

LANGUAGE, CULTURE AND MATERNITY CARE: *'Troubling' Interpretation in an Institutional Context*

Abstract

This article analyses language interpretation in the context of maternity health care. By scrutinising how maternity health care staff reflects upon their experiences from the everyday institutional setting, the article shows that they are caught between a discourse on language interpretation as migrants' rights and a racialised discourse where language is intertwined with notions of 'otherness'. As such, language interpretation becomes subsumed into a range of different practices that seek to discipline migrant women to meet the demands from Swedish society. In the article, therefore, the everyday practice by the health care staff is looked upon as a form of citizenship-making, and the article emphasises how racialised discourses take different shapes in different institutional contexts. Thus, the article shows that the practice of language interpretation cannot, in this context, be fully understood without including the larger socio-political context.

Keywords

Language Interpretation • Maternity Care • Migrant Women • Neo-assimilation • Sweden

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Introduction

We have a new policy here... You know, interpreters are very costly... and if the woman does not show up when an interpreter is booked, well then we have decided that if it happens once more, then we won't book an interpreter until the moment she enters the door next time.

This quote, expressed by a frustrated midwife trying to provide health care on equal terms in a context where budgetary cuts and institutionalised racism hover, captures the key paradox that this article tries to disentangle.

The article sets out from a notion of 'language' as a nodal point in contemporary discourses on migration in Sweden. This is expressed in how 'knowledge in Swedish' increasingly is suggested as both the solution to, and the blame for, 'failed' immigrant integration. Consequently, policy programmes - from national school programmes to local NGOs - emphasise language trainings for migrants as utterly important, while mainstream media paints malicious portrait of migrants living in Sweden for decades without knowing the most basic words in Swedish (Milani 2008; Puskás & Ålund 2013). This has prompted critical scholars to feature the racialisation of language, and argue that language is articulated as a key marker of 'otherness' and thus integral to social and cultural citizenship-making (Jonsson 2004; Milani 2008; Puskás & Ålund 2013).

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However, the issue of language interpretation is, at least on a policy level, generally not included in this overall racialised discourse. Rather, language interpretation is framed in a rights-based discourse, where it is suggested as a way to overcome barriers and promote equality by the law. Speaking particularly of health care, language interpretation is proposed as a way to increase patient participation and promote equal treatment and care (Hadziabdic *et al* 2010).

This article analyses how staff at maternity health clinics talks about their daily experiences of interpreted consultations. The aim is to interrogate potential conflicts of providing language interpretation as means to overcome structural barriers at a time in history where language is highly racialised. Thus, the article will merge theoretical perspectives on citizenship and policy-making in an everyday setting with what could be described as a field dominated by descriptive empirical studies. These studies are often policy-oriented or focusing on the relational aspects of interpretation. Previous health care research has, for instance, underlined the importance of working with interpreters in order to improve quality of care and to overcome health disparities due to inappropriate diagnoses; poorer adherence to treatment and follow-ups; and longer hospitalisations (Brisset *et al* 2013; Karliner *et al* 2007). Other studies have shown that health care staff has conflicting expectations on the interpreter who is presumed to act both as a neutral 'translation machine' and as a provider of emotional support to the patient (Fatahi *et al* 2008; Kale & Raza Syed 2010). While this article contributes to this empirical field, we also set

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out to contextualise our findings in the larger socio-political debate on language and belonging, in particular the contemporary neo-assimilationist policy development that takes place in many western countries (Brubaker 2001; Bredström 2008; Hansen & Hager 2012; Schierup *et al.* 2006). Thus, the article contributes to an increasing amount of studies that interrogates structural and institutionalised racism (see e.g. Gruber 2007; Hertzberg 2003; Neergaard 2006), but in a health care context.

Race/ethnicity and the restructuring of the Swedish welfare state

On a very basic level, language interpretation has strong links to key aspects of Swedish citizenship. It is, for instance, regulated by law that Swedish authorities are to engage interpreters when needed (SFS 1986:223, 8§), and, as mentioned above, health care policy accentuates using language interpreters as means to achieve equality in health care and increase patient participation (Socialstyrelsen 2012). Language interpretation could be described as an illustrative example of how the institutionalisation of social rights provides citizenship with more substantial content, following Marshall's (1950) understanding of social citizenship as a prerequisite for the true realisation of civil and political citizenship.

While Marshall's theory has been revised and critiqued for its narrow focus on class relations, his concepts of civil, political and social citizenship have been fruitful for re-thinking citizenship in a number of ways. With an emphasis on processes of inclusion and exclusion, studies have, for instance, shown how citizenship is racialised, ethnicised, gendered, and sexualised and invoked by intersections of many other axes of differentiation (Yuval-Davis 2011). Similarly, has Marshall's line of procedure - whereby civil are to be followed by political and subsequently, social rights - enabled scholars to point out constructions of citizenship that take other courses. For instance, Hansen and Hager (2012: 34) argue that, present day citizenship in the European Union tends to stress civil aspects but without guaranties of any future social rights, a development that is intimately linked to the crises of the western welfare state.

With neoliberalism, we have, since the mid-1970s, witnessed a restructuring of the welfare state, with increasing restraint on social rights in particular. Thus if, for Marshall - writing in the 1950s Britain - the welfare state held the promises of increasing inclusion, a decade into the twenty-first century the outlook is depressingly the opposite, calling scholars to see national citizenship as 'an exclusive rather than an inclusive status' (Schierup *et al.*, with reference to Dahrendorf, 2006: 1). This is true also for Sweden. Despite its long reputation as the 'quintessential social democratic welfare regime' that strives for universal social rights for its citizens, scholars have revealed that Sweden has gone through a dramatic regime change leading to a fast and vast-reaching dismantling of the welfare state (Schierup *et al.* 2006).

Following these changes, there is a strong turn towards 'individual responsibility' that penetrates and redefines some of the corner stones of the previous protective state-formation. For instance, in relation to health care, 'patient participation' has ascended as a key metonym for the self-management patients are to endorse in present day consumerist system. Nikolas Rose (2007) also emphasises that in advanced liberal societies, health has become an ethical value, leading to a virtual explosion of 'somatic expertise' that provide guidance in how to optimise health through enhancement techniques and risk-surveillance.

Diana Mulinari (2010; 2011) captures the effects of this transformation in her study of birth clinical practices in Sweden. Mulinari shows how midwives related differently to women depending upon the women's ethnic and class backgrounds. White, Swedish-speaking middle-class women were perceived as well-informed and oftentimes as 'too demanding'. In contrast, migrant and working-class women with less access to knowledge and language (both Swedish and medical language) became more 'traditional patients' who the midwives could 'care for'. However, with budgetary cuts and bureaucratisation, there was a distinct limit to any care at all, and the care that was provided was to a large extent informed by cost-efficiency measures, risk-group-thinking, and a medicalised view on giving birth.

This article will further explore how contemporary dominant discourses are articulated in maternity health care, in particular in relation to racialisation and ethnicity. Neoliberal economic forces and diminishing social rights have had vast effects on migration and immigrant integration policy throughout Europe (Hansen & Hager 2012). In Sweden, present labour migration, issued 2008, is influenced by the regime of circular migration. Accordingly, labour migrants are offered a temporary residence with restricted social rights and, most importantly, tied to employment. Social rights for other groups of migrants have also been affected, with increasing demands on both asylum-seekers and family unification (Schierup & Ålund 2011). And in conjunction with these restraining developments, we have seen a shift from the dominant multiculturalist ideology from the early eighties towards what has been characterised as a neo-assimilatory line of thought (Brubaker 2001; Hansen & Hager 2012; Schierup & Ålund 2011; Bredström 2008). As critics have shown, the previous multicultural paradigm highlighted equality, partnership and freedom of choice, yet rested upon a 'culturalist' understanding, singling out migrants and ethnic minorities as 'problems' and reducing social problems to migrant's cultural background, ethnicity or religion. Thus, in the 1980s, essentialist and stereotypical notions of cultural otherness became poignant, in particular in areas where the cracks in the welfare state started to appear. Yet, however, the suggested solution to the same social problem was not to abandon but to strengthen cultural belonging and increase a positive ethnic identification. As the current crisis unfolds, this pluralist multiculturalist view comes to an end. Along with increasing insecurity, higher unemployment-rates, and decreased social rights, the 'right to be different' has vanished in favour of an idealisation of 'core values' often camouflaged as 'human rights' (i.e. in this discourse, gender equality or rights for lesbian, gay, bisexual, transgender and queer people are often constructed as Swedish values and correspondingly, as human rights/universal values [Bredström 2008]). Thus, what is proposed is instead a 'unity in terms of cultural assimilation' (Schierup & Ålund 2011: 134), that is, a form of neo-assimilationist policy. In contrast to postwar assimilatory policy, current neo-assimilationist policies does not target social inequalities but rather thrives on a message of cultural adaptation to, in our case, Swedish values and Swedish culture (Bredström 2008).

Maternity health care as institutional practice

While the above serve as a description of the overall discourse in present Swedish society, capturing these processes in an everyday encounter is another matter. To emphasise that citizenship is an ongoing process that is constructed and re-constructed in everyday practice, Nordberg & Wrede (2015) develops James Tully's concept of 'citizenisation'. This concept, we believe, would account for the

processes that take place in our study as well, covering, in particular the ways in which rights are negotiated in a welfare institutional setting. Others have used Michael Lipsky's (1980) concept of 'Street-level Bureaucracy' to attend to, in particular, public service worker's everyday interaction with clients and others. As such, these bureaucrats are engaged in policy-making in practice. Thus, Lipsky's concept can also be used to theorise the micro level of institutionalised racism (Hertzberg 2003).

In our case, where the midwives are caught between two competing discourses (i.e. language interpretation as a social citizen's right versus language as nodal point in racialised discourse on otherness), such everyday policy-making becomes particularly interesting. Accordingly, we understand maternity health care practice as an institutional practice that can be compared to other welfare state institutions such as social work or education. Speaking specifically of maternity health care, the links to other welfare institutions are apparent. Historically, maternity health care was a crucial institution of the Swedish welfare system already when it was established in the 1940s (Bredmar 1999; Socialstyrelsen 1979). In the 1970s, it evolved into an institution that came to include various prevention and educational activities. By highlighting matters such as breastfeeding, delivery and contraceptive counselling, health and parenthood (Socialstyrelsen 1979; SOU 1978:5; SOU 1997:161), maternity care thus also became a basic parental education, to be continued at child welfare centres, pre-schools and social services. In recent years, maternity health care has been assigned an overall responsibility for reproductive health care matters and thus come to include youth counselling, abortion and prevention against sexual transmitted infections (Socialstyrelsen 1996).

Maternity health care is financed via tax funds and primarily arranged as part of the public sector. It is free of charge to all pregnant women and prospective parents and thus reaches a large group of women. As such, it has also become an important institution for public health matters, institutionalising, for instance, screening programmes such as HIV prevalence (SOSFS 2004:13). With current restructuring of the welfare state, private alternatives have become more available. As is the case with most health care in Sweden, regional authorities have a large say as to how national programmes are to be implemented. Thus, some tariffs and programmes for different check-ups might differ between clinics depending on location and responsible organisation.

In general, however, maternity health care is organised in line with national recommendations as a basic national programme (SFOG 2008; Socialstyrelsen 1996). This programme specifies detailed instructions for the content on each visit and appoints the midwife as responsible for monitoring the pregnant woman's health. The basic programme is designed for normal pregnancies and to be supplemented with extra efforts when complications arise. Some regional authorities have also developed special programmes for 'risk pregnancies' among certain vulnerable groups (SFOG 2008). These include women that have been shown to under-utilise maternity health care, such as some groups of migrant women, young mothers and single mothers from socially vulnerable groups (Darj & Lindmark 2002; Fabian *et al* 2004). Pregnancy difficulties seemingly affect women with migrant backgrounds to a larger extent than native Swedish women, which also makes migrant women more vulnerable as a group (Essén *et al* 2000; Robertsson *et al* 2005). Among other things, lack of interpreters has been identified as an important cause for migrant women's vulnerable position (Esscher 2014).

One of the issues that is highlighted on a policy level as deserving special attention is 'cultural and lingual communication difficulties'

(SFOG 2008:45), and health care policy states that language interpreters should be used if needed (Socialstyrelsen 2012). Interpreter agencies were established in the 1960s and initially run by the public sector, but has increasingly been privatised. It is a well-established institution in Sweden, but characterised by high market concentration and competition for the same clients and interpreters (SOU 2004:15). There is an extensive lack of certified interpreters, in particular specialised in health care and medicine, and the occupation is poorly paid and interpreters often work under precarious conditions (SOU 2004:15.).

Methodology and empirical material

This article draws upon empirical data gathered for a research project on ethnicity and gender in different primary health care settings, including maternity health and youth centres. The data will also be used as part of a larger study, focusing, particularly on language interpretation in healthcare.¹ The material includes transcriptions of roughly 50 single interviews with different staff categories including nurses, midwives, physicians, counsellors as well as central directors, policy implementers and representatives of local NGOs that organises projects such as ethnically profiled 'health communicators' (such as the 'doulas', see below). In addition to this, we have also conducted participatory observation at several clinics and gathered written materials such as local policy documents and patient information brochures. This article focuses on the parts of the material that concerns maternity health care. This includes staff from four publicly run maternity clinics in two different regions of Sweden, located in urban cities, small town areas as well as in the countryside. Migrant women constitute a large part of the patient group in all of these places, and virtually, all interviewed midwives had extensive experience of meeting migrant women in their work at the clinic. They also had wide experience of working with interpreters. It can also be noted that a conspicuous majority of the midwives were middle-aged, white, Swedish-speaking women (see also Mulinari 2010).

The interview guide builds upon our field notes from the participatory observations that we conducted initially. It includes questions regarding policy and daily routines, focusing, in particular on situations and matters where issues of interpretation, language and ethnicity were articulated. The transcripts and field notes do not contain any names, places or other information that could reveal the identity of the participants.² In this article, we focus particularly at those instances in our material where language interpretation is either openly discussed or mentioned in a roundabout way. Next, we will turn to our analysis.

The inflexible institution

On a general mode, language interpretation was not considered a big issue at the clinics we visited. None of the participants in our study had received any particular training in how to use an interpreter, and the institutions' educational efforts had not covered interpretation or language matters, at least not within the past few years. Explicit policies concerning *how* or *when* to use language interpreters were also conspicuously non-existent. Some said that there had been a memo of some kind, and others claimed that there were written guidelines, but could not find them.

Yet, most of those we met saw language interpretation as self-evident, if needed. They expressed it within a rights-based discourse,

as migrants' rights or as women's rights (for instance, in those cases where a husband spoke Swedish but not the pregnant wife, see below). Each institution we visited also had a seemingly coherent practice, that is, it seemed as if there was a forthright policy looking at the routines of how and when language interpreters were used, and the patients were seldom left with any other choice but what the institution offered. Interestingly enough, these institutionalised routines differed between different institutions. That is, some places used only in-person interpreters whereas others used only remote interpretations via telephone.

The issue of language interpretation was also limited to staff-patient encounters and consultations at the clinic, and primarily those that had been scheduled in advance. Thus, there were many of the routine practices that had no system for language translation. For instance, interpreters were not used for consultations over the phone, not even when it concerned more serious matters such as messages regarding various test results. Neither were written accounts, such as emails and regular mail, translated with the exception of some standard information sheets.

Accordingly, we saw a number of examples of how the institutionalisation of language interpretation did not fit with the everyday routines at the clinic. A few months after delivery, for instance, all women are called back for a return visit. This visit is seen as important not only to follow up the delivery, but also to discuss birth control matters and future pregnancies (Socialstyrelsen 1996). One midwife told us about how she went about to call women over the phone to schedule their return visit: 'Hopefully there are someone in the family who knows Swedish so we can ask how the delivery went, how breastfeeding is going and confirm that they have established contact with the child welfare centre as they are supposed to do'.

Another example is when migrant women are provided with pregnancy-related information in Swedish only. At one clinic that we visited, for instance, we observed how some Somali women with hardly any Swedish vocabulary were put in front of a television to watch a film in Swedish about delivery matters. When questioned (by us) about the relevance of a film in Swedish for these women, the midwife explained that 'at least they can follow the pictures'.

Also, in most places we visited, practices that were carried out outside the consultation room, such as blood tests, were routinely taken prior to the interpreters' engagement. Thus, in our material, we have several stories mirroring the below:

Researcher: And why do you wait with the interpreter until after you have taken the tests?

Midwife: Because it takes some time, taking them [the tests] that is, and sometimes they also come in early. The interpreter appointment has not yet started. We take them aside as soon as we can, and point to the injection, again using sign language and show the equipment. 'Yes yes', they nod, so for most people, it is not a big issue. And we tell them that we check for different diseases, sometimes I explicitly say that we check for HIV, Hepatitis, Syphilis, Rubella - you know 'check Rubella' [enouncing clearly]. They do not seem to care that much, 'yeah yeah, you go ahead' they would say.³

Hence, taking a close look at the institutional everyday routines, a number of gaps where language translation did not take place appear to us – despite the fact that most staff underlined its importance – gaps that also made room for a number of other practices: 'We draw a lot', one midwife explained, and use 'simple language'; 'breath!',

'injection', while pointing towards relevant parts of the body. Or as another midwife expressed it, 'we use our hands and feet a lot', she said standing up swinging her hips and signing a large belly by moving her arms in a circle around her stomach.

Filling the needs of the institution

While many of these examples may seem harmless and random - as if it is only a question about practices that fall outside the routine of engaging language interpreters for consulted meetings - a closer look soon reveals a more systematic pattern. Some activities were, for instance, not perceived of as important to translate as others; meetings where a lot of information was to be given to the pregnant woman were perceived as more important to interpret than those times where routine check-ups were carried out. Also, interpreters were seldom used outside of regular meetings such as when group-based parental education was given, or if the woman came outside of a pre-scheduled appointment.⁴ These cases might not even - as was the case with taking blood tests above - be seen as necessary to translate at all. That the women might have questions also on these occasions (regarding both clinical and other matters) thus became subordinated in accordance to the logic of the provider.

The systematic pattern that appears is thus that language interpretation seems to be foremost a practice for satisfying the needs of the institution, rather than for the patient (see also Brisset *et al* 2013; Hsieh & Kramer 2012). Thus, even if the health care providers in our study emphasised that language interpretation was 'self-evident' - that is, it was seen as the patient's right to have an interpreter if they needed one - it was mainly addressed with reference to the importance of being able to carry out a good work. As one midwife put it: 'If we cannot get the information we need from the patient, then we cannot carry out our work'. Even familiarising with the needs and wishes of the patient was not primarily described with reference to patient's rights, but rather as a prerequisite for carrying out good practice:

I mean, it's not possible to work here without an interpreter. If we did not have interpreters, we would not be able to work, or that is to say, the care we would provide would not be any proper care since we would not be able to speak with the women. We could listen [to the baby's heartbeat], and measure the stomach and blood pressure and take different tests, but we could not sit down and talk to them, so it would be really unequal health care one could say. Having an interpreter is essential for providing somewhat equal health care.

This was also mirrored in how patients that were reluctant to having an interpreter were sometimes talked into having one:

Researcher: So how do you go about when you... when do you choose to involve an interpreter, is that something the patient decides, or how you come to that decision?

Midwife: Yes, well, that's when they cannot... when they cannot [speak] enough [Swedish] for me to understand... [...] And they cannot make themselves understood either. Sometimes they think they speak better [Swedish] than what they do, and that's my responsibility too, to say no, 'If I should be able to do my work I need an interpreter'. I'd tell them that 'It's a principle of legal security, I need to understand you so that I can do my

job, it's not about you', which most people accept. Some want to feel capable and they might feel a bit awkward, but I can't... And when you notice after having spent some time with them, that there is no real communication, then by the end of the visit, one could say something like 'did you notice how hard it was to express what you wanted to say?', and that 'Let's have an interpreter next time'.

The only cases that we saw where women were able to negotiate not having an interpreter despite limited Swedish, or using a relative instead of a professional (see below), were those who presented themselves – or were perceived by the midwife – as well-educated, that is, as having an evident middle-class habitus. Some of these women also spoke English and negotiated with the midwife to have English as a mutual language instead.

A problem focused discourse

What is also apparent in the final quote above is that non-Swedish-speaking women are constructed as 'the problem' and that both staff and patients are presumed to speak Swedish for the everyday to run smoothly, that is, the institution normalises Swedish language.

Interpreters were also generally talked about in the interviews within a problem-focused discourse, often with affect. 'They are a real problem'; 'You cannot be sure of what they say'; 'It's a hassle to get a good one' where common phrases in the interviews as well as in the staff room. To speak too much or too little or to give their own advice during the consultation were also signs of incredibility according to the staff. This also corresponds to previous research that has described how interpreters are conceptualised as gate keepers that control or limit the patients' narratives (Hsieh & Kramer 2012), as well as looked upon as time-consuming and impractical (Kale & Raza Syed 2010).

Accordingly, the main character of the interpreter was as that of an 'intruder', not really to be trusted. Apart from a few times where the midwives aligned themselves with the interpreter to 'encourage' (in a rather disciplinary way) the patient to learn Swedish or meet appointments, they expressed a distanced and sceptical attitude towards the interpreter. One midwife, for instance, told how she, after the interpreter had left the room, decided to tell it all over again in Swedish (sic!), 'to see if they had understood everything'. Another talked about how she, in Swedish, had the patient evaluating the interpreter after the consultation:

... I usually do it like this, when I have an interpreter... then I send the interpreter away, the interpreter has a fixed time so that's easily done, and then - when the interpreter left the room - I book a new appointment with the woman or the couple. That's not difficult to do, even if you don't have the language. And that's when I ask them if they were happy with the interpreter. Sometimes I liked the interpreter, but they didn't or the other way around.

The ways in which the interpreters appeared as a 'problem' was also intimately intertwined with the institutional routines of the clinics. One distinct way in which this is made visible is the different ways in which scheduling patient-encounters were organised. Most, if not all, county councils in Sweden have during the last years installed a telephone system where patients are to book their meetings via phone only. However, these systems require a fair amount of Swedish in order

to navigate through different choices. Thus, all the institutions we visited experienced that patients just showed up at the clinic instead.

The everyday presence of spontaneous visits was experienced as demanding, which, in turn, threw suspicion upon the help-seeking women, such as in this case:

But then it could just as well be the other way around, that these Somali women... I know, I was so mad at one, it's a while ago... She just stood there and thought that we should bring her in, and we had no interpreter pre-booked. But anyhow, she could make herself clear and wanted to come in and she asked for this and that, and so on and so on, a lot of things it was, and we have no emergency appointments, all appointments are planned in advance. If there is an emergency, if someone just turns up and really need help, then we try of course, but it is not always manageable. All rooms might be occupied and we might be busy, all of us. But then, when I told her [the Somali woman] that you have to come another day, then all of a sudden 'me don't understand', 'me don't understand'... And she had been standing here speaking really good Swedish explaining why she wanted to come in! So I took her blood pressure and blood count and then I explained to her once more, but she started again like that. And then I did the same, 'me don't understand', I said. That's the only time I have done like that, talking back, but I was really angry with her, I was. She was reckless I thought, but it's the only time I have reacted that way, but she demanded an interpreter although she understood Swedish.

When issues of interpretation become incorporated in everyday negotiations such as these they gain another dimension. Looking particularly at this case, however, it becomes clear that the institutional level is important to take into account. Faced with the same situation, other clinics that we visited had decided to add an organisation within the existing one, by having *both* the telephone-based system and drop-in systems. Also, some care providers set aside twice as much time for patients that needed an interpreter (compared to Swedish-speaking patients), as well as added extra time for individualised parental education, whereas other clinics did no such special arrangements, that is, they were not to diverge from regular schedule. Nevertheless, even if some institutions made efforts to ease up the situation, no institution fully adopted a practice where language interpretation became part and parcel of the health care practice as such, rather interpreted consultations were still constructed as a 'deviance' from 'normal' practice.

Racialising language interpretation

Constructing interpretation as a deviance from normal practice could also be put within the framework of a racialised discourse, that is, understood as a practice associated with 'otherness' and therefore, not part of 'normal' procedure. In general, racialised notions of otherness also permeated the ways the midwives interpreted and expressed their own experiences of working with migrant women. Ethnicity was a demarcation line differing patients from other patients and the midwives alternately spoke of 'migrant' patients as more 'exiting' than the regular 'Swedish' patient, and alternately as more 'problematic'. Within this discourse, culture works as a keyword, where ethnic others were perceived of as different with reference to a static notion of cultural belonging, thus normalising Swedish ethnicity. For instance, racialised apprehensions of culture and ethnicity were

used to legitimise why non-Swedish-speaking women were left out of central parts of the basic programme for pregnant women. This concerned in particular so-called parental education. None of the places that we visited had a solution that seemingly worked to arrange parental education for patients in need of an interpreter (see also Fabian *et al* 2004). Some had given up and decided to incorporate the information in the individual meetings instead (but not always setting aside extra time for this).

Others had made some kind of special arrangement, often in cooperation with other public actors such as local immigrant integration offices. The reasons for such arrangements (instead of regular group meetings with interpreters) also reflect ideas of otherness; 'they are not as used to sit and talk in groups as Swedish people are' or 'they don't take it seriously, they come and go as they please'.

The joint meetings with immigrant integration offices and the like differed from the regular education that was offered Swedish-speaking patients. In addition to information on delivery, pain relief, breast feeding - that is, maternity health care issues - these meetings took up general issues on Swedish society such as insurance matters, access to health care, kindergarten and so on. They were also held by a person of the same lingual, and often ethnic, background, that is, it was seen as important that, for instance, Somali women were educated by a Somali educator. These educators were not trained midwives, rather it was their lingual/cultural/ethnic identity that was prioritised. Behind these measures was an idea of sameness and identification that would lead to greater feelings of security among the pregnant women.

The appointment of non-medically trained assistants whose chief qualification is their ethnic or lingual belonging can also be linked to an ethnically stratified labour market with temporary and insecure positions for this group of workers (Schierup & Ålund 2011). One example of this from our fieldwork is the engagement and training of 'doulas'⁵ that were to support and assist women from migrant backgrounds in delivery. The doulas were supposed to share the same language as the pregnant woman whom she was to assist, and they were brought to use mainly for non-Swedish-speaking women. Nevertheless, in the everyday context, there was a slippery line between language and culture, and the doulas were even referred to as 'cultural interpreters'.

The midwives in our study were generally positive to the idea of having a doula assisting their patients, and they too underlined their lack of insights in different cultural values and practices and saw the doulas as a complement to their own role. This said, however, the 'cultural experts' were also positioned as a threat and not always embraced as a good solution:

This is what we fight about. We could say it like this, we have claimed all along that parental education belongs to us. Professional staff should undertake parental education. It should not be lay persons that talk about how a delivery is carried through. They are not midwives, they have no medical training. But the problem is that they don't really see it that way. They think that, 'we can do it much better than you can', and 'it's better that they come to us than that they don't come at all'. Well, that's true, but at the same time... if the doulas take care of the parental education then sure they get the women to come, which we not always succeed with, and that's a gain you could say, but what if they give them the wrong education? Is it really fair to think that non-educated staff can perform reasonable parental education that holds a good standard? Or why should we accept low-skilled staff for some women, just because of their ethnic belonging?

It becomes inverted justice. All of a sudden one accepts anything just because they have black skin. I have a problem with that way of thinking. Or we have a problem with that.

Similarly, there were also those arguing that having non-professionally trained educators and doulas risked giving migrant women a B-version of the education that Swedish women were offered. This way of reasoning is an explicit example of when a rights-based discourse that emphasises the importance of offering equal health care for all women collides with the institutionalisation of a racialised socio-political context. In concluding, we will return to this problem nexus. Before doing so, however, we would like to point out the neo-assimilatory tendencies of their stories.

Gender quality as a 'Swedish value'

As mentioned earlier, Swedish policy on migration and ethnic relation has developed from a pluralist multiculturalism established in the seventies that rested upon immutable racialised notions of cultural differences - but nevertheless emphasised the need for tolerance and respect - to a neo-assimilatory outlook where cultural unity and 'universal values' are put in the frontline (Bredström 2008).

This neo-assimilatory discourse is evident in the interviews; for instance, several of those we interviewed referred to a wider discourse on immigrant integration where acquiring 'Swedish values' was seen as an important step towards inclusion. Similarly, the way parental education was expanded to include knowledge of Swedish society in general, and matters of Swedish values in particular, could be interpreted within the neo-assimilatory framework.

Without doubt, the most precious Swedish value that permeated this discussion is 'gender equality'. When talking about their patients, the midwife described women as more vulnerable than their husbands and having less access to Swedish society.

This gendered discourse was also played out in relation to having close relatives - often husbands - acting as translators. Having a relative as an interpreter were generally seen as a bad solution, as they - the health care staff claimed - both lacked medical training and were too partial and involved to be able to translate correctly. Thus, even if professional interpreters also lacked medical training, they still appeared more professional and 'neutral' and thus the much preferred choice.

In relation to relatives acting as interpreters, the midwives drew on what can be identified as racialised discourses of 'patriarchal otherness' and portrayed 'husbands' that acted as an interpreter for their pregnant wives as both dominating and over-protecting, and pursuing their own interest rather than that of the midwife or that of the woman:

It's not ideal [to have a partner/husband as an interpreter], I'd say. But in cases like this, when they both want the pregnancy to continue, then it is okay, it could even be a good thing. But if you think of another scenario, where a woman comes to have an abortion, for example, and then have her husband who interprets. That I believe is problematic, you have no idea what he says. He might present his views only, and she might not get a say in it at all. So I think close relatives should not act as interpreters, in general that is.

Some midwives also expressed how they by declining the husband to act as an interpreter support the woman, and, correspondingly,

that encouraging women to practice their Swedish had empowering effects; 'they become so proud when I tell them how their Swedish has improved'. Or they simply took encouraging the women to learn good Swedish as one of their tasks:

...I ask if she attends school [Swedish language classes], and if not, I always ask why not? And I always stress that she, yes everybody needs to learn Swedish. I tell every woman I meet that, even those who have been for ten years and still use interpreters. [But] some of them do not want to [learn Swedish]. 'I live here, I have all my relatives around me, we speak the same language, at the grocery store they speak my language, I watch TV in my language'. But I usually tell them that knowing Swedish is the key to Swedish society. If you don't learn the language you will always be excluded, it's a closed door, your husband will learn Swedish, and your children. They will rule over you I tell them.

In line with this reasoning, some informants told us about cases where they had used an interpreter at first, but then decided that it was 'good' for the woman in question to 'practice her Swedish', or that they 'understand more than what we think they do', that is, they have knowledge of the Swedish language but are simply not used to practice it. Again, here it was emphasised that the most important part of the encounter was that the midwife could make herself clear ('they understand more than you think'), not that the women might have questions that became unasked due to the lack of an interpreter.

Conclusion

In this article, we have seen how interpretation in the everyday institutional practice becomes a 'floating signifier' (Laclau och Mouffe 1985), filled with different meanings depending upon in what context it is articulated. As such, it works as a disciplinary tool towards women who do not sufficiently attend pre-booked appointments, or do not live up to the right measures regarding both language and conduct. Yet, at other times, it becomes essential for the implementation of equality in health care.

Put in other words, language interpretation becomes, on the one hand, perceived of as a migrant/women's right issue - even if poorly attended to by the institution - and on the other hand, infused by racialised and neo-assimilatory understandings and meaning-makings that structure how language interpretation is carried out in different settings. This paradoxical articulatory practice is seemingly formed by, and forms, the institutional setting whereby the politics of belonging and boundaries of social citizenship take different shapes in different local contexts. Thus, in the interviews and field notes, we can see how some institutions emphasised a problem-focused discourse that put the women's problematic culture or ethnic background in front, whereas others pursued a more contextualised understanding that related problems to un-employability, poverty and ill-health matters. Similarly, language interpretation as an institutionalised practice varied from a narrow focus on the (problem's with the) women's behaviours, to a more reflexive outlook scrutinising the clinical routines as well. We also witnessed how more tangible institutional practices turned out to be obstacles for fully incorporating interpreted consultations as part of the daily routines at the clinics. At another level, the article shows how these contradictory discourses are negotiated and dealt with by the midwives in their everyday

practices. As such, health care workers may be conceptualised as street-level bureaucrats. They are, in a sense, the last instance in the policy-making chain, which provides them with some acting space, however, limited. Viewing health care workers as street-level bureaucrats, our results become interesting also for other areas such as jurisprudence and social service where one can imagine that similar processes might take place. And most importantly, our article shows that citizenship-making is an ongoing process and that social rights might be infused with discordant meanings and never to be taken for granted.

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Notes

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2. The project of has been approved by the Regional Ethical Review Board at Linköping University (No. 28-09).
3. This practice collides with Swedish HIV/AIDS policy which states that informed consent is needed for all voluntary HIV-testing, including maternity health screening (SOSFS 2004:13).
4. Including delivery where language interpreters seldom are used in Sweden (see also Esscher 2014).
5. A doula is a woman with experience of child-bearing who is trained to provide on-going support and information to the bearing woman and her closest before, during and after childbirth (Sharareh & Lundgren 2012).

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