



GÖTEBORGS UNIVERSITET

Department of Social Work
International Master of Science in Social Work

The Nature of interaction between African
Migrant Mothers and obstetric care Providers
and its effect on Service Outcome:
A case of Gothenburg City, Sweden

International Master of Science in Social Work and Human Rights
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Author: **Innocent Atwijukire**

Supervisor: **Gunilla Framme, Ph. D**

DEDICATION

I dedicate this thesis to my lovely mum who not only managed to deliver 9 out of her 10 children from home (with no qualified person) but also used that experience to help other mothers in the village during deliveries free of charge. Thanks mother for being such a brave woman during your reproductive age. I remember how you used to rush whenever called upon to help others in labor.

Abstract

This study is entitled “The Nature of Interaction between African Migrant Mothers and Obstetric Care Providers and its effect on Service Outcome: A case of Gothenburg city, Sweden”. The main objective was to try to understand the way African migrant mothers are interacting with obstetric care providers and how this interaction has impacted on how the mothers have benefited from the service. It took a qualitative nature with in-depth interviews with both primary and secondary respondents. It was based a common saying that Africans general have poor health seeking behavior. But whether this habit is kept or not when they come to Sweden which has good maternity services was what the study was trying to find out. It was found out that majority Africans seeks the service as result of the interaction with the professionals and they are satisfied with the service. However, there were those who still kept their traditions and had some reservations over the some modern services. In conclusion, those Africans migrant mothers who were liberal had better service outcomes compared to those who remained tied to their culture and beliefs. But on the whole, all had positive service outcomes from the interaction with obstetric care providers.

Key words

Obstetric care, interaction and service outcome

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1. Introduction

1.1 Background to the study

Obstetric care has overtime gained prominence the world over especially with the international community coming up with efforts to curb down high maternal mortality rates in the developing world (WHO, 2009, p. 1). The complications that mothers were exposed to during pregnancy, delivery and after birth have made the service crucial and it has thus gained prominence. Yet, whereas it is contended that the service is being provided and consumed in all parts of the world, different segments of the world population seem to be more in need of the service than others. This issue gains validity considering that, "...disparity in deaths between developed and developing countries is greater for maternal mortality than for any other global health problem" (Ujah et al, 2005, p. 28). Ujah et al (2005, p. 28) highlight that "the estimated number of maternal deaths worldwide in 2000 was 529,000, almost equally divided between Africa (251,000) and Asia (253,000), with about 4 % (22,000) occurring in Latin America and the Caribbean, and less than 1% (2500) in the more developed countries" (citing Abouzahr, 2003). Besides, for every pregnant woman who died, at least another 30 suffered serious injuries and often permanent disability (Ujah et al, 2005, p. 28 citing Dannay, 2000). Abodunrin et al, 2010 also observes that; Every day, at least 1,600 women die from the complications of pregnancy and childbirth globally with majority, about 90%, of these deaths occurring in Asia and sub- Saharan Africa (Citing WHO, 2004; Gottlieb 2002).

Reproductive Health Matters (2010, p. 202) makes a similar observation that only in 2008, about 1,000 women died due to pregnancy and child birth related complications on a daily basis yet out of these, 570 lived in sub-Saharan Africa, 300 in South Asia and 5 in high-income countries. Ravindran and Berer also state that pregnancy, childbirth and abortion continue to be unnecessarily hazardous for the majority of the world's women... nearly 600,000 women are still dying each year in developing countries (2000, p. 1). Overall, Africa is noted as having the highest maternal mortality ratios (MMRs) (Ujah et al, 2005, p. 28 citing Abouzahr, 2003) and the average risk of dying from pregnancy-related causes in Africa was considered to be about one in 20, compared to one in 2000 in the more developed countries (Ujah et al, 2005, p. 28 citing Abouzahr and Royston, 1993).

This scenario could be denoting differentials in the nature of interactions between mothers and obstetric care professionals, thus differences in susceptibility to death resulting from complications associated with pregnancy and childbirth. Unfortunately, whereas "the risk of a woman dying from a pregnancy related cause during her lifetime is about 36 times higher in developing countries compared to developed countries" (Reproductive Health Matters (2010, p. 202), it can be agreed to that geographical and economic accessibility to the necessary services and high chances of interaction characterize and favor those people and regions at minimal risk. For this reason, it is less surprising that particularly African women have considered the services of Traditional Birth Attendants (TBAs) as a resort even when this puts their health at stake given the fact that they are "unable to identify obstetric emergencies early enough" (Reproductive Health Matters, 2010, p. 202). Even in situations where TBAs were banned from practicing, as the case was in Nigeria, in expectation that mothers would interact with the obstetric care providers as well as using modern medical facilities, reportedly nearly half of all deliveries still occurred outside medical facilities (Reproductive Health Matters, 2010, p. 202). Even within the

obstetric care itself particularly in the developing world “More resources have been put into antenatal care than into delivery and immediate post-partum care, emergency obstetric care ... and yet the vast majority of complications and deaths arise during and after delivery and in the first hours and days post-partum” (McDonagh, 1996 cited in Ravindran and Berer, 2000, p. 4).

The interaction between women and obstetric care providers has been regarded as vital by various scholars. Heritage & Maynard (2006) argue in agreement when they state that the second consequence of Client-centered models “has been increased attention to the role of the interaction itself in shaping outcomes” (cited in McKenzie, 2009, p. 163). It can thus be argued that the interaction between midwives/obstetricians helps in determining the obstetric service outcome. This is because through such interaction, a trustworthy relationship may be developed between the parties involved. This at the end facilitates the sharing of as much information as possible by both parties Besides, some scholars such as Mogren et al (2010, p. 1); Sachs (2004) cited in Mogren et al (2010, p. 2) have argued that “trust is an important concept for the caring disciplines, such as for example nursing and medicine”. Similarly, Byrd (2006) cited in Ebert et al (2009, p. 27) made a submission that “relationships are able to persist with trust and attachment developed as long as people fulfill perceived obligations of behavior and communication”. In particular, Ebert et al emphasized that “forming partnerships with women and working collaboratively with them to offer appropriate support will improve women’s health as well as have a positive effect on the health of their babies and families” (2009, pp. 28-29). On the whole, the utility of interaction between the professionals and clients has been earmarked by Rowe (2002, p. 64) as entailing satisfaction, knowledge and understanding, compliance with advice or treatment, quality of life, and psychological and other health outcomes (citing Stewart, 1995).

Besides, the interaction between women and obstetric care providers can be a source of social support which is very important for the pregnant women as confirmed by Dejin-Karlsson (1996) and Haslam (1997) through their claim that “lack of social support is stressful in pregnancy and may result in increased perceived need to smoke” (cited in Aveyard et al 2005, p. 581). Perhaps, African migrant mothers may be lacking this social support especially from the health professional thus succumbing to smoking during pregnancy which is dangerous for health of the fetus. Ebert et al (2009, p. 26) in their study found out that it is of great importance for midwives to interact with women who smoke during pregnancy and for that matter the midwives stood by their side, not in approval of their smoking behavior but in support of them, encouraging them to stop smoking and to comprehend the dangers it has on their health and unborn babies.

Moreover, utilization of obstetric care can be rewarding in detecting complications early enough during pregnancy especially knowing the health of the baby and if possible abort if the child is sick (Öhman et al, 2004, p. 634 citing Baillie et al, 1999; Garcia et al, 2002). Aniteye and Mayhew (2011, p. 47) while citing The Criminal Code (Amendment) Law of Ghana, PNDC. Law 102, 1985, show instances under which abortion is allowed. They noted; *It is not an offence...if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner...e.g (for example). Where the pregnancy is as a result of rape, incest, poor health of the mother, sickness of the child....*

In Sub-Saharan Africa and South Asia, several factors could be combining together to influence higher pregnancy and child birth related death rates. such factors include limited geographical and economic access to the services—poverty (Ujah et al, 2005, p. 28; Ravindran and Berer, 2000, p. 1); qualified manpower problems, for example, in Africa, Asia and Latin

America, less than 50% of births are attended to by skilled staff (Nyamtema et al, 2008, p. 114); poor health seeking behaviors (Shehu 2000, p. 218); preference for TBAs for some reasons (Reproductive Health Matters, 2010, p. 202; Nylander et al, 1990 cited in Adeoye et al, 2005, p. 102), among others.

However, on a positive note, the situation seems to be taking a better trend world wide as Reproductive Health Matters (2010, p. 202) observes the number of women dying due to complications of pregnancy, childbirth and unsafe abortion has decreased by 34% in 2008. This positive trend could among other factors be attributed to the benefits of obstetric care (Van, 1997 cited in Ravindran and Berer, 2000, p. 1). A number of initiatives have for long been put in place for example the Safe Motherhood Initiative that was launched in 1987 in Nairobi, Kenya during the international consultation of UN agencies, governments, donors and large NGOs (Starrs, 1987 cited in Ravindran and Berer, 2000, p. 1; Marchie and Anyanwu 2009, p. 110), the International Day of Action for Women's Health on 28 May 1988 was also launched by the Women's Global Network for Reproductive Rights and the Latin American and Caribbean Women's Health Network "through a 'Call to Women for Action to Prevent Maternal Mortality', which had been endorsed by participants at the 5th International Women and Health Meeting in 1987 in San José, Costa Rica" (Berer ed, 1988, cited in Ravindran and Berer, 2000, p. 1), the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994, the Technical Consultation on Safe Motherhood in Colombo, Sri Lanka in 1997 (Starrs, 1977 cited in Ravindran and Berer, 2000, p. 1) and the ICPD+5 review process in New York in 1999 (John 1999 cited in Ravindran and Berer, 2000, p. 1) . At the ICPD in 1994, all governments agreed to reduce maternal mortality by one half of the 1990 levels by the year 2000, and by a further half by 2015 (John 1999 cited in Ravindran and Berer, 2000, p. 1).

Many world leaders made a commitment to Safe Motherhood in September 2000 when Millenium Development Goals (MDGs) were launched during the UN summit with MDGs 4 and 5 concerned with the reduction of child mortality and maternal mortality rates respectively by 75% by 2015 (WHO, 2009; UN Millenium Development Goals, 2005; Witter and Diadhiou, 2008, p. 94). Since 1987 global attention to safe motherhood, there have been ups and downs especially in mid 1990s due to "economic crises and cuts in the expenditure by government and donors in the mid-1990s which greatly affected the functioning of health systems and investment in the health sector especially in the poorest countries" (Ravindran and Berer, 2000, p 2). However, this was given more attention in 2000 with the introduction of MDGs. However, Witter and Diadhiou, 2008, p. 94) citing Hill et al (2007) note the progress towards the achievement of MDGs targets by 2015 has been disappointing with MMRs remaining stagnant or even deteriorating in many countries, especially in Sub-Saharan Africa and Asia. It is also worth noting that there are huge rich-poor inequalities in access to maternal health care and in maternal mortality (Gwatkin et al, 2007 cited in Witter and Diadhiou, p. 94).

But nonetheless, this tells little about the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome when one considers living in a developed world. It is even more probable that whereas positive results are being registered more in the developed world (Ujah et al, 2005, p. 28), it cannot be taken for granted that even the African migrant mothers are automatically forming part of these claims. Yet there is no guarantee that by African migrant mothers being in a developed world, they have abandoned the attitudes, practices, behaviors, etcetera, that expose them to such deaths. More so, taking the fact that Antenatal care in Sweden is free of charge and easily available for everyone to use (Mogren et al, 2010, p. 1 citing Pakkanen et al 2004) as well as other obstetric services (Childbirth and

postnatal), it cannot be taken for granted that all women including African women make maximum use of such services given their backgrounds.

It is upon such a background that this study sets forth to establish the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome in Gothenburg city.

1.2 Problem Statement

Obstetric care happens to be profoundly yielding good results in safeguarding the health of the mother and the child and the benefits of the service are spread, though unevenly, between the developed and the developing world. Obstetric care has for instance gone as far as contributing to the reduction of pregnancy and child birth related complications by 34% from an estimated 546,000 in 1990 to 358,000 in 2008 (Reproductive Health Matters, 2010, p. 202). This can be said to be directly addressing MDGs 4 and 5. However, despite such promising improvement, the outcomes of obstetric care tell little about the nature of interaction between obstetric care providers and African migrant mothers in Sweden despite them living in a geographical context where it is known that obstetric care has been and continues to be rewarding.

African migrant mothers in Sweden have emigrated from locations where the rate of pregnancy and child birth related complications are still high and where the benefits of obstetric care have still remained low for several reasons for example being bound by tradition, preference for TBAs, poor transport and communication, poverty, poor health seeking behavior, seeking the service late, to mention but a few (Bisika, 2008, pp. 108, 109, 110; Hussein and Mpembeni 2005, p. 119; Hussein and Mpembeni 2005, p. 119 citing Mpembeni et al 1999; Witter and Diadhiou 2008, p. 95). Yet despite their current residence in Sweden, a developed country, it can never be taken for granted that the considered positive results of obstetric care do apply to them, partly considering that they could be still bound by their cultures and traditional attitudes on one hand and on the other hand, considering that many live in segregated areas which could be limiting their chances of interacting with the professionals. Again it is also possible that their social networks are dominated by their fellow migrant Africans with whom they share traditions, culture and beliefs.

Previous researches that have studied obstetric care have focused on such subjects as: the Third stage of labour specifically studying management, blood loss and pain for example in Angola and Sweden (Jangsten, 2010); the contributing factors of maternal mortality in North-Central Nigeria (Ujah et al, 2005); no association between female circumcision and prolonged labour: A case control study of immigrant women giving birth in Sweden (Essen et al 2005); the Staffing Needs for Quality Perinatal Care in Tanzania (Nyamtema et al, 2008); the Utilization of Antenatal Care in a Nigerian Teaching Hospital (Peltzer and Ajegbomogun, 2005); Perinatal mortality among immigrants from Africa's Horn); The importance of experience, rationality, and tradition for risk assessment in pregnancy and childbirth (Essén, 2001); preventing maternal mortality through evidence, resources, leadership and action (Ravindran and Berer, 2000); focuses on the trends in maternal mortality from 1990 to 2008 (Reproductive Health Matters, 2010); An anthropological analysis of the perspectives of Somali women in the West and their

obstetric care providers on caesarean birth (Essen et al, 2011), etc cetera . Looking at this, the subject of the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome in Sweden, Gothenburg in particular remains undocumented.

1.3 Objectives of the study

1.3.1 General objective

The general objective of the study was to establish the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome in Gothenburg city.

1.3.2 Specific Objectives

- To establish the Obstetric Care seeking behavior of these African migrant mothers
- To find out factors that motivate these migrant mothers to seek these services
- To find out the interaction that goes on between the African migrant mothers and obstetric care providers in Gothenburg city
- To find out how this interaction affects the service outcome

1.4 Research Questions

1. What characterizes the African migrant mothers' health seeking behavior?
2. What motivates or de-motivates African migrant mothers to seek obstetric care?
3. What are the experiences of African migrant mothers that have ever sought obstetric care while in Sweden?
4. What are the experiences of the obstetric care providers who have interacted with these African migrant mothers that have ever sought obstetric care?
5. What has been the effect of this interaction on the obstetric care service outcome?
6. What are the barriers if any to effective interaction and interaction outcomes?
7. How should the system be structured to fit all the users?

1.5 Scope of the study

This study was limited to the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome. The African migrant mothers to be considered were those living in Gothenburg city. Besides, only African migrant mothers who had given birth at least once while in Sweden were studied. This study was limited to Gothenburg city, Sweden. It took approximately four months for this study to be finalized. That time also included writing the final report.

1.6 Significance of the study

This study envisioned to be useful to those providing obstetric care to these African migrant mothers in Gothenburg particular and Sweden at large since it would provide some feedback on the effect of interaction on the service outcome. As a result, the providers of this service may use it to maintain or improve on the quality of their services. The study was envisaged to also help to bring out how this particular segment of Gothenburg community interacts with the obstetric care providers and the health service units. This would be essential in informing the appropriate interventions for encouraging this population to make effective use of the service. On addition, it was also intended to help those obstetric care providers in other areas outside Sweden but who are also working with migrant mothers of African origin in terms of their care seeking behaviors and how they react to the service provided. Since research is an ongoing process and builds on each other, this study may also serve as a source of useful information for those intending to carry out related research in the same area.

1.7 Definition of key concepts

There are three main concepts that were given due consideration under this paper. These included; obstetric care, social interaction and service outcome.

1.7.1 Obstetric care

The term obstetric care can be categorized into two; essential obstetric care encompasses services including family planning and antenatal, intrapartum, and postpartum care. The second category is emergency obstetric care which includes more specific interventions such as blood transfusion, intravenous antibiotics, cesarean section, the management of abortion complications, and vacuum or forceps delivery (Measham and Kalliane, 1995, p. 4). For the purpose of this paper, the term obstetric care was used to refer to the care given to women during pregnancy, at childbirth and for some eight weeks following delivery.

1.7.2 Interaction

Interaction can be defined as symbolically taking the perspective of another and acting on that perspective (Denzin, 2001 cited in Ebert et al, 2009, p. 27). Interaction is also about how people can create meaningful social experiences, change directions, share different perspectives define situations, take roles which all bring about social action at the end (Charon, 1995, p. 145). In this study, the concept interaction was used to mean the way African migrant mothers share/communicate/work with obstetric care professions during pregnancy, at birth and shortly after delivery.

1.7.3 Service outcome

Outcomes reflect the measurable impact of programs and services on the health of a population. In this paper, a working definition for service outcome was adopted to mean the output or results from a service. It means the consequences of the interaction between African migrant mothers and obstetric care providers. It also means the effects which can be either negative or positive depending on the nature of interaction. As African migrant mothers interact with obstetric care providers during antenatal, birth and postnatal care, whatever came out or was realized at the end was what the term service outcome was standing for during this study.

2. Methodology

This section defines the way this study was done. It describes the research design, study area, study population, sample size and selection procedure, methods and tools of data collection, data analysis, ethical considerations and the challenges that were faced.

2.1 Study design

The study was qualitative in nature. It took an exploratory design with an intention to gain an insight into the nature of interaction between African migrant mothers and obstetric care providers and its effect on service outcome in Gothenburg city. A descriptive design aided in understanding the health related interaction between African migrant mothers and obstetric care providers and seeking practices of these migrant mothers as a means to understand the nature of effect on service outcome. Besides, the study was cross-sectional that is to say was conducted at one point in time. This cross-sectional design was deemed appropriate for studying this phenomenon whose understanding may not necessarily necessitate a follow up of respondents at different intervals. On addition, the time allocated for the study qualified this design as the most appropriate. Since the study aimed for a deeper qualitative insight into the subject, it adopted a case rather than a survey design.

2.2 Area of study

The study was conducted in Gothenburg city, Sweden. This was chosen because of its heterogeneous nature since it is known to be having many migrants. Lazacode (2010) citing Statistics Sweden, Demographic Reports (2007, p. 2) identifies that in 2005, there were 108,480 immigrants resident in Gothenburg. This accounts for about 25% of the city's population (Excel document from the townships homepage cited in Lazacode, 2010). Generally, areas that are known to be having many immigrants were targeted. These included Angered, Bergsjön, Biskopsgården, kortedala, and Tynered. These were be given focus basing on their high level of segregation and being habitats for majority of African migrants, women and men (Lazacode, 2010 citing Statistics Sweden, Demographic Reports 2007, p. 2). It was also thought that it could have been possible that the health workers (Obstetricians and Midwives) in the health centers located in these areas as well the general hospitals that have delivery departments have had much contact/interaction with these African migrant mothers in terms of seeking obstetric care services than others in those suburbs that are less/not segregated.

2.3 Study population

This was composed of two categories that is to say primary respondents and secondary respondents. African migrant mothers currently living in Gothenburg and who have ever delivered at least once while in Sweden formed the first category of primary respondents. These formed the study population because they are traditionally considered to have poor health

seeking behavior (Freimuth et al, 1989 cited in Matthews et al, 2002, p. 206). But whether or not this behavior was carried on to here was unknown and would pave way for understanding how African migrant women interact with obstetric care providers and its effects on the service outcome. Besides, the African migrant mothers formed a substantial proportion of the population in the segregated areas of some parts of Gothenburg city, thus studying them was envisaged to inform about the utility of obstetric care in these areas.

Other than studying African migrant mothers, obstetricians and midwives in the respective considered segregated areas were studied as the second category of primary respondents since they were hoped to be interacting with African migrant mothers. These were envisioned to help in substantiating on the views of the African migrant mothers, they were more particularly a good source of information about the mothers' health seeking behavior and the nature of interaction between mothers and obstetric care providers.

In order to fully understand the nature of interaction between African migrant mothers and the obstetric care professionals, doulas— women who are experienced in childbirth and have been given some basic training in providing physical, emotional, and informational assistance and support to a mother before, during, or after childbirth (According the one of the doula project officials), were considered and these formed the category of the secondary respondents. These were to clarify on the issues from both the professionals and the mothers. They were considered because of their role between the professionals and mothers and therefore would have information concerning both parties.

2.4 Sample size and selection procedure

In this study, a total of fourteen (14) respondents were interviewed. Seven African migrant mothers were included in the study. These mothers were not only coming from different countries in Africa but also regional balance was put into consideration for representativeness of the views. They were from Uganda, Somalia, Ethiopia, South Africa, Sudan, Nigeria and Ghana. In addition, five obstetric care professionals were contacted and included in the study. These included two professionals working with antenatal care clinics, two others working with deliveries and a doctor who was currently working a gynecologist but had worked with deliveries. All these professionals were selected from different units given that they work on different issues during prenatal care, at birth and postnatal care. They were thus hoped to give information concerning different stages that women go through right from conception, at birth and after delivery. Lastly, two doulas (one Swedish and another African) were considered because of their intermediary role between the African women and professionals. They were hoped to give views and clarify on both sides.

Non probability sampling technique was applied to select the sample. Precisely, African migrant mothers currently living in Gothenburg and who have ever delivered at least once while in Sweden were purposively selected for inclusion into the sample using snowball technique. Some mothers were met at one of the international churches in Gothenburg city and these were requested, after the interviews, to help identify for the researcher other potential respondents. Besides church, other mothers were also contacted through friends who helped in contacting their friends. This sampling technique was applied since the subject under investigation is specific to particular segment of the population. Besides, it would be hard to obtain or develop a sampling frame to facilitate a probability sampling technique.

2.5 Data collection methods and tools

Basically two methods of data collection were applied that is interviewing, complemented by documentary review.

2.5.1 Unstructured interviews

These were conducted with both primary and secondary respondents. This was a preferred method of qualitative social inquiry and as Fielding and Thomas (2003, p. 124 citing Lofland and Lofland, 1994) observe, Non-standardized interviews best fulfill the case that the essence of research interview is the 'guided conversation'. The method was also intended to enhance flexibility and elicit rich, detailed material and insights that can be used in qualitative analysis (Ibid, 2003). Besides, to allow for a higher response rate and taking into account the discursive nature demanded by the subject under investigation, unstructured interviews became the most appropriate. Three different interview guides were applied as tools to gather the information from both categories of respondents. This was because the researcher was targeting different categories of people which made it hard to use the same tool.

2.5.2 Documentary review

This method encompassed a review of official reports, articles/publications with the aim of getting information to answer the research question. Such public/official documents according to Macdonald (2003, p. 196) aid the understanding of the investigated social world. Besides, this method "remains an invaluable part of most schemes of triangulation" (Ibid, 2003 citing Denzin, 1970). To take into account concerns of authenticity and credibility of documents, attention was paid to issues of when report/document was written, interest of the author, thus questions of "who produced the document, why, when, for whom and in which context" were kept at the back of the researcher's mind to account for quality (Ibid, 2003, p. 204-05). Reviewing documents helped to gather relevant views to the study that would not be possible to obtain by mere interaction with study sample.

2.5.3 Tools

For all categories of respondents, different interview guides were applied too since they were commensurate with semi-structured interviews. Besides, the different guides would allow free, informal and in-depth interaction with the study subjects. A documentary review guide was adopted and this had a list issues to focus on in the process of reviewing documents.

2.6 Data processing and analysis

Data was transcribed and then post-coded into themes emerging from the data themselves, guided by the study objectives. Themes based on objectives were supported with cases obtained during the study. Contextual differences were taken into account while making comparisons among findings from different representatives of units of analysis. This helped to make interpretations and drawing sense from the data. Being a qualitative study, analysis started right in the field by making a follow up of emerging issues in the interviews and discussion.

2.7 Study procedure

A letter of introduction was obtained by the researcher from the Department of Social Work, Faculty of Social Sciences, Gothenburg University where he is a student before going to the field for data collection. Making contacts with intended study participants preceded actual interviews. Since intended respondents were contacted early enough, they had a chance to fix appointments within their own schedules, something that enabled the researcher to get respondents from all the regions of Africa, doula from Africa and Sweden, as well as professionals from all the relevant departments. Interviews were audio recorded to capture full details of the interview but only after being permitted by the respondents. Two of the African mothers were interviewed through Skype and phone calls because they did not have time to meet with the researcher but the researcher still managed to record them with their permission. Verbatim transcription followed later. Data was then managed, coded and analyzed thematically to produce a research report.

2.8 Ethical considerations

The researcher would; introduce himself to the study respondents, inform them about the purpose of the study, the benefits and risks associated with participation in the study. Participants were assured of confidentiality and anonymity of not only the interview but also the data collected. The information provided was limited to the study purpose. The importance of their participation in the study was communicated to them and they were also informed of the voluntariness of their participation that is to say they reserved the liberty to pull out of the interview/discussion at any point.

2.9 Challenges faced

The researcher experienced a problem of language barrier in this study where by some of the potential respondents were not in position to even speak simple english because of the time they had been in Sweden as well as their backgrounds in their home countries. As a result, the majority were speaking Swedish since it is the main language used here given the fact that they have free SFI classes (Swedish For foreign). So it was challenging making the first contact with the respondents or health centers/hospitals as those responsible for answering phone calls often used Swedish which the researcher did not know. However, this was solved by one of my

Swedish classmate who helped me in calling the antenatal clinic personnel for the initial contacts and some professionals who could speak English contacted me on my email address through that. For the mothers, I tried to get only those who could speak English since I feared a third party in the name of a translator would affect the flow of information as well as confidentiality issues. The same applied to documents where I only considered those in English.

Another challenge was the issue of the researcher being a man and interested in asking some questions concerning women's painful moments. Some potential mothers did not feel comfortable sharing some of their experiences with a male interviewer and as a result, turned down the researcher's request for interviews. Even some of those who participated would sometimes not feel easy about using some of the biological names compared to the professionals. Some mothers would laugh loud, smile while or after mentioning some words or names or sometimes would use sign language. This is because in Africa some words are not easily said. However, in cases where signs were used, the researcher keenly observed them and tried to understand what the respondents meant. Also, the researcher capitalized on the fact that some obstetricians are men and have always interacted with the women on the same issues. So, it was thus not taken to be totally new that they are encountering men concerning this issue. But above all, respondents were informed that the information was to be used only for academic purposes.

The area the researcher was getting into was itself challenging in terms of not having very adequate knowledge prior to the study. It was curiosity and interest that led the researcher into the area of reproductive health but he very had little knowledge in the area. This called for a lot reading around the area and visiting one of the professionals just to be informed about the area of obstetric care. The researcher then gained some knowledge and managed to shape his study. Besides, the terminologies used in both interaction and written texts were also challenging. Some professionals would forget and keep using hard medical terms while sharing with a social researcher but follow up questions always helped in getting clarifications.

Lastly, the issue of getting respondent was hard for the researcher. Although this was expected right from the conception of this study, it went beyond the imagination. The researcher got a good number of appointments from mothers but they all said they had time on Sundays which of course, was not a problem. Some of these women kept postponing appointments by a week since they only had Sunday as their free day to entertain others businesses outside work and home chores. The researcher solved this by dropping those who had postponed more than once and making fresh contacts.

3. Theoretical framework of the study

In this chapter, three theories are discussed. These include; systems-ecological theory, social interaction theory, and the empowerment theory.

3.1 Systems-ecological theory

The systems-ecological theory borrows from a biological theory which proposes that all organisms are systems composed of subsystems, and are in turn part of super systems (Payne, 2005, p. 143).

This perspective explains the nature and operation of human society. Like Pincus and Minahan (1973) also highlight, human society is composed of many institutions such as families, schools, health facilities, markets, religious institutions among others, and each of these has a number of elements (cited in Payne, 2005, p. 145). Accordingly, they are these (informal/natural systems, formal, or societal systems) that form people's immediate social environment which they depend on for a satisfactory life. People are seen as always in constant interaction with these. The theory primarily focuses on the quality of the relationship between the client (individuals, groups, families, communities) and the immediate social environment as essential for the normal functioning of the client to maintain stability/equilibrium.

Even if these systems work independently, they are interdependent in a way that when one is affected, the rest are as well affected (Payne 2005, p. 145). The Swedish obstetric care system is organized in such a way that women go to maternity clinics for antenatal, and to hospitals for deliveries or other pregnancy related reasons and then later back to the midwife for postnatal care. All these are interdependent on each other although they appear to be somehow independent. This means that if there is a breakdown in terms of service somewhere for example obstetric complications are not detected by the midwives during pregnancy, the rest of the other units and services are negatively affected as well.

Effective social support requires both planned formal social support groups and also enabling 'informal' or 'natural' carers to help friends, neighbors, and family members who are in need (Walton, 1986 cited in Payne, 2005, p. 155).

Since the theory focuses on the 'whole' rather than the sum of its parts as (Hanson, 1995 cited in Payne, 2005, p. 143) argues, this theory is believed to bear a great potential in aiding the investigation of the environment within which the African migrant mothers live and interact, the quality of interaction and synergies, as well as their respective effect on obstetric care/service outcome. The theory will also guide in informing about the differences in outcome for those African migrant mothers that keep open boundaries compared to those whose boundaries are more closed. Needless to mention, this theory is envisaged to inform a social investigation of the dynamics of such interaction between the obstetric service providers and the African migrant mothers.

3.2 Social interaction theory

Social interaction theory focuses on how social interaction between people can create meaningful social experiences, change directions, share different perspectives, define situations, take roles which all bring about social action at the end (Charon, 1995, p. 145). This theory is deemed fit for this study since the nature of interaction between African migrant mothers and obstetric health care professionals is envisaged to have an effect on service outcome arising from the actions taken by both parties involved in interaction. These actions could in turn be seen to be emanating from the interaction. As Blumer (1953) puts it that “the main important feature of human association is that participants take each other into account” (cited in Charon, 1995, p. 145), the opinions of both African migrant mothers and the obstetric care professionals should be considered during interaction if good service outcomes are to be realized. This means that if this interaction works out very well and African migrant mothers get adequate maternity services, there is a possibility of positive service outcome and the reverse could be true.

As the theory states that people negotiate their social world by adapting to different situations which may be as a result taken by others (Charon, 1995, p. 152), interaction between African migrant mothers and obstetric care professions may force both parties to be adaptive to same situations. For example, a pregnant mother may be forced to stop smoking as a result of the advice given by the midwife or obstetrician concerning the effect of smoking on the health of the fetus. Similarly, an obstetrician may suggest an operation to save the life of the child when the child needs to come quickly and the mother may have to accept in order to have her baby alive.

Social interaction theorist also argues that social roles are themselves considered a kind of symbol which individuals act out in accord with their situation (Charon, 1995, p. 153). That each decision along the stream of action is influenced by a long history of decision making, and each action in that history must be understood as influenced by the ongoing give-and-take of social interaction (Charon, 1995, p. 153). This theory will help in analyzing the effect of social interaction between obstetric providers and African migrant mothers in relation to service outcome.

3.3 The empowerment theory

According to Payne (2005, p. 295), “Empowerment seeks to help clients gain power of decision and action over their own lives by reducing the effect of social or personal blocks to exercising existing power, increasing capacity and self-confidence to use power and transferring power from the groups and individuals”.

Adams (2003, P. 8) notes that “empowerment means different things to different people” citing Thomas & Pierson (1995, p. 134-5). Adams (2003, p. 8) makes a further contribution to the understanding of the concept when he relates it to “...the means by which individuals, groups, and/or communities become able to take control of their circumstances and achieve their own goals, thereby being able to work towards helping themselves and others to maximize the quality of their lives.”

Payne (2005, p. 297) citing Rojek (1986) considers empowerment to be rationalist in nature, thus assuming that changing the environment in client’s favour may be possible. This therefore works towards this direction.

Basing on the fact that African migrant mothers some of whom may be considered powerless as a result of many factors associated with their migration status, the empowerment theory is thought to be relevant in serving as a pointer to the empowerment nature of interaction between African migrant mothers and the obstetric care professionals. Given the focus of this theory, it is expected to help in understanding the relationship as mothers come from different background holding different beliefs and traditions about modern care, the counsel as well as the information the obstetric care professionals may give them can help in making decisions that are informed. Moreover, when given the patriarchal nature of society where men may try to make decisions on the lives of these their wives like in case of cesarean or abortion, these women may be given information that they have a right over their own lives. It is hoped that the support through interaction is enough to give all the confidence they need to take full control over their lives.

4. Literature Review

This chapter is made up of Obstetric care seeking behaviors of African migrant mothers Motivation factors for seeking obstetric care, and Nature of interaction between the African mothers and obstetric care providers and outcomes.

4.1 Obstetric care seeking behaviors of African migrant mothers

Health seeking behavior among different mothers of different backgrounds can be said to be different. In this particular case, it is important to understand the obstetric care seeking behavior of African mothers. A lot of literature reveals a lot about this subject and this section of this paper aims to bring together the contributions of different researches. Ny et al (2007, p. 809) in their study titled *Utilization of antenatal care by country of birth in a multi-ethnic population: a four-year community-based study in Malmö, Sweden* observe that “all foreign-born women, except for women born in Western countries and South and Central America, had significantly increased crude odds for lesser use of antenatal care than recommended. These women had a lower utilization of planned antenatal care and they came late for their first visit as well as attending fewer parental classes (Hemminki et al, 2001; Dejin-Karlsson et al, 2004 cited in Ny et al 2007, p. 805). Considering that this study had a general focus on foreign women, it cannot be taken for granted that the cases of African migrant mothers are documented. This leaves a gap that this particular study aims to close.

Essen et al (2002) concurs with Ny et al (2007, pp. 805, 809) in her observation that some immigrant groups in Sweden tend to receive sub-optimal antenatal care compared to Swedish-born women.

Different accounts are highlighted for the poor health seeking behavior of these foreigners. Ny et al (2007, p. 805) citing Gudmundsson et al (1997); Hjern et al (2001); Essen et al (2002) all attribute the behavior to the mothers experiences associated with their countries of birth and socioeconomic factors that limit chances for seeking the service. However, although such experiences can be appreciated, ideally, they would not count as long as one reaches Sweden where the services are free (Mogren et al, 2010: 1 citing Pakkanen et al, 2004; Roos et al, 2010, p. 1003; Waldenström et al, 2006, p. 554).

The role of traditional birth attendants (TBAs) has been underscored by some studies as one of the factors behind poor seeking behavior among African women. Bisika (2008, p. 107) while quoting the 2000 Malawi Demographic and Health Survey reports that, 22.7% of deliveries were attended to by TBAs, 50. 2% of deliveries were attended by a nurse or trained midwife, 5.4% by a doctor, and 2.4% by no-one. Peltzer et al (2009, p. 155) citing Abrahams et al (2002) studied indigenous healing practices and self-medication among pregnant women in Cape Town, and found that the majority of Xhosa speaking women follow indigenous health practices for both themselves and their babies because of the need to “strengthen” the womb against witchcraft or sorcery, to prevent childhood illnesses, and to treat symptoms they perceive that biomedical services would not be able to treat. It has also been reported that some trained Hussein and Mpembeni (2005, p. 120) citing Mpembeni et al (1999); Rooney (1992) made an

observation that “TBAs refrain from referring mothers with complications until the very last minute, because they are afraid of losing status in the communities that they serve, and that assisting a particularly difficult delivery where both the mother and baby survive is a credit to them”.

As the World Health organization (WHO, 2009, p. 1) argues for good-quality emergency obstetric care that is universally available and accessible, equipped with the presence of professional, skilled birth attendants, coupled with key services integrated into health systems, this can be argued to be present in Sweden. However, the extent to which it meets the demands of the African migrant mothers to the extent that it attracts them to exercise good health seeking behavior remains unknown. This partly forms the focus of this study.

However, while these studies document poor antenatal seeking behaviors of migrant women, studies that have focused on deliveries show an opposite trend. Essen (2005, p. 5) reports a small number of home deliveries in Sweden among migrants whom she reports to be making use of obstetric care at hospital level. Ny et al (2007, p. 811) reported that “Africa had higher utilization visits to midwives at the delivery ward compared to Swedish-born women” although many of the visits by African women were considered unplanned.

Despite the above scenario, it is not enough to take it that in particular, African migrant mothers’ obstetric care seeking behavior is known. Truly, these past researches throw some light about the health seeking behavior of immigrants but as so far noted, some of the studies have had a general focus, yet none has specifically focused on African migrant mothers in Gothenburg and from a social work perspective.

4.2 Motivation factors for seeking obstetric care

These factors form an important variable for this study. Different studies have underscored that one among other factors that motivate mothers to seek obstetric care is the concern for the baby. Öhman et al (2004, p. 634) note that women’s worries during pregnancy have shown that the baby’s health was the most important concern (citing Statham et al 1997; Glazer, 1980). This notably accounts for pregnant women’s anxiety which they thus hope to find redress to by visiting midwives. Because of the worries about the unborn baby’s health, ultrasound screening in particular for Down’s syndrome during pregnancy attracts not only the pregnant women but their family members alike (Öhman et al, 2004, p. 634 citing Baillie et al, 1999; Garcia et al, 2002). Yet as later research has addressed fears among some women that ultrasound might harm the fetus as depicted in early studies, this has even led to more attraction (Öhman et al, 2004, p. 634 citing Garcia et al, 2002; Öhman et al, 2004, p. 637).

Seeking antenatal care with an aim to address anxiety is noted to be paying. That is, it helps to address the consequences of such anxiety. Ryding et al (1998, p. 543) highlights that “maternal anxiety may be correlated with uterine dysfunction, such as hypo or hyperactive contractions, and with dysfunctional performance during labor...anxiety and, specifically, fear of childbirth, as well as a diminished ability to cope with stress, imply an increased risk of intrapartum complications, such as prolonged labor or fetal asphyxia”. And in such a case, even when an emergency Cesarean Section is then sometimes considered the safest way to conclude a complicated delivery, Ryding et al indicates an increased risk of emergency Cesarean Section when a pregnant woman suffers from serious fear of childbirth (1998, p. 546).

Free antenatal and delivery services are identified to be yet another motivational factor. This view is contended to by Adeoye et al (2005, p. 106); Mogren et al (2010, p. 1) citing Pakkanen et al, (2004); Roos et al (2010, p.1003); Waldenström et al (2006, p. 554). However, Adeoye et al (2005, p. 106) argues that the fact that amidst free obstetric care services pregnant mothers seek parallel services, some of which being for a cost implies that this factor of free cost is not sufficient in explaining motivation. On a similar note, the Swedish healthcare is based on principles of equal access to healthcare and equal quality of healthcare provision for all residents which is achieved through free-of-charge maternity services is another motivating factor (Widmark et al, 2010, p. 554).

In view of the above, some of these factors are seen to applying to Sweden while others appear more or less universal. However, the extent to which they apply to the African migrant mothers in Sweden was a matter to investigate. Besides, the cultural aspects were crucial in considering which factors motivate different pregnant women.

4.3 Nature of interaction between the African mothers and obstetric care providers and outcomes

The interaction between women and obstetric care providers has been regarded as vital by various scholars. Heritage & Maynard (2006) argue that the second consequence of Client-centered models “has been increased attention to the role of the interaction itself in shaping outcomes” (cited in McKenzie, 2009, p. 163). It can thus be argued that the interaction between midwives/obstetricians helps in determining the obstetric service outcome. This is because it helps in creating the kind of relationship that helps in getting as much information as possible from both parties involved especially when trust is developed. Some scholars such as Mogren et al (2010, p. 1); Sachs (2004) cited in Mogren et al (2010, p. 2) have argued that “trust is an important concept for the caring disciplines, such as for example nursing and medicine”. Moreover, as Dejin-Karlsson (1996) and Haslam (1997) claim that “lack of social support is stressful in pregnancy and may result in increased perceived need to smoke” (cited in Aveyard et al 2005, p. 581), African migrant mothers may be lacking this social support especially from the health professional thus succumbing to smoking or continue to smoke during pregnancy which is dangerous for health of the fetus.

However, there are several factors that hinder effective interaction between the professionals and obstetric care service providers have been documented by several researchers. These may include limited geographical and economic access to the services—poverty (Ujah et al, 2005, p. 28; Ravindran and Berer, 2000, p. 1), technical/qualified and equipped manpower problems e.g. in Africa, Asia and Latin America, less than 50% of births are attended to by skilled staff (Nyamtema et al, 2008, p. 114), poor health seeking behaviours (Shehu 2000, p. 218), preference for TBAs for some reasons (Reproductive Health Matters, 2010, p. 202; Nylander et al, 1990 cited in Adeoye et al, 2005, p. 102), over waiting in public facilities (Brieger et al, 1994 cited in Adeoye et al 2005, p. 102; Gharoro et al cited in Adeoye et al 2005 p. 102), walking/traveling for long distances (Adeoye et al 2005 p. 102), delayed seeking of care (Peltzer and Ajegbomogun, 2005, p. 160; Berer 2000, p. 198), among others. Moreover, even where obstetric care services are provided free of charge in public hospitals and clinics, some women in Africa still prefer delivering with the help of TBAs and spiritual churches to the

hospital (Etuk et al, 1999 cited in Adeoye et al, 2005, p. 102; Walker 2001 cited in Adeoye et al, 2005, p. 102).

McDonagh (1996) cited in Ravindran and Berer (2000, p. 4) acknowledges that the in obstetric care itself particularly in the developing world, more resources have been put into antenatal care than into delivery and immediate post-partum care, emergency obstetric care ... and yet the vast majority of complications and deaths arise during and after delivery and in the first hours and days post-partum”.

Although the above writers have written about the interaction between the obstetric care providers and service seeker, little remains unknown about the nature of interaction between the African migrant mothers and the obstetric service providers in the case of Gothenburg Sweden. This study sets out to fill this gap.

Ebert et al (2009, p. 26) found out from the midwives interviewed in their study that it is of great importance for midwives to interact with women who smoke during pregnancy and for that matter the midwives stood by their side, not in approval of their smoking behavior but in support of them, encouraging them to stop smoking and to comprehend the dangers it has on their health and unborn babies. In particular, Ebert et al emphasized that “forming partnerships with women and working collaboratively with them to offer appropriate support will improve women’s health as well as have a positive effect on the health of their babies and families” (2009, pp. 28-29). Similarly, Byrd (2006) cited in Ebert et al (2009, p. 27) made a submission that “relationships are able to persist with trust and attachment developing as long as people fulfill perceived obligations of behavior and communication”.

The utility of interaction between the professionals and clients has been earmarked by Rowe (2002, p. 64) as entailing satisfaction, knowledge and understanding, compliance with advice or treatment, quality of life, and psychological and other health outcomes. This follows increasing evidence from researchers that the quality of the interaction between patients and their carers may have a significant effect on a variety of aspects of patient wellbeing (citing Stewart, 1995).

Looking at the above, it is visible that little remains known about the nature of interaction between African migrant mothers and the Swedish obstetric care system and its effect on service outcome. It is thus the aim of this study to fill this information gap.

5. The findings of the study

During the course of this study, a number of findings were recorded. These were categorized under the four main objectives of this study. These include; obstetric care seeking behavior of these African migrant mothers, motivational factors for seeking these services, nature of interaction between the African migrant mothers and obstetric care providers, interactional effects on the service outcome.

5.1 Obstetric care seeking behavior of these African migrant mothers

In this study, a set of variables were considered relevant in informing about the Obstetric Care seeking behavior of the studied African migrant mothers. These include; time of first antenatal visit, visiting the midwife two weeks before the estimated date of delivery, the actual delivery process, visitation to the midwife after delivery and the role of TBAs.

5.1.1 Time of first antenatal visit

The time of making first antenatal care visit was different for different African migrant mothers. Women's past experience was found to be important in determining when to make their first antenatal visits. Those mothers that had children previously were found of coming for antenatal care services a little bit late compared to their counterparts, first time pregnant women. This was because the former believed to have had experience and therefore they could easily know what it is that is needed. Some mothers expressed that they could easily recognize the signs of pregnancy and thus did not have to rush to the clinic or hospital for checkup during early pregnancy. One mother responded; *I went after four months because it was not my first pregnancy. It was the third... I already knew a lot from my first two pregnancies.*

This was also confirmed by one of the professionals from Angered maternity clinic interviewed when she said; *some women are very comfortable in themselves and that they can recognize all the signs and they have had healthy pregnancies previously. So, some of them may come quite late in pregnancy.*

However, despite the acknowledgement that for a number of experienced mothers, seeking antenatal care services was done late, this was not absolute to all. For one experienced mother observed that despite her experience of the previous 3 pregnancies and deliveries, the bad feeling that accompanies her pregnancy draws her to seek the service in time. She narrated; *for me, when I get pregnant, I become sick and I vomit a lot. Because of this feeling, I go to the hospital as soon as possible for medical attention.*

As observed, the story was different for the first time mothers who often made early appearances for the care. One of the reasons for this was that some could not recognize the signs of pregnancy and rushed to the hospital thinking that they were sick. One mother informed; *...but my first visit was after two weeks of pregnancy. I felt sick and went to the clinic like the routine is, upon reaching there, I was advised to test for pregnancy and I tested positive.* In another interview, another mother remarked; *...the first time I visited was after two weeks but I did not know that I was pregnant. I just went there to check what was wrong with me because I was not feeling well.* One other mother confessed; *...I think that was after three weeks when I visited the clinic. I did not visit because I knew I was pregnant but because I was feeling sick. Only to know from there that I was pregnant!*

Like among the experienced mothers whose late coming for antenatal care was not absolute to all, the early visits to clinics by first time mothers was equally not absolute among this category. One of the first time mothers reported having made a late visit. For her case was different because she did not feel any discomfort like the other first time mothers, something that would have forced her to visit the clinic early. She expressed; *for me I did not realize I was pregnant until I was four months and then I called the clinic. I went after four months and for all this time, I had not felt any discomfort.*

Other mothers held that the system delayed their chances of accessing the care in time since they were new in the country. One mother said that she did not have a personal number and could not access the service; *the only problem was that I could not get the service without a personal number and I missed the service for a month and one week. But before my coming here, I had been attending antenatal back home right from 2 weeks after conception. My first time of attending the service, I did not know that I was pregnant. I had visited the hospital because I was not feeling well.*

Another mother expressed that she did not know which clinic to go to since she was just new in the country. She narrated that; *what happened here was that I had just flown in and I got pregnant and I had not been in the system for long. I went to the clinic and they said no, you are not supposed to be here. They told me to look for a clinic that is close to my home. I was new, I did not know anywhere....That is how I spent all the four months before meeting the midwife. Otherwise, it would have been like two months.*

In support of the above mother, one of the doulas remarked that some of these mothers receive information late, the reason why they seek the services late. She confessed; *if they have just arrived here, some do not get the information early and thus seek the service late.*

Other women had their different reasons for appearing late in pregnancy. Some think that it is not necessary to visit the hospital when you are not feeling anything. One mother expressed that some Africans have to feel something before visiting the hospital. She uttered; *Generally in Africa, apart from the things to do with poverty and poor quality services, we tend not to visit hospitals/clinics very often. The reason is that we have to feel something before we think of the hospital.*

This scenario was also pointed to by a doula who in her remark noted; *some decide to wait even when they know they have a right to free access of the service. The reason is that they do not think that it is necessary.*

In agreement with the above doula and mother, one of the professionals from Angered maternity clinic expressed; *But some appear later because they are not used to the system where medication is sought very early like the Swedish. ...I think they do not feel that it is necessary to come here. They have a tradition that you do not visit the doctor when you are not feeling any*

problem. That it is more necessary in the middle of pregnancy when they start to feel the child's movements and they come here.

But irrespective of the reasons, many African migrant mothers were found of making obstetric care visits like women from other parts of the world. Many of the stories heard from the professionals, doulas and mothers show that visitations for many African migrant mothers are not much different from those made by the Swedish themselves. Reportedly, African mothers seek for the service for almost the same number of times and around the same range of time. This is however, not to imply that there are no African migrant mothers who do not seek obstetric care service. This notwithstanding, it was unearthed that many African migrant mothers go for visits between eight and twelve weeks upon conception. One midwife from Angered maternity clinic narrated that; *most of them come in the third month of the pregnancy, you can say. So, they come between week 8 and 12.* In support, another midwife from the delivery department in Östra Sjukhuset (The East hospital) remarked that; *Women come for services after two to three months of pregnancy.*

To this effect, one mother made a confession; *seven to eight times I visited while still in my country and 7 times here in Sweden.* Another mother narrated the same story. She expressed; *It was after two and a half months of pregnancy that I went to the clinic. From that time, I was visiting as per appointment.*

From the above, it is observable that different mothers exhibited different obstetric care seeking behavior, something accounted for by the differences in circumstances faced by the respective mothers but also reluctance among others. To some mothers constrained by circumstances, such happened, to a large extent, to be out of their control.

5.1.2 Visiting the midwife two weeks before the estimated date of delivery

An interaction with the professionals revealed that visiting the midwife two weeks before the estimated delivery is a necessity for pregnant mothers to get more prepared for the eventual delivery. In turn, the extent to which the mothers in question lived up to this standard was deemed a key variable in telling the mothers' health seeking behavior.

It was found out that all the African mothers who participated in this study had made a visit two weeks before the estimated date of delivery as required by the professionals. Accordingly, no one reported having missed the visit as they were making four visits in the final month of pregnancy. Asked if they made visits, one of the mothers observed; *I visited twice in the 8th month and in the 9th month, I was visiting every week.* One other mother also reported; *when you visit, the midwife gives another appointment of when to go back. You have to follow the appointment and that is what I did. I had a late delivery... I was going to the hospital every day in that extra one week for special attention.*

In confirmation of the above, one professional from Angered maternity clinic noted; *...But again I would say that most African women do come.*

Contrary to the stories above, a set of professionals and doulas interacted with held another side of the story. They informed that some African women do not make it to the required number of times as it is required under the Swedish obstetric care system. To them, African migrant mothers are not used to the Swedish system of seeking care all the time. Reportedly, some African mothers think it is too much and they choose to miss some appointments.

One of the professionals from Angered maternity clinic made a confession; *yes, I have had some clients who have missed appointments but what I do is that I call them to make sure that they are alright ... It is a little bit different I think and I do not think that Swedish or other European women miss their appointments.* Another professional from Angered maternity clinic remarked; *some of them say that they can wait a little bit and some of them do not appear for the booked visits. They come the next time and if you see for a lot of African women, you also see that they go more seldom to the midwife compared to the European women. I think, they think that it's a little bit too much for them.* A midwife from Östra Sjukhuset reported; *they come more seldom to the midwife because they are not used to this system of over visiting the clinic.*

The above voices of the professionals were supported by one of the doulas when she remarked; *no, not all of them. African migrant women sometimes make fewer visits compared to others like the Swedish. The reason is that they do not think that it's necessary.*

Some mothers also confessed in agreement with the above professionals and the doula. To them, seeking obstetric care early enough or making all the visits is not that necessary. As a result, some stated that the Swedish maternity care system does not leave them with any free time to do their own things. One mother expressed; *it was the third pregnancy and it is always when it is your first pregnancy that you do not know anything. I already knew a lot from my first two pregnancies. That is why I went late.* Another mother also remarked; *when you are pregnant, they check you a lot. All the time midwives give you appointments. And if you do not go for the appointment, they call you and ask why you have not turned up for the meeting. I think it is too much monitoring because sometimes, you need space.*

From the above arguments, it came out that the interaction between the mothers, doulas and obstetric care providers was vital in pulling these women into seeking the service. Many others sought care although they had other beliefs, something that can be attributed to the interaction of the three aforementioned parties. The obstetric care givers go an extra mile to make phone calls and fix appointments for the mothers which in a way encourages them to be committed and to go for the service.

5.1.3 Actual Delivery

Under normal circumstances and ideally in these modern times, deliveries should be done in formal health settings with support of technical staff. Thus, whether or not African migrant mothers had their deliveries in such clinics or hospitals as planned rather than induced practice was thus deemed a necessary variable in informing about health seeking behavior of African migrant mothers.

This study reveals that all the participants went to the hospital when it came to delivery and no one had a home birth or birth with the help of other experienced mothers in their neighborhood. Reportedly, women narrated their labor experiences at the hospital and how they interacted with the professionals during the whole birth process. Some of the following confessions by the mothers indicate that they actually delivered from the hospital. One mother expressed; *like I told you, my labor was long but the midwives kept me not to worry, that I would make it and that is what gave me the confidence during my labor.* There was another mother who noted; *when it came to delivery, I had to be sent to another hospital outside Gothenburg because Mölndal and Östra Sjukhuset were all full and I had no room. That is where I delivered from.*

Another woman mentioned; *I do not know how they were doing it but I remember the time the baby was supposed to come, the midwives gave a pain killer and very quickly, the baby came out.*

The fact that women were able to deliver from the hospital not only tells about a good health seeking practice when it comes to delivery but also shows that the interaction between these women and the service providers worked a lot. Mothers were able to see the importance of delivering from the hospital through interaction. It cannot be ruled out that perhaps without such interaction, some mothers would have their deliveries in the hands of non-professionals outside hospital or clinic settings.

5.1.4 Visitation after delivery

According to the Swedish obstetric care system, around 6-8 weeks after delivery, all mothers together with their babies are supposed to visit the midwives that took care of them while still pregnant and discuss some pertinent issues including among others the delivery experience, their current state and family planning services. Whether or not mothers made this particular visit was also regarded as useful in understanding the obstetrical health seeking behavior of African migrant mothers.

Reportedly, most African women made this final visitation to the midwives. Most mothers' confessions inform about their visitations after deliveries. One mother recalled; *I visited my midwife once after delivery. She checked the stitches done and she advised me to make some exercises to make the muscles stronger.* Another mother also informed; *I visited my midwife. We talked about many things such as emotions, how it is going especially with the new member of the family and you also talk about family planning.* .

One of the professionals believed that even when these African migrant mothers do not actually get back to the midwives, they go somewhere else for the service. She had a conviction that in one way or the other, they make the final visit. She remarked; *yes, African women quite often. If they do not come here, they go somewhere else for the service if they are actually still staying in the area.*

5.1.5 The role of the Traditional Birth Attendants (TBAs)

In the wake of the process of pregnancy and its management, the role of the TBAs obtains an insight. Respect is paid to the perspectives of the mothers themselves, the professionals and the doulas. During the conceptualization of this study, it was envisaged that TBAs could be having a role in influencing the health seeking behavior of African migrant mothers.

From the findings, there were mixed reactions towards the issue of TBAs. Some professionals, doulas and African migrant mothers said that TBAs are okay and can help in delivery in areas where there are few qualified obstetric care providers. It was reported that the services of TBAs are no longer in Sweden. However, these respondent categories insist that where they are, TBAs should be given some training to know how to manage the whole process safely.

In the above respect, one of the professionals from Angered maternity clinic reported; *in some countries without enough health workers, it is very good if they can be given some basic*

knowledge like hygiene. Another professional from Angered maternity clinic observed; *where there are less certified personnel or midwives or doctors, it is a good thing for the pregnant woman to have someone around her.*

In line with the above views of the professionals, one of the doulas remarked; *it is not done in Sweden but it is good in the countries where it exists since they have the trust of these women. But they need to be trained to have more skills in handling all the pregnancy and childbirth related activities.*

Some African migrant mothers also expressed their views in agreement with the above professionals and the doula. One noted; *the only advantage is that they are closer to people and they can be reached very fast.* Another mother advised; *you know there are some areas that are too remote. There is much difficulty in accessing health center. In that case, TBAs can help women to deliver.*

However, much as some of the study participants hailed the TBAs for being such advantageous, in some ways, almost all respondents highlighted the risks that one runs by seeking the care of these TBAs. The African migrant mothers, the professional and the doulas alike said the woman who seeks these services puts her life at stake and death is inevitable in case of any complications. Issues of cleanliness, disease control, and good care were cited to be centrally at stake. Some extremist mothers said they can never risk their lives with TBAs. And for such mothers, the role of the TBAs was in no way a barrier to their seeking formal healthcare services.

In the above regard, one mother responded; *it is risky because these people come with bare hands to help in cutting the umbilical cord and that is unhealthy. They do not even check the beats of the baby. In my country, there is HIV/AIDS today and the child may end up getting the virus.* Another mother added; *there is also blood involved and the woman can end up over bleeding which may lead to her death. TBAs do not have the skills to help a mother who has over bled, cannot operate in case of complications.* In another interview, a mother remarked; *it is too risky for the women's lives and the lives of their babies too. I would never risk my life with such people in this era full of complications during the whole process.*

One mother noted; *the old woman might be old fashioned, thinking that what used to work still works today. Besides, she is old and has probably forgotten what it means to give birth. In terms of hygiene, TBAs do not match the standards and that is what kills most women at birth. TBAs can also beat you to push the baby out.*

In consensus with the above mothers regarding the risks a mother runs by seeking the care of TBAs, one of the professionals from Östra Sjukhuset delivery department explained; *but the problems can be over bleeding, some child are weak during delivery and end up dying during the process because they lack the care that they deserve. Other women die during delivery due to complications beyond the TBAs control, there are infections also because the unhygienic conditions.*

It was deduced that the interaction between the mothers and the obstetricians could have had a positive impact on the mothers themselves since they seemed aware of the risks associated with solely seeking the services of the TBAs. Although some mothers said that the services of the TBAs can be used, they all noted that it should only be when the obstetric care services are very far citing its risky nature. To this category, the services of the TBAs did not affect their interaction with the obstetric care givers.

5.2 Motivational factors for seeking these services

One of the objectives of this study was to find out the factors that motivate the African migrant mothers to seek obstetric care services. A number of factors motivating these African migrant mothers to seek obstetric care here in Sweden were identified and they include among others; The need to know the health of their unborn babies, mothers' own health, desire to get information, and Free, timely and good quality services.

5.2.1 The need to know the health of their unborn babies

Like all mothers, professionals highlighted the need to know the health of their unborn babies as the major motivating factor that influences their interaction with these professionals. For mothers, many showed concern about the situation/condition of their children and to some, ultrasound seemed more vital since they had a chance of seeing their unborn babies on the screen. Professionals also cited the health of baby as a big motivator. These were some of the voices put across by both the mothers and professionals respectively;

On the mothers' side, one expressed; *I was visiting for the sake of my baby's health. I wanted to know if my baby was fine and healthy...* Another held the same view when she observed; *the reason I had to check all the time was the health of the baby. I wanted to know if the baby was fine, moving well so that I do not get problems.*

One of the professionals from Östra Sjukhuset in agreement complemented that; *the mothers want to take care of their babies. They want to go our ways. They know we are doing it here.* One of the midwives from Angered maternity clinic reported; *...to make sure that the baby and they themselves are okay... That is the main aim to make sure that the baby is okay.*

5.2.2 Mothers' own health

Commonly reported was that in addition to the mothers' concern over the health of their unborn babies, women also were motivated to visit for the sake of their own lives and health. Some mothers noted that they wanted to make sure that they were safe and that everything was going on well. Some were worried that if they do not go for the service, they may develop complications any time during pregnancy, at birth or after birth. One of the mothers reported; *you know when you are pregnant your life is at stake. You therefore have to go and check if everything is alright with you. Otherwise, if you wait and go late and there are a lot of complications, you are risking your life and that of your child.*

Again, sickness itself during pregnancy was a motivating factor identified during this study. Many African migrant mothers said that they were visiting a lot because they were feeling some illnesses. Although some women did not know they were pregnant and thus thought they were sick, others knew of the pregnancy but were not feeling well, something that prompted them to seek the services.

With regard to the above, one of the mothers confessed; *during my pregnancy, I could not eat food and I was vomiting especially in the first month. I kept going there because of vomiting but the midwife told me that they could not give me medicine... Later in pregnancy, my body was peeling because I had diabetes.*

In agreement with the above mothers, some obstetric care professionals expressed their views. One professional from Angered health center remarked; *it is the same like for any other woman that they want to have a healthy baby and they want something for themselves, that is to say their own health.* Another professional from Angered health center also confirmed; *sometimes, some women feel very sick and they come. Pregnancy sickness cannot allow some women eat any food or drink anything. That is why they come for our help.*

5.2.3 Desire to get information

Another motivating factor for these women that the researcher found was the need for information. Some women expressed the desire to have information regarding their health, that of their unborn babies, how to feed during pregnancy and any other vital information regarding their pregnancy situations. To some women, the obstetric care professionals were the sole source of information since they did not have friends, aunties, and other relatives in Sweden. They had limited or dysfunctional networks/ social systems. Such women thus sought the care to have their questions addressed as well as the necessary support that the professionals would offer them. One of the African migrant mothers expressed; *for me, it was my first child and I wanted to make sure that everything was alright. I wanted to feel free in my mind by getting the information that I am fine.* Another mother narrated; *in Sweden, we do not have aunties to give us advice. The only place I could go to and get information was antenatal clinic. The midwives give you all the information you need. I even asked them how I came to have twins that were not identical and they explained.*

While agreeing with the expressions of the above women, one of the professionals from Angered noted; *because they think they are pregnant and they want to check if that is the fact... They need some advice on how to live during pregnancy.* Another professional from Angered also explained: *some women are very young, they are so much afraid and sometimes, they do not have friends, relatives and the husbands are not at home, may be working in another city or abroad. Such women therefore come in search of our support.*

5.2.4 Free, timely and good quality services

Some African migrant mothers reported having got all the services during pregnancy, at birth and after birth in time and at zero cost. Both the professionals and the mothers noted that some of these mothers are coming from countries where obstetric care services are not only paid for but also the quality and time one spends waiting are worrying for a pregnant mother. Reportedly, free obstetric care services attract these mothers. Some mothers also said that in Sweden, the service is not only free, but also timely and of good quality compared to their home countries. To them, this was a motivation to seek obstetric care services. One of the mothers recited; *... if it was in Africa, where I would have to pay too much money, it would have been hard. But here, I was in the hospital and I did not pay anything... in Sweden, they have everything and it is free. They take good care of you more than the people you pay money back in Africa.* One of the mothers had already attended antenatal care in home country narrated; *in my country, the professionals would give you an appointment but they were never punctual and you*

wait for like six hours for the service. But here in Sweden, when the midwife gives an appointment, she comes and picks you at the exact time and you get the service.

One of the professionals from Östra Sjukhuset, delivery department in support of the above mentioned; *they get information from other women about our services and if one woman has had positive and good experience, they come. They believe that in Sweden, we have high quality services in the hospitals. Women also know that these services are free; they do not have to pay to see a nurse or doctor. That is why they are motivated to come.*

The interaction between the professionals and the pregnant mothers was seen to be quite central in motivating the latter to seek obstetric care. The interaction during the first visit notably influenced a great deal mothers to make the second and subsequent visits till delivery and after delivery. All these visits can be seen in a framework of the interaction between these two groups (the professionals and the mothers) but also the doulas.

5.3 Nature of interaction between the African migrant mothers and obstetric care providers

The nature of interaction between the African migrant mothers and the obstetric care providers formed one of the objectives of this study. And to understand this, focus is made on such aspects as information shared; women starving themselves during pregnancy; medical checkups and results; abortion advice; the issue of Female Genital Mutilation (FGM); final period of pregnancy; labor time and extent of involvement of the husbands, families and friends in the interaction

5.3.1 Information shared

With regard to this, findings reveal that a lot of concentration is on the women's family health backgrounds, how they are feeding, whether or not they make exercises, how they are feeling themselves. The professionals stated that all this is given attention in order to see how to intervene especially in the beginning of pregnancy.

A professional from Angered maternity clinic observed; *We talk a lot about health as regards what you eat, taking rest, exercising, looking after one's self, taking care of one's own body and your mind. ...Then of course we inform them of all the tests we take, ultra sound, check the water that surrounds the baby to check of any abnormalities.* One other midwife Angered maternity clinic also responded in the same way. She narrated: *I think it is important in the beginning to talk about health, try to tell the women about how to eat, what you can do by yourself to feel good when you are pregnant.*

In agreement with the above two professionals about the information shared, one the doulas remarked; *First time mothers do not know anything, we teach them on how to feed themselves, how to do exercises, breast feed the child, how to raise children.*

In confirmation of what had been said by both the doula and the two professionals above, some mothers also added their voices. One of the mothers reported; *during pregnancy, visiting the midwife/clinic helps to follow the baby's health, get useful information regarding the need of exercise, signs of labour, how to get relief from labor pain without medication et cetera.* Another mother also remarked; *midwives ask you about your family health background, how you*

are feeling and what you eat. My midwife was always giving me tips on different things during pregnancy.

5.3.2 Medical checkups and results

During this study, it was also discovered that the two interacting parties share a lot about the results from various tests carried out by the professionals on these. Ultrasound which is normally done after four months of pregnancy was discovered to be attracting both men and women. As a result, many men were reported to have accompanied their wives during this part of the interaction to see their babies on the screen. Other tests reported included checking for the blood group, diabetes, high blood pressure, water around the children to check if they are normal or not, among others. The professionals expressed that they do not only do tests, but also give advice on the results e.g. when they realize that the baby might be abnormal, the mothers are advised to have an abortion.

One of the mothers reported; *the first time I went to the clinic, the midwife took my blood sample and checked for different things example blood group, blood pressure. This was also supported by a mother who remarked; for me, I had diabetes which they discovered in the 7th month of pregnancy. The midwives and doctors had to control it throughout pregnancy. After birth, I kept visiting the hospital for a full year until I was told that I was healed.*

In agreement with the above three mothers about the checkups during pregnancy, one of the professionals from Angered maternity clinic expressed; *in the beginning of the pregnancy, we talk about if they want to check the baby, check extra ultra sound tests to test for the baby's chromosomes. We have a lot of information about that, so we try to make the woman informed so that she can decide if she wants to check up or not.* Another professional also from Angered maternity clinic remarked; *then of course we inform them of all the tests we take, ultrasound, check the water that surrounds the baby to check of any abnormalities.* A midwife from Östra Sjukhuset, delivery department informed; *in the last month of pregnancy, we put a lot of emphasis checkups. Every week a woman has come here and we check her condition. She might be having a lot pressure and if it is too high, it is not good for the mother and the baby.*

To this effect, the number of visits and the decisions to take which medical checkups were found to be as a result of the interaction of the mothers and the professionals. Otherwise, without this interaction, it would have been hard to imagine women seeking this care on their own.

5.3.3 Abortion advice

Part of the information shared was about the possibility for abortion in case of any abnormal detection. The professionals observed that there is a possibility of making an abortion until five months. They said an abortion is based on medical reasons e.g. when the child is sick, the mother is not in good condition, if the mother is not ready for the child, among other reasons. One midwife from Angered maternity clinic remarked; *we have the possibility to make an early abortion till five months if the baby is sick or if there is any other problem with the woman.* However, to some African women, abortion was a strange and shocking advice and they thought that midwives were not being fair to their unborn babies. One mother noted; *I was very shocked*

about the idea of abortion because at that time, my pregnancy was over ten weeks. I felt the midwife was very unkind to my baby and I strongly rejected the idea. I was told it is normal here but it is not okay in my home country.

In agreement with the above mother, one of the professionals from Angered maternity clinic observed; *most women if they are of the Muslim religion, they do not want to see the answer from the test or hear the advice we are offer especially if it is abortion. They want to have the baby whether sick or not.*

The interaction between these African migrant mothers and the obstetric care providers seemed to have cleared this misconception and misunderstanding as regards the issue of abortion. The midwives explained the context in which they work while in Sweden and showed that their background is different which the woman understood although some were reported to have rejected the advice.

5.3.4 Final period of pregnancy

In the final period of pregnancy, the professionals revealed that the focus is put on how to prepare the mother for delivery and the time after delivery. In case of a first time mother, the professionals confessed that attention and information concerning what happens in the delivery room is given priority. The midwives inform mothers about the labor pains and the possibility of having pain alleviators/killers if they chose to use them. However, it was reported that some African migrant mothers declined taking the pain killers. Mothers were also informed of how to take care of the children because some did not have experience. For circumcised expectant mothers, information about how the delivery will go is given. One of the mothers informed; *visiting the midwife helps to get useful information regarding the need of exercise, signs of labor, how to get relief from labor pain with or without medication.*

In agreement with the above mother, one of the midwives working at Angered antenatal clinic recorded; *later on we try to prepare the woman for delivery, what is going on in her body when she is coming to her delivery. We talk about pain relief and how she can prepare herself. And we also try to inform the couple who are the first time parents about what it means to be parents, the challenges ahead and how they can talk to each other through the whole process.*

5.3.5 The issue of Female Genital Mutilation (FGM)

Another important finding in the study was the issue of circumcision of females. Information about how circumcised women are handled during delivery is shared between the midwives and the women during pregnancy. It was revealed that some African migrant mothers—the majority of whom come from the Horn of Africa are circumcised. The professionals narrated that during delivery, circumcised women are cut to create more space for the baby to come out. It was reported that when women are circumcised, they are partly closed down and there is a small hole left which makes it hard for the baby to come out without first opening/cutting it. One of the professionals from Angered maternity clinic informed; *one big problem is circumcision... It may impact on delivery because it is a small hole and they might have to cut it open.* A midwife from Östra Sjukhuset, delivery department observed; *you have to*

operate down there. You cut up, down, and in the sides because there is little space compared to the size of the baby's's head. Otherwise, the woman tears a lot.

It was reported that physically, circumcision does not have any effect on delivery because the outcome is the same when the woman is cut/opened. Some professionals observed that delivery for a circumcised woman is like for any other uncircumcised woman after opening. One of the professionals from Lärjedalens health center noted: *what I know is that it does not have any decisive effect on delivery. This is because the midwife cuts or opens it and the delivery is normal.* Another professional who works in the delivery department at Östra Sjukhuset informed; *the outcome whether circumcised or not is the same that is the baby. When women are opened, the delivery becomes normal.*

Nevertheless, confessions from women indicated that even though female circumcision may not cause physical complications when a woman is delivering, it actually impacts negatively on delivery. Mothers narrated that the process of cutting/opening itself is very painful. One of the mothers observed; *although giving birth is painful for all women circumcised and uncircumcised, it is more painful for us because they have to cut.* Another mother also informed; *the midwives have to cut the woman during labor and that is painful.*

One of the doula also concurred with the above women on the issue of cutting. She recorded; *because women are circumcised, the size of the hole is small and the baby cannot pass through. The midwives have to cut and that is painful.*

In agreement with the above two women and the doula, some of the professionals also put across their views. A midwife from Angered maternity clinic informed; *...circumcision makes women afraid, more actually because they know they will have a problem with delivery that they should not have had if they were not circumcised. More pain because they may need intervention such as cutting/opening during delivery.* Another professional from Östra Sjukhuset, delivery department reported; *...But the effect is that cutting is hurting and painful for the woman even if we have pain killers to give these women.*

In addition to the pain caused by actual cutting, it was reported that more pain is experienced by circumcised women when the midwife is stitching or closing the part they opened somehow after delivery. Some women cited stitches as being painful and for the first week, they revealed it is hard for a woman who has been sewed to sit or urinate. One mother informed; *you know when the child cuts you when it is coming out and that is okay because that can heal naturally without stitches. But when the midwives cut you, they have to stitch you which makes us get double pains. You know they put stitches and for a week, you cannot sit, you cannot urinate freely.*

Identified to have been caused by circumcision were the worries of some of the expecting circumcised women. Accordingly, it was reported that some women worried about how the delivery will go, what might be wrong during the process, feel ashamed of talking about it with the professionals while others may have emotional stress especially when you remember how circumcision was when you were young, among other side effects that are psycho-social in nature. Some mothers viewed the cutting during the delivery as the reopening of the scar of a childhood painful experience since it is in the same spot.

These women's experiences were put forward by the doulas with experience on this matter. One doula expressed; *the midwives have to cut the scar that the woman got while she was still young which is not easy and causes stress to mothers during delivery.* Another doula observed; *circumcision may not be that bad but the stress, fear and also the shame it brings to*

the woman to the extent of not bringing it up sometimes as one of her worries is the one that affects the whole process.

The above views of the two doulas were supported by some professionals. One professional from Lärjedalens health center noted; *many women have talked about their experiences when they go for examinations during pregnancy or gynecology and how they have been surrounded by many medical workers not to help but to observe. Some say that experience was worse than the experience of circumcision itself...especially in 1990s.*

The professionals informed that they close the woman up to the level similar to that of uncircumcised women but not the way it was before delivery. It was reported that closing it up again like it was before is against the Swedish law which criminalizes circumcision of females. The professionals stated that they close it up to the some level to help in the healing process. But during the study, it emerged as a finding that the information provided on the extent to which the cut part is closed was inadequate among some circumcised mothers. Some of the mothers were not sure how far the original cut is closed. The obstetric care professionals and doulas revealed that the law does not allow stitching the circumcised women like the way they were before delivery but one of the mothers said they stitch like the way it was before. That it is the same way it is done in women's home countries. One of the mothers informed; *they have to close it. Otherwise, it will not heal. They have to sew where they cut not where the baby cuts... In our country, they do the same thing like here because they close the only part they cut.*

Contrary to the understanding of the above woman, one of the professionals who works with Östra Sjukhuset, delivery department reported; *we close women up after delivery but not the way they were. We make it like for any other woman who is not circumcised.*

5.3.6 Women starving themselves during pregnancy

This was another issue that was considered during their interaction with the African migrant mothers. Feeding well during pregnancy was one of the issues given attention by the professionals as discussed under the information shared above. But during the study, it was discovered that despite the information and advices the professionals share with African migrant mothers, some women starve themselves during pregnancy in order to have small babies at birth that are easy to push. Some women informed that they fear being cut or operated during delivery if the size of the child is big because they are circumcised. Some women reported that they do not like cesarean since it greatly accounts for maternal mortality in the hospital back home in their countries.

One of the mothers remarked; *I have heard from my friends that they should not eat much sugary stuff because the baby will be heavy which will make it hard for them to push out.*

One of the doulas also added in agreement with the above mother. She observed; *women are worried about eating a lot and the baby becomes big which can necessitate an operation at delivery which they do not want. They are also circumcised and the size of the baby also worries us too if the woman is to be opened in order to have a normal delivery. If women eat enough and their baby is big, they are cut so much during delivery.*

Some professionals clarified on this matter raised by the doula and mothers. Some said that it is an old tradition of African especially those from the Horn of Africa starving themselves during pregnancy. A midwife from Östra Sjukhuset, delivery department reported; *some women from Africa do not want babies to grow so big and that is why they eat less. They want the*

delivery to be easy. It is common with women from the Horn of Africa. Another professional from Lärjedalens health center also remarked; true, they starve themselves during pregnancy in order to give birth to small babies. This is because in their countries especially in Somalia, if one fed well and had complications during delivery, they would offer cesarean and the majority died.

However, there were confessions made by some women of having never starved themselves during pregnancy. They expressed concern over their children if they did not eat well. One of such mothers who narrated; *I do not think it is wise to do so. What if something in your baby does not develop well because you did not eat as required? You may end up hurting your child mentally. I know some mothers do not want to put on weight during pregnancy but it is not advisable to do so because of the baby.* Yet again another mother noted; *this may lead to underweight of the baby at birth. The development of the baby may also be hindered because some food nutrients are missing.*

One of the professionals from Lärjedalens health center also shared the same concern about those who starve during pregnancy. He expressed; *starvation has effects. It causes stress to the mother during pregnancy. On the child, it causes underweight. Most of the children who have been born by women who starved themselves are underweight.*

From the above, with some women having such misinformation about how to feed during pregnancy, they would be in trouble without an interaction with the professionals. For those women who spoke against the idea of starvation, it was revealed that the interaction had a positive impact on them compared to their counterparts.

5.3.7 Labor time

During labor, both African migrant mothers and the professionals talked of having a long time together. Most of them said they had labor for more than 20 hours and they shared a lot with the professionals at the hospital. Women talked of having been given words of assurance by the midwives that everything will be okay. Some women reported having been given pain alleviators during the delivery process. One of the mothers observed; *I had a long labor. It was about 24 hours of trying everything. The midwives even gave me a pain reliever in the back but I think it did not help me that much.* Another mother narrated; *during, the midwives gave some information on how to handle pains, the time when I would start some actions and if I needed of pain killer among other things.*

The stories of the above two mothers were confirmed by one of the midwives from Östra Sjukhuset, delivery department. She reported; at the hospital, when a woman is in labour, I ask her whether or not she needs pain alleviation during delivery. This is the information they get from the midwife during pregnancy.

5.3.8 Final visit focus

On the final visit which is always after the woman has delivered, two variables were identified. These were namely contraceptive use and other final issues.

Contraceptive use

It was reported that when a woman has finally given birth, she is expected to go back and visit the midwife that took care of her during pregnancy after six or eight weeks. One particular issue was identified among the information shared on the final visit is contraceptive use. Family planning, an issue that is also talked about during pregnancy was reported to be a common topic discussed between women and midwives during this final visit. Reportedly, all women were given a chance of selecting the method of family planning they wanted. However, it also came up that some women especially the Somalis did not accept to use any of the contraceptives.

One of the mothers reported; *we also shared about family planning and the midwife gave a chance to choose the family planning method for myself which I did.* Another mother expressed; *we also talk about family planning because they do not want to have another pregnancy in just two months.*

However, the family planning issue did not apply to all the African migrant mothers. One of the professionals said that because of religion, some Muslim women do not accept contraceptives. It was reported that some Muslim women give religion as a reason for not using family planning and that is why their children's spacing is very short and they produce a lot of children. One of the professionals from Lärjedalens health center informed; *one difference that I saw and I still see is that they do not always want to use contraceptives. This is common and they give religion as a reason for not using contraceptives. It might be too general but you can look at their spacing compared to those women from Sweden or Europe and other countries. Many of them especially the Somalis have five, six or seven children.*

The views of the above obstetric care professionals were also supported by African migrant mother who reported; *...but if it is for Muslims who produce a lot of children, then they reject any family planning methods. Their religion supports them to produce many children.*

Other final visit issues

It was also revealed during this study that during the final visit by the woman to the midwife, other issues are given consideration as well. Reported issues included among others the women's experiences in the labor room, their emotions, checking on their stitches if in case a woman was sewed, how it is going with the child as well as discussing any worries among others. One mother observed; *we talked about many things such as emotions, how it is going especially with the new member of the family....* One other mother recorded; *my midwife checked on the stitches they put during delivery and she advised me to make some exercises to make the muscle stronger.*

Beyond the information shared, it was put to the fore that such information was not just for its own sake but for a purpose. It was reported to have substantially had an impact on the preparedness for the delivery, the health of the baby and the mother, the subsequent care for the baby, among other things. The effects of the information shared in particular and the interaction in general are underscored in another one of the subsequent sections labeled interactional effects on service outcomes.

5.3.9 Extent of involvement of the husbands, families and friends in the interaction

It was found out that some men are active when it comes to seeking obstetric care. The study also revealed that husband's support is vital because these women lack social network since many are relatively new in Sweden. Some men were reported having accompanied their wives for antenatal, parent's meetings and delivery. To some mothers, men were helpful in translating and asking questions through the whole pregnancy process on their behalf since they did not know Swedish. The study also revealed that men's presence in the delivery rooms gave support, comfort, security to some women. Moreover, men having witnessed the process of delivery and how painful it is, it was revealed that they may give more respect to women. Reportedly, when a man goes with his wife, all of them get to know of the same information concerning pregnancy and the man feels that he is responsible.

A mother in view of the above recorded; *during our parents meetings, they were using Swedish and in case there was something that I did not understand, my husband always explained to me. Even when I wanted to ask a question of my own, I could ask him to ask on my behalf since my Swedish was still poor.* Another mother also reported; *I used to go with my husband for antenatal visits and even during delivery. It is good because you all get the same information and he gets to know what to do. I think when a man is there and sees how hard it is to have a baby, he gets a chance of respecting a woman thereafter.*

One of the doulas also discussed in favor of the above women on the issue of men accompanying their wives through the whole process. She expressed; *many of these women have little social networks. Some of them are new in Sweden, may be the husband has been living here and he has just brought her. Before she establishes much contact, she is already pregnant and the only person she knows is her husband. She misses her mum, family, aunties that would be helpful during pregnancy, birth and after birth.*

In agreement, one of the professionals from Östra Sjukhuset, delivery department observed; *when time for delivery comes, we go with her together with a friend, mother, husband or any other person they need besides them. We need to support her in any way during delivery because it is a journey. Some men have said that after going with their wives through all that pain and they have the baby at long last, it is their best moment in their lives.* One of the midwives from Angered maternity care also remarked; *I think it is very good because then I can give information that is good for the man too.*

Some family members and friends were also noted to have been supportive during the whole process. One of the mothers observed; *my people and friends were encouraging e.g. when I was pregnant, there was another woman at church who was also pregnant. We were able to keep talking about our conditions, sharing experiences and encouraging each other.* Another mother also narrated; *everybody was very supportive because I had waited long to get pregnant. Whenever I wanted anything, they were always there to help me. It was a positive influence throughout the whole process.*

However, some women reported not feel comfortable with having their husbands in the delivery rooms. That they do not wish their husbands to see what happens there and that they feel ashamed. One mother narrated; *I was not feeling okay because of many things that happened there. There are many things that happen there which he should not see. You are just there naked, people seeing you in his presence and other things that come with the baby. I feel ashamed because of what happened.* One other mother observed; *my opinion is that it is good to*

have him by your side but not the time when the baby is coming out. I do not want him at the time of pushing the baby out because I know his worries. He gets worried from the time I am pregnant up to the time I get the child.

Other women reported that if one knows her husband is fearful or the relationship surrounding the pregnancy/delivery is not that good, then he should not be in the delivery room. One woman informed; *anyway, my husband was not there because he is an African man, very committed to tradition and he did not buy my decision to have cesarean. I thought there was no need of having him there.*

As for social networks, one of the mothers contacted friends who had bad experiences, something that affected her during pregnancy. As a result she reported having difficulties in making a decision over whose advice to follow. In her story, she recounts; *I had a friend and she was younger than me but had already given birth. She told me that since I had twins, I was going to give birth four times, that is to say, I was to push two babies and two placentas... I also asked my sister... She refused to at least give me tips. Another friend had serious complications because her baby died from inside and she was asked to push a dead body. It was so scary from what I had been hearing and marrying them with what the midwife was telling me.*

Observed was that the involvement of the women's husbands and members of their social networks was not equally beneficial to all. Whereas it benefitted some, for others it turned out to be more or less a liability. But nonetheless, for the latter category of women, their interaction with the professionals was very paramount in clearing up such myths and misinformation.

5.4 Interactional effects on the service outcome

This was one of the objectives of this study. It was envisaged to help in understanding whether the interaction between the mothers and the professionals had any impact. As a result, a number of variables were identified including among others the good health of both the mother and the child; trust, respect, consultation and confidence; psycho-social benefits; African mothers' satisfaction of the care; the system and its impact on interaction.

5.4.1 Good health of both the mother and the child

Some mothers and professionals reported good health of both the mother and the child was one of the benefits from the interaction. They highlighted that good health was registered not only for the mothers but also for their children. Some mothers informed that they got healthy children as a result of the efforts of the obstetric care providers. Other women narrated stories of their diseases that were paid attention to during the interaction. One mother observed; *I had diabetes which they discovered from the 7th month and they kept controlling it. But even after giving birth, they kept checking me for a full year to see if I still had the problem which they finally said it was no more.* Another mother also expressed; *the midwives and doctors did everything they had to do and I got my twin babies in good health. This is because if I had missed most of my visits, I would have died or lost one or both babies in the process.*

The views of the above women were supported by one of the professionals from Angered maternity clinic remarked; *obviously, the benefit to these women is good health for herself and the babies health.*

5.4.2 Psycho-social outcomes

It was revealed that this interaction helped/benefitted mothers psycho-socially. Psychologically, some mothers seemed well prepared and confident as a result of the interaction. Some of the mothers reported having felt well during the whole process. Some said that they even developed bondages with their midwives at different levels. It was noted that this interaction did not just end after delivery, some women developed personal relationship with the professionals.

One of the mothers in respect to the above viewpoints expressed; *I benefited in such a way that I felt so secure during the whole process. Even after delivery, when I was still in the recovery ward, one of the midwives came and visited me and the baby. For the midwife who took care of me, I gave the photo of my son and we are still in touch.* Another mother also informed; *I gained a lot of confidence because I knew everything was okay with them. I felt really secure, even at the time of birth. I found the hospital so comfortable.* In the same line, another mother also expressed; *the midwives were good to me. At the hospital, the midwives would not do anything without my consent. I did not feel any fears in me.*

5.4.3 Trust, respect, consultation and confidence

During the study, another interesting finding that was revealed was presence of trust, respect, consultation and confidence during the interaction. Such issues were seen to be the characterizing features of the interaction between these service providers and seekers. Many African migrant mothers felt respected and they found the obstetric care providers respectful. Some mothers narrated that this respect that the midwives had for them was seen in the fact that midwives consulted them on many actions or decisions they were to take. Some mothers confessed having had confidence and trust at the time of delivery because of the way they were treated/handled by the professionals.

One of the mothers informed; *all the staffs I faced were kind and respectful, committed to their work, especially when I compare with the medical staff in my country. I felt much confident especially when it came to labor.* In the same tone, another mother expressed; *the midwives were always involving me in everything they were doing throughout the whole process. They were always asking me about everything thing they wanted to do on me .* Another mother also observed; *they really keep you much informed and they try to comfort you as much as possible... I had confidence in them.*

The views of the above mothers were supported by one of the doula who remarked; *at first, African mothers do not have confidence... But as time goes on, these mothers gain confidence with their midwives and everything is okay. Midwives here in Sweden are respectful, merciful in handling women unlike some of those in Africa.*

Professionals on the other hand also felt that these African migrant mothers respected them compared to the Swedish mothers. They said some tend to cooperate well and they have trust in them which makes their work easy. Therefore mutual respect was underlined which inevitably is essential in human service work.

One of the midwives expressed; *it is a wonderful experience because African mothers are easy people to work with. Even when sometimes they do not speak the same language, you can hug her, joke with her... During delivery, they are not so demanding like the Swedish women if I am to compare. They believe that we know what we are doing, we have the facilities, more knowledge. African mothers have trust in whatever we tell them. They do not oppose. May be it is a cultural issue from back home in their countries of origin.*

However, one midwife from Östra Sjukhuset, delivery department made a counter argument. She noted that these mothers believe in their own power and sometimes they uphold their own stand. She narrated; *some mothers do not trust us. They trust their power. I am pregnant, my mother was pregnant and it used to be normal. Many women from Africa believe in the tradition that delivery should be normal and they keep it.*

5.4.4 African mothers' satisfaction with the care

Another interesting finding was the fact that all the African migrant mothers that participated in this study were pleased with the service. In their responses, they appreciated the obstetric care professionals for their kindness and commitment. Some were also comparing the service here with what would have happened if they were in their respective African countries. Some mothers confessed that they had fears because of what they had been told back home about the rough treatment by the professionals back home.

One of the mothers who had part of her antenatal care in her home country prior to coming to Sweden informed; *in Sweden, it is very good. They have everything. I had a very nice interaction and experience with the midwives... The midwives really took good care of me. I had heard from friends back home that the midwives are rude and they add stress to you while already in pain. But here, the midwives instead relax you.* Another mother narrated; *the midwives were very nice people. I was happy with everything they did for me. Even something that would have changed their attitude did not e.g. while pushing the baby, I pushed 'toilet' (fecal material) as well. But the midwives remained positive and did their work. I think if it was in Africa, the midwives would have abused me like I have heard from other women back home.*

The above notwithstanding, some dissatisfaction was also noted by some mothers. Some of the issues raised included among others many appointments, documentation of data, being asked to go back home even after their water had broken (one of the signs of eminent delivery) which they found strange, language, time of pushing the child and fighting to have some decisions made. This is what they had to say;

When you are pregnant, the midwives check you a lot. All the time, they give you an appointment. And if you do not go for the appointment, they call you and ask why you have not turned up for the meeting. It is too much monitoring because sometimes, you need space... complained one of the interviewed mothers. Another mother also added; *...the time I pushed. They were 2½ hours just pushing the baby and that was too long. I told my mum and she was like after an hour, a cesarean section would have been appropriate for me. For ultrasound, I felt I needed more of that.*

5.4.5 The obstetric care system and its impact on interaction

Regarding the obstetric care system generally, many of the obstetric care professionals, African migrant mothers said that it is good. They seemed happy with the way services are offered with some of the African migrant mothers comparing it with those in their home countries. One mother mentioned; *the system is good because you can have your midwife and if there is need for a doctor, you can have him or her too. The professionals do all the checks and give all the information they think a pregnant woman wants. Another African mother observed: the Swedish maternity system is okay. The Swedish midwives and doctors are good and they take care of you.* One other mother also reported; *it is good especially when I compare it with what I am familiar with back home. It is adaptive generally.*

In agreement with the above women, some professionals added their voices. One of the midwives from Östra Sjukhuset, delivery department reported; *...we have security, well equipped hospitals, meals and cleanliness.* One of the professionals from Lärjedalens health center recorded; *the system is good because we can have checkups of the fetus and see if it is okay. We can also see if the mother has high blood pressure or if she is sick. So, she could get some care to protect her and her fetus. So generally, it is good we have all these services.*

However, some women and doulas had some reservations about the obstetric care system. Some reported that the documentation is not that good since they do not give you any papers from the clinic regarding your pregnancy. One of the mothers observed; *true, everything in Sweden is computerized but they need to do something when it comes to pregnancy. Even if they are four months of pregnancy, you need to a book of record when you are moving out Sweden. Otherwise, they will have to re-do all the tests if you visit another country's antenatal care as my case was when I went to London.* Another mother reported having missed the service for some time because she had just arrived in Sweden and did not have personal number. She addressed; *the only problem was that I could not get the service without a personal number and I missed the service for a month and one week.*

One of the doulas (Swedish) raised a concern about meeting several professionals in a very short time. She reported this to be common at the hospital during labor where a woman meets different midwives depending on their shifts and the days she spends there. She observed; *when you look at the Swedish obstetric care system, it is not the best for an African migrant mother. The woman will go to the hospital for delivery where she will meet different midwives depending on their shifts and the number of days she spends there. She meets all these professionals with in a very short and vulnerable time which is not very good. A lot of information could be lost, given that some women cannot speak Swedish or English.*

5.4.6 Barriers to effective interaction and service outcome

Some hindrances to effective interaction and service outcomes were observed during the study. They include; language difficulties in relation to interaction, the influence of traditional beliefs and cultures on interaction between the parties that is to say religious faith among the African migrant mothers, mothers' reluctance to meet or be attended to by male service providers

Language difficulties in relation to interaction

Many of the African migrant mothers and professionals reported language as a big blockade to interaction with the professionals. As a result, they could not freely express themselves in Swedish yet some of the professionals did not know English. One of the mothers addressed; *when I came to Sweden...I was just speaking English and some of the midwives did not understand English.*

The worst scenario arose when the African mother neither knows Swedish nor English which reportedly was not uncommon. Consequently, they end up not understanding each other in the process. A doula made her submission in this regard when she noted; *you know, at the beginning when you have just moved into this country, you do not know the language... Some women do not even speak English and when they have just come in, it is very difficult to communicate. You do not understand them and they do not understand you.*

Some women demonstrated failure in understanding everything especially when midwives were communicating amongst themselves during labor. Other women reported that failure to understand what was happening even when they were being consulted by the professionals. To some mothers and doulas, the possibility of losing the information as these meet many professional during the labor stage with little or no knowledge of the language was reported.

One mother while giving her experience narrated; *I remember, I had few midwives at the beginning of my delivery but they called doctors in the middle. I do not know what had happened because at that time, I did not understand Swedish which they were using to communicate amongst themselves.* Another mother reported; *even when the midwives and doctors are trying to consult you e.g. in case of an operation, it is hard for you to understand them because of the language problem.*

The same doula above noted that unlike a migrant African mother, a Swedish mother with command of the language is capable of interacting more with and always reminding the professionals of certain things that she regards important. She thus considered an African migrant mother without good knowledge of the language to be incapacitated. She mentioned; *it is a big difference that a Swedish woman is assertive and knows the language and can always remind the midwives of some issues which she thinks are important for her. But a new migrant with no command of the language may not be in position to do so.*

However, it was reported that this is when the doulas become relevant. When the two sides cannot understand each other, then the doula translates or keeps asking for things that she knows are necessary for the woman. One of the doulas confessed; *a doula can also make the communication with the midwife easy by explaining to both sides. We tell the midwife what the woman is thinking or what she needs and also explain to the woman what the midwife is saying.*

One of the professionals from Östra Sjukhuset, delivery department in support of the view of the above doula reported; *...Doulas also explain things for woman. They help in translating for both parties and we are able to communicate with common understanding when the woman cannot speak Swedish or English.*

The influence of traditional beliefs and cultures on interaction between the parties

These influenced the way people were seeking for the care and how they were interacting with the professionals. They include; Religious faith among the African migrant mothers, some mothers' reluctance to meet or be attended to by male service providers and rejection of some medical advice.

- **Religious faith among the African migrant mothers**

It was revealed that most of the African migrant mothers (both Muslims and non-Muslims) based their interaction with the professionals on faith. Non-Muslims and a Muslim doula showed that even though they had confidence in the professionals as regards the job to be done, there was God whom they knew was in control of the situation. .

A mother who was going to deliver twins but had been informed by the doctor that one child had lied across and could not be delivered normally believed that is how God had positioned them and nothing should be changed by the doctor. She expressed; *I think if the doctor tried to change the way God put my babies there, one of us would have died that is me and the babies.* Therefore whereas the intention is not to judge these women, the fact is that some of their religious beliefs ran counter to the technical advice of the professionals.

- **Mothers' reluctance to meet or be attended to by male service providers**

Some African migrant mothers of Muslim faith were found to be unprepared to go for obstetric care services if the services were to be provided by men. Both the women and professionals reported Islamic religion as a factor that hinders the women's willingness to meet with male professionals. It was indicated that their religion does not allow some of their body parts to be seen by men who are not their husbands. Moreover, this resistance/reluctance stood amidst the concerted effort during interaction by the professionals regarding the utility of obstetric care.

One mother in respect to the above addressed; *you know we are Muslims and we are not supposed to be seen by other men apart from our husbands. It is religious and I do not like the man to see everything.* Another mother added; *there are some religions which do not allow their women to expose some parts of the body. They expect them even to cover their hair. And if they cannot expose their hair, then you cannot expect them to undress before men who are not their husbands.*

This position found the backing of the doulas. She affirmed; *it is our culture back home because men do not work on those issues. It does not allow us to be with men like that. It is supposed to be done by women. It is because we are Muslims and we do not like being seen naked by men who are not our husbands.*

The views of the above three women and a doula were equally identified by a professional from Angered maternity clinic when she observed; *if we have a male doctor for*

example, some Muslim women might not go to see him. They do not also shake hands with the male professionals.

However, for some Muslim mothers, they seemed to be somewhat liberal. They contended that out of circumstances, there is need to permit room for flexibility. One of the Muslim mothers contacted informed that if she goes to the hospital and there are no female professionals, then she can allow an interaction with a man. She noted; *if I go to the hospital, I ask if I can meet a female gynecologist or a doctor. But if there is no woman, I can see a man.* In line with the above mother's view, another mother also recorded that irrespective of one's religion, the professionals should be allowed to do their work because they are simply professional. She remarked; *when you are pregnant or in labor, whoever can help you is always welcome. I know some Muslim women do not like it because of their religion. They are professionals and they just do their work on you and religion should not be part of it.*

The above mothers' views were supported by one of the doulas who expressed; *but when we come to Sweden, we do not have a choice and somehow, we accept to meet male professionals.*

In confirmation of the above views of the doula and two mothers, a professional from Lärjedalens health center informed that although some women do refuse to see him when asked to do so, many of them accept to see him. However, he noted that they come with their female friends or else call a female nurse in the examination room. He addressed; *I see women here every day. Some of them do not want me as a man to work on them but others say it is okay as long as there is another woman in the examination room. They usually come with friends or else, invite a female nurse to the room so that the woman can feel secure. I would say that half of the women that are allocated to me allow me to their examinations but others do not.*

Rejection of some medical advice

One finding in the interaction between African migrant mothers and the obstetric care professional was refusal of some medical advice given by the professionals. Some of the advice was said to be clashing with what they traditionally/religiously believed in or what was regarded as risky basing on their backgrounds/home countries. Some respondents revealed that advice or decisions such as cesarean were risky and one could easily die in the process. One of the mothers narrated; *my husband did not accept cesarean. You know he is an African. My husband's reaction was not fun. It was not like saying good. He was wondering why cesarean?*

Her view was supported by some obstetric care professionals. A midwife from Östra Sjukhuset, delivery department reported; *some women from Africa have said no to cesarean. This is because they have heard from their countries that caesarean is risky and you may die... We had a case 10 years ago where the mother completely refused and when the baby was finally born, it was not in a good condition. But those are not common cases.* Another midwife from Östra Sjukhuset, delivery department also added; *some people think that an operation is very dangerous e.g. Somalis think that delivery should be normal... Perhaps they have been close to people being born and dying in their home. Children are born at home and even the old people die there.*

Like the women and the professionals above, the doulas also commented in confirmation of their views. One of them noted; *there has also been more than one case where caesareans have been proposed by the doctor during delivery but some African migrants especially say no.*

Because of their background because the risk of losing life through caesarean or child birth in Somalia is very high. ... The Somalis are afraid of caesarean because they think they are going to die. Another doula remarked; women refuse operation because many women die in Africa during an operation. They think and believe that when they are operated, they become handicapped. These days, we brief them together with midwives about its possibility but it is hard to change some people.

To some women, it was revealed that if a child dies during delivery, it is normal in their culture. It was reported that instead of the other children remaining without a mother who might die in the process of saving one child, it okay for one child to die and the rest keep their mother. Other women believe that there a possibility of her conceiving and producing again. One of the doulas revealed; *some women say that they have a chance of delivering many other children and so do not feel that it is a big loss when this one dies. That instead of being operated and die, this child can die and then they conceive again.*

In confirmation with the above doula, a midwife from Östra Sjukhuset, delivery department reported; *I had a case where she rejected an operation saying it was very dangerous for her health. I have also been told by several women that they believe that as a mother of eight or ten, it is normal to lose one or two children as they grow but it is important for the other children to have a mother.*

It was reported that some women were in favor of normal delivery because they had delivered other children normally before coming to Sweden. Reportedly, such women refused delivery by cesarean arguing it is dangerous. In this regard, a mother informed; *because we know an operation brings complications. Our mothers, grandmothers did not have operations while delivering us. Even when you have had three children in home country naturally and normally and you have the fourth pregnancy; it is hard to understand what is wrong this time for you to be operated. Why they want to operate you on the last child is hard for us to accept because it is not common in our country.*

As a role played by the doulas, they come in to convince these women to accept the operation. She expressed; *there has also been more than one case where cesareans have been proposed by the doctor during delivery but African migrants especially say no. But as doulas, we try to convince them that it is not risky, it is good for their babies and some women finally accept.*

The above notwithstanding, this same study revealed that whereas some African migrant mothers say no to medical operations or cesareans, others came demanding for it. That some women come with their mind set to have an operation and they reject any advice even when they are normal and healthy to deliver normally In this regard, a midwife from Östra Sjukhuset, delivery department reported; *other African mothers come when they absolutely want a cesarean. She comes when she needs to be operated and it is hard to change her mind to have a normal delivery.*

One African mother testified in conformity; *I requested for a cesarean but they first refused because they said I was healthy and I should deliver normally. So, I kept pushing for it until it was granted after three months. It was a hard experience though to have my request granted.*

But one of the professionals from Östra Sjukhuset, delivery department informed that they do not allow cesarean if it is emergency. She observed; *we do not just give an operation because our ground belief is having a normal delivery. But if it is impossible to have a normal delivery, then we operate a woman.*

Without the interaction between the women, doulas and obstetric care professionals, such beliefs would have had serious and negative effects. It is also vivid that those who accepted cesarean were positively affected by the interaction they had with the obstetric care providers.

6. Analysis and discussion

This analysis basically considers the four objectives of this study. These include; obstetric care seeking behavior of these African migrant mothers, motivation factors, nature of interaction between the African migrant mothers and obstetric care providers and interactional effects on the service outcome. This will be based on theories, reviewed literature and the researcher's viewpoints in line with the findings of the study discussed in the preceding chapter.

6.1 *Obstetric care seeking behavior of these African migrant mothers*

6.1.1 Visiting the midwife

One of the objectives of this study was to find out the obstetric care seeking behaviors of African mothers at different levels: during pregnancy, at birth and after birth. Some studies confirm some of the findings of the current study. One of the findings was that most women, though not all, do seek obstetric care. This is confirmed by Mogren et al (2010, p. 1) citing Pakkanen et al (2004) when they note that “antenatal care in Sweden is free of charge, easily available, and used by almost all pregnant women”. This observation supports the revelation by mothers and midwives interacted with that generally, these mothers in question do seek obstetric care. Ny et al (2007, p. 806) in their study note that the Swedish National Board of Health and Welfare recommends (citing National Board on Health and Welfare, 1996), that “first time mothers are offered 8 to 9 planned antenatal visits to a midwife, and women who have delivered before, 7 to 8 times. It is recommended that the first visit should take place between gestational weeks 8 and 12”.

In relation to that ideal framework, study findings revealed that mothers went for the antenatal visits at different times and for different reasons. This preempted the midwives to try their best to at least check on the women through phone calls. This tells something about the poor health seeking behavior. An analysis of such a scenario leads to a possible judgment that the behavior ultimately exhibited after the midwives' intervention (that is to say the eventual seeking of the service) is an outcome of the social interaction between the midwives and these mothers, something that Charon (1995, p. 145) calls taking on roles which bring about social action at the end.

The finding on the relative poor health seeking behavior among some African migrant mothers is equally pointed to by Ny et al (2007, p. 809). These found out that, “all foreign-born women, except for women born in Western countries and South and Central America, had significantly increased crude odds for lesser use of antenatal care than recommended (below 7 visits). More so, in the same study, Ny et al (2007, p. 809) note that, “the foreign-born women had a lower utilization of planned antenatal care than the Swedish-born women”. Compared to Swedish-born women, foreign-born primiparous women made fewer visits to a midwife during pregnancy, they came later for their first visit as well as attending fewer parental classes (Hemminki et al, 2001; Dejin-Karlsson et al, 2004 cited in Ny et al 2007, p. 805). Such findings

were not uncommon in this current study. An association is made between such behavior and a negative outcome of a pregnancy and birth (Ny et al, 2007, p. 805 citing Gudmundsson et al, 1997; Hjern et al, 2001; Essen et al, 2002). Although such cases were not reported, midwives interacted with reported a potential for the same to occur. In addition, some immigrant groups in Sweden are noted to receive sub-optimal antenatal care compared to Swedish-born women (Essen et al, 2002). All the above studies are in conformity with the findings of this study considering that some midwives and doulas reported that some women make few visits, others came late in pregnancy either intentionally or because of circumstances beyond their control e.g. lack of personal numbers or being new but others indicated that it was not necessary to seek the care when they are feeling okay. This somehow shows that, for those who sought the service late on the basis of feeling healthy, it is part of their health seeking behavior. Therefore, as Payne (2005, p. 145) argues that if there is a breakdown in one of the parts of the system as the case was in case of those women who did not have personal number, then the rest of the subsystems are affected. It is vital that all the subsystems of obstetric care services in Sweden are working well if the interaction is to be move smoothly without some women being locked out of the system.

6.1.2 Delivery at the hospital

Delivering at the hospital was vital in showing the obstetric care seeking behaviors. In line with the findings of this study where all women reported having delivered at the hospital, other earlier studies confirmed these findings. To begin with, some of the women's experiences in this study are similarly noted in earlier findings. Essen (2001, p. 42) notes that "many women relayed fear regarding risks inherent in delivery, and some expressed a feeling that delivery was a condition somewhere between life and death". Essen in her study quotes one respondent saying; *the only thing I thought about delivery was fear of dying. I had dinner with a friend while still in Somalia but suddenly she developed labour pains but when she went to the hospital, she and the baby died that day.* This experience relates to that of a mother who heard three bad experiences from friends which made her fear and thought she would die. The above notwithstanding Essen (2005, p. 5) once again reflects other women's experiences. She notes, "the number of home deliveries is very low in Sweden and all the migrants use obstetric care at hospital level". Also Ny et al (2007, p. 811) reported that "Africa had higher utilization visits to midwives at the delivery ward compared to Swedish –born women". Important to note about this observation is that it should not be misleading that Swedish women opted to have home deliveries, rather it is probable that statistically, more African women conceived and thus visited the delivery wards compared to the number of conceptions among the Swedish women. Waldenström et al (2006, p. 554) noted that "almost all births in Sweden (more than 99%) take place in hospital, and all intrapartum and postpartum care is financed via taxes within the public sector". To this effect, none of the mothers interviewed in this study reported having given birth outside the hospital. Their interaction with the obstetric care professionals could have brought about what Charon (1995, p. 152) calls "people negotiate their social world by adapting to different situations which may be as a result taken by others".

In addition, Ny et al (2007, p. 811) noted in their study that "Many of the women made unplanned visits to the delivery ward in this study, more than 50% to a physician and 30% to a midwife. But they could not classify reasons for seeking unplanned care. In a related area, they

remarked that the African-born women who took a higher degree were multiparous, as well as single, made a higher number of unplanned visits to the delivery ward Ny et al (2007, p. 811). In addition, WHO (2009, p. 1) records that “stakeholders agree that good-quality emergency obstetric care should be universally available and accessible, that all women should deliver their infants in the presence of a professional, skilled birth attendant, and that these key services should be integrated into health systems”. In line with the above, Jangsten 2010, p. 10 citing Rogers et al (1998); El-Refaey and Rodeck (2003) also notes that the third stage of labour is considered to be the most critical part of childbirth due to the risk of post-partum haemorrhage this is why the mother has to stay at the hospital for some nights in order to first recover well and to avoid bleeding in the absence of a professional or go home after a thorough check to confirm their wellbeing. In agreement, Johansson and Darj (2004, p. 230) inform that “The Swedish National Board of Health and Welfare has defined early discharge as being when both mother and infant are discharged from the hospital between six hours after birth and, at the latest, three days after birth”. In a related development, The 2005 World Health Report recommended “provision of professional but de-medicalised care through midwife-led birthing centres located close to people's homes” (WHO, 2005, cited in Iyengar 2009, p. 9). On the whole, these studies are in line with the findings in this current study that most deliveries are done in the hospital and at the presence of an obstetric care giver. Adams (2003, p. 8) calls this outcome service users maximizing their quality of their lives when they are empowered.

6.1.3 Visiting the midwife after delivery

It is worth noting that according to the recommendations of the Swedish National Board of Health and Welfare after delivery, a mother is expected to make one visit to the midwife that took care of her and her baby during pregnancy for follow-up of the delivery as well as getting advice on family planning (Ny et al, 2007, p. 806 citing National Board on Health and Welfare, 1996). In relation, Ravindran and Berer (2000, p. 4) observed that even though WHO recommends at least one post-partum contact with a health worker during the first three days following delivery, 18 postpartum care does not feature as an essential part of maternal health care in developing countries, if at all. Yet there can be no greater tragedy than a woman going all the way to a district hospital to deliver and being discharged within a few hours or a day because of the shortage of beds, only to go home and die without medical help, days or even hours later. The above notwithstanding, this study posted a better picture. The findings of this study revealed that all the respondents reported having made the final visit to the midwife just like the midwives also agreed that most mothers make this visit. One can thus say that the services offered right from the time of pregnancy, at birth and after birth help in achieving good maternal outcomes. No wonder, Sweden is one of the countries with the lowest maternal mortality rates. In totality, exerting such an influence and consequently achieving such an outcome can be appreciated as a function of the interactional role mediated by the professionals (Charon, 1995, p. 145). On the other hand, the openness of the mothers’ systems is important for taking in the information shared with and advice given by the professionals. The synergy arising from the interacting units within the bigger system in part do account for the better service outcomes (Hanson, 1995 cited in Payne, 2005, p. 143).

6.1.4 The role of TBAs

There were mixed reactions from all the study participants about the services of TBAs. Some appreciated it to some extent while all of them raised concerns about the risks associated with it. This finds the backing of previous studies done by other researchers. Hussein and Mpembeni (2005, p. 119) note that “the proportion of deliveries that are assisted by skilled personnel in Tanzania is 36%; TBAs assist about 20% of all the deliveries while relatives and friends assist 29% (citing TRCHS, 1999)”. In addition, Witter and Diadhiou (2008, p. 95) record that “Only 7.5% deliver with a TBA, but 35.7% are assisted by a relative or other person (and 4.2% delivery alone). Huque et al (2000, p. 53) note that “Some rituals surrounding childbirth may negatively affect the health of women and newborns. In many situations, immediately after delivery the woman takes a cleansing bath to remove the gross ritual pollution associated with birth and blood”. Peltzer et al (2009, p. 155) observe “traditional health practitioners especially the TBAs play a significant role in pregnancy and postnatal care, and also with the assistance of delivery”. On the whole, all the above support the findings of this study although the emphasis was reported to be put on training the TBAs and allowing their operations in case of few medical workers but not in Sweden where obstetric care services are highly professionalized.

Bisika (2008, p. 108) also highlights some of the weaknesses associated with TBAs as poor working environment, inadequate lighting, small and dirty rooms, poor equipment, lack of supplies, unhygienic procedures, unreasonable fees, illiteracy and old age. Hussein and Mpembeni (2005, p. 120) citing Mpembeni et al (1999); Rooney (1992) report that “some trained TBAs refrain from referring mothers with complications until the very last minute, because they are afraid of losing status in the communities that they serve, and that assisting a particularly difficult delivery where both the mother and baby survive is a credit to them”.

It is worth noting that the services of TBAs are not available in Sweden. But given the above misinformation, it can be argued that the interaction between these African women and the obstetric care professionals was important in clearing the air and showing them the dangers of seeking the services of TBAs. Without this interaction, probably some mothers would have been exposed to the risks above.

6.2 Motivation factors

Considering that one of the objectives of this study aimed to underscore what motivates African migrant mothers to seek obstetric care, some of the revelations of this study hinted on the mothers' concern for the need to know the state of the unborn baby as well a concern for their own health, the need to be prepared for the actual delivery but also not leaving out the need to get preparation for the eventual care for the baby once delivered. These findings concur with the findings of Öhman et al (2004, p. 634) citing Statham et al (1997) and Glazer (1980). These note that the baby's health was the most important concern among studies on women's worries during pregnancy. In their view, they contended that presumably, pregnancy gets increasingly associated with vulnerabilities which deem it reasonable to make an intervention aiming at looking for fetal abnormalities that may affect women's anxiety. In the same way, Öhman et al (2004, p. 634) citing Baillie et al (1999) and Garcia et al (2002) point to recent reviews of ultrasound screening during pregnancy that have concluded that ultrasound scans are very

attractive to women and families. The worry for the fetus as a factor for mothers to seek obstetric care was equally identified among Swedish women. These reportedly expressed a major worry about the health of the fetus when asked in gestational week 16 (Öhman et al (2004, p. 638 citing Hildingsson, 2002).

Whereas some studies are reported to have observed that some women held fears that ultrasound might harm the fetus (Öhman et al, 2004, p. 634 citing Garcia et al, 2002), it is contended that interaction between the professionals and the mothers helps to demystify such misinformation, speculations, superstitions or even myths.

An analysis of the whole scenario that characterizes the motivation for African migrant mothers seeking obstetric care can in part be summarized in terms of anxiety, stress, uncertainty and worry. According to Ryding et al (1998, p. 542), these have a deleterious effect on the outcome of pregnancy. They report that women that are victims of these run an increased risk of dissatisfaction with their delivery experience (citing Areskog et al, 1983) while others tend to have an increased rate of cesarean section. This finding confirms the argument for interaction between the professionals and these mothers and it is not surprising that mothers interacted with reported psychological support and strength obtained as a result of such interaction. Through this way, mothers have been empowered greatly as they are provided with the right health information to break away from the cultural ties that are based on misinformation (Payne (2005, p. 295).

The cost-free obstetric care services identified as one of the motivating factor finds confirmation in the work Mogren et al (2010, p. 1) citing Pakkanen et al (2004) when they observed that antenatal care in Sweden is free of charge and easily available, thus attracting a wide range of pregnant mothers to seek the service. Adeoye et al (2005, p. 106); Roos et al (2010, p. 1003) all do concur with the issue of free services and its motivation effect. Widmark et al (2010, p. 554) in their study “Obstetric care at the intersection of science and culture: Swedish doctors’ perspectives on obstetric care of women who have undergone female genital cutting” note that the Swedish healthcare is based on principles of equal access to healthcare and equal quality of healthcare provision for all residents which is achieved through free-of-charge maternity services.

However, these in a counter argument contend that “despite the free antenatal and delivery services rendered in EBSUTH, the fact that many women attending the antenatal booking clinic concurrently utilized other formal and non-formal sources of antenatal care (47.5% of their study population), many of which being fee-paying (used by 37.5% of the study population), free services may not, therefore, be the only factor affecting utilization of antenatal care services at EBSUTH”. Although this exact finding was not noticed in this study, in a related matter some women during our interaction reported using African local herbs alongside the modern care obtained from clinics. The African herbs though were reportedly equally free. But at least the same conclusion can be reached that free services are just one among other factors that motivate African migrant mothers to seek obstetric care. Nonetheless, costs’ weight of influence cannot be underestimated considering that these very African women reported having shunned antenatal care in their home countries which involved a cost.

6.3 Nature of interaction between the African migrant mothers and obstetric care providers

This includes aspects such as abortion advice, female genital mutilation, women starving themselves during pregnancy Contraceptive use, husbands and family members/ social network.

6.3.1 Abortion advice

Abortion emerged as part of the advice given to women during pregnancy when it is found out that the pregnancy cannot be retained due to, among other things, the possibility of the baby being sick, poor condition of the mother and other factors. This particular finding gains support from other studies that have already been carried out. Aniteye and Mayhew (2011, p. 47) in a study on the women who were admitted to hospital in Ghana due to complicated abortions observed that, abortion in some of these countries is only allowed under almost the same circumstances as in Sweden. Citing The Criminal Code (Amendment) Law, PNDC. Law 102, 1985, Aniteye and Mayhew show instances under which it is allowed. They noted; *It is not an offence...if an abortion or miscarriage is caused in any of the following circumstances by a registered medical practitioner... where the pregnancy is the result of rape...incest...where the continuation of the pregnancy would involve risk to the life of the pregnant mother or injury to her physical or mental health ...where there is a substantial risk that if the child is born it may suffer from or later develop a serious physical abnormality or disease....*

However, the same study reveals the resistance that any abortion suggestions invoke, for instance, the advice of the midwife was strongly rejected even when the woman seemed depressed. The mother instead viewed the midwife as being unfair to her unborn baby since abortion is seen as murder in some countries of Africa and therefore, something that should not at least come from the midwife. Lauro (2011, p. 18) citing Rossier (2007) concurs with the above mothers as the researcher observes that although people's abortion levels are going high in urban areas, there was a negative attitude towards it and in away, "induced abortion was seen as murder". In addition, other studies have indicated that it does not depict good morals and at the same time it causes moral stigma when a woman conceives before marriage or out of wedlock and attempts an abortion even in countries where it is legal (Aniteye and Mayhew, 2011, p. 47, 50; Lauro 2011, p. 19) . In line with the above studies, one can argue that the orientation of African migrant mothers is so strong in them given the fact that abortion is talked about badly in the above cases. Although women had a chance of aborting legally just like the cases in this study, some women refused and said were shocked by the suggestion.

Whereas a woman in Africa is ashamed when she gets a pregnancy outside the wedlock as shown above and in a situation where the only alternative is abortion, the act of abortion itself is even more shameful (Lauro, 2011, p. 19 citing Johnson-Hanks, 2005). On the other side of the story, it may also be shameful for an African married woman to abort a baby who truly belongs to her husband. With all these social pressures that are clashing the modernization, mothers are living in dilemma. Moreover, some of the medical personnel from the same community may not be in favour of abortion since they have also been oriented in the same community. Abdi and Gebremariam (2011, p. 36) in their study titled *Health providers' perceptions towards safe abortion service in selected health facilities in Addis Ababa, Ethiopia* revealed that "even after liberalization women's access to safe abortion is limited partly due to provider's unfavorable attitude towards abortion" (citing Ethiopian Society of and Gynecology, 2002). As regards the

above issues, it is against human and reproductive right which is against their dignity and autonomy (Abdi and Gebremariam 2011, p. 35).

Moreover, even the best practice of contraception cannot totally eliminate the need for induced abortion, as all the available family planning methods have some potential of failure at some point (Åhman and Shah 2010, p. 80). By failing to embrace abortion-given that it can be one way of family planning- the implication would be failing to achieve third and fifth Millennium Development Goals on gender equality and maternal health respectively in developing countries that are intended to be achieved by 2015 (Abdi and Gebremariam 2011, p. 35 citing World Bank, the Millennium Development Goals for Health, 2004) since some cases of maternal death also are a result of failed or mismanaged abortion. In addition, some “programs do not give full information on the relative benefits, risks and effectiveness of all methods of fertility regulation” (Abdi and Gebremariam 2011, p. 35 citing UNFPA, 1994). In this way, the professionals are forcing women to deliver children for the people they do not want to.

It is however important to note that, this was contrary to our findings since the midwives were reported to be in favour of abortion, in any case they suggested it whenever they assessed and envisaged some danger. Women admitted having been told about the context in which abortion is viewed in Sweden, however, some remained resistant. This means that although African migrant mothers have migrated to Sweden which is a developed country, they have not changed their beliefs, traditions and some practices. The ecological systems theory notes that society ideally is like a tea bag which allows water in and out but keeps the content. The theory equally emphasizes the nature of boundaries of systems—either open or inclined to closedness (Payne, 2005, p. 144). In this case, the above claim of the theory applied to these women. And in these cases, women can be said to have exercised power in their decision making as they stood firm on the ground to counter the advice of the professionals.

6.3.2 Female genital mutilation

This emerged as another vital finding during this study where it was revealed that physically, it has no impact on delivery provided the woman is reopened. It is estimated that around 130 million girls and women have undergone circumcision (Adeokun et al, 2006, p. 49; Finke, 2006, p. 18; Berggren et al, 2006, p. 28 citing WHO, 1998; Monjok et al, 2007, p. 36 citing WHO fact sheet, 2000). Some studies support this finding. For example, Essén et al (2005, p. 8; 2001, p. 50); observed that circumcised women, the majority who had undergone infubulation, were found to have had a shorter second stage of labor and a lower risk of prolonged labor than non-circumcised women. Moreover, Essén et al, 2005, p. 8; Essén, 2001, p. 51) remark that it is not likely “that the scar tissue resulting from circumcision would be too tough to be torn by the uterine contractions, as the frequency of both prolonged labor and instructional virginal delivery was not found to be higher among the circumcised women... since any form of circumcision does not affect the birth canal itself, there should be no reason for obstructed or prolonged labor”. Another study carried out in Saudi Arabia discovered a significant prolongation of the second stage of labour among the circumcised women, compared to the non-circumcised women of another ethnic background but the writer suggested that if the woman is opened, then prolongation may not be experienced (De Silva S 1989 cited in Essen et al, 2005, p. 8). In my current study, it was reported that women are opened as soon as it is

detected that it is the right time for the baby to come out and this could be one way of avoiding prolongation.

Again Essen et al (2005, p. 10); Essen (2001, p. 50); Essén et al (2005) cited in Johnsdotter and Essén (2010, p. 34) Prolonged labour in case of women who are circumcised may not be experienced in affluent countries because of the presence of high standard antenatal and obstetric care, which include routines of how to handle circumcised women. In another study that was carried out in Sudan, Campbell (1995) cited in Essen (2001, p. 20) observed that “non-obstetrical factors such as FGM, poor access to local transportation to the health/delivery centers, and the fact that women do not seek care unless they are seriously ill all appear to be non-obstetrical factors associated with maternal mortality. This coincides with Paul (1993) cited in Essen (2001, p. 21) observation that although there is no scientifically controlled study on this area, FGM has been commonly associated with prenatal and maternal mortality because Infant and maternal mortality are the highest among countries that widely practice FGM. In all the above cases, WHO confirmed through an “announcement that no evidence was found to confirm the relation between obstructed and prolonged labor and genital circumcision” (WHO, 1998 cited in Essen et al, 2005, p. 8).

Other researchers have highlighted some of the African beliefs about safety during delivery when a woman is circumcised. Osifo and Evbuomwan (2009, p. 22) in the study; *Female Genital Mutilation among Edo People: The Complications and Pattern of Presentation at a Pediatric Surgery Unit, Benin City* noted that “many people believe that circumcision allows safe delivery during reproductive age, babies would die on making contact with the clitoris during delivery and as part of initiation rites to womanhood” and also that “Religious-cultural and superstitious beliefs were the main indications for female genital mutilation despite the long contact with western civilization”. Related to the above, Monjok et al (2007, p. 36) reported that “in some communities in Eastern Nigeria, it is believed that if the head of the neonate touches the clitoris during child birth, the neonate will not survive” that is why they cut the clitoris (citing Program for Appropriate Technology in Health (PATH) 1998).

Others mentioned complications such as obstructed or prolonged labour, perineal tearing, reinfibulation, fetal distress during delivery among the long term effect of FGM; Sakeah et al, 2006; Anonymous (1995) cited in Adeokun et al (2006, p. 50); Berggren et al (2006) citing Shell-Duncan (2001); Monjok et al (2007, p. 37) citing Larsen et al (2002). Essen and Wilken-Jensen (2003, p. 684) noted that “Childbirth complications are described as prolonged labor, fetal distress, mental retardation, epilepsy, perinatal death and maternal fistulas” (citing Toubia, 1994; Elchalal et al 1997; Arbesman et al, 1993). Yet Widmark et al (2010, p. 553) citing Widmark et al (2002) indicated that they recognized some midwives’ insufficient technical skills for the care of genitally cut women, but felt they had little support from policy guidelines. Such cases of insufficient skills however were unheard of in this study.

Regarding the beliefs highlighted, although not all of them were not raised during interviews for this study, the existence of knowledge among Swedish professionals interacted with that such beliefs do exist was deemed fundamental to strengthening interactions with the circumcised women so as to demystify such beliefs. This was considered important in enabling these women appreciate utilizing the formal services like any other women. In this way, through meaningful interaction with the professionals (Charon, 1995, p. 145), women are given information that was deemed necessary to empower them by knowing how the delivery will go. This gives women self-confidence at the time of delivery Payne (2005, p. 295).

6.3.3 Women starving themselves during pregnancy

One of the areas of interaction and information shared between the midwives and African migrant mothers surrounded starvation. It was a finding of this study that some African women particularly from the Horn of Africa tend to starve themselves with a belief/intention of having small babies at birth. To these African women, they believe that this can save them the dangers of having big babies including facing cesarean section. This belief/practice has found documentation in Essien's research work. She documents that "...among immigrants from low-income countries, it is known that some of them, in order to avoid a large fetus and the complications it might bring during labor, many women eat less during pregnancy (Essen et al, 2000 cited in Essen et al 2005, p. 9; Essen, 2001, p. 42). Quoting one of her respondents saying that *...during pregnancy, I ate very little. I was afraid of a great rapture or being delivered by Cesarean section*, Essen in her reference to nutritional habits emphasizes that; "many women believed that if they ate too much, their babies would grow so large that would increase their risk of caesarean section, so they had to restrict their dietary intake during pregnancy" (2001, p. 41). In the same way, studies from Somalia have described the same tradition of employing limited food intake in order to prevent the fetus from gaining too much weight so that it can pass the birth canal in a normal way (Essen, 2001, p. 58 citing Omar, 1994 and Kassamali, 1998). Essen in this present thesis confirms the fact that such a practice continues even after emigration to a country with very advanced obstetric care such as Sweden (Ibid). The same practice has been underscored by (Neilsen, 1998) in an observation that "research conducted in India where FGM is not practiced, has shown the same phenomena of reducing food intake to avoid complicated deliveries such as caesarean".

It is worth acknowledging that whereas the midwives appreciated the different cultures that these women emerge from, they took it upon themselves to sensitize and advise these women about the dangers of starvation. Nonetheless, not all took up the advice. The scenario where women close off from the advice is what Bowler (2003, p. 216) referred to as non-compliance, something that turned to be consequential. He notes in his study that, "...some women were described as non-compliant because they had poor diets, suffered from anemia, lacked vitamin D and did not follow nutritional advice or take advice". Analyzing this from a systems perspective, such women can be considered to have closed off their boundaries, thus maintaining a closed system. Less surprising, systems closed to information and energy are bound to suffer from 'lack of positive influence' which exactly was the case for such women whose boundaries remained impermeable despite the efforts of the midwives. On the contrary, the reverse can be said to be true. Women that did not only listened but paid attention to the midwives' counsel were reportedly able to manage their pregnancies, had safe deliveries and bore healthy babies. Such sufferings from anemia, lack of vitamin D were unheard of among this category of women. To this effect, it can be contended that mere interaction between the pregnant women and the midwives was not reassuring of positive outcomes for the whole process, rather the extent to which the mothers maintained an open system with permeable boundaries mattered most (Payne, 2005, p. 144).

6.3.4 Contraceptive use

Family planning issue was one of the findings of this study. Bowler (1993, p. 217) while studying the south Asian migrant women seeking antenatal in a teaching hospital in Britain discovered that; “during the postnatal home visits, the midwife plans for the future pregnancy with a new mother. They decide on when to have the next child. Women from Asia were however considered not to be interested in advice on family planning use by the midwives and so they were producing many children”. This finding among such Asian migrants is similar to this study’s findings where one of the professionals felt that some African mothers were not interested in using contraceptives. Other studies e.g. Mishtal and Dannefer (2010, p. 233) citing Kramer et al (2005) “religious affiliation had little influence on the degree to which Polish women used contraception”. Similarly, “religiosity was not associated with contraceptive use among Latino women in the United States” (Romo, 2004 cited in Mishtal and Dannefer, 2010, p. 233). These two studies in a way identify religion as a denominator in influencing contraceptive use despite its lack of influence in these particular studies. However such findings are contrary to the findings of this study. In this study, religion was found to have had a strong bearing on the women’s decision to use any family planning methods available.

Mishtal and Dannefer (2010, p. 233) citing Sarkar (2008); Nakiboneka and Maniple (2008, p. 130), noted that the “the Church forbids sexual intercourse that is interrupted in one way or the other by use of condoms and other family planning measures because they “amount to the ‘destruction of seed”. Again, some believe that “hormonal contraceptives and intrauterine contraceptive devices act as abortive agents by preventing an already fertilized egg from attaching to the uterine wall (John Paul II, 1995 cited in Mishtal and Dannefer (2010, p. 233). Mishtal and Dannefer (2010, p. 239) in their study discovered that in Poland “between 1991 and 2007, modern contraceptive use more than doubled, rising from 19% to 56%, and use of no method declined dramatically. Despite the strong faith of the Polish people, family planning is rapidly on the increase. In the above case, one of the mothers could have viewed the destruction of the seed as murder due to her religious faith and that is why she thought the midwife who proposed abortion was unfair to her unborn baby.

Tengia-Kessya and Rwabudongo (2006, p. 29) citing Elphis (1991) observes that “religion has been documented to be the most controversial factor influencing use of modern family planning methods. The Roman Catholic Church for example, advocates abstinence or use of natural methods for family planning, as the use of modern methods is against the religious beliefs”. In another study, Åhman and Shah (2010, p. S80) were concerned that some women in developing countries who want to use family planning measures do not access or use them in a proper way. This in turn forces them to rely on unsafe induced abortion services in countries where abortion is still illegal or of poor quality. In the case of this study, this was conflicting with our findings where the services of family planning are available and safe abortion is guaranteed but some women still declined the offer. Aryeetey et al (2010, p. 30) while studying *Knowledge, perceptions and ever use of modern contraception among women in the Ga east district, Ghana*, found out that some of the barriers to contraceptive use include fear of contraceptive failure, non-supportive influence of male partners, and religious beliefs. This supports the findings of the study as religion came out as one of the blockades to contraception use.

6.3.5 Husbands and family members/social networks

It should be noted that the interaction between the African mothers and obstetric care providers involves the mothers' family members especially the husbands. This revelation in this current study finds support in Essen (2001, p. 42) when she noted that "nearly all women identified differences between motherhood in Sweden and Somalia. In Somalia, the family looks after the woman for forty day after delivery". In her study, she records that mothers from Somalia feel lonely and isolated by being away from their families. One of her respondents informed; *My husband helped me but he couldn't help me as my parents or mother-in-law could. Here in Sweden, I only have my husband and I have to do everything by myself*".

Odimegwu et al (2005, p. 61) in their study "Men's Role in Emergency Obstetric Care in Osun State of Nigeria" note in Northern Nigeria, there was reluctance of men to grant permission for operative delivery when their wives are in prolonged labour. This is because they perceive this as a sign of reproductive failure, and such actions have been known to have fatal consequences (citing UNFPA, 2001; Harrison, 1996). In other studies, it was pointed out clearly that "the culture of male superiority and authority over the wife's reproductive rights has implications for women's total wellbeing (citing United Nations Program of Action, 1994; Afonja, 1996; Renne, 1993)". In line with the above cases, although a man is not the one to sign for an operation in Sweden, they still have a strong say when it comes to women's reproductive issues. In this study, one of the African mothers reported that her husband did not accept a cesarean but of course he did not have the authority to say no. It can be argued that if a man in that case was to sign, he would refuse or delay the cesarean which would not have been good for both the mother and the baby. But since the woman was empowered and she knew her rights, she went ahead and had her cesarean delivery without the support of the husband.

Odimegwu et al (2005, p. 63) in the same study found out that "majority of the men would support or encourage their partner to eat fruits and food and do a lot of physical exercises during pregnancy. They believed that this would aid proper fetal and maternal development and health, which is usually recommended at the antenatal clinics". This also confirms the findings of this current study since men in Sweden have been trying their best to help their wives in support as well as covering up for the absent family members who would have helped the woman after during pregnancy, at birth and after delivery.

Ladfors et al (2001, p. 132) recorded that approximately 80% of all women reported that they would feel very safe if their partners were present at the delivery. Yet Iliyasu et al (2010, p. 22 citing Mullick, 2005) observe Men generally do not accompany their wives for antenatal care and are not expected to be in the labour room during delivery. They further found that men were more likely to accompany their wives and pay for treatment when complications arose (2010, p. 29). It is less surprising that they report a low participation of men in maternity care. But at least they observed higher participation among younger educated men, a finding that is similar to the findings among Indian men (citing Shahjahan, 2006-2007). This could be due to the fact that younger men are more adventurous and likely to challenge cultural norms.

A reflection on the above depicts the ideology of a system. Whereas the actual business is between the mother and the professional, a lot of influence derives from different corners. And it is important for the professional to take watch of these since not all is capable of bearing positive outcomes as so far observed. At the same time, what can be deduced from the above is that the advice from the professional is essential in empowering the mother to make her own decision bearing her rights in mind amidst all sorts of influence from the family members and other social networks (Payne, 2005, p. 295).

6.4 Interactional effects on the service outcome

These include; Health of the mother and the baby, Psycho-social outcomes, Trust, respect, consultation and confidence, African mothers' satisfaction with the care

6.4.1 Health of the mother and the baby

It will be recalled that throughout this study, it came out loud that the information shared between the African migrant mothers and the professionals was not for its own sake. Among other things, it accounted for the trust, open communication and bond between the two groups, health of the mothers and their babies, etc. This finding comes in agreement with the findings of Ebert et al (2009, p. 26). These found out from the midwives interviewed in their study that it is of great importance midwives to interact with women who smoke during pregnancy and for that matter the midwives stood by their side, not in approval of their smoking behavior but in support of them, encouraging them to stop smoking and to comprehend the dangers it has on their health and unborn babies. In particular, Ebert et al emphasized that "forming partnerships with women and working collaboratively with them to offer appropriate support will improve women's health as well as have a positive effect on the health of their babies and families" (2009, p. 28-29). Similarly, Byrd (2006) cited in Ebert et al (2009, p. 27) made a submission that "relationships are able to persist with trust and attachment developing as long as people fulfill perceived obligations of behaviour and communication". In view of this, it can be agreed with certainty that a number of African migrant mothers and professionals alike found reason to cooperate through the obstetric care phase but also afterwards.

The utility of interaction between the professionals and clients has been earmarked by Rowe (2002, p. 64) as entailing satisfaction, knowledge and understanding, compliance with advice or treatment, quality of life, and psychological and other health outcomes. This follows increasing evidence from researchers that the quality of the interaction between patients and their carers may have a significant effect on a variety of aspects of patient wellbeing (citing Stewart, 1995).

6.4.2 Psycho-social outcomes

Psycho-social outcomes also emerged as a finding of this study. Some women and professionals reported satisfaction while others reported not having been in position to settle especially being worried about how delivery will go. Essen et al (2005, p. 9) citing Sjöström (2002) during a study on anxiety observed that some women who were worried about the delivery and their own health had a short second stage of labor compared to women who were worried about their child's condition. This is in support of the findings of this study since worries by circumcised women were reported. Although no case in this study was reported to have been caused by the fact that some mothers were circumcised which could have been as a result of worries, the fact remains that these women especially the first time mothers were not psychologically prepared for delivery. Some even reported that although the midwives struggle to explain to them how labour would go when time comes, some women reported not understanding well. It can thus be argued from this perspective that physically, circumcision

does not affect delivery as confirmed by the WHO (WHO, 1998 cited in Essen et al 2005, p. 8), it is important for these women to be under no stress, worries, thoughts.

A close link between psychosocial reactions and FGM is identified. Monjok et al (2007, p. 37) citing WHO (2006) noted that the complications of FGM are immediate and long-term, including medical, psychosexual and psychosocial. Severe gynecological, obstetrics complications of FGM at birth as well as reinfibulation have been observed. In the same line, circumcision affects women's preparedness for delivery. Moreover, some could be worried of reinfibulation in communities where it is done. It could be that some circumcised women after delivery in Sweden where they are not stitched like in their home countries could be going back for being closed again.

Monjok et al (2007, p. 37) citing Dorkenoo (1996) again highlighted that FGM has been associated with psychological trauma including post-traumatic stress and chronic behavioural ailments such as generalized anxiety, unipolar affective disorder, chronic irritability, frigidity and marital conflicts. As already shown, stress and trauma may arise given the fact the scar that one got during childhood is the same place that the midwives re-open during delivery. In addition, Monjok et al (2007, p. 37) admits that specific health and social complications of FGM has been observed to vary with the type of FGM.

It is reasonable to point out that this study revealed silence about some of these reactions especially among the circumcised (but not the young mothers) but at least as observed so far, the professionals reported knowledge that at least they do exist especially among young (first time mothers) and circumcised women as the major affected groups. As such, preparing such mothers to have safe deliveries became a priority whenever such reactions presented. To this effect, credit may be worth being accorded to the professionals. This is what Charon (1995, p. 152) calls negotiating their social world by adapting to different situations which may be as a result taken by others.

6.4.3 Trust, respect, consultation and confidence

These emerged as some of the outcomes emanating from the interaction between the obstetric care providers and the African migrant mothers. Considering that different African mothers that participated in this study had varying backgrounds from different parts of Africa, each has her unique experience. Some carried with them a belief that midwives are abusive and harsh on pregnant women while others had in their minds that interaction is only limited to professional issues. And for such reasons, many were of the view that seeking obstetric care should be done only when it cannot be avoided for instance after a number of months into the pregnancy. Far from such beliefs and stereotypes, mothers interacted with reported an opposite reality with the Swedish obstetric care providers whom they described as kind, social, supportive, encouraging, concerned, etcetera following the interactions they had with them. Notably, this became foundational to the trust and confidence in these service providers and the whole obstetric care system by the mothers. The necessity of such traits in building trust are inferred to by Wendt et al (2004, p. 1210) in their study *Trust and confirmation in a gynecologic examination situation: a critical incident technique analysis* when they noted that; Opportunities for trust were created when the personnel promoted the women's participation in the examination situation, created confidence, and were supportive. When this was not fulfilled, there was a lack of trust.

The fact that antenatal care in Sweden is free of charge and easily available (Mogren et al, 2010, p. 1 citing Pakkanen et al, 2004) remarkably attracted use by all mothers interacted with.

Trust—considerably built over time between the caregiver and the patient (Mogren et al, 2010, p. 2 citing Hupcey et al, 2001) neither be taken to be for its own sake nor for granted. Hupcey et al (2001) argues that it is “an important concept for the caring disciplines, such as for example nursing and medicine” while Bell et al, (2009) cited in Mogren et al (2010, p. 1) identify it as an important element in the nurse-patient relationship. Similarly, Sachs—a Swedish socio-anthropologist labels trust as “a crucial property in encounters within medical care” (Sachs, 2004 cited in Mogren et al, 2010, p. 2). In her reference to researchers such as Harrington and Brody (Harrington, 1997), Sachs emphasizes the importance of diagnosis, but states that “the diagnosis should be done by a trusted person, preferably a professional and at the same time a trusted fellow being”. She notes further that where there is trust the patient tends to feel comfortable and that there are thus two sides to a patient’s trust in a doctor or midwife i.e. trusting the professionals because of their perceived medical competence, but also because of their empathy and human kindness. All this comes in support of the findings of this study. It is imperative noting that whereas Sachs for instance identifies two bases of trust, the later basis i.e. trusting the professional for his/her empathetic and kind character was found to be more reinforcing of the former. This argument is based on the consideration that a recap of the experiences of mothers that had ever delivered before immigrating to Sweden were dominated by mistrust and dislike of the midwives in their countries. These midwives had the professional training but this was inadequate to win the mothers’ trust given that they were not empathetic and kind to the mother.

In addition, it was this trust that kept mothers to maintain contacts with their midwives even after the obstetric care period. Once again, through trust of the professionals, mothers were able to give good testimonies about these professionals and the overall healthcare system, something that positively lured other new immigrants to rethink and change their negative attitudes towards seeking antenatal that they often carried with to Sweden. And in the due course of interaction, trust was central in enabling mothers to feel secure enough to ask midwives all sorts of questions without fear or doubts yet these reportedly were regarded significant in preparing the mothers for the management of pregnancy, actual delivery and care for the baby after delivery.

To this effect, while arguing from the empowerment perspective, it can be argued that trust formed an empowering ground for mothers to interact more freely, ask relevant questions, and later on care for the babies. Of greater significance, trust and confidence reportedly empowered mothers to make informed decisions well aware that they had the right information from trusted sources and thus worth relying upon in making such informed decisions. Payne (2005, p. 295) considers that one among other goals of empowerment is that it “seeks to help clients gain power of decision and action over their own lives by reducing the effect of social or personal blocks to exercising existing power, increasing capacity and self-confidence to use power...” However, the above notwithstanding, the empowering effect of trust and confidence was not absolute to all mothers interacted with in this study. It can be noted that mere trust not backed by openness on the part of the mother hardly if at all yielded any empowerment effect. Some mothers maintained closed systems stemming from culture/tradition and religion as barriers to openness to advice given by the professionals. In turn, some of such mothers registered negative or unintended outcomes. I therefore contend that both trust and maintaining

an open system to let in advice, information, energy from the trusted system are equally important and ought to be seen as complementary rather than acting in isolation (Payne, 2005, p. 144; Charon, 1995, p. 153).

6.4.4 African mothers' satisfaction with the care

Satisfaction emerged as one of the outcomes identified by African migrant mothers following their interaction with the professionals. These mothers prior to seeking obstetric care and interacting with the professionals, the bore fear that perhaps their own delivery experiences in Africa coupled with those expressed by others that delivered in Africa would resurface here in Sweden. To the contrary, this was not the case, something that bred satisfaction to these mothers. The most vivid case was of a woman who had fecal material as she pushed the baby but the midwife continued in good spirit encouraging her. Jaffre and Prual (1994, p. 1070) equally point to the abuses that mothers undergo during delivery. They put it that "In spite of the fact that midwives are themselves less than conscientious, apparently they do not hesitate to insult their patients/pregnant women when they do not comply. This is especially true when patients/pregnant women prefer squatting during labor and delivery, rather than lying in the lithotomic position on the delivery table. When the woman insists, she is compelled by the personnel (midwives and cleaning staff), to clean the floor herself immediately after delivery." the interaction between the mothers in question and the professionals accompanied with the bond that followed saved these mothers from such treatment. However, this is not to create an impression that had it not been for this interaction, the Swedish professionals would subject the mothers to such ill treatment. Rather it could be the case that the good care towards such pregnant mothers is in part embedded in the Swedish obstetric healthcare system. In another study, Waldenström et al (2006, p. 557) note that "women were more satisfied with intrapartum care than with postpartum care. This outcome may have many explanations. One could be that women's experience of intrapartum care was more consistent with their expectations than their experience of postpartum care".

Besides, the African migrant mothers exhibited due satisfaction with the whole obstetric care package and the closeness and follow up that professionals ensured towards the mothers. But at the same time as earlier on observes, to some mothers, this very close follow up seemed to be more or less equated to 'policing', leaving them with no space to do their own things—something that such mothers were dissatisfied with. Essen (2001, p. 41) observes a similar phenomenon among migrant mothers that is characterized by satisfaction with the care but at the same time questioning some aspects of management and delivery of obstetric care. In her study titled "Perinatal mortality among immigrants from Africa's Horn: The importance of experience, rationality, and tradition for risk assessment in pregnancy and childbirth", a similar revelation was made that "Majority migrants expressed satisfaction with the routine antenatal care in Sweden.

However, a few women could recall the instructions regarding prenatal 'surveillance' and precautions from the midwives and obstetricians". In her study, one of the respondents is quoted saying; *I do not remember them telling me anything useful. I do not really understand why and have blood test. I think you are nice here in Sweden, but I want to know why I have to be checked.* It is thus apparent that despite the satisfaction these African migrant mothers derive from the Swedish obstetric care, it runs parallel with some aspects that these mothers find odd.

But nonetheless, their interaction with the professionals serves as a bridge between the mothers' ignorance of why the system works the way it does and the mothers' eventual appreciation of the system and consequential compliance.

In line with Swedish obstetric care system, Shapiro et al (1983, p. 144) in their study "Information control and the exercise of power in the obstetrical encounter" noted; Indeed it appears that patients in the public hospital are 'processed' through many stages and thus have few opportunities to establish a relationship with their health care providers. This confirms the finding where some mothers complained of many appointments. Again, one of the doulas reported that in the Swedish system, a mother meets many professional in a short vulnerable time especially at the hospital which makes it hard for her to establish a relationship or keep all the information they are get because of language problems.

6.4.5 Barriers to effective interaction and service outcome

These found to be the serious blockades towards the nature interaction between the African migrant mothers and the obstetric care providers. They include; Language difficulties in relation to interaction, attitudes towards Cesarean during delivery, the influence of traditional beliefs and cultures on interaction between the parties i.e. religious faith among the African migrant mothers and mothers' reluctance to meet or be attended to by male service providers, and rejection of some medical advice.

Language difficulties in relation to interaction

Considering that language barrier formed one of the barriers to effective interaction between the professionals and the service seekers and consequent outcome, in the same way, its weight has been underlined by Bowler (2003, p. 214). While referring to south Asian migrants seeking antenatal care in the maternity department of a teaching hospital in Britain, Bowler underscored that the level of competence in English was observed to be generally low which resulted in women being characterized by being "unresponsive, rude and unintelligent". "It was difficult for them to form a personal relationship with the midwives and to challenge the assumptions made against them". Similarly, according to The Epidemiological center, Stockholm, (1996) cited in Essen (2001, p. 20), "a study done in California on the effect of language on reproductive outcome indicated that the Mexican-born english speakers had a low profile of adverse pregnancy outcomes than the US-born Spanish speakers and US-born speakers of English because the Mexican-American experience positive adaptation to the American society by having a better command of the language".

It is proper to highlight that the above experience of Asian migrants characterized the scenario of some African migrant mothers especially those that had just come without knowing English and Swedish or only knew English which some midwives never knew. This is true for a mother who observed that after delivery, they stitch them the way it is done in Somalia by closing where they are opened during delivery yet the professionals reported that they close up to the size of any uncircumcised mother. This can be said to be in part arising from the miscommunication. In this similar spirit, *Changing Childbirth*, the report of the Expert Maternity Group, commissioned in 1992 by the Department of Health to review maternity care in England

and Wales, highlighted the importance of good communication yet at the same time, it recognized that “in many cases communication is not as good as it should be” (Rowe, 2002, p. 64 citing Department of Health 1993). In addition, “Studies of women's views of maternity care suggest that good communication is central in determining whether women are satisfied with the care that they receive” (Ibid, 2002, p. 64 citing Garcia et al, 1998). Failure to reflect on these can be said to be missed opportunities on the part of the women and at the same time a blow to the healthcare system as it hampers on trust which arguably is very fundamental in any human service profession.

In relation to this, Bowler in dissatisfaction was displeased with “the midwives’ rare motivation to take trouble to checkout with the women and to ensure that they understood what the women intended to convey to them and what they intended to convey to the women (2003, p. 215). The consequences of this miscommunication and the limited effort on the part of the midwives to ensure that they communicate on the same line with the mothers can be far reaching. It means that more likely, the two may act outside each other’s expectation, may necessitate a third party something that is not uncommon yet this impacts on trust and confidence, it may as well undermine the total quality of interaction together with the benefits that accrue from it. The situation becomes exacerbated in the event where hospital administration for some reasons is not in for employing interpreters as Bowler (2003, p. 214) exclaims: “none of the midwives was Asian and there were no interpreters. But the hospital consultant when contacted argued that they did not have enough midwives, why should they think of employing interpreters” Bowler quotes the hospital consultant when contacted as saying, *of course, not. We haven’t even enough nurses. If you ask me, they should not be allowed into the country until they can pass an English test.* Whereas Sweden can be considered exceptional and not subject to this scenario, the reality for some mothers who are not in for interpreters may be no better. The only difference is that in the British case, the mother is powerless, without access to the right to an interpreter. This is contrary to Sweden where the mother’s right to an interpreter or a doula is guaranteed but the mother exercises self- determination and turns down this right Payne (2005, p. 295).

As Bowler notes further, because of language difficulties, women find it difficult to assert their moral status and cultural differences make it hard for them to make personal relationships with the midwives (2003, p. 224). Whereas the first part of this observation was found a reality among African migrant mothers who because of lack of command of language they lacked the assertiveness to remind nurses of some important things leading to loss of some information, to the contrary, the second part of Bowler’s observation does not hold as per the findings of this study. According to this study, cultural differences did not form a variable important in establishing a personal relationship with the professionals. Mothers from diverse cultural backgrounds similarly reported having established personal relationships with midwives. It can possibly be argued that this was so because Sweden is a multicultural society and mothers irrespective of their cultural backgrounds are all embraced the same way. This on one hand can be taken as a credit but on the other hand, one can say that being sensitive to the cultural diversities would be of equal importance as it would help shape the professionals’ appropriate response to the cultural barriers to effective interaction. This especially gains weight when one considers Bowler’s remark that “some misunderstandings between women and midwives can be attributed to differences in social and cultural background rather than the women’s poor grasp of language” (2003, p. 215, 221).

The concern of language competence among African migrant mothers becomes appalling considering that even the chance accorded to mothers like other immigrants to learn basic Swedish gets eroded by the mothers' child care role unlike for the men. Essen (2001, p. 20) citing The National Integration Report (1999) makes explicit the disgruntled situation that mothers get subjected to by the child care role. Essen asserts; "There is no Swedish-Somali dictionary... in a study of 1454 students who had Somali as their mother tongue, every third one dropped out the basic course in Sweden. The main reason was lack of child care". Not surprising, Somali women like other migrant women speak less Swedish than their counterpart men (Ibid) yet the former need the language much more than the latter when it comes to interaction with professionals in the event of seeking obstetric care.

The shortfalls of language barrier find more emphasis in the work of Essen observing that "inadequate verbal communication was identified by perinatal audit to be a sub-optimal factor likely to have contributed to 5 cases of perinatal deaths solely among Ethiopian and Somalis women (Zeitlin et al cited in Essen 2001, p. 29)". Essen (2001, p. 61) notes that a study in France showed that Sub-Saharan Africa immigrants had the highest relative risk of prenatal mortality. "Although such increased risk may reflect low socio-economic status and medical problems", Essen points out that these authors are careful to discuss alternative explanations, such as language difficulties. In a related matter, "a study in Denmark identified inadequate communication between immigrant women and health care providers: insufficient use of trained interpreters was claimed to be an obstetric risk factor" (Jeppesen, 1994 cited in Essen, 2001, p.61). Although this depiction was not come across during this study, its potential to happen cannot be ruled out given that women from the different cultural backgrounds are not equally represented by interpreters, doulas and sometimes husbands. These representatives can be said to be very conversant with the languages of the different mothers.

In view of the above, it is imperative to acknowledge that considering that "increasing evidence from researchers continues to reveal that the quality of the interaction between patients and their carers may have a significant effect on a variety of aspects of patient well being" (Rowe et al, 2002, p. 64 citing Stewart 1995), some authorities in different parts of the world have embarked on interventions to address the situation. Notably, "in the NHS Plan, the Department of Health in England announced plans for new training in communication skills across all professions in the NHS" (Rowe et al, 2002, p. 64 citing Department of Health, 2000). For Sweden's case, the measures to contain the situation can be said to be part of the free SFI programme, guaranteed right to an interpreter and the local government support towards the Doula project.

Religion/ faith among the mothers

This was one of the findings of this study and majorly, it was a barrier to the interaction and interaction effect. Essen (2001, p. 56) in her study reports that, "the women had strong, pragmatic religious faith. Few admitted to the fear of their child's health (sudden death, for example), a fear that is common among the Swedish women. Although they put forth all the best efforts to care for their children, if a child were to die, they saw it as a predetermined act of God" one of the respondents believed the way her twins were positioned in her womb was God's plan and therefore, they had not to change anything. But contrary to what Essen said, most of the women who participated in the study showed fear the health of their children. On the other hand,

some professionals and doulas reported that that some mothers believe that if a child dies, there is a possibility of conceiving again.

Moreover, religion and culture came out as a blockade for some mothers in terms accessing obstetric services provided by male professionals especially from the Muslim religion. Hilden et al (2003, p. 1030) in a study “*Women’s experiences of the gynecologic examination: factors associated with discomfort*” observe that “apart from the physical discomfort, the psychological factors are important: the gynecologic examination involves exposure of intimate parts of the body in a vulnerable situation with loss of control. The woman is influenced by many feelings such as embarrassment about undressing, worries about cleanliness, qualms about vaginal odor, and concern that the gynecologist might discover something about sexual practices, fear of discovery of a pathological condition, and fear of pain” (citing Seymore et al 1986, Millstein et al, 1984). In addition to the above forms of discomfort, Hilden et al (2003, p. 1031) reported that, “most of the above-mentioned aspects might be even more conflicting when the gynecologist is male”.

In another study, “there is some evidence that women prefer a female gynecologist when asked prior to an examination; nevertheless, when asked after an examination, carried out by either gender, the preference is not as strong (Hilden et al, 2003, p. 1035 citing Seymore et al, 1986). In a study from 1997 on behavioral indicators of anxiety during gynecologic examination, it was found that the gender of the examiner had no bearing on anxiety levels, nor had his or her professional training (Hilden et al 2003, p. 1035, citing Reddy et al, 1997). Some of the Muslim women reported that they fear exposing themselves to men who are not their husbands. Besides religion, some women said that they do not want men to see everything and that is why they need to see female professionals. Other women recorded that if they go to the hospital, they first ask for a female gynecologist and then settle for a male professional if they fail to get a man. To other women, they just have to visit male professionals because they have no alternative but they are not comfortable with it since they are in such a vulnerable situation. Other women who seemed liberal and empowered reported having no problem with meeting the male professionals.

Social interaction in such cases is especially essential in influencing women to agree to services of a male professional more so where there is not any female professional. Likewise, the more open to such counsel the mother is, the easier for her to retune her mindset to accept the services of the male professional and the reverse is true (Charon: 1995, p. 145).

Rejection of some medical advice

Some of the advice was said to be clashing with what they traditionally/religiously believed in or what was regarded as risky basing on their backgrounds/home countries. One of the pieces of advice or decisions that were feared and regarded as a short cut to death during the process was cesarean. As a result, some African migrant mothers rejected the proposal of being operated. The findings of Essen (2001, p. 42) support this finding. In her study, she notes that “women expressed fear of cesarean because it would limit the number of children they could have and also because of their anxiety of dying during the procedure. Essen (2001, p. 42) cites a mother; *Cesarean—it is a nightmare. I know women who did not survive. If you survive, it gives you other problems. You can’t get pregnant until two or three year after.* This is also linked to the findings on family planning that Muslims do not accept family planning. The spacing of 2 or 3 years is a worry for a mother which communicates the time they take to delivery again,

something that one of the professional commented on during the current study. The same attitude against cesarean was reported in the current study with some mothers refusing completely. Basing on their background, they think they are going to die since they have seen many who have not survived childbirth. This is one reason why they try as much as possible to avoid caesarean at birth by starving themselves. In her study, Essen remarks that “these women consider safe delivery to be normal virginal delivery, and thus reduce on the food intake to limit the growth of the fetus and therefore avoid caesarean section and maternal mortality (Essen, 2001, p. 42). This is in total agreement with the findings of the study basing on the remarks of the doulas, mothers and professionals.

Essen (2001, p. 57) in her research also notes that all the cesarean cases among the Ethiopians and Somalis were considered emergency, implying that the operations were done too late given the negative attitude towards the act. She notes that “Ethiopian or Somali mothers have often refused or delayed emergency caesarean, even when experiencing such severe symptoms as virginal haemorrhage or a threat to the fetal asphyxia—condition of being prevented from breathing”. Even after having interaction with both the doulas and professionals during antenatal care assuring them of safety during the operation, some mothers in this study still did not believe cesarean can be safe. Essen confirms this when she observes that “the notion among these Ethiopian and Somalis seems to be that caesarean causes death, rather than understanding the procedure as an attempt to prevent fatal outcomes (2001, p. 57).

McCarthy and Maine 1992 cited in Wardlaw and Maine 2000, p. 25) observed that “in theory, there are three main pathways to reduce maternal deaths: reducing the number of pregnancies and births; reducing obstetric complications; and preventing deaths among women who have developed serious obstetric complications. In this case, if a woman is pregnant and can deliver normally, it becomes reasonable to opt for a cesarean, something that this current study has identified having a lot of rejection from some African migrant mothers.

Other studies also support the findings of this study. Gunnervik et al (2008) support the findings of this study: Al-Mufti (1997) observe that in a study from London, 17% of obstetricians wanted caesarean deliveries for themselves even in the absence of clinical indications and 31% of female obstetricians said they would choose elective cesarean section (cited in Gunnervik et al (2008, p. 443). Another study of 365 trainee obstetricians in the UK reported that 15.8% would prefer a cesarean section (CS) for themselves (Wright et al 2001 cited in Gunnervik et al (2008, p. 443). In another study, Scandinavian obstetricians seem to have a more restrictive opinion on CS; in Denmark only 1% and in Norway 2% of obstetricians would prefer elective CS in an uncomplicated pregnancy at term for themselves (Bergholt et al, 2004, Backe et al, 2002).

Gunnervik et al (2008, p. 443) also found that the Swedish obstetricians and gynecologists were in overwhelming agreement (99%) on the hypothetical question on preferred mode of delivery— they would prefer a vaginal delivery for themselves, their partner and daughter. It was also revealed in the current study by the professionals that they believe in normal deliveries and that is why they are hesitant to allow a cesarean on personal request especially if they are healthy and normal. One mother during the interviews had to push hard for three months to have request for cesarean granted because she was health and normal. Habiba et al (2006) cited in Gunnervik et al (2008, p. 443) had reported that obstetricians from countries with low cesarean rate were less willing to perform an elective cesarean section compared to those who were from nations with highest cesarean rates. Ryding (1993, p. 280) in a study “investigation of 33 women who demanded a cesarean section for personal reasons” observes

that; in Sweden, obstetricians rarely perform cesarean section in the absence of obstetric complications of pregnancy or childbirth (Nielsen, 1984). Again Cranky 1983 cited in Ryding (1993, p. 280) noted that “many of both the members of the medical professions and parents-to-be also believe in the psychological benefits of as natural a childbirth as possible”. Sjögren and Thomassen (1997, p. 951) observed; Obstetricians try to restrict cesarean section, to minimize the complications of operative delivery (citing Nielsen 1984) and because of an understanding of the positive physiological effects of vaginal delivery. Essen et al (2011, p. 12) in their very recent study named *An anthropological analysis of the perspectives of Somali women in the West and their obstetric care providers on caesarean birth* reported that “The Somali women in our study believed that Cesarean section delivery might likely result in maternal death, while the providers identified cesarean as preventive care that is intended for saving the life of mother and infant.

However, since there are no private obstetricians in Sweden, one cannot buy such services, the obstetricians though they do not find it easy; they have an obligation to allow a cesarean in case a woman demands it for personal reasons. This is in accordance with Sweden’s Health and Medical Care Act of 1982 (Ryding, 1993, p. 280). This confirms the findings of this study where a woman’s request was granted even though as Ryding (1993, p. 280) observes; In Sweden, repeat cesarean section is not performed unless there are imperative reasons such as serious pelvic abnormality. It could have been because of this that one of the respondents found it hard.

Ryding (1993, p. 281) in his study reported three reasons that were given by those women who demanded for cesarean. Reportedly, “bad experiences of pain all had longer or shorter periods of feeling close to death, either dying of pain or wishing for death to end the pain; basing on their backgrounds whereby eleven women had been brought up by mothers who had told them about very negative childbirth experiences and lastly, their own reasons; women who had delivered before stated that the main reason for a cesarean section was fear of the pain during the opening stage of a vaginal delivery. One could say that some women were influenced in their decisions basing on all the above factors as Ryding recorded.

In either cases where healthy women for some reasons demanded caesarean and where women with possible complications sensed by professionals, the influence of social interaction was fundamental to reaching a compromise by the involved parties. Likewise, mothers open to the advice from the midwives found it easy to agree with the professionals unlike their counterparts with closed systems.

6.5 Validity of the study

Kvale (2009, p. 241) notes that validation should permeate all the stages from thematizing to final reporting. In this study therefore, the validity of the findings can be based on the fact that it is not something that can happen at just one stage in the study but rather at all the stages. Right from the beginning of the study, the researcher thought about the research area which was generally reproductive health and finally narrowed it down to the nature of interaction between African migrant mothers and obstetric care providers but also a theoretical framework. At the formulation level, after formulating the research question, objectives that would help in answering the research question were full developed. The researcher then came up with three interview guides that were sufficient to generate the information that he had set out to get. All the

guides had adequate and understandable questions for the respondents not to misunderstand them and answer them contrary to the researcher's expectations.

During the interviews, the researcher was able to ask follow up questions, consistence and confirming questions as well as seeking more clarity whenever it was deemed necessary. The interview environment for all the categories of respondents was secure, non-scary and determined by the respondents themselves. For example, the professionals booked the researcher during their free time at their workplaces and thus used their offices without interruptions. Thus, it hardly if ever, interfered with the quality of information obtained. To ensure convenience and safety, two African of the African mothers were interviewed through skype and phone calls because they did not have time to meet with the researcher. Interviews including the ones on phone and skype calls were audio recorded to capture full details of the interview but after being permitted by the respondents.

The interviews were transcribed verbatim by the researcher who kept referring to the transcripts and the audio recordings throughout the whole study. Data was then managed, coded and analyzed thematically to produce a research report.

During analysis, the researcher kept on referring to some of the voices of the respondents in order for readers get it the way it was said by the respondents and this shows that the researcher did not use only our own views but also the views of the respondents as well. Although all the respondents were from different continents with different backgrounds and traditions, different academic qualifications, responses were analyzed by the researcher under the four main themes that is to say obstetric care seeking behavior of these African migrant mothers, motivation factors, nature of interaction between the African migrant mothers and obstetric care providers and interactional effects on the service outcome. Any information that could lead to the identification of the respondents was not included in the analysis of the findings.

The researcher had an open mind free from bias from the beginning of the study and came up with three theories. Though there were theoretical assumptions preconceived prior to conducting the interviews, these served as guiding rather than restricting devices to obtaining interview knowledge. Three theories and previous researches were also frequently used in the explaining/analyzing the findings of this study. About the choice of respondents, only those African migrant mothers who had delivered from Sweden at least once as well as being current residents of Gothenburg city. Balancing the different regions of Africa was also one criterion that the researcher had in mind and that was achieved. This was intended to have a better sample representation.

6.6 Generalization of the study findings

The results of this study have the possibility of being generalized to other African migrant mothers with in Sweden. This is because they are living under the same state and are free to access the same obstetric care services. the fact that they are coming from the same continent and living in the same country as well as interacting with obstetric care professionals is what Kvale (2009, p. 261) calls same situation, implying that the findings can apply to them as well. These study findings however cannot be generalized to illegal African migrant mothers who are not within the system and may not access the services. The study can also be generalized to other African migrant mothers in other developed countries that are offering free and accessible obstetric care services to all people despite the country. This means that the mothers will be in

the same situation as in Sweden. Other women from other continents to countries with the same obstetric care services like Sweden but at the same time have migrated with their cultures and beliefs. These could be having related experiences as the African mothers that have been studied.

7. Summary and Conclusion

This begins with the summary and a conclusion will follow thereafter.

7.1 Summary

In summary, this study found out that obstetric care seeking behaviors of African migrant mothers were generally good with the majority of them being able to access services. Many African migrant mothers were reported having made the recommended number of antenatal visits and seeking the care within the recommended time after conception. However, it was highlighted by some professionals and doulas that not all the African mothers make the recommended number of visits or come in early as per antenatal clinic schedule. A number of factors for inconstancies were raised some of which were personal whereby they did not feel it was that important since they did not feel any discomfort as well as others developing a feeling that the appointment were too many for them—the midwives are not giving them space. Some other women did not know they were pregnant till late and thus ended up going late for the service. This was however done in good faith and the intention was to have better obstetric care outcomes. Others who made late or less visits had systemic constraints e.g. some did not know where to go for the service while others had no personal numbers. There were those who were not used to the system of seeking care early in pregnancy.

An interaction with the professionals revealed that visiting the midwife two weeks before the estimated delivery is a necessity for pregnant mothers to get more prepared for the eventual delivery. It was found out that all the African mothers who participated in this study had made a visit two weeks before the estimated date of delivery as required by the professionals. As a result, no one reported having missed the visit as they were making four visits in the final month of pregnancy. It can be argued that the interaction between the mothers, doulas and obstetric care providers was key in attracting these African migrant mothers into seeking the service.

In addition, all the seven mothers admitted having delivered from the hospital with the help of the obstetric care providers, something that the professionals also confessed too. As a result, this could inform the researcher about the African migrant mothers' health seeking behaviors. No one was reported having delivered from home or with the assistance of fellow women. Through interaction with the professionals, African mothers were able to see the importance of delivering from the hospital. Otherwise, some would have opted to seek the services of the TBAs.

It was reported that most women make the final visit after delivery to their midwives. The mothers and professionals reported that the mothers make the final visit to the clinic. Some pertinent issues including among others the delivery experience, their current state and family planning services. Some respondents appeared to support the role of TBAs only in areas with a few trained professionals. However, they were all quick to raise skepticisms citing complications and risks involved that a woman is exposed to in that process, the main one being death.

A number of factors that motivate these African migrant mothers to seek antenatal care were raised which included among other things; the need to know the health of their unborn babies whereby most mothers and professionals were worried about their condition of their babies. Some mothers had concerns over their own health and therefore wanted to play safe by visiting the midwife while others were affected by pregnancy sicknesses. Desire to get information since some women reported the desire to get information about their health, that of their unborn babies, and any other vital information regarding their pregnancy situations. Other

African women saw the professionals as the sole source of information in the absence of their aunties or other family elders in Sweden who could have offered some advice during pregnancy. Reported to have been attractive and motivate to these women were free, timely and good quality services. Both the professionals and the mothers informed that having come from countries where services are characterized by fees, untimely and poor quality feel motivated to seek for the service in a country where the reverse is true.

There were a lot of issues that came up during the study concerning the nature of interaction. The focus of the professionals and African migrant mothers was categorized as; information shared that is to say how to feed, information concerning their health and that of their babies, doing exercises; medical checkups the and results that is to say various tests were carried out by the professionals on these women with ultrasound, blood pressure, diabetes being on the schedule; abortion advice was offered in case the baby was detected to be sick or the mother had other reasons. But this was faced with strong rejection from some women with religion fronted as the basis. This misunderstanding was cleared through the interaction between the professionals and women; the issue of FGM would also be discussed during pregnancy in order to let the women know of the procedure during delivery especially the extent of cut and closure. This was however not fully understood by some women who reported that they stitched the way they were before yet the midwives noted that they only stitch up to the level similar to that of uncircumcised mothers since FGM is criminalized in Sweden; women starving themselves during pregnancy—those from the horn of Africa with the aim of limiting the fetus growth in order to have simple and easy delivery when the size that would not call for a cesarean that is considered as dangerous. Without this kind interaction, some women having such misinformation about how to feed during pregnancy would be in serious trouble; final period of pregnancy was used to prepare women for delivery, give signs of eminent delivery and keep close monitoring of the unborn baby.

Contraceptive use was also given attention at the time when a woman went back and to visit the midwife that took care of her during pregnancy after six or eight weeks after delivery. Women were offered a chance to choose for themselves the method they wanted. However, not all mothers welcome the advice with open hands since some based on Islam religion to say no; and involvement of the husbands, families and friends. Some men were reported having accompanied their wives for antenatal, parent's meetings and delivery. It was discovered that the presence of men in the delivery rooms gave support, comfort, security to some women. Observed was that the involvement of the women's husbands and members of their social networks was not equally beneficial to all women. Whereas it benefitted some, for others it turned out to be more or less a liability. But nonetheless, for the latter category of women, their interaction with the professionals was very paramount in clearing up such myths and misinformation. This interaction was boosted by the activity of the doulas. This interaction was reported to have substantially had an impact on the preparedness for the delivery, the health of the baby and the mother, the subsequent care for the baby, among other things.

Finally, a number of benefits were identified to have been as a result of the interaction between the mothers, doulas and the professionals. These include; the good health of both the mother and the child. It was reported that good health was recorded not only for the mothers but also for their children courtesy of interaction; psycho-social benefits that is to say some mothers seemed well prepared and confident as a result of the interaction. Some of the mothers reported having felt well during the whole process. Some said that they even developed bondage with their midwives at different levels; trust, respect, consultation and confidence—many mothers

reported having been respected and consulted them on the actions they were to make on them which brought about confidence the interaction. Some professional observed that African mothers are easy people to work with and often times, they cooperate compared to the Swedish women. However, one of the professionals reported that instead, African mothers trust their poor and tend to maintain what they believe in especially normal delivery; African mothers' satisfaction of the care. All the mothers that were interviewed appreciated the obstetric care professionals for their kindness and commitment. Some mothers compared the service here with what would have happened if they were in their respective African countries. Some were however dissatisfied with some aspects which included among others many appointments, documentation of data, language, and time of pushing the child and fighting to have some decisions made; the system and its impact on interaction as many of the obstetric care professionals, African migrant mothers said that it is good. This was however challenged some women noted that there are so many appointments.

However, barriers to effective interaction and service outcome were reported. Namely; language difficulties in relation to interaction that is to say that some women could not freely express themselves in Swedish yet some of the professionals did not know English. The worst scenario arose when the African mother neither knows Swedish nor English which reportedly was not uncommon; the influence of traditional beliefs and cultures on interaction between the parties that is to say religious faith among the African migrant mothers, mothers' reluctance to meet or be attended to by male service providers. Some African migrant mothers of Muslim faith were found to be unprepared to go for obstetric care services if the services were to be provided by men. Both the women and professionals reported Islamic religion as a factor that hinders the women's willingness to meet with male professionals since they are not expected to show some parts of their bodies to men that were not theirs.

One the other hand, some Muslim mothers permitted room for flexibility by accepting to allow an interaction with a male professional in case there are no female professionals; refusal of some medical advice— some of the advice was said to be clashing with what they traditionally/religiously believed in or what was regarded as risky basing on their backgrounds/home countries. Among them was cesarean with some mothers saw as the easiest way to reach death basing on their experiences back home in their countries. Some women were reported by that professional that they believed normal delivery and rejected any suggestion of cesarean and can conceive again in case a child dies.

7.2 Conclusion

The Swedish obstetric care system is well organized and professionalized with the professionals trying their best to save the life of the mother and her baby. The structure itself lays a fertile ground for the mothers to seek the services from a nearby health center, interdependency of the midwives and obstetricians though the two units seem be independent have impacted on the service outcome as Payne (2005,p. 145) puts it. Moreover, the coming in of the doula a third party has further improved the interaction especially in the area of communication and safety between the obstetric care providers and seekers, thus better service outcomes. It has somehow helped African migrant mothers to accept using some of the modern medical services, good quality care and good health outcomes.

However, it cannot be taken for granted that all the African migrant mothers have benefited equally from this obstetric care service arrangement. It cannot also be said all the mothers are happy with the system as some of them see it as clashing with their cultures, beliefs and religions e.g. the issue of being examined by male professionals, failure to close circumcised women like they were before or cesarean delivery. One can argue that such mothers are getting the same services or interacting with the professional against their own will and that does not generate the psychological satisfaction. In addition, these mothers may not find it easy to trust the midwife outside the professional field. They may go for the service given the fact that some say it is 'policing' because they have no option and they are sure that the professionals have the necessary skills to provide them with the service. But trust and confidence is an important issue in this case of medical care if a client is to derive satisfaction (Mogren et al, 2010, p. 2 citing Hupcey et al, 2001). Those women who have kept closed doors as Payne (2005, p. 144) noted, cannot achieve high quality service outcome. On the other hand, although some of these mothers get the services against their will, it is important to note that at least they benefit in one way or the other as a result of this interaction that is to say in terms of health, information and other social benefits.

It can thus be argued that however much the interaction has been faced with a number of barriers by some women keeping themselves closed to some advises, the results of this study did not show bad obstetric outcomes as result of clashes. Women were able to come to some form of agreement with the professionals through doulas and received some services at the end of it all. The interaction has been beneficial to them to a certain level.

In a nutshell, it is clear that those women that were so liberal and open to the system have had good interactional service outcomes compared to those who are closed to system in the name of beliefs and religion. Nonetheless, there have been more positive interactional outcomes to the African migrant mothers whether liberal or closed. As long as some mothers maintained the closedness, the goal of interaction will be far from being achieved. Likewise, as long as the professionals do not appreciate the culture of the African migrant mothers, it is more probable that the two will keep communicating along different lines. A further study should be carried out to find out whether the mothers who are circumcised but are opened during delivery and they are not closed up the way they were before delivery try to go back to their countries to be fully circumcised. Another study can focus on the full role of the satisfaction of the African mothers as far as the role of the doulas and interpreters is concerned. It is also important to do further studies in the area of communication between the African migrant mothers and obstetric care givers.

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Appendices



GÖTEBORGS UNIVERSITET

Consent Form

My name is Innocent Atwijukire, a Second year student at the University of Gothenburg pursuing a Masters programme in International Social Work and Human Rights (MSWHR).

As a requirement for the fulfilment and attainment of the award of this Degree, like any other student, I am obliged to undertake a research project. Thus, I am conducting a study titled, "***The Nature of Interaction between African Migrant Mothers and Obstetric Care Providers and its effect on Service Outcome: A case of Gothenburg city, Sweden***". Specifically, the study aims to study/interact with Obstetricians, Midwives as well as African migrant mothers on the nature of interaction and its effect on service outcome.

You have therefore been chosen as a potential participant to take part in this study. The following is a presentation of how the data collected in the interview will be used.

In order to ensure that this project meets the ethical requirements for good research I promise to adhere to the following principles:

- You will be given information about the purpose of the project.
- You have the right to decide whether or not to participate in the project, even after the interview has been concluded.
- The collected data will be handled confidentially and will be kept in such a way that no unauthorized person can view or access it.

The interview will be recorded as this makes it easier to document what is said during the interview and also helps in the continuing work with the project. In my analysis, some data may be changed so that you may not be recognized. After finishing the project the data will be destroyed. The data collected will only be used in this project.

You have the right to decline answering any questions, or terminate the interview without giving an explanation.

.....
Respondents signature

Researcher/student

Innocent Atwijukire
atwinno@yahoo.com

0734948591



GÖTEBORGS UNIVERSITET

Letter of introduction

My name is Innocent Atwijukire, a Second year student at the University of Gothenburg pursuing a Masters programme in International Social Work and Human Rights (MSWHR).

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You are welcome to contact us or our supervisor in case you have any questions (e-mail addresses below).

Student name & e-mail

Supervisor name & e-mail

Innocent Atwijukire
atwinno@yahoo.com

Gunilla Framme, PhD
gunilla.framme@socwork.gu.se

Tel. 0734948591

Tel. 0733-424035

Coordinator of the MSWHR: Ing-Marie.Johansson@socwork.gu.se
Tel+ 46 31 786 1889
Fax+46 31 786 1888

An interview guide for Midwives and Obstetricians

1. At what time do the African migrant mothers usually make their first visit during pregnancy? (Probe for: in case it takes them long, what accounts for that? And if it takes them a short time what were the accounting factors?)
2. How do you spread the information about the service to these women?
3. What motivates these African migrant mothers to seek these services?
4. What is the ideal number of visits that are expected of a mother during pregnancy, at birth and after birth? (Probe for whether African migrant mothers make these visits)
5. Where do you put much emphasis during all these stages? Is it during pregnancy, at birth or after birth?
6. How do you distribute resources when it comes to these stages?
7. What kind of information do you always shared with these mothers?
8. What has been your experience with these women of African origin? (describe the nature of interaction between the two)
9. Is your experience with African migrant mothers different from that with women from other parts of the world? (Probe how and why so)
10. In your own opinion, how helpful do you think this interaction is for these women?
11. What do you think others African migrant mothers who do not interact with obstetric care professionals miss during this period?
12. What is the nature of power relations between you and these African migrant mothers? Do you think they feel powerless, intimidated? Or take you as being too superior? Is there power balance? Probe for why so?
13. What is your view about seeking the services of TBAs? Do you find any signs of traditional beliefs among these African migrant women? If yes, how are they handling?
14. Do you see any traditional issues or aspects that you may consider worth seeking from TBAs?
15. What is your view about the social networks of these African migrant mothers in relation to their obstetric care seeking behavior?(probe for people they associate with, their families and their neighborhood)
16. Does your interaction with these African women involve their husbands? (probe for its implication on the quality of care if yes or no)
17. What is your view about the Swedish obstetric care system? Do you think it is adaptive for all women?

An interview guide for African migrant mothers

1. Which health center did you visit for obstetric/maternity care?
2. What information did you have before seeking the care? (probe for: what they knew before about the pregnancy, about the service in Sweden, where to get it, how they got the information)
3. After how long from the time of conception did you make your first visit? (Probe for: in case it took her long, what accounted for that? And if it took her a short time what were the accounting factors?)
4. How many times did you get the service during your pregnancy? (probe for the reasons for the defined number of times she sought the service in relation to the ideal number of times)
5. Did you make any visit two weeks before the estimated time of delivery? (probe for clients' knowledge about this, the exchanges the client had with the medical personnel)
6. Comment on your labour experience (treatment by doctors and midwives, involvement in decision making, etc)
7. Did you make any visit after birth? (why or why not)
8. What motivated you to seek these services?
9. Comment on the nature of interaction you had with your midwife/obstetrician (probe for: satisfaction with the service, respect from the medical staff, information shared, nature of communication, character of personnel—e.g. kindness, rudeness, etc)
10. What was the nature of power relations between the medical personnel and you? Did you feel powerless, intimidated?
11. Did it make a difference by visiting and interacting with the medical personnel during your pregnancy, at birth and after birth? (probe for details)
12. In your opinion, how useful was this interaction (during pregnancy, at birth and after birth)? What benefits accrued from such interaction?
13. Would you encourage your peers or any other pregnant woman to seek the services of trained professionals such as the ones you sought? (give reasons for why or why not)
14. What did you find unpleasing or discouraging following your visits and interaction with the staff?
15. What is your view about seeking the services of TBAs?
16. Do you see any traditional issues or aspects that you may consider worth seeking from TBAs?
17. Do your social networks affect your interaction with your maternity staff?(probe for people they associate with, their families and their neighborhood)
18. Did you make visits to the health center with your husband? (What is your about men accompanying their wives to the health centers or hospitals during antenatal, labour or after birth?)
19. What is your view about the Swedish obstetric care system? Do you think it is adaptive for all women?

An interview guide for doulas

1. What kind of activities do you offer have under your project?
2. How do these mothers come to know about your project and the services that you offer?
3. What happens as soon as you get into contact with these African migrant mothers?
4. At what time do the African migrant mothers usually make their first visit during pregnancy? (Probe for: in case it takes them long, what accounts for that? And if it takes them a short time what were the accounting factors?)
5. What motivates these African migrant mothers to seek these services?
6. What is the ideal number of visits that are expected of a mother during pregnancy, at birth and after birth? (Probe for whether African migrant mothers make these visits)
7. What kind of information do is normally shared between African migrant mothers and professionals?
8. In all this interaction, where do you come as doulas? (probe for their role as doulas).
9. What has been your experience with these women of African origin? (describe the nature of interaction between the two)
10. In your own opinion, how helpful do you think this interaction between doulas, pregnant women and professionals is for these women?
11. What do you think others African migrant mothers who do not interact with obstetric care professionals and doulas miss during this period?
12. What is the nature of power relations between the professionals and these African migrant mothers? Do you think they feel powerless, intimidated? Or take professionals as being too superior? Is there power balance? Probe for why so?
13. What is your view about seeking the services of TBAs? Do you find any signs of traditional beliefs among these African migrant women? If yes, how are they handling?
14. Do you see any traditional issues or aspects that you may consider worth seeking from TBAs?
15. What is your view about the social networks of these African migrant mothers in relation to their obstetric care seeking behavior? (Probe for people they associate with, their families and their neighborhood)
16. Does your interaction with these African women involve their husbands? (Probe for its implication on the quality of care if yes or no)
17. ghWhat is your view about the Swedish obstetric care system? Do you think it is adaptive for all women?