



## More than re-establishing the partner relationship: Intimate aftercare for Somali parents in diaspora



Pauline Binder, BSc (Postgraduate research student)<sup>a,\*</sup>, Sara Johnsdotter, PhD (Professor)<sup>b</sup>, Birgitta Essén, MD, PhD (Senior Lecturer)<sup>a</sup>

<sup>a</sup> Department of Women's and Children's Health (IMCH), Uppsala University Hospital, 75185 Uppsala, Sweden

<sup>b</sup> Faculty of Health and Society, Malmö University, Sweden

### ARTICLE INFO

#### Article history:

Received 25 April 2012

Received in revised form

16 August 2012

Accepted 3 September 2012

#### Keywords:

Postpartum sexual aversion

Midwifery guidelines

Proxy for anthropology

### ABSTRACT

**Objective:** to explore the sexual relationship and couples' perceptions about intimate partner support following childbirth.

**Design:** a hermeneutic design using a naturalistic inquiry framework as a qualitative proxy for medical anthropology. Data were collected using a fictional and culturally-specific narrative during focus group discussions (FGDs) in early 2011. Analysis was conducted by 'functional narrative analysis' and interpreted for conceptual constructions. Recruitment was by snowball and purposive sampling.

**Setting:** a diasporic context among participants living in six urban centres across Sweden.

**Participants:** successful recruitment included 16 Somali-Swedish fathers and 27 mothers. Three FGDs were conducted with fathers (3–7 participants) and seven with mothers (3–6 participants).

**Findings:** within day 40 post partum, parents learn to rely on each other in the absence of traditional support networks. After the first 40 days, the re-introduction of sexual intimacy is likely to occur. Of the fathers experiencing postpartum sexual aversion, these seemed to experience 'existential angst' resulting from a combination of profound remorse over having put the partner into what they perceived as a life-threatening situation during childbirth and their perceived moral and ethical obligations to provide support in this setting. Mothers in general did not directly discuss their own sexuality. Women could imagine men's sexual aversion after witnessing childbirth. However, they seemed unaware of men's potential for angst. Mothers are situated between the loss of traditional postpartum support networks, comprised of close female kin, and their own newly-defined responsibilities in the host setting. Fathers embrace their new role. Both partners articulated the mother's new role as enhancing autonomy and independence in the host setting. However, women held mixed attitudes about fathers replacing traditional kin support.

**Implications for practice:** to date, late postpartum aftercare for immigrant African parents is anecdotally linked to evidence-based recommendations, which have been identified for parents who are ethnically-congruent to a western study setting. Our findings suggest that aftercare meant for Somali parents living in these settings requires an understanding of how traditional intimate support and the postpartum sexual relationship are re-negotiated in the diasporic context. This includes recognition of the father as a willing and supportive partner.

© 2012 Elsevier Ltd. All rights reserved.

### Introduction

The World Health Organization recommendation for care following childbirth focuses on the needs of the woman and child, as well as those of the partner and family (Chalmers et al., 2001). In Sweden, the national guidelines for maternal care following discharge from hospital were modified in 2005 to target evidence-informed,

structured home-based aftercare (SFOG, 2008). Midwife-led surveillance is well supported (Persson and Dykes, 2002) and well utilised (Ellberg et al., 2005) during the period immediately following discharge, i.e. when a planned visit occurs up to 3–5 days after birth. However, the responsibility for late aftercare, defined as up to 12 weeks following birth, is left voluntary as a cost-effective measure (Ellberg et al., 2006). To better cope with these aspects, strategies such as videoconferencing have been initiated (Lindberg et al., 2009). The national recommendations encourage midwives to monitor the recovery status of the mother, the progress of breast feeding, and to initiate discussions with mothers about contraceptive use and lifestyle factors, such as smoking, diet, and exercise.

\* Corresponding author.

E-mail addresses: [pauline.binder@kbh.uu.se](mailto:pauline.binder@kbh.uu.se) (P. Binder), [sara.johnsdotter@mah.se](mailto:sara.johnsdotter@mah.se) (S. Johnsdotter), [birgitta.essen@kbh.uu.se](mailto:birgitta.essen@kbh.uu.se) (B. Essén).

Late aftercare also includes indirect surveillance for 're-establishing the partner relationship' (SFOG, 2008:129).

Seen through a wider lens, evidence-driven enquiry into late intimate aftercare, including the couple's sexual relationship, usually focuses on mothers and fathers who are ethnically-congruent to a western study setting (Morse et al., 2000; Ahlborg and Strandmark, 2001; Ahlborg et al., 2005; Ellberg et al., 2010). Yet, this attention occurs despite clues in the literature that immigrant mothers have relatively more complicated deliveries (Robertson et al., 2003) or worse social and medical outcomes related to childbirth (Essén et al., 2000a, 2000b) or such post partum outcomes as depression (Fung and Dennis, 2010; Collins et al., 2011). Furthermore, before birth, immigrant couples seek and utilise perinatal care to a significantly lesser extent than Swedish-born parents (Ny et al., 2007). However, we only suggest awareness of their postpartum care-seeking through studies conducted with midwives (Olsson et al., 2011).

Efforts taken by midwives to provide optimal aftercare to those immigrant mothers and fathers voluntarily seeking it must rely on contextualised evidence considered normative for non-migrant parents. We thus find an opening for Ryding's (1984) call for increased surveillance by midwives to observe for failures to re-establish the intimate sexual relationship—outwardly exhibited as postpartum communication-related problems. Among Swedish couples, the inability to communicate individual emotional needs following childbirth is apparently suggestive of a sexual relationship beset by misunderstandings and unmet intimacy demands (Ahlborg et al., 2000). But what of immigrant couples? If we consider sub-Saharan African immigrants, for instance, why might these parents experience sexual problems after birth? Should western care providers assume a simple taboo about sexual communication, brought with the parents from their sub-Saharan setting of origin? Poor sexual communication skills among these groups are, after all, widely reported (Kesby, 2000; Phetla et al., 2008).

This study explores the postpartum intimate experiences among a group of diasporic immigrants living in Sweden. Our aims are to elicit parents' perceptions and attitudes about re-establishing sexual contact, and, more generally, to explore their perspectives about postpartum intimate partner support in this setting. The type of migration in this study context is 'diasporic', according to Farah (2000), meaning that our participants took flight from the homeland in specific response to social and political upheaval and instability.

## Methods

Ethical approval came from the Swedish Regional Research Ethics Board in Uppsala (Dnr 2010/423) for conducting interviews and focus group discussions (FGDs) among immigrant African parents to explore their obstetric experiences in Sweden. The present study represents a component of the FGDs, where a topic- and culture-specific fictional narrative was read aloud or paraphrased aloud during each session. Snowball sampling identified key facilitators, who then purposively located participants across Sweden. Even if multiple facilitators were suggested, only one per city was used (Bernard, 2006). The inclusion criterion for the purposive recruitment was having experienced (mothers) or having witnessed (fathers) at least one birth in Sweden.

### Participants

Outcome of the recruitment was 16 fathers for three FGDs (with respective three, six, and seven participants) in three urban centres, and 27 mothers for seven FGDs (five with three participants and two with six participants) in six urban centres. Two discussion sessions

were carried out at the same study site but were conducted four months apart. Four fathers declined participation after being approached, and three fathers had agreed to participate but then left early because the start-up process took too long. Three mothers declined, and three mothers left early because of sudden commitments elsewhere. The main reason cited for declining participation was dissatisfaction with previous research outcomes as reported by the public media about Somalis living in Sweden. Potential participants either left before researchers could obtain future contact details or declined to provide them. Participant ages ranged from early-20 to mid-60 years, and time lived in Sweden with permanent residency at least one year to approximately 20 years. At the time of the study, all fathers were married to the same partner with whom they had experienced the birth. Some of the mothers had experienced multiple marriages or were divorced when the FGDs took place. Range of living children was 1–14 children. Professional status for both sexes included student, homemaker, jobseeker, business professional and national-level politician. At least one Imam identified himself among the father's group.

### Data collection

The audio recorded sessions were conducted at a participant's home, at a conference centre of the researcher's hotel, or in a room at a community social centre. The first author (medical anthropologist) conducted all FGD sessions together with a female research assistant, who is a Somali-English linguistic and cultural interpreter and who is also university educated in the social sciences. Throughout the collection process, constant debriefing took place during numerous breaks. Any concerns about misinterpretation were dealt with immediately. Random back-translation of four transcriptions was performed by a second Somali-English interpreter, who was not affiliated with the research group.

### Development of the narrative

The narrative evolved from a story told informally by the study interpreter during the first author's ethnographic engagement in two Somali communities, located in central and southern Sweden. Using Wolcott's (1999) 'hang around method' before, during and after the data collection, it was possible to become more intimately familiar over time with people in each community. Suggestions for the characters' names were sought informally while visiting one community, and were then validated during informal meetings that occurred in the second community. In Somali, 'Abdullatif' translates as 'Allah, knower of subtleties.' The choice for 'Jabir' was based on the definition, 'one who comforts'. 'Zahra' was conveyed as meaning either 'white flower' or 'princess', meant to suggest pureness of authority. 'Asha' means 'life'.

### The narrative—an excerpt

In frustration, Asha visited her neighbour one morning, just after she returned from dropping-off her two older children at the neighbourhood school. Only three months old, her infant slept peacefully. Asha's husband, Abdullatif, a trained mathematics teacher-turned-taxi chauffer after migrating two years ago from Mogadishu to Stockholm, had left home for work early that morning. ... Asha had considered that such stresses were becoming more and more frequent for her husband since he had begun his new job, but especially since the arrival of their new baby, a boy they'd named Jabir. In her failed attempts to alleviate her husband's stresses, Asha began to feel reservations about trying. She did not wish to show anger, but could not find explanation for why Abdullatif rejected her embraces and her advances to bring him comfort.

[In her neighbour's kitchen]... 'Thank you for the tea. I really needed something sweet today. My husband is a good man and we do not have any real troubles in our marriage. But, lately, he won't touch me or come near me. When I approach him, he says he is tired and busy in his head with work. I begin to wonder if he is searching for a new wife.' Asha's neighbour, Zahra, a woman in her 60s who has had 13 children over the course of two marriages, responded, 'No, no, you should not worry yourself like that! I have heard many other women describe such things before! These things can happen after the birth of a child. Men! They simply cannot cope with sharing our special place...'

...Zahra reflected, 'If I could give you some advice ... do like this: tomorrow morning, tell Abdullatif that you are ill and cannot get out of bed. I will come and make the 'canjeero' [flatbread] before he goes to work.' The next morning Abdullatif found himself seated in the kitchen ...Zahra spoke from a distance and without turning around. 'Oh, this 'canjeero'! It sticks together just like a woman after she's given birth, it's such a sticky thing, and so tight to pry apart! You just know there must be something sweet hidden in there!' A few days later, Asha greeted Zahra with a big smile....

### Analysis

The analysis combines two hermeneutic approaches to create a qualitative proxy for medical anthropology. First, the FGDs emerged within a naturalistic inquiry framework (Lincoln and Guba, 1985). The process of analysis begins at the first FGD, with 'emergent design'; that is, comments from one FGD were used to elicit further introspection from co-participants or to inform subsequent sessions. We conducted early member checking as the data collection progressed from city to city. Once the overall findings had been member-checked, the data were discussed among all co-authors (one obstetrician and a social anthropologist).

Second, for the main analysis we used 'functional narrative analysis' (Bruner, 1991) to capture participants' reflexive connection to a particular character in the narrative. The analysis began after the audiotapes were listened to multiple times, and the transcribed text was reread and sorted for relevant discussions about a specific character's name. Such 'intuitively convincing accounts' are chosen for their functionality, i.e. their ability to provide rhetorical meaning to both the narrative and the experiences that participants considered to be most significant (Bruner, 1991: 7–11). Meaning was further interpreted according to the order of participant responses. Primary responses, i.e. first spontaneous responses, were considered as most significant because they ultimately directed the flow of subsequent discussion. Interpretive concepts were constructed as inspired by Tetley et al. (2009).

### Findings

#### *The role of Abdullatif*

The character, Abdullatif, represents a father who has reservations about sexual intimacy after the birth of his son but relies on subtlety to avoid expressing it. Across the men's FGDs, all three primary responses related the character to having witnessed the childbirth. For example:

To be honest, I did not feel comfortable with all of the births of my children. ...After the birth of our first child, especially, I could not go to my wife. So, men have to understand that it is okay for them to go to therapy, to go for help. There is some research done in Norway that says, seeing the birth of a child can damage a sexual relationship. It's true. To see my wife in pain, and all the

blood, and to know there is nothing I can do to make it better for her. I accept her suffering as my own, because this is a child we created together, but it is not enough. It really affected me in a serious way for a long time, having seen that. ...We went to a family therapist to discuss the problem and to seek guidance on how to overcome the difficulties (father of four children, born in Sweden by vaginal delivery).

Secondary responses supporting this openness included, 'the sexual relationship was not the same after the birth. I was there and saw everything and things have not been the same' (father of three children, born in Sweden by vaginal delivery). Similarly, in a different FGD, the birth situation was magnified:

Of course, things change for men sexually after the birth. How could they not? The pain she went through, her suffering became my suffering. The blood, her pain, my pain, and how, how did that child come out from that tiny place? At first, they asked me to stand where I could see the birth, where I could see the baby coming out. But, no, no that was way too much for me. I started to drop to the floor. So they told me to stand near my wife's head so that I could be near her. That was the first birth, so you can imagine I knew better where to stand when the second one was born [laughs]. I felt like a changed man after that (father of two children, born in Sweden by vaginal delivery).

In the third FGD, the first father to speak linked his memory to his own responsibility:

I saw that my wife was in the worst pain possible, and she was screaming and there was nothing I could do. Then, the nurse took a scissors and cut her open down there. I can still see the nurse bent over and contorted. My child was so big that he could not fit through. I felt so miserable and so responsible. If I had not made my wife pregnant, then she would not have had to be cut open like that! It is remarkable that my wife could forget that experience and want more children after that! (father of two children, born in Sweden by vaginal delivery).

Secondary responses to this description also conveyed rich detail, and for one father, his experience was vivid even many years after the birth of his last child:

This was really, really bad for me, too.... During this long time, watching down there and waiting for the baby to come out, my mind started to wonder, How can it be to have sex after something like this? Maybe we will have to try it another way? [produced laughter among the group] No, serious, I thought at that time, I will never forget this, ever! But then, amazingly, after 40 day, I did not think about it again at all, and my wife, she even started talking about having babies again during the next week. How could she forget so easily? My wife is very strong! (father of seven children, two born in Sweden by vaginal delivery).

Men who shared opposing, secondary views waited patiently for their turn to express them. Late in one discussion, a father provided a response, which directed the group's attention towards accepting responsibility for the suffering of the wife: '...it cannot only be about waiting to hear, 'It's a boy!' we have to suffer because she is suffering. It is important to be there for her because we are alone in Sweden and it is our obligation!' (father of one child, born in Sweden by caesarean delivery). Another added:

About obligation, we are in Sweden now. I threw my mother-in-law out of the room, because she was expecting to be there with my wife. But, we are here now and have to face whatever we find, and it is my responsibility to be there for my wife!

(father of six children, three born in Sweden, two by vaginal delivery and one by cesarean delivery).

In a separate discussion, another summarised his thoughts before changing the subject, 'it is a moral obligation and a compulsory obligation, these are different, but they are both ours' (father of five, three born in Sweden by vaginal delivery). One father, who had been sitting quietly and listening to the others, provided a similar summary. 'What happens between a man and his wife is extremely private, and it is not our custom to discuss these matters in this way. I cannot say that this has not happened, but I cannot say it has, either' (father of four children, two born in Sweden by vaginal delivery).

#### *The role of Asha*

The character, Asha, reflects the idealised life-giver to a child whose name embraces comforting and care. The sense of irony brought out in the narrative is that, a mother, who is providing care to both her children and husband, remains uncertain about her husband's disposition towards her based only on unspoken avoidance of her sexual advances. Asha perceives the impact of Abdullatif's unspoken reservations as negative, but avoids taking up the issue directly with her husband.

Before the interpreter was finished relaying the narrative, one mother interrupted by saying, 'I understand that woman exactly. I can understand this story perfectly. I did not want my husband there during the birth of my children. For such reasons, I do not want him to ever see me like that' (seven children, two born in Sweden by vaginal delivery). Another woman agreed, 'I delivered both of my children in Sweden and my husband was with me both times. I did not want him to see me like that, there have been some problems, so I do not want him to see me if there will be more [children]' (two children, born in Sweden by vaginal delivery). The primary response from another FGD continued in this direction:

For two children in Sweden, I was all by myself. I prefer that. But, then, with the next child I had problems, and with that child, my husband was with me. There were problems with too little water, and he did not want me to be alone, but I didn't want him to see me. Men cannot cope with this business' (five children, three born in Sweden, two by vaginal delivery and one by cesarean delivery).

The first secondary response to this comment was from a mother who described herself and her husband as thriving and as firmly established in Sweden. She explained, 'My husband helped me a lot with the pregnancy and birth and he is very kind. He is very good at changing diapers. But, there were sex problems that began after our first child came. ...I have never had an orgasm. I have children but I have never had an orgasm' (mother of four, born in Sweden by vaginal delivery).

Participants of one women's FGD had no direct response to the characters, but to its implications. For example, 'For me, I don't like for my husband to be with me. I don't want him to see me like that [giving birth]. It is not good for me' (five living children, one born in Sweden by vaginal delivery). Secondary responses included, 'This is like a double sword, because it is good that the men are there and can see the pain we go through. But they might be so shocked that they don't find their way again after it's over' (three children, born in Sweden by vaginal delivery).

Additional secondary responses across the groups included topics, such as mother's loneliness and loss of close female kin. These aspects appeared worse or more pointed among women who perceived distance from the husband, i.e. from assuming or perceiving their partner as not bothering about the pregnancy or birth. For

example, 'My husband, he does not show any interest in the birth, the children or when I have my big belly. He has come to the check-ups with me, but he never says anything, and never asks any questions' (five children, born in Sweden by vaginal delivery).

Among those women who remained silent during the primary and secondary discussions, when probed for their experiences, they shared unoptimistic views. One mother offered, 'Directly after the baby came, my husband seemed not to notice that anything was going on. We talked a lot about what to do with the baby and how to care for it, and he was good at that. Later, he was talking all the time about coming after me for sex. I just kept telling that I was so tired and did not want to have him again for a long time.' From there, it followed, 'Yes, these are times when we really need our own mothers' (two children, born in Sweden by vaginal delivery).

#### *The role of Zahra*

The character of Zahra represents the loss of experienced and trustworthy female kin, who traditionally played a role in providing insight into the childbearing process as well as exclusive care to the new mother for the first 40 days post partum. Only one focus group offered an initial, primary response for this character:

I was completely alone in Sweden when delivering my children. At that time, there was no one for me to rely on, like that woman, Zahra, in the story. I lost my mother and my sisters, and my husband was, for the birth of one child, still in Africa and for the other, he was too busy with his studies. He came to the hospital, but then realized there would be a lot of blood, so he went out from there (three children, two born in Sweden, one by vaginal delivery and one by cesarean delivery).

Across the other focus groups, for both sexes, the implicit importance of this character led to reflective discussions about the juxtaposition of supportive roles between the husband and wife. From one mother:

My husband was really supporting me, wiping my brow. In Somalia, it is that you have your mother and sisters right with you, before, during and after the birth, and your husband is not allowed to see you for 40 days. He waits for you at the hospital, takes you home afterward, and that's it. Here in Sweden, you don't have your mothers or sisters or aunts or anybody, and your husband has nothing to keep him from seeing you when he is not supposed to. And, nothing to stop him from wanting you in 'that way' once you're back at home. Maybe in Sweden, it is true that he would see you and see you sweating when the baby comes, and when he is with you, he can see the process in a proper way. But also here in Sweden, we don't have 40 days to make ourselves beautiful again' (mother of seven children, one born in Sweden by vaginal delivery).

Another mother explained, 'For me, it was no problem. My husband never looked [where the baby came out] for any of the births. But, I am glad for the 40 days because a man cannot see you healing for that time!' (mother of eight children, one born in Sweden by caesarean delivery). One father commented:

When the baby comes, it is the worst period for a woman. She gets so many wounds in different ways when the baby comes out. In Somalia, men have no idea about this, and they just buy a goat for all this trouble. But, here in Sweden, how can I help? All of the attention she deserves from her mother and sister are not here. Is it enough to cook for her, to shop for her? There is nothing to do to make her wounds heal faster and to take away her pain. When our first child came, it was hard for me

to see those wounds and to imagine how I could help her (father of four children, born in Sweden by vaginal delivery).

Conversely, some men had already made up their minds about women’s perspectives, ‘My wife, she wants a female to be there with her. This is a woman’s process, so what could I do? It is better to buy her things and to support her during the 40 days.’ (three children, born in Sweden by vaginal birth). Among both fathers and mothers, some gave a very practical account of the 40-day period. One father articulated:

We are now living in Sweden, and we should not expect anything on this matter. I believe that, here, some women don’t ask for this 40-day period because they want to be independent, and I believe that my wife wants to show herself that she can manage. But, I understand, for other women, they don’t believe they can do anything themselves, and they long for that care (two children, born in Sweden by vaginal delivery).

The sexual reunion at the end of the 40-day period was emphasised by both sexes. Some of the fathers, for example, who had experience in both Somalia and in Sweden, lamented the loss of the traditional celebration on day 41. Still others explained that it was up to them to create that moment again for their wife, to keep her happy without the extra attention she’d missed, ‘No, no. In Sweden, it is possible to make it happen, even if I have no experience from home. There’s nothing sweeter than that moment, when you know it will be again like the first time’ (two children, born in Sweden, one by vaginal birth and one by caesarean section). One mother shared:

Oh, when that time comes and he comes home from work, you know, I have already made the house prepared and have put on something sexy under my clothes. While he’s just sitting there, watching TV, then I touch my foot to his leg [demonstrates]. Then, he knows, it’s time! Forty days or not, we manage here in Sweden! (three children, born in Sweden by vaginal delivery).

Exemplified in one father’s comment is the mystique and anticipation of this time of sexual reunion:

Oh, when a baby comes, we must do everything to keep her happy! During the birth, I hold her hand and focus on her. I do not like blood, so I do not watch the baby come out. But, during the 40 day, I buy her gifts and clothes and new furniture, whatever she wants! When she is done, she is so sweet and her body has returned to normal, just as a young girl’s body (eleven children, one born in Sweden by vaginal delivery).

Day 40 post partum

Fig. 1 conceptualises two important areas in the provision of postpartum aftercare to Somali parents living in a diasporic context. Within 40 days, parents must renegotiate their support strategies in absence of traditional social networks. After the 40th day, parents might experience sexual reunion problems. Traditionally, this date was anticipated with celebration and sexual reunion, which some parents tried to emulate in this setting, but most ended up with a ‘no choice but to cope’ attitude. By coping, some parents rejected all the traditional ways, so that new norms could be created.

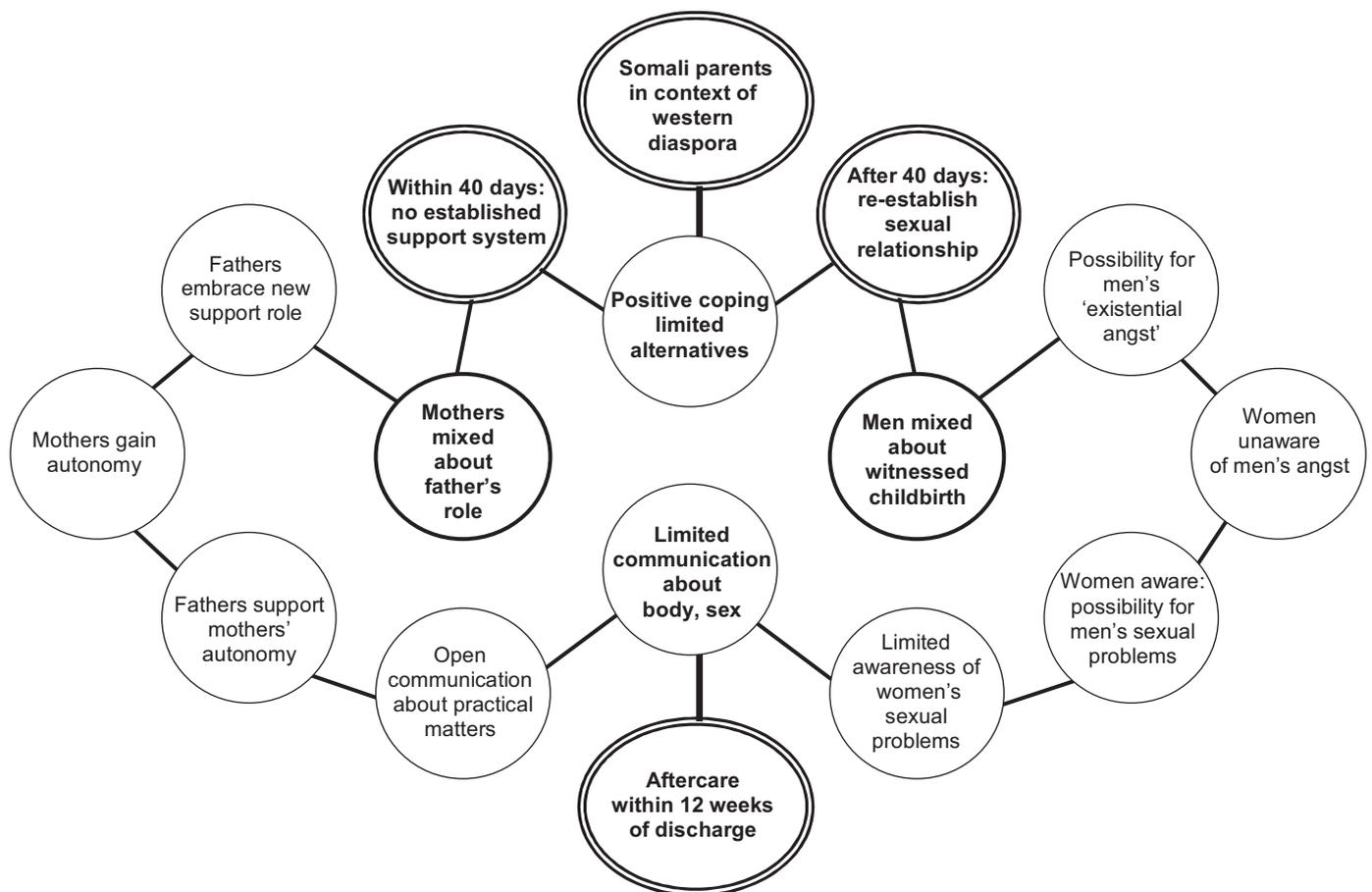


Fig. 1. Somali parents living in a western, diasporic context renegotiate postpartum care of the mother as well as the re-introduction of the sexual relationship. A potential exists for limited ability to articulate sexual problems to an aftercare provider.

None of the mothers directed their comments towards the role of Abdullatif, but did exhibit awareness of the possibility for men to experience sexual problems. The men's aversion to sexual activity might have related to 'existential angst', especially if a man simultaneously perceived being exposed for his uprootedness during the childbirth, if he felt responsible for his wife's pain by impregnating her, and if he felt strongly about solely upholding a moral and ethical obligation to support his wife. In general, women appeared unaware of men's potential to experience this angst, and did not directly discuss sexual problems except if they were approached during the traditional 40-day period of rest.

Mothers linked the breadth of their experiences via the characters, Asha and Zahra, and to the loss of traditional female support networks. This might correspond to being situated between the loss of traditional support systems and newly gained autonomy. Both parents related to the latter. The loss of the traditional support system opened the requirement for better articulation of needs between the partners and, for fathers, to become open to learning from their partners about maternal processes. By this, men's recognition and willingness to embrace their new role in childbearing opens a window of opportunity for women's enhanced sense of autonomy and independence.

Despite these gains, parents did show signs of a measured acceptance of typical Swedish norms related to maternal aftercare. For example, some mothers wished to avoid being seen by partners during either the birth or the healing period. Similarly, fathers reflected on the great distance to providing adequate support during childbearing processes. Both parents might be hesitant to seek help for sexual intimacy problems, even if they know that help is available during the first 12 weeks post partum.

## Discussion

Swedish guidelines for the postpartum period encourage midwives to provide late aftercare with the support of evidence-based knowledge (SFOG, 2008). However, explicit social norms associated with intimate experiences in a diasporic context are heretofore unidentified in the evidentiary literature. Parental responses and insight into apparently common postpartum difficulties have yet to be elaborated for groups such as our participants. Openly verbalising intimate sexual problems in relation to having witnessed the birth, for example, seemed to alert some men for the first time that they are not alone with sexual aversion. The father who discussed Norwegian research in relation to therapy likely referred to Brudal (1981), who identified dissatisfaction with sexual intercourse in one-third of the Norwegian couples she surveyed at one year post partum. Our participants did seem to give meaning to the idea that, witnessing the birth of a child can damage one's ability to maintain a satisfying and intimate sexual relationship. Whether witnessing childbirth and maintaining sexual intimacy are related requires further exploration, as most of these participants chose against elaborating how they and their partners managed the situation.

However, Brudal's findings conceptualised that men's desire to initiate sex after childbirth can be vulnerable to 'existential angst' if the experience during the birth event is so traumatising and simultaneously perceived as life-threatening to the intimate partner. Our fathers further constructed a sense of responsibility for having placed their wives into the threatening situation, simply by having impregnated her. We shall detail these Swedish-Somali men's first attendance at childbirth in a future reporting, but references made during this narrative study provide initial insight into the likelihood for men's existential angst.

One reason for the paucity of attention given to immigrant men's need for aftercare might be a general reticence among researchers

about exploring the topic of intimate sexuality (von Sydow, 1999), especially among religious study participants. Swedish midwives who were asked about task-oriented strategies used for counselling new parents initially waited to be asked for help (by the mother) before engaging in open dialogue about the couple's sexual problems (Olsson et al., 2011). Some of the midwives in that study identified language difficulties and a lack of knowledge about cultural diversity as having constrained their ways of counselling about the 'delicate topic' of sex. Our experience suggests that, Somali-Swedish fathers are willing to articulate their sexual concerns simply because they have been asked and have a need to share.

Nordic men initially feel left out of the birth process and question why their own needs are neglected (Brudal, 1981). This aspect turns into aversion when avoidance of sex becomes rooted in guilt for blaming the infant. Olsson et al. (2011) describe that Swedish midwives interpret similar experiences for the Swedish fathers in their care. Additionally, one study did identify first-time Swedish fathers' postpartum feelings of neglect by their partners in favour of the infant (Ahlborg and Strandmark, 2001). However, no fathers in our study articulated this sense of neglect. Ahlborg et al. (2005) further identified that, even if both parents are satisfied with their intimate relationship, they can still find it difficult to keep up their pre-pregnancy sexual life from circumstances such as fatigue. It is likely that mothers in our study were more prone than fathers to such negative outcomes. The change to their social roles, resulting from the loss of traditional female support, appears to contextualise their experiences in a different way. Similarly, according to Olsson et al. (2010), men's reduced sexual desire can result from fatigue, but also from having to set new priorities towards care of the infant. This caused fathers to re-negotiate sex into their transition to fatherhood. However, none of our participants articulated this feature, leaving it open to further exploration.

Ryding (1984) recommended several decades ago that Swedish midwives be alert for postpartum sexuality problems within couples. By now, mothers' experiences have been branded as 'postpartum female sexual dysfunction' (Sayasneh and Pandeva, 2010). Furthermore, there is, perhaps, an assumption that if the mother is experiencing sexual difficulties, then the father must be, as well. However, to date, the scant evidentiary literature on immigrant men's postpartum sexual experience only serves to confirm anecdotal awareness. Our findings also suggest that, among the wives of our male participants, as well as among the mother's in our study, most are either unaware of fathers' angst or are hesitant to discover their partner's sexuality concerns in relation to their own. Such women might not articulate postpartum difficulties to inquiring health professionals, despite caregiver expectations for it (SFOG, 2008). In any case, sex is unlikely to be a relevant topic for discussion for many Somali-Swedish couples until after day 40 post partum. This finding is supported by a Canadian study exploring the birth experiences of Somali immigrants, which showed that two-thirds of the participants re-introduced sexual intercourse only after postpartum day 40 (Chalmers and Omer Hashi, 2000).

### *Clinical implications: recognising midwives' window of opportunity*

These findings offer an opportunity for midwives to gain insight into the postpartum life of Somali parents in the context of diaspora. Fathers' self-prescribed, axiologic obligation includes giving their wives appropriate support during childbirth. It seems important that men whose wives experienced caesarean section were much more vocal about this aspect than the men who had witnessed a vaginal birth. Mothers' response to this obligation seems to be mixed. In the absence of close, female kin, some

struggled to maintain traditional maternity roles, where fathers are banned from both witnessing childbirth and from providing support up to day 40 (Omar, 1994). Some upheld attitudes that men are generally disinterested in childbearing processes. However, this perception was neither supported by men's perspectives nor their articulated experiences. Women appeared to regret the loss of their traditional female support systems, i.e. close female kin. Wishful longing to rely on female relatives for support might disrupt the opportunity for mothers in the diaspora to articulate intimate needs to the partner and aftercare midwives. Nevertheless, both mothers and fathers recognised women's increased potential for autonomy and independence, which resulted from the loss of their traditional network system. Their new postpartum roles might thus create the opportunity for these parents to steadily transition into the care model of this setting, which can create a window for aftercare midwives to gain crucial insight into the needs of this group.

For groups such as our participants, patterns of communication related to the sensitive areas of sexual pleasure or responses to birth traumas or to postpartum support, first require insight on how to openly discuss the body. Makhlouf Obermeyer (2005) has described necessity for this type of communication in relation to female genital cutting (FGC). However, in our study, FGC was not discussed in response to the actual narrative. We do note that during our process of informal member checking, only one respondent conjectured that Somali men might wish to avoid sexual activity after childbirth because they have witnessed the infant exiting from an area of the wife's body that he has already seen subconsciously as 'mutilated'. Such ethnographic claims would need to be explored further before making interpretations for this context.

#### Methodological considerations

The use of a proxy for medical anthropology – naturalistic inquiry combined with functional narrative analysis – allowed us to avoid limitations usually confronting qualitative analyses that miss 'how' and 'why' differences in the data (Daly et al., 2007). Furthermore, as we constructed the narrative with the assistance of informal 'insider' sources, derived during the ethnographic fieldwork, we contend that it was designed with cultural legitimacy (Bruner, 1991). The narrative presents a valid approach to explore the sensitive topic of postpartum intimate partner experience. It should have been better to add at least one additional focus group with fathers, which is an area for future research.

#### Conclusions

Although midwives strive to provide best care to all new parents, our novel findings suggest that Somalis living in the diasporic context are underrepresented and anecdotally linked to aftercare recommendations across western settings. Guidelines targeting an evidentiary platform might better include specific-needs aftercare for these parents, bearing in mind their pace towards progress. Embracing normative models of westernised care includes acknowledging and growing accustomed to their own intimate partner experiences in the new setting. For these parents, aftercare is thus more profound than simply re-establishing the partner relationship.

#### Conflict of interest statement

All authors have no financial or personal relationship conflicts of interest that can inappropriately influence this work.

#### Acknowledgements

The authors wish to express gratitude to all of the Somali-Swedish parents who participated in these discussions and to the facilitators, who helped us locate potential informants. We especially thank Barni Nor, PhD, for valuable feedback on early drafts of the manuscript. The Swedish Council for Working Life and Social Research (FAS 2006–2007) and the Faculty of Medicine at Uppsala University, Sweden, are acknowledged for financial support.

#### References

- Ahlborg, T., Strandmark, M., Dahlof, L.G., 2000. First-time parents' sexual relationships. *Scandinavian Journal of Sexology* 3, 127–139.
- Ahlborg, T., Strandmark, M., 2001. The baby was the focus of attention—first-time parents' experiences of their intimate relationship. *Scandinavian Journal of Caring Sciences* 15, 318–325.
- Ahlborg, T., Dahlof, L.G., Hallberg, L.R., 2005. Quality of intimate and sexual relationship in first-time parents six months after delivery. *Journal of Sexuality Research* 42, 167–174.
- Bernard, H., 2006. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*, 4th edn. Altamira Press, Oxford.
- Brudal, L., 1981. *Psysiske reaksjoner hos kvinner og menn i tilknytning til fødsel [Psychological Reactions in Women and Men in Connection With Childbirth]*. Doctoral Thesis. Norwegian Psychological Association.
- Bruner, J., 1991. The narrative construction of reality. *Critical Inquiry* 18, 1–21.
- Chalmers, B., Omer Hashi, K., 2000. 432 Somali women's birth experiences in Canada after earlier female genital mutilation. *Birth* 27, 227–234.
- Chalmers, B., Mangiaterra, V., Porter, R., 2001. WHO principles of perinatal care: the essential antenatal, perinatal, and postpartum care course. *Birth* 28, 202–207.
- Collins, C.H., Zimmerman, C., Howard, L.M., 2011. Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Archives of Women's Mental Health* 14, 3–11.
- Daly, J., Willis, K., Small, R., et al., 2007. A hierarchy of evidence for assessing qualitative health research. *Journal of Clinical Epidemiology* 60, 43–49.
- Ellberg, L., Lundman, B., Persson, M.E., Hogberg, U., 2005. Comparison of health care utilization of postnatal programs in Sweden. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 34, 55–62.
- Ellberg, L., Högberg, U., Lundman, B., Lindholm, L., 2006. Satisfying parents' preferences with regard to various models of postnatal care is cost-minimizing. *Acta Obstetrica et Gynecologica Scandinavica* 85, 175–181.
- Ellberg, L., Högberg, U., Lindh, V., 2010. 'We feel like one, they see us as two': new parents' discontent with postnatal care. *Midwifery* 26, 463–468.
- Essén, B., Hanson, B.S., Ostergren, P.-O., Lindquist, P.-G., Gudmundsson, S., 2000a. Increased perinatal mortality among sub-Saharan immigrants in a city-population in Sweden. *Acta Obstetrica et Gynecologica Scandinavica* 79, 737–743.
- Essén, B., Johnsdotter, S., Hovelius, B., et al., 2000b. Qualitative study of pregnancy and childbirth experiences in Somali women resident in Sweden. *British Journal of Obstetrics and Gynecology* 107, 1507–1512.
- Farah, N., 2000. *Yesterday, Tomorrow. Voices from the Somali Diaspora*. Cassell, New York.
- Fung, K., Dennis, C.L., 2010. Postpartum depression among immigrant women. *Current Opinions in Psychiatry* 23, 342–348.
- Kesby, M., 2000. Participatory diagramming as a means to improve communication about sex in rural Zimbabwe: a pilot study. *Social Science and Medicine* 50, 1723–1741.
- Lincoln, Y., Guba, E., 1985. *Naturalistic Inquiry*. Sage, New York.
- Lindberg, I., Christensson, K., Ohrling, K., 2009. Parents' experiences of using video-conferencing as a support in early discharge after childbirth. *Midwifery* 25, 357–365.
- Makhlouf Obermeyer, C., 2005. The consequences of female circumcision for health and sexuality: an update on the evidence. *Culture Health and Sexuality* 7, 443–461.
- Morse, C.A., Buist, A., Durkin, S., 2000. First-time parenthood: influences on pre- and postnatal adjustment in fathers and mothers. *Journal of Psychosomatic Obstetrics and Gynecology* 21, 109–120.
- Ny, P., Dykes, A.K., Molin, J., Dejin-Karlsson, E., 2007. Utilisation of antenatal care by country of birth in a multi-ethnic population: a four-year community-based study in Malmö, Sweden. *Acta Obstetrica et Gynecologica Scandinavica* 86, 805–813.
- Olsson, A., Robertson, E., Björklund, A., Nissen, E., 2010. Fatherhood in focus, sexual activity can wait: new fathers' experience about sexual life after childbirth. *Scandinavian Journal of Caring Sciences* 24, 716–725.
- Olsson, A., Robertson, E., Falk, K., Nissen, E., 2011. Assessing women's sexual life after childbirth: the role of the postnatal check. *Midwifery* 27, 195–202.
- Omar M., 1994. *Womens Health in Rural Somalia*. Thesis. Department of Epidemiology and Public Health, Umeå University.

- Persson, E.K., Dykes, A.K., 2002. Parents' experience of early discharge from hospital after birth in Sweden. *Midwifery* 18, 53–60.
- Phetla, G., Busza, J., Hargreaves, J.R., et al., 2008. 'They have opened our mouths': increasing women's skills and motivation for sexual communication with young people in rural South Africa. *AIDS Education and Prevention* 20, 504–518.
- Robertson, E., Malmström, M., Sundquist, J., Johansson, S.E., 2003. Impact of country of birth on hospital admission for women of childbearing age in Sweden: a five year follow up study. *Journal of Epidemiology and Community Health* 57, 877–882.
- Ryding, E.L., 1984. Sexuality during and after pregnancy. *Acta Obstetrica et Gynecologica Scandinavica* 63, 679–682.
- Sayasneh, A., Pandeva, I., 2010. Postpartum sexual dysfunction. A literature review of risk factors and role of mode of delivery. *British Journal of Medical Practitioners* 3, 316.
- SFOG, 2008. Svensk Föreningen för Obstetrik och Gynekologi: Mödrahälsovård, Sexuell och Reproductiv Hälsa [Swedish Society of Obstetrics and Gynecology: Maternity Services, Sexual and Reproductive Health]. Rapport nr 59, 45–46, pp. 127–129.
- Tetley, J., Grant, G., Davies, S., 2009. Using narratives to understand older people's decision-making processes. *Qualitative Health Research* 19, 1273–1283.
- von Sydow, K., 1999. Sexuality during pregnancy and after childbirth: a metacontent analysis of 59 studies. *Journal of Psychosomatic Research* 47, 27–49.
- Wolcott, H.F., 1999. *Ethnography. A Way of Seeing*. Altamira Press, Oxford.