

TRUST, VACILLATION AND NEGLECT

Refugee women's experiences regarding pregnancy and birth giving in Finland

Abstract

The paper analyses how refugee women experience pregnancy and childbirth in interaction with professionals. The narrative analysis identifies three storylines: one about 'good' experiences and emphasizing satisfaction; another about dramatic experiences and disappointments with maternity care; a third about tragic experiences as a result of failures of the maternity care system. Building on the theorizing on the relevance of trust and confidence in salutogenic theory, the analysis concludes that all women, regardless of how they interpret their experiences, value reciprocal relationships with care providers. Social recognition as an equal partner in care helps women to overcome difficult experiences related to pregnancy and childbirth.

Keywords

Refugee women • salutogenesis • Finnish maternal care

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Introduction

The aim of this paper is to explore how refugee women experience pregnancy and childbirth in interaction with the Finnish maternity care professionals. The study employs the salutogenic (from the Greek *salus*; meaning health, and *genesis*; meaning origin; means the origin of health), theory that defines a human being as a capable and resourceful agent. Health and wellbeing are subsequently considered as a complex interplay between an individual's ability to solve problems and to use resources available in their surroundings (Anderson, Björnberg & Eastmood 2010: 4, 21; Antonovsky 1979; Eriksson & Lindström 2011: 67). The focus is not only on the women's abilities to cope but especially on the circumstances that structure refugee women's access to the maternal care. To emphasise individuals as capable, with an ability to behave with agency, is important and opposite to the stereotypical view of refugees as passive. A sense of agency has an impact on wellbeing and a sense of control over one's life. It develops through social relations, such as the maternal health care system. An ability to take action is related to a power balance but also to a sense of meaning, it becomes meaningful to act in a certain way (Anderson et al. 2010: 22–23).

Antonovsky (1979) introduced his salutogenic theory and its core concept the 'sense of coherence' (SOC) as an overall life orientation, claiming that the way people view their lives influence their health. The second core concept is the 'generalised resistance resources'. The key to develop a SOC lies in the ability to identify resistance resources, to use and reuse them in a health-promoting manner, that is, to find reliable social support. Resistance resources are defined

as any characteristic of a person that is related to their ability to cope and solve problems that occur during life. Antonovsky divided them into internal and external resistance resources at a person's disposal. Internal resources are, for example, knowledge or religion. External resources can consist of family support or of the maternal care system in the local surrounding. Having a SOC means that people have the ability to understand the situation and find the energy necessary for solving problems (Eriksson 2007, 98; Suominen 2011).

The sense of coherence consists of three key components: 1) comprehensibility – the cognitive component; 2) manageability – the behavioural component; and 3) meaningfulness – the motivational component. These three components strengthen a person's ability to take charge of her health and wellbeing (Eriksson 2007, 98). However, pregnancy and childbirth challenge the sense of coherence, as a layperson has limited capacities to comprehend the course of physiological conditions and even professionals cannot predict their course with certainty.

In this study, I examine whether and how refugee women experience the services provided by the Finnish maternity care system as an external resistance resource. Since all refugee women with residence permit are entitled to use the maternal care services free of charge, I explore to what extent refugee mothers experience it as an external resource to take care of their particular needs.

In Finland health and social service are based on the universalistic principles of equal right to professional care. The maternal care is free of charge and based on voluntary choice for all inhabitants in

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Finland (including migrants with residence permit). Almost all (99.5 %) families with children under school age are registered service users. Finnish maternity care is based on expert related authority and carried out within the local municipalities that are responsible for organising the maternal care. It has been divided into two different units with two different types of health care professionals, those who take care during the prenatal stage and those who provide care during childbirth (Wrede 2001). The central purpose of the prenatal care is to provide regular follow-up appointments by public health nurses (PHNs) and medical doctors (GPs) during the pregnancy. Childbirth then takes place in hospitals where midwives and obstetricians are specialised in this particular maternal care (Liljeroth 2009: 21–22; Anttonen & Sipilä 2000).

In general, the public in Finland values professionally established maternity care, recognizing it as a high quality service (Anttonen & Sipilä 2000: 173). This means that maternal care professionals enjoy high prestige, the kind of which Bourdieu identifies as 'symbolic capital' in that, 'they are perceived and recognised as legitimate' (Bourdieu 1991: 230). This recognition ensures legal power to define care-related needs and interventions according to normative professional knowledge and practices. Consequently, normative institutional practices structure the professional behaviour and ethos toward high quality work which is subordinated to individual values. However, regardless of the high quality of professional practices, birth is a physiological process involving risks and complications that cannot always be predicted or hindered. Furthermore, all types of health care practice may involve mistakes with potentially irreparable tragic consequences.

Refugee women usually arrive from circumstances where maternal health care is not well developed. Their knowledge about maternal health care, as it is practiced in Finland, varies greatly, and if the system is unable to provide them with the needed knowledge, the mismatch of expectations can cause different kinds of distress and communication problems (Malin & Gissler 2009; Malin 2011). Linguistic barriers may also be caused by maternal care professionals' difficulties to interact with migrant women and of unsatisfactory interpretative service (Lyberg et al. 2011).

My research examines to what extent the care of pregnancy and childbirth as practiced in Finland is comprehensible, predictable and meaningful to the 11 interviewed refugee women. How did the interviewed refugee women experience their pregnancy and childbirth from their own point of view?

Next I discuss my salutogenic approach to maternity care interactions, after which I present the data collection and the analytical framework. In the presentation of the analysis, I first discuss the women whose relations with maternity care evolved in a reciprocal manner, after which I consider one case example of birth-related experiences where the women's expectations for maternity care were not met and their needs were neglected, resulting in events that were experienced as dramatic as well as tragic. I conclude by discussing the relevance of reciprocity and trust in building good relationships between refugee women and maternity care professionals.

The demands of developing trust and confidence in the Finnish maternal care

Within the salutogenic theory, the concept of SOC focuses on trust and confidence. Having SOC means that the impulses individuals get from the internal and external world are comprehensible and

worthy of engagement. The emphasis lies in trust and confidence that resources are available if needed and that they are sufficient to take care of the demands (Suominen 2011: 98). A refugee woman becoming pregnant and giving birth in a new country, depends on the ability of the maternal care providers in that country to invoke her trust in the health care professionals.

From a salutogenic perspective, the sense of trust is embedded in social recognition within interactions in family networks and a local society. Trust is socially learned and socially recognised expectation an individual experiences in reciprocal interactions. This social recognition means that an individual is received with symbols and talk that signals positive values and an invitation to reciprocal relationships. Social recognition means being acknowledged. The opposite of social recognition is being unacknowledged, for example, by not acknowledging greetings or ignoring questions (Björnberg 2012: 277–278). Culturally sensitive care helps developing trust and gives a sense of being socially recognised as a unique individual. It facilitates a sense of confidence, especially in situations when one's language skills are rudimentary (Dengi et al. 2012). However, cultural sensitivity has been critiqued for understanding individual behaviour as culturally determined and to overlook complex individual differences (Griffith 2010).

To develop trust and confidence as a reciprocal process seems to be a current challenge for health care providers in Finland. In her study of migrant integration into the Finnish society, Varjonen (2013: 157–159) points out that integration has not been featured as a reciprocal process. Rather the main responsibility for integration into the Finnish society seems to rely on the migrants themselves. She emphasises that successful integration do not materialise if Finns do not make more efforts to develop reciprocal relationships with migrants. Varjonen asks if migrants, who feel uncertain of their sense of belonging, are expected to repeatedly show an extended sense of gratefulness that it prevents well-founded critique of poorly organised services or of services that are difficult to comprehend (see Niner & Kokanovic 2013).

According to a study of health care providers' experiences of providing maternal care to Somali women living in Finland (Dengi et al. 2012), there are widespread communication problems due to culture and language differences that sometimes cause challenging situations. Additionally, a lack of interpreters who would know medical terminology was perceived as an obstacle in communication with the Somali women (Degni et al. 2012: 330–339). The data of the present study indicates that the interpretation service within Finnish maternity care is not systematically organised, which is not surprising considering the heterogeneity of the service in Sweden (see Bredström & Gruber 2015).

My study supports the finding that the most obvious problem within maternity care was related to communication, especially in relation to women who lack elementary language skills, and need to communicate through an interpreter (see Bredström & Gruber). When asked if an interpreter was routinely present, my interviewees said no. Secondly, while Finnish maternity care organises prenatal classes for the native Finnish-speaking women and their partners expecting their first child, such education appears not to be available for refugee women. When I asked my interviewees if they have participated in prenatal classes, they did not understand my question. It turned out that refugee women and their families were not offered such a maternity care service in their native language, even they could be expected to benefit from preparing to birth and meeting other couples.

Studying refugee women's experiences

The data was collected in collaboration with local authorities in the city of Vantaa within the Helsinki metropolitan area that was carrying out a pilot project connected to the implementation of the new Act of Integration. The project was targeted to migrant women outside of the labour market who care for their infants at home.

The local immigration authorities invited mothers who could be identified as refugees to participate in individual, semi-structured 'cross-language' interviews, that is, interpreters were used. My criteria for selecting informants were that they are refugee women 1) who have been granted a residence permit in Finland, 2) who have lived for at least 2 years in Finland, and 3) who currently take care of their child(ren) at home. The interviewed women are here categorised as refugees since they arrived as asylum seekers with their family or husband. In Finland, the majority of migrants came because of work, family reunion or studies, while only 10% came as asylum seekers (Martikainen et al. 2013: 39). Thus my interviewees represent a minority among migrants of whom there is limited research knowledge.¹

I ultimately met with 10 women (6 Somali, 3 Russian/Chechen, 1 Iranian and 1 Afghan) for an individual interview. In addition, one of the interpreters who fulfilled the study criteria volunteered to be interviewed.²

Even when I made efforts to develop a reciprocal relationship with the interviewees, I was aware of an imbalance in status and power between us. Regardless of my outspoken explanations of not being a representative of any authorities, the interviewees may have nevertheless seen me as a representative of a dominant societal power position (Hyden 2008: 126), which has impacted on what they told me and how they framed their narratives. Another obstacle for reciprocity was the fact that the use of interpreters was a prerequisite for gathering data, since I did not have a shared language with any of the participants, apart from the volunteering interpreter.

Six of the interviewees had given birth to their first child in Finland. Five women had two or more children and had delivered both in their native country and in Finland. The age of the children born in Finland ranged from 3 months to about 2 years of age. The mothers were between 20 and 37 years of age and all lived with their husbands. All women experienced their husbands as supportive in the child care. A few had extended family members living close by, some practiced transnational contacts while some were disconnected from their relatives. Regarding the women's educational background, two mothers were illiterate, six mothers' schooling ranged from 1 to 11 years, one had a high school diploma, one university studies and had correct the end of the sentence; a completed degree in nursing. These women had lived about 3 or 4 years in Finland prior to the interview.

When interviewing is made possible through interpretation, besides engaging in reflexive elaboration on the thematic and dynamic aspects with each interviewee, the interviewer has to develop an equally good interaction with the interpreter, since language and communication always transfer verbal, and nonverbal information (Lillrank 2012: 281). Thus, good interactional relationships are essential since professional interpreters participate in situations where they are able to understand everything said and thus can exercise a certain control over the situation (Wadensjö 1998: 105). Similar to my experience, Wadensjö (1998: 8) suggested a 'dialogue model' because 'the meaning conveyed in and by talks is partly a joint product'. This means that an interpreter is part of the interaction between an informant and a researcher (Wadensjö 1998). Here, the

interpreters also contribute to the communication based on their cultural and social background.

The researcher examines the way a story is told – how it is expressed and how it convinces the interviewer of its authenticity. Since the narratives about experiences follow a cultural style of storytelling, the translated and transcribed interviews require multiple readings. Working with translated interviews – because of the uncertainties of language and meaning – raises interpretive problems that all qualitative analysts face, regardless of being a native speaker or not (Riessman 2000: 130). It was not always possible to know if the translated questions were understood as I intended them to be understood, or to follow up uncertain lines of thoughts. Even when authorised interpreters were used, they varied in their language proficiency.

Another dilemma of particular relevance for this study is the second translation and meaning-making from Finnish into English for English-speaking readers (see Riessman 2000: 133–144). Since it was a challenge to understand and sometimes make sense of the interviewees' thoughts through the process of interpretation during the interview, I have included relevant parts of our interactions to unfold our joint construction of the data (Lillrank 2012: 281).

My analysis began with a thematic content analysis on 'what' these women narrated about their pregnancy and birth-related experiences. In analysing what they told about their interactions with the maternal health care professionals, I am aware of my 'ghostly' position as representing the local authorities, that may have impacted on the women selecting what to tell and what to omit. In this analytic task I rely first of all on the transcribed interviews but also on my personal intuitions and field notes about our interactions. For example, I sensed that women tended to easily portray a situation as positive if my question was formulated with alternatives. Or, that they wanted to present themselves as 'happy migrants' without delving into too much confusion of the professionals' habits. Sometimes I felt that the women wanted to tell about poor treatment episodes since they were either overwhelmed with misunderstanding or perhaps perceived me as a representative of local authorities who could improve circumstances. Sometimes I also wondered, like Molly Andrews, 'Am I really able to hear that which I have not experience of' (2007: 16, 17–25). She discussed how the interviewees' perceptions of her may have impacted on how they told their story.

Characteristic for the interviews were short episodic narratives of pregnancy and childbirth. In these narratives 'what' they experienced were usually intertwined with 'how' they experienced something. Determining how an experience is experienced, 'is a central task for the listener and subsequently for the analyst as they interpret meaning or the 'point' the speaker wishes to make, and it is not always an easy task' (Riessman 2012: 370). In my analysis, I have strived to explain and understand their experiences from their point of view.

My analytic approach builds on the idea that 'events perceived by the speaker as important are selected, organised, connected and evaluated as meaningful for a particular audience' (Riessman 2008: 3). These analytical 'lenses' have guided me to focus on how they experienced their pregnancy and childbirth. The first storyline emerged in accounts of women who generally presented their experiences as good and expressed appreciation toward the maternity care system. The second storyline represents women who recapitulated dramatic experiences and had experienced disappointments with maternity care. The third storyline came from women with tragic experiences who felt that the maternity care system had let them down.

Women who are satisfied with the maternity care experience

Several interviewees accounted for their experiences in an appreciative fashion. Women who emphasised their satisfaction with the services typically arrived from countries where maternity care is rudimentarily organised. This may explain why refugee women are used to considering pregnancy and childbirth as scaring events, which influences their expectations (Lyberg, et al. 2011: 288). This has probably influenced their expectations and experiences of Finnish maternity care.

In this storyline, women told short narratives of some important events during the pregnancy and childbirth that they featured as good because they experienced being treated with care and respect. Nobody narrated at length about their relationships to the professionals and almost all compared the received care to the care practices in their native countries. In this comparison, they considered the received care as good. They did not report on any particular complications during the pregnancy or childbirth, which probably added to their sense of happiness. The women who framed their experiences as satisfactory were pleased about the possibility to participate in the prenatal care in the maternity care clinics and they reported using it on a regular basis. It gave them a sense of confidence because the care was regularly scheduled and professionally organised, indicating that they experienced the maternal care as an external resource.

Besides regular prenatal care, the women were very pleased about the supportive way they were taken care of during *the pregnancy*. The mothers described the nurses as responsive and helpful, because they were given time to ask questions, and discuss what mattered to them. Two mothers mentioned access to Russian-speaking professionals as a resource.

The stories belonging to this category described a well-functioning service. During nurses and doctor's appointments, an interpreter was often present, and if not, a phone interpretation could be arranged. If an interpreter was not present, the mothers were assured they knew what was on the agenda, such as routine check-ups, which helped to build a sense of predictability. During these interactions, the mothers gained knowledge about the pregnancy, what to expect, and how things were going. The nurses prepared the women for childbirth and many of them mentioned that they visited the local hospital before the delivery. Almost all emphasised the safety of the care as an important issue as it increased their sense of well-being. The experienced sense of safety was connected to social support and a possibility to easily get in touch with the professionals if needed. This seemed to result in an increased sense of predictability of the pregnancy itself and the expected childbirth.

However, it is difficult to know to what extent the women have downplayed complaints during our interviews. For example, Leila, whose husband partly participated in the interview, mentioned that 'if we noticed something to complain about it was caused by our language problems, because we could not speak for ourselves and understand everything'. In this modest way, this couple recognised communication problems and admitted that they did not understand all given information, but blamed themselves for the inability to understand what was said. Other women also mentioned that interpreters were not always present. So I assume that communication problem were recognised but most likely downplayed in the interview interaction.

Childbirth was featured as a good experience because these women experienced the midwives and doctors as supportive.

Second, the women felt safe in the hospital because they had gained knowledge of childbirth itself. Thus, a sense of agency was an important feature that characterised the women's good experience. Two women who had given birth in their native country compared and mentioned that their previously experienced childbirth had been horrible. They were very happy about the Finnish maternal care as it was completely different – helpful because epidural shots were administered and because midwives were encouraging – something completely beyond their expectations.

Finally, adding to the good experience was the experience that hospital nurses cared for the newborn infants so that the mothers were ensured rest. Additionally, the nurses taught the new mothers how to care for the newborn. The satisfaction expressed in the first storyline was related to this kind of quality of care, indicating that the informants had lower expectations regarding the way their needs of care and guidance would be accounted for and that the considerate attitude of professionals had helped them to develop trust and confidence in the service.

These experiences of care as much better than expected are explicit in my interview with Marina, who had 6 years of schooling and, gave birth to her third child in Finland. Her external resources consisted of a supportive husband and her mother living close by.

A: How did you experience the cooperation with the professionals?

Marina: Yes, the cooperation functioned very well. They explained everything very calmly and precisely and involved me in the entire process...

A: If we dwell on your visits to the maternity care clinic during your pregnancy, how were you explained about the pregnancy and the movements of the foetus and about the birth giving?

M: I was told everything in a very detailed way, I was told what to do and what to expect, I learned a lot, they also told me things [about my body] that I did not know previously.

A: You experienced that you also gained new knowledge and enough knowledge about your pregnancy and birth giving?

M: Yes, I am overall happy with this Finnish maternity care services and also about the birth giving because I compared it all the time to my two previous deliveries [in my native country] where the circumstances were horrible. I was really very afraid of this third birth giving because I thought it is going to be similar to my two earlier ones. But it was not. The staff was always close by and supported me during different phases of my pregnancy. I would say that I am really in ecstasy of this [birth giving] since I received so much help.

In these interviews, the maternity care was characterised as good because the care relationships were understood as reciprocal and reliable. The interviewees experienced that their needs were recognised and that the professionals acted in a supportive way leading to a sense of meaningfulness, a central feature of a sense of coherence. The women experienced having agency. This was connected to a sense of safety; since their pregnancy and childbirth were felt to be predictable and manageable events, the two central features of a sense of coherence. These mothers responded to the offered care by developing trustful relationships with the professionals because they experienced that their needs were respected. This enabled them to develop trust and use the maternal care as an external resistance resource that contributed to a meaningful experience and increased their sense of coherence in a new country (Björnberg 2012: 277–278, Eriksson 2007).

Accounts of faltering recognition of needs

The second storyline, represented in this data by four interviews with women who came from countries outside of Europe, was characterised by an experience of faltering recognition of needs from the part of the maternity care system, resulting in vacillations of trust. Earlier research suggests that the existence of a cultural distance between the women and maternity care professionals may hinder the development of a good care relationship (Dengi et al. 2012).

The drama in the accounts consisted of a cultural shock between the way the women themselves define pregnancy and childbirth compared to the Finnish maternity care practices. The need to tell their own story departed from 'collision between expectations and experience (what, as it turned out, happened) gives narrative discourse its drama' (Mattingly 1998: 157). These women's pregnancy and childbirth were stressful experiences because of a lack of sufficient provided knowledge and a subsequent uncertainty about how to understand and cope with an unfamiliar maternity care practice. For three mothers, the dramatic experience consisted of the great fear of childbirth. Since I have extensively discussed the fear of birth giving elsewhere (Lillrank 2013), I focus in this paper on the collision between expected and experienced communication difficulties with health care professionals. Characteristic for these stories are that regardless of unexpected cultural shocks between expected and received treatment they were able to reflect on their disappointments and reinstall trust in local professionals. In the following, I examine one story of faltering recognition.

Saynab's and Ahmed's story

When we arrived to interview Saynab, her husband, Ahmed, was also at home. From the beginning, Ahmed, in a friendly manner, took the role of the protagonist in the interview interaction, telling us that they want to tell us the story about her second pregnancy that ended in miscarriage. Saynab identified the beginning of the dramatic events to a situation when she unexpectedly started bleeding on a Friday and went to see a maternity care nurse, being 3 months pregnant:

'Then [the nurse] said that it is nothing to worry about, that sometimes women can have bleedings even when they are pregnant. This was a shock to me, because in my culture if a woman is pregnant she cannot have periods. Then they [the nurses] just told me that this is nothing to worry about because it is only a period. But I could not understand it, how can a pregnant woman have periods'.

While Saynab could not comprehend the nurse's explanation she did not insist on help but returned home bewildered. When Saynab's bleeding continued the next day, Ahmed came home from work and took Saynab and their little daughter to an Emergency Room. Ahmed explained:

'We arrived to the ER around eleven o'clock in the morning. But nobody took care of Saynab. So four o'clock in the afternoon, even when my wife was very sick and we had our little child with us... It was an upsetting and a very difficult situation... When nothing happened even when we were waiting ... so then we just left and went home...

A: Did nobody take care?

Ahmed: No, [the nurse] said that all others wait too, you just have to wait. I said that this is a completely different situation, my wife is bleeding, she is ill... Nobody did react in that situation so we came home. Next day my wife was very sick and we were at home. Then

on Sunday she said that everything has come out, so I realised that everything has gone [a miscarriage had happened]'

It remains unclear why nobody took the time to explain why and how long they would have to wait for an appointment, nor whether the health professionals understood them. What is clear is that the couple responded to the lack of care by leaving the ER in the middle of a critical situation. Their dramatic experiences are characterised by a sense of shock and unexpected suffering (Mattingly 1998: 95–96).

However, Saynab described how after the miscarriage took place, they immediately contacted the maternity care clinic anew: 'On Monday we went to the maternity clinic and [the nurse] directly called the hospital and got an appointment to me. My husband came with me to the hospital and they immediately took care and made an ultrasound examination. The doctor said that everything has come out, it looks clean, the foetus has disappeared'.

Regardless of confusing miscommunication with the maternity care nurse, Saynab and Ahmed reconnected with the maternity care nurse, perhaps out of necessity. The two episodes of care appointments after the miscarriage made sense to them, because the professionals responded immediately and they felt socially recognised and cared for. The lack of care and a sense of being socially unrecognised were shocking experiences to them. When they received responsive treatment, it helped them to regain trust in the professionals.

Saynab's next pregnancy proceeded without drama, but their experience of birth care was again dramatic. Ahmed explained how the birth began: 'A Saturday morning my wife began screaming when she suddenly began losing the amniotic fluid. I called an ambulance, and the arriving driver asked for the maternal chart. He said that the pregnancy is not yet at term, why did you not call a cab?' I replied: 'what are you waiting for look at the floor where all the ammoniac fluid has gone'... Luckily the ambulance nurse consulted the hospital staff that advised them to immediately take the mother to the hospital. But when we were on the way to the hospital the baby's head was already visible and they called the hospital that a doctor should wait at the door... and immediately when we were inside the hospital the baby was born'.

Saynab and Ahmed experienced the encounter with the ambulance staff as shocking because their need for the ambulance was questioned with reference to the due date. At the core of their experience of the situation as dramatic lies the couple's vulnerable position when care providers question their judgment of the seriousness of the situation. The situation is resolved when Ahmed is able to provide an argument that the care providers recognise and after the birth of their daughter in the hospital where everything worked out, they felt confident about the hospital care since their needs were recognised.

Saynab and Ahmed account for the incident with the ambulance staff as a minor misfortune and as something that could have happened to anyone, even Finns suffer from poor treatment. Indeed, regardless of the upsetting experiences, Saynab and Ahmed were able to reflect on their interactions with the maternal health care professionals that showed their abilities to cope with the challenges. Ahmed functioned as Saynab's external resistance resource since they had no relatives around. He had lived several years in Finland, held a regular work and spoke Finnish. This probably enabled them to identify the professionals as social resources, to reconnect with them and re-establish trust. Their experiences might have been very different if better information in their national language would have been available, as both early pregnancy miscarriage and deliveries starting with breaking of water are common phenomena.

Tragic accounts of neglect and lacking recognition

The third storyline, represented here by two interviews, can be characterised as tragic accounts, both of which in this data were stories of women of Somali origin. Sayda gave birth to her first child in Finland and Samira to her third child. In the narrative perspective, a tragedy is a violation of the natural order of an expected storyline. A tragedy is opposite to a heroic story because the protagonist is unable to overcome obstacles. Or, a protagonist understands only afterwards the real cause of his/her troubles (Hänninen 1999: 96). Samira's and Sayda's stories were both tragic because they could not predict the situations that escalated toward a tragic childbirth experience. Samira believes that the fact that her child was born disabled resulted from the neglect of the care providers. For Sayda, childbirth resulted in a sense of bitterness and unhappiness, even though her child was born healthy. Both women experienced that their particular needs of care were unrecognised by the health care providers. According to their experiences, reciprocal care relationships did not develop and they felt being unable to speak for themselves. Both of them felt traumatised by the childbirth experience. Next, I present Samira's story, as it developed into a tragic experience regardless of her individual resistance resources as an educated nurse.

Remaining socially unrecognised in relation to the obstetric professionals

Because of her degree in nursing, Samira considered herself also owning symbolic capital of professional knowledge and expected to be recognised as an equal by the maternal care professionals. However, she acknowledged that she was unable to help herself because she was in another role as a birth giver. In the end, Samira concluded that '[the hospital staff] underestimated me because I am a professional myself. I would have demanded better treatment if I would have been a different kind of Finn. But [they] did not recognise me as a Finn because of my [foreign] name. They underestimated several things but I know how things should have proceeded. This is my greatest disappointment'.

In telling her story, Samira takes a retrospective view of how she understood her childbirth. In doing so, she evaluated her experiences from her professional point of view, coloured by her unexpected traumatic experience, 'In my opinion the birth giving did not develop well.'

Samira's pregnancy was almost at term when she was hospitalised because of severe asthma. Because of her breathing problems, she suggested to her doctor a caesarean section. Her doctor did not agree on it and gave some explanations, but it remained unclear to Samira. The next day, when she was about to be discharged from the hospital, the doctor discovered that she had not enough amniotic fluid and prolonged her hospitalisation. At this point, the doctor said that they are going to induce labour the following day. According to Samira, at this point, a chain of misunderstandings between her and the hospital staff began. And her husband was not notified of the changed situations.

Unexpectedly for Samira, the next day the doctor ordered an electrocardiogram (EKG) follow up. After a while, Samira realised that at one point the foetus' heart rhythm collapsed on the EKG so she squat down, since as a nurse she knew what to do, and called a nurse. The midwife, who evaluated her situation, recognised that the EKG had deteriorated but nevertheless decided to refer

her for vaginal delivery in a delivery room, a decision that Samira considers a mistake that put her at risk. In the interview, Samira interpreted that her expertise had not been recognised: 'The doctors and nurses downplayed my worries about a collapsed EKG heart diagram (before she was sent for a section delivery). They would have needed to immediately react, but they did not. They should have called a doctor for an emergency section but I was sent to the delivery room as a normal birth giver. And a doctor should have needed to be waiting for me ... because the foetus' heart beats disappeared... this was a mistake'. According to Samira, it took more than 40 minutes before the emergency section was performed and she points out that according to the law, a section needs to be performed within 20 minutes after the EKG heart diagram has disappeared. Why it took so long before an emergency section was performed remains unclear to Samira.

When her daughter finally was born, she received 0 Apgar points and her heart was barely beating. The baby was rescued and taken to the intensive care unit. Her baby suffered from shortage of oxygen and was later diagnosed with cerebral palsy.

The following night, after the delivery, Samira suffered from heavy internal bleeding. 'I called all the time the nurse, nurse... The nurses were surprised and when a doctor arrived blood was pouring into a pot... I was in a shock, because I am a health professional myself. I was scared and realised that this is not a good situation... I lost so much blood all night... When a nurse performed a blood test my blood count was 39 and I received six packs of blood ... During that night I struggled for my life. I did not even remember my newborn baby'.

After the childbirth, Samira stayed in the hospital for 19 days. She concluded her hospital stay by saying: 'Afterwards I was thinking that if I would not have been a professional myself I would probably have died. Because I had so much knowledge I was able to demand [treatment]'.

However, Samira said she still does not know what really happened in the hospital. Afterwards the hospital staff did not explain to her what happened during childbirth. Samira assumed that the time frame was unfortunate – the hospital was crowded with only one nurse in charge while she was in a critical condition. When Samira later on read her daughter's case record she saw that there was a question mark on the information of the mother being a nurse.

In this data, Samira was a resourceful woman because of being a nurse herself. It helped her to demand treatment since she had knowledge of medical treatment proceedings that in her opinion saved her life. However, she felt being neglected several times because the maternal professionals did not explain to her afterward what had happened, she had no energy to speak for herself. Samira lost her confidence in the professionals and was not prepared to complain because her sense of coherence deteriorated. As a highly regarded but conservative professional institution, maternal care professionals may not easily recognise their patients as professionals themselves and perhaps even less a foreign born, racialised, professional woman. This featured her tragic experience as a mother of a disabled daughter.

Conclusion

The aim of this paper was to explore how refugee women experienced pregnancy and childbirth in interactions with the Finnish maternal care professionals. More precisely, whether and how did they experience the maternity care as an external resistance resource?

Several women had a modest education and some have had poor birthing experiences in a native country. Hence they compared it with the Finnish one, and were happy with the received care because they experienced being treated with care and respect. These reciprocal and reliable relationships enabled them to use the maternal care as an external resistance resource. It appeared to them as manageable, meaningful and comprehensible enough, which increased their sense of coherence and wellbeing.

Saynab and Ahmed who experienced drama vacillated in their trust because of a lack of sufficient provided knowledge and, a subsequent uncertainty about how to cope with uncaring practices. Their interactions with the maternal care professionals revealed their ability to cope with problems, especially after the professionals recognised their needs and provided good care. This enabled them to re-establish trust in the professionals, reuse the maternal care as an external resource that reinforced their sense of coherence.

Samira, who experienced that her agency and needs were neglected, was unable to overcome communication problems with tragic consequences. Unpredictable care prevented the development of trustful relations that reduced her sense of manageability. Thus, for Samira the maternal care did not function as the external resistance resource she had expected. Instead, she lost her confidence, which violated her sense of coherence and wellbeing.

The interviewees were careful in their complaints about the maternal care practices due to their limited knowledge of the Finnish maternal care and, because of the acknowledged communication problems due to a lack of systematic interpreter service. This inequity is obvious in the study. Migrants, who feel secure in their belonging to a new country, take entitlement to good care for granted, as well as the right to complain if a care is unsatisfactorily organised. On the contrary, a lack of sense of belonging reveals refugee women's unequal power position in relation to professionals (Niner & Kokanovic 2013: 549). This limits their possibilities to negotiate and question care practices.

The women with apprehensive and dramatic experiences highlight the main finding in this paper; when social recognition was communicated, it strengthened their ability to develop trust in the maternal care and use it as an external resistance resource. This reinforced their sense of coherence and wellbeing.

Finally, all women's core experience consisted of the interaction with the maternal care system, and their national and ethnic background can hardly be the sole explanation for the different reactions among the refugee women. Instead, the importance of reciprocal relationships made the complexity of the issue visible. This emphasises that cultural sensitivity among professionals is not enough in encounters with migrant women. Individual behaviour cannot be seen as culturally determined because it overlooks complex individual differences (Griffith 2010). Thus conscious effort to facilitate social recognition and reciprocal relationships functions as a key to successful migrant integration.

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Notes

1. In 2013 Finland received 3238 asylum seekers and 1827 persons were granted a residence permit (www.migri.fi).
2. Some of the contacted women refused to participate, and some could not be reached by phone. Since I did not have direct access to potential participants, I do not know why some refused to participate. The interviews were a mixture of semi-structured thematic and narrative interview practices, lasting 1–1.5 hours. One informant was interviewed twice. All informants except for one agreed to allow the interview to be tape-recorded. However, during the interview, the informant who first declined recording decided to allow it. All of the interviews were conducted between May and November 2012, took place in the interviewees' homes, except for one with the volunteering interpreter, who was interviewed in a cafe. At the homes, one or several children were present, and in two of the families, the husbands were at home and participated actively in the interviews. Before the interview began, I explained the purpose of the study and gave the interviewees the opportunity to ask additional questions about the study. As the interviewees were not necessarily able to understand what it means to participate in a research study, I was especially careful to emphasise the confidentiality of our interaction and underline that their anonymity is protected. All of the study procedures were reviewed and approved by the Institutional Research Review Board of the Vantaa Migrant Authorities. All women are given pseudonyms in this paper.

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