked and shared with the research team. Furthermore, in study 2, regular reflections along with note-taking were made with the interpreters on content, nuances, possible uncertainties and upcoming thoughts. The choice of thematic analysis enhanced the quality as it is a well-described and structured, yet flexible approach. Using the same method throughout all qualitative parts added to the quality as my skills in applying it gradually increased. Varied selections of participants in both studies contributed to the credibility. In study 3 we included ANC clinics in both small cities and larger metropolitan areas and chose not to interview more than two informants from the same clinic. In study 2, participants were recruited via five different sites with only partly overlapping recruitment areas.

The different data collection techniques combined in study 2 also allowed us to derive data on sensitive aspects without violating the dignity of the informants. The vignette-based interviews shifted focus from the individual to the phenomena being studied.

Limitations
In study 1, the limited study population might influence the generalizability. Wide confidence intervals in some variables can be a reflection of this. Some of our findings might be due to confounding factors, and might not have been significant if controlled for age, para, occupation or marital status. However, due to the limited number within the sub-groups, descriptive statistics and group comparisons between Somali-born women and native Swedish women was therefore the choice of analysis. Furthermore, the retrospective design relied on data that had already been collected for clinical reasons and not for research purposes. This led to incomplete data for some variables, which was more pronounced in the records for the Somali-born women and is thus a caution when interpreting the results.

Varied forms of violence were included in this thesis. A risk when taking a broad approach is to lose stringency. However, this approach was chosen to capture violence in the diverse forms it might be revealed in the care encounter between the midwife and the Somali-born woman. Despite this intention, a decision to focus on “adult” experiences on violence and not actively probe for female genital cutting or childhood abuse was made, since these areas in themselves are broad, which might have left little room for the other forms of violence in this thesis. I soon realized that I had to probe actively and be explicit when bringing up violence during the interviews. Thus a potential limitation is that I, as a researcher, influenced which aspects of violence were raised.

The women in study 2 did not reveal their own experiences of non-partner sexual violence or intimate partner violence during our interviews and therefore the findings may or may not reflect perceptions and experiences of direct survivors of these kinds of violence. Due to the silence surround-
ing these phenomena, such experiences might have been left out by the women, but they also described how hearsay or actions of non-partner sexual violence in the neighbouring areas triggered flight for women before it became realized in their own family. Also, the informants were aware that escaping by air, as most of them did, was safer than by land, and that this may have saved them from exposure to violence during their journeys.

Research on vulnerable groups must gain important knowledge impossible to retrieve in other ways (148). Particularly in study 2, safety, social and emotional consequences were potential risks, with the presence of an interpreter adding to these. Therefore, prior to starting data collection in study 2, suitable female interpreters with good reputations and an interest in women’s health were sought. They were thoroughly informed before and repeatedly throughout the data collection process about content, confidentiality and the interview approach. Documents were signed ensuring their confidentiality before starting and they were involved in the development of the topic guide. Another approach would have been to use anonymous interpreters over the telephone, but in the quest for a relaxed interview situation, and myself being an “outsider”, I considered the interpreter as a facilitator, which was proved correct. The interviews were held with openness for the informants’ willingness to share or not to share experiences. Three informants openly chose to leave out difficult parts. All informants were provided with contact details in case questions or emotions would occur after the interview. Additionally, follow-up appointments were carried out with a number of the informants.

We did not pay attention to clans while performing the interviews in this thesis. The Somali-born women’s approach guided this strategy. They themselves only anecdotally mentioned clan in their narratives, and never referred to their own clan belonging. The interview situations were relaxed and held in a friendly and open atmosphere, but apart from that, potential influences of the interpreters’ own clan affiliations during interviews are difficult to evaluate.

Words and intents might change meaning in translation (191). Three independent interpreters crosschecked and transcribed parts of the original digital recordings to check for and minimize these consequences. The approach and analysis method (146) were chosen with a focus on capturing experiences and perceptions, rather than on the exact wordings used (191). Follow-up interviews and informal gatherings with informants in study 2 served partly as a form of member checking (141), which further enhanced the credibility.

Reflexivity
Reflexivity and awareness of one’s own subjectivity is crucial for enhancing the transparency and interpretation of findings, particularly in qualitative
Being a Swede, a midwife, and a mother has most likely influenced my interaction with participants, the data collection procedures and the analysis. A positive aspect of being an outsider in relation to the Somali-born women is that it allowed the asking of questions and elaborating on issues that might have been irrelevant or had passed unnoticed if I had been an “insider”. At the same time, I lacked knowledge about some cultural and unspoken issues, with the language barrier adding further to this. Deepened relationships and repeated reflections with the interpreters were useful in this regard. Furthermore, partaking in Somali-born women’s groups and in informal gatherings, and encounters with Somali-born women in clinical situations have helped in broadening and deepening my understanding along the way. Parallel visits to refugee settings neighbouring Somalia and to Hargeisa, Somaliland, including encounters with midwives, students, social workers and other women, has provided invaluable background perspectives and knowledge. My position as a midwife was useful in the interviews with midwives as it meant being on equal terms with the informants. In relation to the Somali-born women I interviewed in this thesis, it might have placed me in a power position, but might also have been a bridge, further enhanced by sharing mothering experiences as the interviews went by.
Conclusions

Against backdrops of war related violence, separations and balancing acts during migration transition, the Somali-born women interviewed in this thesis expressed contentment, wellbeing and the desire to move forward. The women we interviewed highlighted women’s strength, spirituality and social networks as crucial for navigation and wellbeing in a context of war. Together with motherhood, these factors were also found to be important for finding coherence in the new society after migration.

Our findings of late and lower antenatal care attendance, together with adverse maternal and perinatal health after migration to Sweden, indicate, however, that Somali-born childbearing women still constitute a group in need of targeted attention in the maternity healthcare system. On arrival in Sweden, encounters with maternity healthcare services are shaped by weak state-based structures in a context of political violence, with previously limited access to maternal healthcare and a lack of state-based support after exposure to violence. A prominent focus on “moving on”, including motherhood, spiritual faith, social coherence and preference for practical support, rather than on counselling, indicates pragmatic ways of coping with violence and refugee-related stress. However, these must be balanced against potential unspoken needs in the care encounter after migration, where psychological counselling and a maternity healthcare system built on public health, preventive care and active patient involvement might be unfamiliar. Due to the centrality of motherhood among Somali-born women, they might encounter Swedish maternity healthcare shortly after their arrival in Sweden, with limited outbound links and knowledge of Swedish society. This is a situation where the midwife is well-placed, and where the duty of asking routine questions on violence can be utilized as a “bridging-function” to the wider society. Central features would be information about healthcare and societal support systems, confidentiality, links between violence and health and women’s rights. Mutual trust and interaction are crucial for this bridging function.

Even after migration, family and social networks continue to constitute a source of support. But in a new society new demands are encountered. Thus we found a heightened need for internal partner dialogue and societal support to families undergoing transition. Supporting couples and families undergoing changes in family structure and gender dynamics can help prevent power tensions in close relationships and subsequent risks of intimate part-
ner violence. Collaborations with key members within local Somali communities, maternal healthcare and social services increase the possibilities for providing this kind of support in relevant ways.

In a wider sense, the individual care-provider and the healthcare system also take part in a transition within a changing society. Care encounters with a diversity of women can be energizing, but time and financial constraints risk limiting flexibility, collaborations with other stakeholders and access to relevant knowledge. Inter-cultural and cross-language communication in care based on women-centred principles needs time, knowledge and creative solutions. This call for flexibility, not only in the individual care encounter, and it should be a priority at a system level in healthcare organizations, to fulfil the goals for equity in health care.
Implications for practice

- Somali-born women in this thesis emphasized inner strength/faith, the desire to move on and social networks as resources to orientate in the new society after war related violence, separations and during migration transition. They preferred practical support from the society. A woman-centred dialogue could facilitate openness of individual ways to deal with violence and avoid risks of stereotyping on group level.

- Midwifery encounters and conversations about violence can be utilized as “bridging functions” to the wider society. This platform for information about healthcare and societal support systems, confidentiality, women’s rights and links between violence and health could in the longer run contribute to a sense of coherence in the new society after migration. Information is suggested to be given whether openly asked for, or not, and written information is not enough, even if given in their native language.

- The maternity care arena can promote connections between Somali-born women who have not yet established social networks in their new country. Collaborations with Somali communities can further be utilized for supporting women at risk and families in transition. Interprofessional collaborations can help facilitate groups in which also topics of laws, rights and violence can be included.

- Changed family patterns with power shifts between men and women and new demands on parenthood require increased partner dialogue. Encouraging men’s involvement in maternal health care and parental education/support has potential to influence both partner relations and utilization of maternity health care services.

- Communication is a key in all care encounters and particularly in conversations about violence. Professional language interpretation is essential, but cannot remove all barriers inherent in divergent languages. Therefore, conversations about violence and wellbeing might require more time or encounters to be fully captured in relation to Somali-born women.

- Somali-born women, couples and families have their origins in a war-torn country and a collective life system where social networks are central. Accessibility to preventative maternity care has not been made
available to them prior to their arrival in Sweden. Once in Sweden, these women are confronted by a society with strong, state-based support structures that are part of an individualistic life system. Knowledge of the importance of preventative care and being an active patient is assumed. An awareness of the balancing act between these two systems is necessary for both the patient and the health care provider and can facilitate in health care situations that differ from what these women, or the care providers, are accustomed to.

- Dialogues on social authorities as a resource versus threat can respond to potential unfamiliarity among Somali-born women with a maternity healthcare system engaging in “family issues” such as violence.

Studie ett (artikel I) utfördes på ett mellanstort länssjukhus i en region i Mellansverige där antalet somalisk-födda invånare hade fyrfaldigats under de sista sex åren. En fall-kontrollstudie genomfördes där vi jämförde vårdutnyttjande och graviditetsutfall baserat på 258 medicinska journaler från somalisk-födda kvinnor och 513 journaler från svensk-födda kvinnor. Beskrivande statistik med odds-kvot och konfidensintervall användes.

Vi fann att de somaliskfödda kvinnorna initierade sina mödrahälsovårdbesök senare under graviditeten samt gjorde färre besök jämfört med de svenskfödda. De vårdades i högre utsträckning för kraftigt graviditetsillamände men rapporterade i mindre utsträckning psykisk ohälsa samt psykiatrisk behandling före och under graviditet. Mindre medicinsk smärtlindring användes vid de somaliskfödda kvinnornas förlossningar och fler förlossningar avslutades med akut kejsarsnitt i denna grupp. Större andel barn med lägre födelsevikt återfanns i den somaliskfödda gruppen. Proportionen för tidigt födda barn var likvärdig som helhet, men i gruppen mycket för tidigt födda var andelen högre i den somaliskfödda gruppen.

I studie två (artikel II och III) tog vi del av somaliskfödda kvinnors perspektiv med fokus på erfarenheter av och uppfattningar om barnafödande, våld och välbefinnande före och efter migration. Via nyckelpersoner i somaliska nätverk, mödrahälsovård samt barnahälsovård rekryterades 17 somaliskfödda kvinnor för kvalitativa intervjuer. Två somalisktalande kvinnliga tolkar assisterade vid alla intervjuer utom tre, som genomfördes på svenska. Med fem kvinnor gjordes en upprepad intervju efter 6-9 månader. Intervjuerna baserades dels på kvinnornas egna berättelser, dels på en fiktiv berättelse om en somaliskfödd kvinnas liv och migration till Sverige. En halv-
strukturerad intervju-guide användes som stöd. Intervjuerna spelades in, skrevs ut i text och analyserades med tematisk analys. Artikel II fokuserade på situationen före migration artikel III på efter.


Efter migration (III) fortsatte kvinnorna applicera strategier från tiden före migration samtidigt med gradvis integrering av resurser i det nya samhället. Barnmorskans frågor om våldsutsatthet sågs inte som självlklara utan våld beskrevs som en privat angelägenhet och om stöd behövdes var det dominerande valet informella nätverk. Dock ansågs barnmorskan kunna vara en bro till information om stödfunktioner i det nya samhället. Det framkom att frågor om våld kunde göras mer relevanta i vårdmötet om kunskap om sekretess samt om hälsorisker för mor och barn förmedlades. Ingen av kvinnorna beskrev sig som våldsutsatt av partner eller annan person i nära relation till dem. Förändringar i familjedynamik med nya roller för kvinnors och män beskrevs, som gav möjlighet till okad självständighet och skydd, men som också kunde leda till spänningar mellan makar med våld som yttersta risk. Ett pragmatiskt förhållningssätt var framträdande, som inkluderade praktisk hjälp samt att lämna svårigheter bakom sig, att vara i nuet och att se positivt framåt. Detta ansågs tillsammans med tron på mening, ett socialt sammanhang samt moderskap vara centrale för välbfinnandet och som mer konstruktivt än professionell samtalshjälp. En positiv atittyd till förebyggande mödrarålsövård dominerade men samtidigt skapade fokus på kontroller och risker under graviditet viss oro, då det kunde upplevas som att ta ut problem i förväg. Olika budskap rörande barnafödande från sociala nätverk respektive kvinnohälsoavärden beskrevs som en osäkerhetsfaktor, fram-
förallt om språkkunskaper eller egna erfarenheter av barnafödande i Sverige saknades. Här föreslogs nyckelpersoner med fördjupad kunskap eller av somaliskt ursprung eller kunna bidra med stöd och överbryggnings-

I studie tre (artikel IV) intervjuades 17 barnmorskor verksamma inom mödrahälsovård i invandrartäta områden i mellersta och norra Sverige. Syftet var att utforska hur barnmorskorna arbetade med våldsfrågor i vårdmöten med somaliskfödda kvinnor. En halvstrukturerad intervjuguide användes, intervjuerna spelades in, skrevs ut och analyserades med kvalitativ tematisk analys.

Trots migration och bakgrunder av krig och separation var det inte barn-
morskornas erfarenhet att de somaliskfödda kvinnornas var generellt extra sårbara eller traumapåverkade. Barnmorskorna upplevde somaliska kvinnor snarare som resursstarka trots deras många gånger hårda flyktigefarenhet-

Sammanfattningsvis visar denna avhandling hur de somaliskfödda kvinnorna fokuserade på nuet och framtid, trots långvarigt krig, migration och separationer. Nedsatt hälsa relaterat till barnafödande kan konstateras kvar-
stå, med senarelagt vårdökande vid graviditet. Vid ankomst till Sverige är strategier relaterade till mödrahälsovården präglade av icate fungerande sam-
hälleliga strukturer med ett fokus på stöd via sociala nätverk. Att integrera tidigare välfungerande strategier med nya resurser är en process däremot barn-
morskan kan vara en tidig och naturlig länk till det nya samhället. Pragma-
tiska strategier fokuserade på att gå vidare indikerar kapacitet att hantera våld och stress. Samtidigt får individuella behov av stöd inte förbises. Ett individcentrerat arbetssätt, grundat i tillit och dialog och med tyngdpunkt på information om vårdssekretess, länkar mellan våld och hälsa samt vägar till samhällets stödstrukturer är därför viktigt. Samarbete, över professionsgrän-
sor samt med lokala somaliska nätverk och nyckelpersoner kan bidra till att stöd för somaliskfödda kvinnor och familjer i balansen mellan två världar blir relevant.
Dagaalada sokeeye iyo nabad geliyo la’aan ka jirta Somalia dhowr iyo 20 kii sano ee ugu danbeeyay waxay sababeen in Soomalida kunool Iswidhan in ay sadex jibaar u soo bataan tobankii sano la soo dhaafay. Dagaalka iyo socdaalka (ama qaxa) waxay kordhiyaan rabshadaha, caafimaad darro iyo wal-wal.

Cilmibaadhistan (Thesis) waxay ka koobantahay saddex qaybood, kuwaas oo usii kala baxay afar daraasadood oo saynis ah (Paper 1-4). Daraasadda koobaad (paper 1) waxaa lagu sameeyay cisbitaal gobol oo kuyaalla badhtamaha Iswiidhan. Gobolkaas oo soomaaldia daggan ay shan jibbaar-meen 7 dii sano ee ugu dambaysay Daraasad la xakameeyay (case-control study) oo ku salaysan diiwaanka caafimaadka taas oo aan is bar-bar dhignay natiijooyinka iyo isticmaalka daryeelka caafimaadka ee 258 hooyooyin soomaaliyeed iyo 513 hooyooyin iswiidhis ah oo uu leh. Waxa la isticmaal lay tirakoob la sharxay (Descriptive statistics) oo leh saami kinsi ah (odds ratio) iyo confidence intervals.

Waxaan ogaanay in hooyooyinka soomaaliyeed ay tagaan xarunta hooyada uur kaleh xilli dambe iyo inayna marar badan tagin xarunta marka loo bar bar dhiigo hooyooyinka Iswiidhishka ah. Waxa ugu badan ee laga daweeyay hooyooyinka soomaaliyeed waxay ahayd xanuunka wallaca laaki-in waxaa ku yaraa xanuunada maskaxda iyo dhimmirka ka hor iyo xilliga uurkaba marka la bar-bar dhiigo hooyooyinka isiishishka ah. Daawooyinka xanuunka bi’iya way ku yaraa hooyooyinka soomaaliyeed laakiin waxaa ku badnaa in ilmaha si dag-dag ah loogu qalo. Waxaa kale oo ku badnaa carruurta miisaankoodu hooseeyo iyo ilmaha oo uurka ku dhinta. Dhiciska way ka sinnaaeyn hooyooyinka soomaaliyeed iyo kuwa iswi-
iddhiska ah laakiin ilmaha oo dhasha isagoon gaadhin shinkiisa ayaa ku badnayn hoooyooyinka soomaaliyeed.


Socdaalka kaddib waxay haweeku isku garab wadeen xeeladiihi ay horay usoo isticmaali jireen socdaalka kahor, iyo fursadaha jira bulshada cusub (III). Su’aalaha ummulisada ee ku saabsan rabshadaha qoyska looma arkaynin wax si guud la isu waydiin karu balse ay tahay arrin shaqsiga u gaar ah. Laakiin su’alaahaa ku saabsan rabshadaha qoyska waxaay la muujin karaa haddii dadka laga dhaadhicay in ay sir ama qarsoodi u tahay ni-daamka daryeelka caafimaadka iyo xidhiidh ka dhexeeyay dhibaattada qoyska
Ummulisada waxaa loo arkayay in ay tahay buundo isku hidha haweenka iyo warbixin ku saabsan kaalmada ka jirta bulshada iswiidhan. Dumarka lawaraystay midna ma sheegi inay tahay dhibbane IPV. Laakiin waxay sheegeen inay tahay yahay doorka raga iyo haweenka. Haweenku waxay saxdaa fursad ugu darran, waxay u kordhaa in ay tahay bulshada iswiidhan. Ummulisooyinka uma arkiin in haweenka somaaliyeed ay u nugul yihiin ama si gaar ay u saamisay dhawwacayda qaabilsan dagaalka ugu qaatay ay dhi-baato dagaal iyo qax ay soo mareen. Dabecadda ama fikrad ah "halkaan iyo maanta" iyo walaaltinimo ayaa waxay u muuqatay in difaac ay u tahay. Hasee ahaatee, waxay, cabarka ku adekeyeyey muhimadda ay leeadahay daryeelka shakhsiyeed ee gaarka ah iyo in haweenkaas aan daryeel koodu lagu saleysan jinsiyad ama dii. Fahan xaddidan oo ku saabsan xidhaanta bulshada somalida ama aqoon ku saabsan dhaqanka, diinta iyo aragtivo ku saabsan rabshadaa ayaa lagu tilmaamey caqabadaha iman Kara. Waxaa wada hadalkaas ka soo baxa in doorka matalayoo buundada, ay aad muhim utahay warbixinta ku saabsan sharciyada, xuquuq aadamiga iyo kaalma-daha ay heli karaan dadka dhibatooyinka ama rabshadda ku dhaqacyaa. Waxaa kale doodaaq ka soo baxday muhimadda warbibixintas ay u tahay dumarka wadanka ku cusub ama aan xiriir bulshadeed. Luqadda la wadaago ayaa lagu iftiimiyey in aad muhim ee u tahay wadahadalka ku saabsan rabshadaaha (qoyska ama sokeeyaha), hadii kale waxaa halis ah in in doodays ku joogito meel aan macna lahaayn Howlaha koox-koox laqo qabto waxa loo arkay in ay ku soo kordhin karto faahana balaaran ku saabsan doorka jinsiga.
Gabagabada qoraalkaan waxay soo bandhigtay inkasto dagaal, socdaal iyo kala go’aay soo mareen, ahmiyada waxaa la siye wakhtiga hada la joogo iyo mustaqbalka. Daahida ay ka soo daahaan iyo gaabsashada ay ga gaabsadan tagida daryeelka caafimaadka dumarka iyo caafimaad xumada lasoo darsay dhalmar waxay muujinaysaa in dumarka somalida oo wax dhalay in ay u baahanyihiin cawinaad gaar ah xagga nidaamka daryeelka caafimaadka. Xeelado ku sulaaysan kulamada ka dhaxay doqon daryeelka caafimaadka dhalmaado, caafimaad guud oo hoyada iyo shaacinta rabshada qoyska soo gaadhay markii ay wadanka iswidha soo galaan ama ku cusubiyiihiin. Isla markii na la saarayo qofka adkaysiigis iyo xidhiidkooda bulshada. Hab waaqici ah iyo sawirka liidata laga heeesto dumarka qaxooyiga ah iyo warbixin ku saabsan helitaanka fursadahaa ka jira bulshada. Laakin waxay u baahantahay in lagu dheeltiro baahida qarsoon ay qabaan sii bi markay la kulmayaan xaarunta daarcelka caafimaadka. Habkaas waqiciga la adeegsanaayo Xaga habka shaqsiyaada oo labada hanaanka (kii socdaalka ka hor ay istacmaleysay iyo ki dambay wadanka cusub ay kustacmalaysoo) isku darayo, umulisada waxay noqon kartaa bundu muhiim ah oo aamin iyo isdhexgal ku salaysan. Iskaashi dhow ka dhaxaayso bulshada somaliyeed, xaarunta daryeelka hoyada iyo adeegyada bulshada waxaay gacan ka gysaan kartaa is bedelka xiriirka jinsiga ama qoyska iyo ayna daboosha bahida ka jirto daryeelka caafimaad iyo kaan bulshada rasmiga iyo kuwakale.
More than 20 years of war and instability in Somalia have resulted, over the last decade, in a threefold increase of Somali-born residents in Sweden. War and migration increases the risk of exposure to violence, stress and poor health. Research has shown links between violence, stress and poor pregnancy outcomes and one of the antenatal care midwife’s duties is to ask questions about exposure to violence. Therefore, this thesis aimed to gain a deeper understanding of Somali-born women’s health and needs regarding pregnancy and childbirth during the parallel processes of migration and childbearing, with a special focus on the maternity healthcare encounter and violence.

The thesis consists of three studies which resulted in four scientific papers. Study one (Paper I) was conducted at a medium-sized county hospital in a region in central Sweden in which the number of Somali-born inhabitants had increased fourfold over the previous six years. In a case-control study based on medical records we compared the outcomes and healthcare usage of 258 pregnancies of Somali-born women and 513 pregnancies of Swedish-born women. Descriptive statistics with odds ratios and confidence intervals were used.

We found that the Somali-born women initiated their antenatal care visits later in pregnancy and made fewer visits than Swedish-born women. They were treated for severe hyperemesis (morning sickness) to a greater extent, but reported less mental illness and psychiatric treatment before and during pregnancy than the Swedish-born women. Less medical pain relief was administered to the Somali-born women during delivery and more deliveries in this group ended with an emergency Caesarean section. There was a greater proportion of low birth weight children in the Somali-born group. The proportion of pre-term and post-term infants was similar as a whole, but the share of very premature babies was higher in the Somali-born group.

In study two (Papers II and III) we turned to Somali-born women’s perspectives, focusing on experiences and perceptions of childbirth, violence and wellbeing before and after migration. With the help of key persons in Somali networks, maternal health and child health services, we recruited 17 Somali-born women to participate in qualitative interviews. Two Somali-speaking female interpreters assisted in all but three of the interviews which were conducted in Swedish. Six to nine months after the initial interviews, a second interview was conducted with five of the women. The interviews
were based on the women’s own stories and on a fictional story about a Somali-born woman’s life and migration to Sweden. A half-structured topic guide was used, and interviews were recorded, written out in text and analyzed by thematic analysis. Paper II focused on the situation before migration and paper III focused on the situation after migration.

The women described how broken families, displacement, and disruptions in both schooling and livelihood led to instability in the presence of war (II). Antenatal care was non-existent. Childbirth took place with scant access to equipment or medical care. Mobilization of militia restricted women’s clothing, work and childbirth care. Threats of forced marriages and families’ fear of sexual violence were triggers for flight. None of the women reported their own experiences of non-partner sexual violence, however, they did describe how victims of sexual violence were without any legal protection, which reinforced their shame in the community while the perpetrators went free. The women’s perceptions of intimate partner violence (IPV) before migration varied. Women were both viewed as having no rights and thus easily subjected to IPV, and as respected, with families constituting protection against IPV. They described the women’s strength in the presence of war and how platforms for women were broadened, with increased opportunities for income-generating activities and decision-making power in the family. Strong social networks, ability to endure, trust in God and their focus on the present and the future were what enabled survival.

After migration, the women simultaneously continued to apply strategies they had used prior to migrating along with the integration of available resources in the new society (III). The midwife’s questions about exposure to violence were not seen as self-evident; rather, violence was seen as a private matter. The midwife was however parallel regarded as a bridge to information on available support in Swedish society. Questions of violence could be made more relevant if confidentiality within the healthcare system and links between violence and the health of mother/child were clarified. None of the women described herself as a victim of IPV. However, they did describe changes in the family dynamics which included new roles for men and women, giving women the opportunity for greater autonomy and protection but with an increased risk of tensions between spouses as a consequence, with IPV being the most extreme. This entailed an increased need for partner dialogue. For women’s overall wellbeing and coherence, a social network and motherhood was central. A pragmatic approach that included practical help, to leave difficulties behind, and to be in the present and look forward positively was considered to be more constructive than professional counseling. Regarding the antenatal care offered in Sweden, appreciation dominated, but simultaneously, a focus on risks connected to childbearing before problems arose, also brought forth worries. Contradicting messages from social networks and maternity care providers were viewed as inducing un-
certainty and key persons of Somali origin or with particular interest in cross-cultural care were considered vital for bridging such gaps.

In study three (Paper 4), 17 midwives working in “multi-cultural” antenatal care in mid and northern Sweden were interviewed using a qualitative approach. The aim was to explore how midwives worked with the question of violence during meetings between the Somali-born women and the healthcare providers. A half-structured topic guide was used, and the interviews were recorded, transcribed, printed and analyzed with thematic analysis. The midwives did not consider that the Somali-born women they met were, in general, particularly vulnerable or affected by trauma, despite backgrounds including separation, war and experiences of migration. A “here-and-now attitude” and sisterhood were seen as protective factors. The importance of individualized care and that a woman should not be judged on her basis of ethnicity or religion, was stressed. Limited insight into Somali networks or knowledge about culture, religion and views on violence were outlined as potential barriers. Acting as a bridge became critical when information regarding laws, rights and support for those exposed to violence were discussed and also when encountering recently arrived women who lacked social networks. Shared language was highlighted as central in conversation about violence, with risks, despite professional interpreters, that conversations would stagnate on a superficial level devoid of nuance. Group activities were seen as possibilities for broadening, preferably with interdisciplinary collaboration, the reflections of gender roles and rights in Swedish society, but required a significant level of stamina.

In conclusion, this thesis outlines a focus on the present and the future, despite experiences with a protracted war, migration and separations. Later and lower antenatal care attendance together with adverse pregnancy-related health indicates that Somali-born childbearing women constitute a group in need of targeted attention in the maternity healthcare system. Strategies related to maternity healthcare encounters, wellbeing and violence disclosure are upon arrival in Sweden shaped by political violence, with focus on inner resources and social networks for support and strength. Attitudes of moving on, including motherhood, spiritual faith, social coherence and preference for pragmatic solutions challenge pictures of vulnerable refugee women and indicate access to alternative resources, but need to be balanced against risks for hidden needs in care encounters. In the individual processes of gradually integrating benefits of dual systems, the midwife can be an early and valuable bridge, with trust and interaction being central. Close collaborations between Somali communities, maternal healthcare and social services can contribute with support in changing gender relations within families and bridge gaps to state-based social and care services.

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Appendix

*Table 7. Interview guide I, study 2, topic areas and examples of probes/questions posed to Somali-born women*

<table>
<thead>
<tr>
<th>Topic area: pre-migration</th>
<th>Can you please start to tell about your life before you moved from Somalia?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topic area: the flight</td>
<td>Can you please tell about the circumstances of your journey from Somalia to Sweden?</td>
</tr>
<tr>
<td>Topic area: post-migration</td>
<td>Tell about your life after arrival in Sweden. Probes used when needed, under the above topic areas: Good things - threats, danger, bad events - events of particular importance - violence - to be pregnant or give birth - maternity health care contacts - to be a mother - family life - support and coping strategies – thoughts of the future</td>
</tr>
<tr>
<td>Topic area: Perceptions regarding men’s violence against women</td>
<td>Would it ever be ok for a man to use violence against his wife? Why/why not? When? How? What counts as violence?</td>
</tr>
<tr>
<td>Topic area: Perceptions regarding the Swedish ANC midwife’s role in asking about violence</td>
<td>In Sweden, the antenatal care midwife asks about exposure to violence during health visits, What do you think about the midwife asking these questions? Have you encountered this? Would you answer if you got the question?</td>
</tr>
</tbody>
</table>
This is the story of Asma. She is not a real person and the story is not true. Asma is brought up in Somalia. She is married and has four children with her husband Mohammed. The situation in Somalia is difficult due to the war and the family decides that Asma has to escape. The three oldest children remain with their father in Somalia. Together with the youngest daughter, she first travels by land, crossing the border to Ethiopia and then by air to Sweden. She is granted a resident permit after some months. She is worried about her children still staying in Somalia and sometimes she cannot sleep during the night. Mohammed has to hide periodically and then the children are scattered with relatives. After two years, Mohammed and the children are allowed to come to Sweden based on family ties. Now they all live together in an apartment; Asma becomes pregnant and looks forward to having another baby. She starts to visit the antenatal care clinic. She has friends she visits regularly. She has also a preparation position for employment after finishing her Swedish studies. In Somalia, Mohammed was employed outside the family, he is not used to her earning money, and he asks her to let him keep the money so she can ask him for money when needed. He is not secure with her being away from home that much and wants her to stay at home more, to care more for the home, the children and him and tells her to ask him if she is allowed to leave the home or not. Sometimes he forces her to stay at home. When Asma suggests they can share the housework, as she is working and he has still not started his language studies, he becomes angry and cannot avoid hitting her. Asma is very uncomfortable being near him and starts to stay away from him more and more, even though he wants her to sleep with him. She is also worried that Mohammed will hit the children. At the ANC clinic, the midwife tells her that she should ask all patients she meets whether they have experienced violence at any time. Today, she is asking Asma.

Topic area: gender relations and intimate partner violence
The story we heard is not true. Is it realistic/does it happen?

What do you think about the situation of Asma and Mohammed?
What should Asma do? Mohammed?
Physical violence/ Psychological/economical control/sexual force within marriage

What kind of help or support does Asma need in this situation?
The midwife asks Asma about violence – what do you think about that?

How is marriage and family life affected by migration?

Have you heard of similar situations? Can you tell about them?

Topic area: non-partner violence
It is not told why Asma had to flee. What if she had been subjected to sexual violence before the flight? What would then happen to Asma / how could that situation be handled?

Have you heard of other such situations?
Can you tell something about sexual violence during flight? After arrival to Sweden?
If someone has been through difficult things like Asma might have been – could there be a need to share these experiences and with whom?
Table 9. Interview guide study 3 and examples of questions posed to antenatal care midwives

Can you please start to tell about a care encounter with a Somali-born woman where a component of violence was included?

What are your spontaneous reflections regarding Somali-born women and violence?

Reflect upon your role as a midwife in the encounter with a Somali-born woman and the task of asking about exposure to violence. Possibilities and barriers, strategies, resources

Have you reflected over consequences of potential exposure to violence for Somali born women? For the general wellbeing, for pregnancy, for delivery

If you would have a new colleague or another care provider, who asks for advices about how to work in a satisfactory way with the questions of violence and women with Somali origin, what advices would you give?

In general, how do you consider the task of asking about exposure to violence?

Any other aspects you want to share related to reproductive health and care of Somali-born women?
A doctoral dissertation from the Faculty of Medicine, Uppsala University, is usually a summary of a number of papers. A few copies of the complete dissertation are kept at major Swedish research libraries, while the summary alone is distributed internationally through the series Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine. (Prior to January, 2005, the series was published under the title “Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”.)