CHAPTER II

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Empowerment and resistance resources for immigrant women - A case study of implementing salutogenic theory in practice

Introduction

Compared to other Nordic and Western countries, Finland has a rather small immigrant population. Finland was a culturally homogeneous country until 1990, when refugees and other immigrants from Russia, Somalia, Iraq, Iran, Afghanistan and Congo began to arrive (Degni et al. 2012, 332). In 2008 about 4.1 percent of the Finnish population consisted of foreign-born first generation migrants. During the years 1987-2005 about 22 percent of the immigrants were between 0 and 14 years of age, while 68 percent were between 15 and 44 and only 9 percent were over 45 years of age. Thus far, the immigrants have mainly settled in the Helsinki metropolitan area (Martikainen & Haikkola 2010, 22-30). The Finnish authorities have not systematically registed reasons for immigration. the Ministry of Labor has approximated that the majority of migrants (60-65 percent) who arrived in the 1990s and early 2000 came because of family reunion. About 15 percent arrived as refugees, about 10 percent as homecoming Finns, about 5-10 percent as labor migrants, and about 5-10 percent for other reasons, for example, as students. Työministeriö 2005, 5, quoted in Martikainen, Saari & Korkiasaari 2013, 39).

Migrant women participate substantially in prenatal care in Finland. From 1999 to 2001 the birth rate for immigrant women slightly increased. The Russian migrant population had
the highest number of births (27.1%), followed by Somalis (12.5%) and East Europeans (9.1%). The type of treatment given to them or needed by them varied widely. Women of African and Somali origin had the most health problems, which resulted in the highest perinatal mortality rates. The infants born to Somali women had a significant risk of low birth weight and for being small for gestational age; in addition, Somali first time mothers had the most cesarean sections (Malin & Gissler, 2009). This chapter focuses specifically on refugee women.

A great number of refugee women arrive as young adults, often at a child-bearing age. They come from poverty, restless areas involved in war, and/or persecution for their religion or minority status. This means that they often have to leave their family members, friends, culture, and language behind in order to develop a new life in a peaceful country. The concept of acculturation describes the process in which cultural beliefs and values are confronted and changed and which affects former interaction, parenthood, and child-raising practices (Alitolppa-Niitamo 2010, 45). Over and above being familiarized to external differences, a considerable part of an individual identity and a sense of belonging may need a life-long adjustment process, which causes stress and demands multiple coping strategies and resistance resources. At the group level, acculturation means that the family has to separate from their social networks and social institutions in their country of origin and must cope with a new culture and traditions in a new country. At an individual level migration means confronting a new culture that demands problems to be solved in new ways. Acculturation can also be understood as a reciprocal process, where even the new country and the local setting are affected. Recent research on acculturation shows that even though coping strategies vary among individuals, the problems related to an adjustment to a new culture seem to be the same independent of the recipient country (Berry 2006, 15).

Many refugees suffer from poor health or from various undetected chronic diseases. Migration-related stress may have damaged their health (Tiilikainen 2003, 198-203, Kristal-Anderson 2001). According to Sam (2006, 403), immigration and acculturation may be inherently risky and might make people vulnerable to a number of problems; however, risks
are in themselves not destiny. Refugees may not necessarily adopt poorly over the long term, depending on how acculturative stress is managed. How do young refugee mothers manage acculturative stress when giving birth? What kinds of resistance resources do they have at their disposal that facilitates adjustment to a new culture of giving birth? These questions lead to consideration of salutary factors, such as a sense of coherence and generalized resistance resources (Antonovsky, 1979; 1987) and interactive empowering experiences (Freire, 1970).

This chapter discusses the idea that young refugee women bring with them the resources to take responsibility for their lives, to cope with stress, and to find creative solutions in the experiences of pregnancy and birth in a foreign country. This approach is based on the salutogenic theory that defines human beings as capable, resourceful, and able to create a sense of coherence as an attitude toward life (Antonovsky 1979, 1987, Eriksson and Lindström 2011, 67). This emphasis on a positive approach about human beings as resourceful agents is further supported by the concept of empowerment. For example, according to Moula (2009, 102), “empowerment is a special form of changing one’s mind when an individual discovers one’s own resources to solve problems in order to gradually become self-reliable.”

The aim of this chapter is to explore what kinds of resistance resources one Somali woman had at her disposal to handle pregnancy and birth and how an empowering dialogue with Finnish maternity care professionals developed.

**The concept of empowerment**

The concept of empowerment has raised considerable interest in virtually all scientific disciplines and has been applied in practice in fields from human sciences to political programs (Hokkanen 2009, 315; Hur 2006). The origin of the concept of empowerment was developed by Freire (1970) as a way of learning to mobilize the resources of oppressed people through education. In general, the concept is about giving people control and
mastery over their lives. Its aim is to develop people’s abilities and coping skills to endow them with the ability to actively work towards critical conscious-raising. Mann Hyan Hur (2006), who has developed a theoretical synthesis of a variety of cross-disciplinary studies on empowerment, concluded that thus far no comprehensive framework on the process of empowerment exists (Hur 2006, 524). However, Hur (2006) identified five progressive stages in an empowerment process: “an existing social disturbance, conscientizing, mobilizing, maximizing, and creating a new order” (Hur 2006, 535). According to Hur, the process of empowerment starts from dissatisfaction in individual, administrative, social, or political circumstances. It could also be understood as a sense of powerlessness, alienation, or inequality. When empowerment is understood as a process of both thought and action, it is an endlessly evolving dynamic development (Hokkanen 2009, 320-322; Hur 2006, 535).

However, the concept has also been criticized for being too abstract, for being rather idealistic about equality between professionals and lay people, and for ignoring complexities in power relations (Kuronen 2004, 288-289).

As the concept is closely related to the idea of power-related inequalities and expected changes in power relationships, Starring (2007, 70-72) introduces an empowerment-oriented framework that departs from efforts to achieve equality in interaction. He suggests a respectful interaction that features a connecting use of language balancing between emotional neutrality and emotional engagement, which creates a sense of belonging that strengthens self-confidence. For example, this type of interaction would be characterized by an encouraging way of talking, using phrases such as “how interesting, would you like to tell me more about it… I am glad you like it.” The connecting use of language creates a sense of mutual satisfaction that reinforces one’s self-confidence in stressful situations.

In an attempt to connect individual empowerment-based aspects of salutogenic thinking, Koelen and Lindström (2005, 12) define it “as a process by which people gain mastery (control) over their lives, by which they learn to see a closer correspondence between their goals and a sense of how to achieve these goals, and by which people learn to see a relationship
between their efforts and the outcomes thereof.” The focus is here on resources, both internal and external, in a learning process that leads to creating a sense of coherence. According to Antonovsky, life experiences (consistency, load balance, participation in shaping outcomes, emotional closeness) shape the sense of coherence while generalized resistance resources provide the individual with sets of meaningful and coherent life experiences (Antonovsky, 1987).

**The salutogenic theory**

The medical sociologist Aaron Antonovsky introduced the salutogenic theory to the research community (Antonovsky 1979, 1987). Salutogenesis, stemming from the Greek salus (= health) and genesis (= origin), means the origin of health. Antonovsky claimed that the way people view their life has a positive influence on their health. He asked the question of why some people stay healthy and others do not under the same conditions. His original idea was that it is more important to focus on peoples’ resources and capacity to manage stress and their ability to maintain health in life-threatening situations and stressful life events than to put an emphasis on the risks for diseases. The core of the salutogenic theory is an orientation towards problem solving and the capacity to use available resources. He started from the assumption of human nature as chaotic and full of constant changes, the challenge being how we are able to cope with these difficulties. Two concepts are essential for the coping process, a sense of coherence (SOC) and generalized resistance resources (GRR). The ability to comprehend the whole situation and the capacity to use the resources available is called the sense of coherence. This capacity was a combination of people’s ability to assess and understand the situation they were in, and to find a reason to move in a health-promoting direction, while having the capacity to do so. According to Antonovsky, the SOC consist of comprehensibility, manageability and meaningfulness. The sense of coherence is a global orientation that expresses the extent to which one has a pervasive, enduring, and dynamic feeling of confidence that (1) the stimuli from one’s internal and external environments in the course of living are structured, predictable, and explicable; (2) the resources are available to meet the demands posed by these stimuli;
and (3) these demands are challenges, worthy of investment and engagement (Antonovsky, 1987, 19). The SOC is a coping resource that enables people to manage tension e.g., in connection to migration, with reflect on their external and internal resources, to identify and mobilize them, to promote effective coping by finding solutions, and to resolve tension in a health-promoting manner. The key to developing a SOC lies in the ability to identify resources, and to use and reuse them in a health-promoting manner, e.g., to find reliable social support. However, what is more important than the resources themselves is the ability to use them (Eriksson 2007, 98).

Generalized resistance resources (GRR) can be found within people as resources bound to their person and capacities but also to their immediate and distant environment (Lindström and Eriksson, 2005, 440). GRRs have both a genetic and constitutional and a psychosocial character, and include knowledge/intelligence, ego identity, self-confidence, coping strategies, money (rational, flexible, and farsighted strategies), social support, ties, commitment (continuance, cohesion, control), cultural stability, magic, religion/philosophy/art (a stable set of answers), and a preventive health orientation. GRRs provide a person with sets of meaningful and coherent life experiences stemming from the resources at the person’s disposal. In the following section, the research project “Resources for pregnancy and motherhood among refugee women in Finland” is presented.

The research project

About the data collection

The data collection was carried out in close collaboration with local authorities in a city within the Helsinki metropolitan area. This city has had a dramatic increase in migration and has a large number of welfare professionals involved in facilitating immigrants’ integration. The city was granted government funding for a pilot project to develop its integration policy and practices with migrant women outside of the labor market who care for their infants at home. This pilot project is connected to the implementation of the new Act of Integration.
We invited about 10-16 refugee mothers through the local migrant authorities to participate in individual, semi-structured “cross-language” interviews, that is, together with an interpreter. My criteria for selecting informants were that they are 1) refugee women who have been granted a residence permit in Finland, 2) who have lived at least two years in Finland, and 3) who currently take care of their child(ren) at home. Some of the women refused to participate, and some could not be reached by phone. Through a local key migrant secretary I was able to invite five Somali, three Russian, one Iranian, and one Afghan mother who were willing to participate in an individual interview. Since I did not have direct access to the potential participants, I do not know why some refused to participate. I conducted 11 interviews with 10 different women. One mother was interviewed twice. In addition, I interviewed one Somali interpreter about her birth experience in Finland. The targeted group is rather small since as refugee mothers, because of language problems and their work caring for small children at home, they are very difficult to contact, even for the local immigrant authorities.

The interviews took place during May- August and in November 2012. All of the interviews took place in the interviewees’ private homes, except for the Somali interpreter, who was interviewed in a cafe. In all of the interviews one or several children were at home. 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 interviewee(s) the opportunity to ask additional questions about the study. Since the interviewees were not necessarily able to understand what it means to participate in a research study, I was especially careful to emphasize the confidentiality of our interaction and to 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 informants except for one agreed to allow the interview to be tape-recorded. One informant did not agree to this, so we started the interview without a tape recorder. However, after a while she felt confident enough to let us record it. The interviews usually lasted from
an hour to an hour and a half. The interviews were a mixture of semi-structured thematic and narrative interview practices. During or after the interview we were served refreshments in a friendly and hospitable atmosphere.

Five of the interviewees had given birth to their first child in Finland. Six 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 three months to about two years of age. The mothers were between 20 and 34 years of age, and all lived with their husbands. Two mothers were illiterate, while the others’ education ranged from two years of school to university studies.

Six women had good experiences of pregnancy and delivery, while three had dramatic or unexpected experiences, and two had poor experiences. Those with good or mixed experiences were happy about the way Finnish maternity care was organized, while the women with poor and/or dramatic experiences felt traumatized and that they were poorly treated by the hospital staff.

In this chapter one Somali woman is presented to illustrate what kinds of resources she had available and how a trusting dialogue developed with her Finnish maternal care professionals. For this purpose I have chosen an interview with a Somali mother, here named Nadina, for several reasons. Firstly, her interview is rich in details and thick descriptions of her pregnancy and birth experience. Secondly, her story represents the first time mothers in the data who had unexpected problems during the pregnancy and a dramatic birth experience. Third, her story is unusual in the self-confident way that she was able to develop trust and rely on Finnish health care professionals and in how vividly she remembered the professional encounters. This interview highlights from a refugee woman’s point of view what an empowering and encouraging dialogue with a maternity professional can be like (Jacobson & Meeuwisse 2008, 50-51). My interview interaction with Nadina was also greatly appealing because her “quality of mind transmitted to me through her characterization, motivation and description, and commentary” during the interview (Mishler 1986, 81) with an impression of a both vulnerable and a self-confident woman explaining and evaluating
her pregnancy and birth experience. This presentation and interpretation of the interview are filtered and jointly constructed through my interaction with Nadina and Shukri, the interpreter.

**The challenges of interviewing through an interpreter**

In the study, five interpreters fluent in Somali, Russian, Farsi, or Sorani were hired to function as interpreters in the cross-language interviews. Four translated into Finnish, while one Farsi-speaking interpreter translated into English. A fundamental prerequisite for gathering data was the use of interpreters, since none of the participants were fluent enough in Finnish, Swedish, or English. 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, nonverbal, and emotional information (Lillrank 2012, 281; Lillrank 2002). 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 communication and interaction between an informant and a researcher (Wadensjö 1998). Here, the interpreters also contribute to the communication based on their cultural and social background, as Temple suggests:

> The use of translators and interpreters is not merely a technical matter that has little bearing on the outcome. It is of epistemological consequence as it influences what is “found”. Translators are active in the process of constructing accounts and an examination of their intellectual autobiographies, that is, an analytic engagement with how they come to know what to do, is an important component in understanding the nature and status of the findings. When the translator and the researcher are different people the process of knowledge construction involves another layer. (Temple 1997, 614)
Qualitative analysis requires the systematic transcription of the interviews and responsiveness to the role of interviewer, interpreter, and reader in the construction of meaning (Riessman 2000: 130). Shukri, the Somali interpreter who participated in this interview, was fluent in the native language of the Somali interviewees as well as in Finnish. She belongs to the Somali culture and has a social understanding through being a mother herself. Shukri related her own experiences of giving birth in a Finnish maternal care hospital. She was able to explain and clarify differences between these two cultures, which constituted a valuable addition to the development of my understanding of the interviews. Consequently, the ethnicity and the social background of the interpreter is an important resource (Temple & Young 2004, 171).

The analytical framework

The researcher examines the way a story is told – how it is expressed and how its presentation convinces the interviewer of its authenticity. Since the telling and narratives about experiences follow a particular cultural style of expression and 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). “Meanings are problematic and ambiguous, most obviously because of translation” (Riessman 2000, 133-134). For example, in translating this interview, the interpreter took the role of the interviewee without giving precise translations of verb tenses which made it sometimes difficult to determine the course of events. Also, this style of interpretation did not consequently specify who said what, which prevented a structural analysis of the interview text.

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). In this chapter the presented interview and the quotations are translated into
English by the author. Further, qualitative methods are always partial, incomplete, and placed in a certain historical context. Thus my analysis should be seen as a possible interpretation of the case study, since no one can claim to really comprehend another human being (Kristensson-Uggla 2007).

My analysis began with a broad thematic content analysis on “what” Nadina said about her pregnancy and the delivery. Next, I focused on “how” Nadina experienced and evaluated these life events (Jacobson & Meeuwisse 2008; Riessman 2008; Gubrium & Holstein 2009) in an attempt to explain and understand her behavior (Ricoeur 1976). In my analysis I have reconstructed the told from the telling, as recommended by Misher (1995). In other words, I have reconstructed a core narrative (“the told”) on the basis of my interview (“the telling”). My analytic approach departs from the idea that “events perceived by the speaker as important are selected, organized, connected, and evaluated as meaningful for a particular audience” (Riessman 2008, 3). I have interpreted Nadina’s narrative as her way of finding and using the resistance resources available to her to cope with the challenges of pregnancy and giving birth demands, to make sense of them, and to create a sense of coherence out of the lived experience.

A narrative is usually organized according to a protagonist’s cultural understanding of a situation, or a cultural script. A cultural script describes ordinary knowledge of how to understand and behave in a certain situation, such as giving birth. Cultural scripts could also be defined as a world view that is taken for granted for members of a certain society (Andrews 2007, 53; Katisko 2011, 48-51). In my interview with Nadina she gave rather short answers to my questions but explained and evaluated the unexpected turning points during her pregnancy and the delivery, with short narratives that were dense in meaning and “tell-ability”(Andrews 2007, 33; Gubrium & Holstein 2009). This triggered the “why tell” that imposed something significant about Nadina’s pregnancy and birth experience. In other words, when a cultural script is either breaking down or demands creative ways of coping, it calls for a story (Katisko 2011).
How did the Finnish cultural script confront the Somali cultural script? In Somali culture women marry young, and the purpose of marriage is to give birth to as many children as God gives them. Becoming a mother and motherhood is considered a natural cornerstone of a Somali woman’s identity. However, life in Finland changes the traditional gender roles since extended families seldom live together. This force Somali husbands to participate in childbirth, care for children, and carry out household tasks. Consequently, living in Finland may blur familiar gender structures, which may cause stress and new situations (Tiilikainen 2003, 174-175). Next, I present Nadina and my joint interview with her and Shukri, the interpreter.

**Presentation of Nadina**

Nadina is a 28-year-old Somali woman who arrived in Finland in 2008. She has completed about two years of primary school in her native country. Nadine married a native Somali man that she met in Finland. She knew that he did not have a residence permit in Finland, but she hoped that he would receive one, and they were in the middle of the application process. Shortly after, Nadina’s husband had to leave for the country where he had a residence permit, and she found out that she was pregnant. When Nadina’s pregnancy came to term, she gave birth by cesarean section to a healthy daughter, who was at the time of the interview one and a half years old. Immediately after the delivery Nadina was rushed to another hospital for emergency heart surgery. She was then diagnosed with a chronic heart condition. The day after the delivery, Nadina’s husband arrived in Finland. The hospital staff taught him how to care for the baby. Based on a doctor’s statement, he received a residence permit in Finland. Nadina does not have any close relatives living in Finland.

The interview took place in Nadina’s home, where she and her daughter waited for me and Shukri. Nadina was beautifully dressed in a traditional Somali woman’s outfit with a hijab. We sat at her kitchen table, and explained the purpose of the interview. Nadina immediately agreed to allow the interview to be tape-recorded, and she signed a letter of consent. Her
daughter placed herself in her mother’s lap and sat there quietly during the entire interview, which lasted about an hour. She played with some colorful advertising flyers, and seemed very happy, safe, and relaxed in her mother’s lap. Only when the little girl became tired did she become somewhat restless, but Nadina gently comforted her, and after a while she fell asleep in her mother’s lap. Nadina and her daughter gave the impression of having a good and loving mother-child relationship. Nadina was relaxed and easy to interview. I intuitively felt that it was all right to ask her follow-up questions during our interaction, an intuition I did not have with all of the interviewees.

Reflecting back on the interview situation, I was rather bound by my semi-structured questions and did not realize that Somalis are known for a rich oral tradition and for being skilled storytellers (Degni et al. 2012, 332). When I later asked Shukri to listen to the recorded interview and to review the transcribed interview, she evaluated it as a good interview because of the clearly formulated questions that helped her to do a good job as an interpreter, which is an important level of knowledge production. However, regardless of how correctly narratives are transcribed, they leave, by definition, loose ends and gaps in the storyline, so that researchers always work with fragments (Riessman 2000, 145). Furthermore, I had not understood that 98 percent of women from Somalia have experienced female genital mutilation or circumcision. These procedures involve the partial or total removal of the external female genitalia for non-medical reasons, which can have consequences for giving birth (Ameresekere et al. 2011). Because of my lack of knowledge and uncertainty, I was not prepared to ask about this and, neither Nadina nor any of the other interviewees raised the issue. However, during my analysis I have gradually gained insight in its importance in better understanding Nadina’s pregnancy and birth experience.

**Nadina’s resistance resources and empowering experiences**

In the Somali tradition, women experience and view pregnancy as a natural part of life, and it is regarded as a health experience. Neither prenatal nor preventive medical care is practiced in Somalia, since the extended family teach each other and provide social support
during pregnancy. Often women rely on each other to act as midwives during home births. Somali women have traditionally placed their faith in God rather than in medical science. Consequently, Somali women who have immigrated to Western countries and enter a new and unfamiliar maternal care system are especially vulnerable during pregnancy and childbirth because of the lack of traditional family support (Hill et al. 2012, 72-75). In addition, Somali women are vulnerable to social challenges since many have gone through highly stressful war-related experiences (Degni, 2012, Tiilikainen 2003).

**Nadina’s pregnancy-related challenges – and her resources for coping with them**

Shortly after Nadina’s husband had to leave for another country, she discovered that she was pregnant. To be alone was her first unexpected challenge. When I asked how she felt about and coped with this unexpected situation, Nadina shortly mentioned that it was a difficult situation, but she did not elaborate on it any further.

The Somali culture is characterized by a strong sense of community. For example, the way that individuals are brought up in extended families means that they have practically no experience of being alone (Shukri, personal communication). Nadina coped by participating in a Finnish language class organized by immigrant authorities until she was about five months pregnant. By participating in a language course, Nadine helped herself to lessen her loneliness by being with other course participants that also were newly arrived immigrants. Participating in a group gave her the opportunity to make friends and discuss common experiences and to familiarize herself with the new culture, language, and country. Her resolute behavior gives an impression of agency and the ability to connect with others (Laliotou 2007, 60).

Later in the interview, Nadine presented herself in a following way; “I am an open-minded person, and I enjoy meeting with new people because it is always possible to learn something new from others. And being with others has helped me a lot… it makes me happy to be in others’ company.” Shukri further clarified Nadina’s presentation of herself as being an
independent individual who wants to get to know new people in order to learn new things.

In my interpretation, her independence reveals her self-confidence, an internal resource that meant that she felt in control of the situation and knew what to do and how to help herself. Her goal-oriented behavior demonstrated her ability to take control of her situation. Among Nadina’s external resistance resources were her ability to find and socialize with others around her, which helped her gain strength in a challenging situation.

Her second unexpected challenge arose when she was seven months pregnant. Nadina shortly mentioned that a doctor discovered that she had a heart problem, but she did not elaborate further on how it was discovered or what it was about. She only mentioned that it prevented her from familiarizing herself with the hospital before the delivery. Nadina coped with her illness by taking it for granted, and when she later evaluated it, she made it meaningful by believing the illness to be predestinated by God. The Somali cultural script may help understand her way of thinking. Namely, in the Somali anatomical understanding, the heart and the stomach are of central importance. The heart is the core of life, and the stomach regulates the bodily functions (Tiilikainen 2003, 210). Somali migrants often comprehend illness as an expression of homesickness and as a result of an imbalance and excessive emotions. Further, health and illness are connected with Islamic beliefs, which may also include medical explanations (Mölsä et. al. 2010). In the Somali way of thinking, natural and supernatural illness explanations together with family members’ interpretations of symptoms combine to explain a particular illness (Serkkola 1998, 70-71; Degni et al. 2012, 331). This cultural script and her belief that her illness was predestinated by God functioned as Nadina’s resistance resource, which gave her the self-confidence to go on with her pregnancy and later on with her life.

Her third unexpected challenge appeared when she was eight months pregnant. During a scheduled appointment at the maternity clinic, a nurse discovered that the fetus had not moved into the birth position. The nurse unsuccessfully tried to turn the fetus into the right position. She then suggested an appointment with an obstetrician and scheduled it for her,
explaining that if the fetus is still in the same position, the doctor may suggest a cesarean section. When Nadina visited the specialist, this doctor confirmed that the fetus had not changed position because of the shape of her hips. During this appointment the doctor decided to deliver by cesarean section. Since the majority of migrant Somali women are circumcised, it is possible that this was an additional reason for the doctor’s decision to deliver by section (Ameresekere et al. 2011).

A: What did you think about this?

N: It was very scary, I was afraid.

A: Did the doctor explain how the section would be done?

N: Yes, it was very good that an interpreter was present when this was said. And then the doctor also said that we are going to help you. I was extremely afraid, but the doctor said that we are going to care for you as long you need help and we will help you until you are able to take care of your own child. [The doctor also said] that I can stay in the hospital until I have recovered. And they promised to take care of me. And then there was also an interpreter.

Nadina’s short narrative of this appointment begins and ends with the statement that an interpreter was present. When a protagonist repeats something twice in more or less identical words, it features something of core importance for the entire narrative (Katisko 2011, 71). It was of vital importance for Nadina that an interpreter was present to ensure that she received comprehensive explanations about this subject. The interpreter allowed Nadina to feel supported in a frightening situation and to understand what the doctor said about delivering by section. In this segment of the interview, Nadina’s second main focus was on her understanding of the doctor’s supportive assurance of medical help. These two core experiences probably helped to strengthen her self-confidence and to allow herself to trust the professional and supportive care of health professionals.
After she had emphasized the presence of an interpreter and the doctor’s assurance of help, Nadina revealed her primary emotional state of mind; her great fear of the cesarean section. Her sense of great fear dominated her state of mind through her telling of her birth experience – which she repeatedly contrasted with the supportive and empowering interactions with the doctors. Because she was supported to feel somewhat secure, she felt safe enough to reveal her major emotional experience (Lillrank, 2002). While she was sharing this fear, she showed her struggle to make sense of the cesarean section, which probably kept her on the verge of a sense of chaos even though she clearly understood the doctor’s assurance of medical care and the doctor’s emotional ability and willingness to support her through the delivery and the postnatal period in the hospital. This supportive and empowering dialogue was based on medical knowledge and authority that included emotional and social support, characteristics of Börjeson’s concept of the professional fellow-being (Börjeson 2010, 168).

Nadina emphasized how this doctor, as a professional fellow-being, developed through the help of an interpreter a dialogue with her. The dialogue elevated her self-confidence to better understand the situation and decide to continue trusting and complying with the doctors and the health care system.

When discussing how to understand Nadina’s ability to trust the doctors and nurses with Shukri, she emphasized that the doctor’s comforting way of taking responsibility and his or her assurance that everything would work out constituted the cornerstone for Nadina’s ability to trust the doctors and nurses. This essentially strengthened her belief that everything would work out. In other words, she gained self-confidence and hope, important resistance resources, in an extremely stressful situation. Even when the delivery had an unexpected outcome that no one could have predicted at this point, Shukri pointed out that Nadina was realistic in that she did not expect any miracles. In spite of the unexpected outcome of her delivery, she continued to trust the doctors because she understood their sincere willingness to help her and care for her. Last, but not least, Nadina had good self-
confidence to begin with, which enabled her to feel confident in the individuals around her, an interpretation that Shukri also agreed with. In the following part of the interview, the above interpretation was underlined.

A: Did you feel that you were treated well, even when you were very afraid, that they took care of your fears and they tried to comfort you?

N: Yes, it was a relief when I was told that everything is going to work out and the interpreter was present, but after the section another story happened to me. It was very difficult, the newborn baby girl stayed in the hospital and I became seriously ill.

A: Would you like to tell me how the delivery went and why you were hospitalized?

Before Nadina continued her narrative about her birth experience, she once more wanted to emphasize and elaborate on how the doctor comforted her, which gave her the courage to go through with the cesarean section.

N: The doctors comforted me and scheduled a certain day and time when I should come to the hospital [to give birth]. But the doctor said that it might be - I think that the doctor understood that I was extremely afraid - and then they said to me that perhaps the section is not going to be necessary, perhaps the baby turns around and everything works out normally and we may not need to do the surgery. That is what the doctor said to me.

In the two sequences where Nadina explained and evaluated what the doctors said to her, by repeating her narrative twice about the doctor’s ability to comfort her and interact with her as a professional fellow-being, Nadina returned to the main idea and a core experience in her narrative (Katisko 2011). From this short sequence, as it is here translated from Somali
into Finnish, it is apparent that Nadina did not verbally explain to the doctor about her fear of a delivery by section. However, from the way the doctor interacted with her, Nadina concluded that the doctor had nonverbally recognized her fear and wanted to comfort and encourage her. Nadina responded with a remarkable ability to trust and gain confidence from the doctor’s assurance to help and support her through the delivery. This dialogue gave Nadina courage and empowered her in this new and demanding situation. It helped her to compose herself and to increase a sense of predictability and meaningfulness. From the translation of the interview, we do not know if the doctors were female or male.

According to the empowerment model developed by Moula (2009), human beings have a stock of opinions of an actual situation that are articulated in a dialogue. A dialogue enables an individual to organize her thoughts and emotions. Language and communication are the most important way of developing relations with others. A language is seldom neutral, and immigrants usually need an interpreter to clarify and make sense of interactions since language and culture are intertwined. A characteristic of human beings is the ability to express emotions, since it is not possible to separate behavior and thoughts from emotions. Further, individuals express wishes about something that they want to do. Human beings behave through actions – focusing on actions enables us to acknowledge individuals as they develop. The capacity to develop relations is inherent in human nature – we become individuals in interactions with others, and we need human relations in our lives. Human beings are capable of solving problems and learning the consequences of their own behavior. Thus, individuals are able to change their circumstances (Moula 2009, 109-111). Antonovsky also emphasized that comprehension, manageability, and meaningfulness develop in interaction with others. Nadina’s internal resource, here a capability to trust, was greatly supported in an encouraging dialogue with the responsible doctor.

**Nadina’s birth experience**

Giving birth in a foreign country is considered a particularly demanding and stressful situation. It is a real challenge for Somali women, since experiencing such a life event with
little or no access to well-known traditions or familiar social support can be assumed to test one’s available resources and coping strategies (Hill et al. 2012; Wiklund et al. 2000). Since female circumcision in various forms is generally practiced in Somalia, it may impact or complicate giving birth. This cultural tradition, a female rite of passage, ensures a girl’s status as “a good wife-to-be” and a respected adulthood. In Somalia it is performed by special practitioners passed on from mother to daughter to secure the daughter’s marriage and social acceptance in local communities (Matsuuke 2011, 8-12). Women who have experienced female circumcision are more likely to have cesarean deliveries, compared with women who have not experienced it, especially in countries where health providers have less knowledge of this tradition (Ameresekeere et al. 2011, 227-229; Essen et al. 2011; Essen et al. 2000). In addition, Somali women have fatalistic attitudes and a real reason to be afraid of giving birth. The statistics of the World Health Organization (2010) concludes that the maternal mortality rate in Somalia is approximated to be 1,200 per 100,000 live births, which means that Somali women are one of the highest risk groups in the world (Hill et al. 2012, 72; Essen et al. 2011).

Anthropologists have discussed the wide variety of conceptions about pregnancy and birth among different cultures. This belief system, conceptualized as the birth culture by Hahn and Muecke (1987), “informs members of a society about the nature of conception, the proper conditions of procreation and childbearing, the workings of pregnancy and labor, and the rules and rationales of pre- and postnatal behavior” (quoted in Helman 2007, 169). Western birth culture is based on medical science and technology that separates the mother from the infant. The medical view of pregnancy and delivery abstract it from the mother’s life experience and handle it as a remote medical event. The mother and the obstetrician may have different opinions on how to assess quality, measure successful outcomes and decide the pace of the birth itself. For the woman, giving birth is integrated into other aspects of her life. With a first delivery in particular, she gains a new social role as a mother, which changes her marital status, housing situation, and personal relationships (Hellman 2007, 170-172). In other words, trying to comprehend giving birth as a medical process instead of a natural process (Helman 2007, 171) stretches one’s ability to predict
its course, manage one’s behavior, and make sense of it.

N: I came to the maternal hospital [on the scheduled day when the pregnancy was at term]. They took a blood sample, checked the child, and the doctor said that it has not changed position. Yes, we are going to do the section.

A: So the final decision was made at that time?

N: Yes, even though the doctors had already told me about the section, but then they perhaps wanted to comfort me, so the final decision was made at that point. I actually knew it already, but yes, at that point the doctors made the final decision.

Nadina had some time to prepare herself for the delivery by section. This final decision may also have been due to the doctors’ uncertainty of how to handle a woman who has been circumcised during delivery. In her narrative Nadina again emphasized how she was comforted by the doctors’ way of handling her situation and by their sensitivity and respect for her fear. Even though the doctors did not change their mind about performing the cesarean section, Nadina trusted the doctors’ actions and sensed their effort to emotionally understand and support her. This balance between fear and comfort dominated Nadina’s preparation for her birth experience.

A: How did you feel being hospitalized, did you feel secure or unsecure?
N: Yes, I was extremely afraid, I would have liked to escape from the hospital, I was not at all in my usual state of mind.

Nadina was probably afraid for several reasons. Firstly, it must have been difficult to understand and predict the medical course of the delivery by section. Nadina had seen a televised documentary about a section that had increased, not lessened her fears. Shukri emphasized that the cultural knowledge needed to predict how the birth process will develop in a hospital is very important, although difficult to explain. Secondly, Somali women
in general fear having a cesarean delivery because they believe that it limits the number of future babies and can result in maternal death (Ameresekere et al. 2011; Essen et al. 2011). All Somali women are afraid of giving birth because it is by definition a risky event in Somalia due to the high risk of maternal mortality rates compounded by high pregnancy rates. In addition, Somali women belong to a culture with a strong oral tradition, where narratives of natural birth experiences circulate among women, and almost everyone knows someone with a poor birth experience. “To give birth may open one’s tomb” (Zahra Abdulla, a Somali midwife, personal communication). Over the centuries, oral narratives have educated and transmitted practical knowledge among women who lack a formal education.

A: How did you cope with this fear?

N: Yes, I had somebody with me - a girl was with me… I had a supporting person with me.

A: You could hold her hand?

N: Yes, earlier [before the delivery] the doctor had asked if I had a [significant] friend to whom I want them to tell about my situation. Then I mentioned this girl, a particular friend of mine, and the doctor then phoned her and asked her to come to the hospital at the time of the section. And my girlfriend came and sat beside my bed, she held my hand and supported me.

A: So this helped you?

N: Yes she always supported me and stayed close so that I did not need to be alone in the hospital.

Nadina had one female friend that her doctor called and asked to come and be with her. This caring and interactive behavior shows that this Finnish doctor did care and that he
or she deliberately took a role as a professional fellow-being with Nadina. Her only close friend in Finland was a native Somali woman who spoke Finnish and was familiar with Finnish culture. Such a friend is called “a senior, or an adviser” within the Somali women’s networks in Finland. They often function as mediators between Somali women and health care professionals (Degni 2004, 75). She provided valuable social support that prevented Nadina from being lonely. Nadina gave birth to a healthy daughter and named her baby after her supporting friend.

A: How did the birth giving experience … proceed?

N: After the section delivery [the doctors] discovered that I stopped breathing that I could not breathe normally, it was very difficult, and the doctors’ realized that something is wrong with my lungs or the heart. The doctors said that they cannot treat me in this (maternity care) hospital, that I have to be sent to another hospital. And then I was taken in the ambulance to another hospital. They said that they will take care of the baby until I recover and then the baby was cared for there [in the maternity care unit]…

A: How long did you stay in the other hospital?

N: A week.

A: Such a long time?

N: The day after I was taken to the hospital, the father came, the father of my baby. He went to the maternity care hospital … and the staff showed him how to take care of the baby. He was taught how to care of the baby, and then…

A: Did you return to the maternity care hospital?
N: After three days I was just crying and crying, I did not know why. And then the
doctors said that they would try to get a small bed for the baby so that we could
be together. After three days the baby came and we could be together.

Nadina’s birth experience is dense with unexpected turns. She cannot remember much
from the birth of her daughter because her memory was blurred by heavy medication. The
birth itself unexpectedly resulted in heart surgery in another hospital. Third, her husband
arrived and was taught to care for the baby. After the surgery Nadina’s thoughts were probably
with her newborn baby and her husband. In this overwhelming and heartbreaking
situation, which was probably very difficult to comprehend, she responded by crying. The
doctors interpreted her crying as caused by her separation from her baby and took action
to bring them together. Nadina remembered that the baby came after three days – and that
she was reassured that the baby was now close to her and that her husband was taking
care of the baby. Her ability to remember these events marked their meaningfulness for
Nadina. She ends her tale with an evaluative comment: “and we could be together.” This
seemed to make Nadina happy and indicated that the doctors’ interpretation of her crying
and attempt to comfort her were well directed – she had become a mother and wanted to
be close to her newborn daughter.

Next Nadina explained how her birth experience resulted in a chronic illness that impacted
her future in many unexpected ways:

N: [The doctors said] that I have a serious heart condition and that I cannot give
birth to more babies because it is a risk to my life. And I cannot do many sport activities
or run anymore… that I have two blocks in the blood vessels of my heart.
That it does not function well.

A: Was it a relief that your husband arrived?

N: Yes, he has taken care of the baby and helped a lot.
A: What is his situation then, did he receive a residence permit?

N: The doctor said that I cannot care for the baby alone, because I am ill. And then my husband just told [the doctor] that he has not received a residence permit for Finland, that he is in the middle of the application process and cannot stay in Finland. Then the doctor addressed a statement to the immigrant authorities and asked us to take it to the Immigration Service. We did so, and after a while my husband received a residence permit for Finland.

Nadina’s heart disease enabled the immigration authorities to make a quick decision about reuniting the family. Another change included the recommendation that she should have no further pregnancies, which challenges her cultural script of marriage and her social identity as a Somali mother of many children. The reunited family changed her husband’s traditional gender role by involving him closely in child care and household tasks (Tiilikainen 2003).

Finally I asked her how she was coping and what made these new changes comprehensible and meaningful:

N: Yes, I believe in God, and God has always supported me and helped me a lot. That is how I have survived.

A: That your trust in God, that God helps you?

N: Yes, I also believe that everything is predestined, also that the illness is meant for me…

An important coping strategy and internal resistance resources for Nadina were her belief and trust in God. The Islamic belief makes suffering meaningful while also explaining how to mitigate it (Tiilikainen 2003, 171). An ill individual needs to be patient, since human
beings undergo trials if they remain true believers of Islam. Thus suffering from an illness may have positive consequences if a sufferer stays patient and loyal in her belief. However, the ill person needs to seek a cure for herself. Since God has created the illness, God has also created a cure (Perho 1995, 145-146; quoted in Tiilikainen 2003, 39). In general, Somalis in Finland consider the Finnish health care system to be reliable in the treatment of physical diseases (Tiilikainen 2003, 219-220).

Conclusions

The aim of this chapter was first to explore what kinds of resistance resources Nadina had at her disposal to handle her pregnancy and birth experience in a foreign country. This interview revealed that Nadina’s self-confidence and her capability to connect with others, such as language class participants, her doctors, and other health care providers and her friend that she trusted and relied on for help and support were her internal resistance resources. In addition, she emphasized her belief and trust in God. She comprehended her heart disease as manageable and meaningful by believing it to be predestined by God. She had the ability to use and reuse her available resources.

According to Antonovsky (1991), the sense of coherence has three key components, comprehensibility, manageability, and meaningfulness. When Nadina confronted her pregnancy and birth challenges, her resistance resources enabled her to manage her situation by trusting others, giving her a sense of belonging to a language class and the ability to entrust herself to the care of the health care providers. Her fear of delivering by cesarean section was probably due to several reasons, such as fearing of death and not being able to predict or comprehend the medical course of action. At this critical point, Nadina was able to develop and rely on an empowering and caring dialogue with her doctor, who made conscious efforts to strengthen her sense of manageability and her ability to entrust herself to the care of medical professionals. This reciprocal dialogue strengthened her ability to achieve a sense of meaningfulness. According to Antonovsky, an individual develops these three key components in close interaction with her social surroundings. A strong sense
of coherence is always a result of the interplay between an individual and her surroundings (Lindstein 2001, 212).

However, the salutogenic theory, a macro sociological theory, has not specified how a sense of coherence actually develops in human beings. It has more or less taken for granted a “basic personality structure that involves a strong sense of coherence” (Antonovsky 1979, 151). In a similar way, Koelen and Lindström (2005), in their attempt to connect individual empowerment with the salutogenic approach, departed from an abstract description of a solely individual ability of people to “gain mastery of their lives.” Neither of these theoretical approaches specifies how human interaction, the vital role of a reciprocal relationship as a dynamic process, facilitates a sense of coherence, or how the process of empowerment develops. In agreement with Volanen (2011, 64), who emphasizes that the sense of coherence is psycho-emotional and that the most significant resistance resources are related to close human relationships, I propose that a strong sense of coherence is essentially social since it develops in a trusting and respectful dialogue with an(other) human being. As this chapter indicates, a supportive and reciprocal relationship is essential in order to develop understanding, to cope, and to make sense of challenging life events.

**The salutogenic dialogue**

Based on Nadina’s experiences, I will outline a model of what a reciprocal dialogue that includes elements from salutogenic theory and the concept of empowerment could be like, the second aim of this chapter.

The purpose of the salutogenic dialogue is to use the resources that refugee women have to cope with the Western birth culture in a process leading toward meaningfulness and empowerment. By using a connecting language that gives a sense of belonging (Starring 2007), the dialogue enables comprehension by making giving birth a relatively predictable and manageable event. The salutogenic dialogue is facilitated by a professional fellow-being, a concept developed by Börjeson (2010, 168-169) within social work practice. A
professional fellow-being is characterized by a mastery of professional knowledge based on science and its practical utility, and an ability to involve the personal self to emphatically understand and offer emotional and social support. Trained to communicate trust and understanding in professional encounters, doctors, nurses, and social workers enable the creation of an encouraging dialogue that supports refugee mothers to better comprehend and cope with distressing events. The dialogue includes efforts to understand and respect each other to develop mutual interaction in the acculturation process.

The interpreter plays a fundamentally important role in facilitating a trusting dialogue to develop. Achieving a reciprocal and empowering dialogue often needs several meetings. When the salutogenic dialogue strengthens comprehension and identifies resistance resources to empower a sense of manageability and a sense of trusting the maternal care system it increases a sense of meaningfulness. By integrating the salutogenic theory and the concept of empowerment in the dialogue between a professional fellow-being, a refugee mother, and an interpreter in a dynamic interaction, it increases a sense of meaningfulness in birth experiences. Thus, it facilitates the promotion of health and well-being for mothers and newborn babies in refugee families.

Case study is a useful research method when a holistic, in-depth investigation is needed (Feagin et al. 1991). This case study is drawn from a small sample size representing refugee women who are difficult to locate and contact. The knowledge developed from a single interview cannot be generalized to include all migrant Somali women in Finland or to all maternal health care providers. However, this case study illuminates some important practical and contextually related aspects from a refugee woman’s perspective: the vital importance for health care providers to take time to develop a salutogenic dialogue through an interpreter that identifies refugee women’s resources and culturally inherited (death) fears in order to empower them to better cope with the Western birth culture (see Jacobson & Meeuwisse 2008). Further research could provide deeper insights into how providers can develop trust in Somali women and Somali women’s perception of Finnish birth practices.
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