



## Somali women's experiences of antenatal care: A qualitative interview study

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### ABSTRACT

**Objective:** To explore Somali women's experiences of antenatal care in Norway.

**Design:** A qualitative study based on individual semi-structured interviews conducted either face-to-face or over the phone.

**Setting:** Norway.

**Participants:** Eight Somali-born women living in Norway.

**Key findings:** Four themes were generated from the analysis. From their experiences of antenatal care in Norway, the Somali women described: 1) when care was provided in a way that gained their trust, they made better use of the available health services, 2) the importance of continuity of care and of sharing commonalities with the caregiver, 3) a need for accessible information, specifically tailored to the needs of Somali women and 4) how culturally insensitive caregivers had a negative impact on the quality of care.

**Conclusion and implications for practice:** The Somali women in this study were grateful for the care provided, although the quality of antenatal care did not always meet their needs. This study should serve as a reminder of the importance of establishing trust between the pregnant woman and the caregiver, strengthening interpretation services and assuring tailored information is available to Somali women at an early stage. The findings further suggest that antenatal care for Somali women may be improved by offering continuity of care and improving clinical and cultural skills in clinicians. Suggestions for practice, and future research, include initiating group antenatal care especially tailored to Somali women.

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### Introduction

Migration is increasing globally and today one in seven of the world's population are migrants (World Health Organization, 2018a). With an increasing number of migrant users of the health care system, public health services must adjust to meet the various needs of different migrant groups (World Health Organization, 2018b). In Norway, migrant women accounted for 29% of all births in 2018 (Statistics Norway, 2019), and Somali women constitute the largest non-Western group of birthing women

(Dzamarija, 2017). Most Somali women have a refugee background, live in low-income families (Henriksen, 2007), and give birth to more children than other women in Norway (Tønnessen, 2014). Further, refugees in Norway are often welcomed in the districts; however, tend to move to larger cities if the opportunity arise (Tønnessen, 2014). Migrant women's first encounter with the Norwegian health care system is often related to pregnancy and antenatal care (Ahlberg and Vangen, 2005), underlining the importance of exploring migrant women's experiences related to such care.

Somali women are in several studies identified with increased risk of adverse pregnancy outcomes, such as stillbirth and infant death (Naimy et al., 2013; Small et al., 2008; Vangen et al., 2002; Vik et al., 2019; Villadsen et al., 2009). In industrialized countries, infant mortality appears to be greatest amongst refugees (Gissler et al., 2009) and most Somali women in Norway have

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a refugee background (Statistics Norway, 2018). Antenatal care in Norway is free of charge for all women (The Norwegian Directorate of Health, 2017) and the health care system is built on the principle of equal access for all, regardless of country of birth or social background (Mossialos et al., 2016). However, it has been shown that migrant women tend to use the health care services less than the general population (Fadnes and Diaz, 2017). A Norwegian study reported that 71% of Somali women had difficulty understanding and accessing the health information and health services available (Gele et al., 2016) and a Swedish study found associations between being born in Somalia and an increased risk of having inadequate functional health literacy (Wångdahl et al., 2014). Somali women have also been found to be less compliant with antenatal and labour care and often lack trust in the information conveyed to them (Agbemenu et al., 2019; Essén et al., 2011).

Literature on migrant women's experiences of antenatal care is scarce and the specific needs of pregnant migrant women deserve further investigation (Balaam et al., 2013; Gele et al., 2016). We therefore set up a study to investigate Somali women's experiences of antenatal care in Norway in order to increase our knowledge and understanding of Somali women's strategies during pregnancy.

The aim of this study was to explore Somali women's experiences of antenatal care in Norway.

## Methods

We conducted a small-scale qualitative study of eight Somali-born women in Norway. Women eligible to participate in the study were first generation, Somali-born immigrant women with experience of Norwegian antenatal care. Somali women have been described as a group which is frequently inaccessible to researchers (Hill et al., 2012; Bulman and McCourt, 2002). We therefore contacted two fellow student midwives of Somali descent, (i. e., registered nurses studying for master's degrees in midwifery) who inspired the trust of Somali women. They contacted Somali women in their network who, in turn, helped promote the study within the Somali community. This snowball sampling method has been presented as a pragmatic solution for recruiting from hard-to-reach populations (Bernard, 2017; Shaghghi et al., 2011).

Two nulliparous and six parous women, between the ages 22 to 35, participated in the study. At the time-point of the interviews, the women lived in the three largest cities in Norway, and they had lived in Norway for periods ranging from nine to 24 years. Three of the women were single, five were married, and they had given birth to one to five children each. All of their children were born in Norway, and altogether the women shared their experiences from 21 pregnancies in Norway. The women had given birth in Norway within the last seven years, and none had given births recently (i.e. during the past four months). They were either working, studying or combining both work and studies. One of the women stated that she was a job seeker. The interviews were conducted in Norwegian as all women spoke the language fluently at the time of the interview. However, not all the women spoke Norwegian at the time of birth.

### Data collection

Data were collected between November 2017 and April 2018, using individual semi-structured interviews lasting 20–38 min (mean 30 min). Two face-to-face interviews took place at a location chosen by the women and six interviews were conducted by telephone due to long distances.

The opening question for the interviews was: "Could you tell us about your first contact with antenatal care in Norway?". The interview guide included background questions on maternal age, parity, educational level, marital status, length of stay in Norway

and work situation. All the interviews started with these questions, enabling the interviewer to create a safe and friendly atmosphere and to encourage the participant to talk freely about their experiences (Polit and Beck, 2016). The rest of the questions were as follows: "Could you tell us about your most positive experience in relation to the care given?", "Could you tell us about any aspects of the care given that you experienced as challenging?", "In what way do you think care provided could have been better tailored to you and your needs?" and finally "Is there anything else relevant to the topic that you would like to add?".

### Data analysis

The interviews were transcribed and analysed using systematic text condensation (STC); a thematic cross-case analysis method suitable for interview studies (Malterud, 2012, 2017). The analysis consists of four steps: 1) Each interview was read and re-read to enable the selection of temporary themes in order to gain an overall impression of the material. In line with the method description (Malterud, 2012), we aimed to identify four to eight themes relevant to our research question. 2) Meaning units were found describing Somali women's experiences of antenatal care in Norway. In this step, the first and second authors initially worked separately, before later meeting with the last author to discuss the sorting of the material. The meaning units included solely data relevant to the research question: by the end of this step, the material was sorted into the following five temporary code groups: positive experiences, negative experiences, communication, cultural differences and suggestions for improved practice. 3) Subgroups were identified in each of the code groups and the meaning units in each subgroup were then summarized and condensed. The essence of each subgroup was captured in written condensed units, using a first-person perspective based on the meaning units within each subgroup. 4) These summaries were rewritten, from a third person perspective, into the final analytic text. Relevant quotations were included, for the purpose of elucidation, for each text representing each subgroup.

### Ethics

The participants were given oral and written information about the purpose of the study before the interviews started. They signed a declaration of consent and were supplied with information about confidentiality and advised of their right to withdraw from the study at any time. The study was approved by the Norwegian Social Science Data Service (NSD; 56,657) and assessed by the Regional Committee for Medical Research Ethics (REC), but considered to be outside the remit of the Act on Medical and Health Research (2017/1262A).

### Findings

Four themes were generated from the analysis. In their encounters with antenatal care in Norway, the Somali women described: 1) when care was provided in a way that gained their trust, they made better use of the available health services, 2) the importance of continuity of care and of sharing commonalities with the caregiver, 3) a need for accessible information, specifically tailored to the needs of Somali women and 4) how culturally insensitive caregivers had a negative impact on the quality of care.

*When care was provided in a way that gained their trust, they made better use of the available health services*

Women who expressed confidence in Norwegian antenatal care explained that being able to trust the caregiver made them feel

safe during their pregnancy. Some of the women described respectful caregivers and explained that being treated with respect lessened their anxieties. The Somali women described how they were grateful for the existence of free antenatal care in Norway. They also appreciated caregivers they described as available, caring, informative, trustworthy and understanding. The women expressed how trusting the caregiver afforded them the opportunity to share matters of an intimate nature, or ask questions they might never have had the courage to ask. One woman with four children was especially grateful for her midwife, who made her feel welcome at any time:

*"I would rather go to a midwife than a doctor (...) The midwife takes her time, gives me good advice and asks me how I'm doing (...) The doctor asks me more basic things. (...) I like talking to my midwife (...) The midwife always had time to talk to me (...) She made me feel welcome and that she genuinely cared about me." (Fatima)*

The women also expressed distrust of Norwegian antenatal care when they explained that they were reluctant to open up to the health care professional or that they failed to make use of the recommended number of antenatal check-up appointments. The women explained that they found it difficult to share their various concerns and that they lacked the confidence to ask questions during consultations. They revealed how they were met with prejudice, or assumptions related to their Somalian background, which made them feel stigmatized or anxious and even caused some women to withdraw from actively participating in consultations. Most of the women explained that they would rather turn to family, friends or the Internet for advice rather than ask their midwives or RGP. A younger first-time mother said:

*"I didn't share all my worries with her (the midwife). My friends and I felt judged (...) I didn't ask much and therefore I didn't know much either. (...) I asked questions like if it was OK to eat fish and stuff. The midwife didn't answer me, but told me to go home and read the brochures and take better care of myself. (...) I therefore pulled away. Like, I didn't share too much with them. Most of my information was from my mother. In fact, ALL of my information was from my mother." (Mina)*

Some women stated that they were afraid to go and see the midwife or their RGP. They expressed a fear of being misunderstood, or perceived as not being interested in becoming a good parent, if they did not ask the 'right' questions. Some were afraid that health care professionals would report them to the child welfare authorities: indeed, a general mistrust of health care professionals with a Norwegian background was reportedly an issue within the Somali community. The women disclosed that the midwife or RGP often did not understand that there were differences between the needs of pregnant Somali and Norwegian-born women and consequently experienced uncertainty that their concerns would be understood. One woman with five children said she had never felt the need to see a midwife during her pregnancies and she explained, in the following way, why she preferred to consult with her RGP:

*"It's much easier going to the doctor. I don't know. With the doctor everything goes quickly. He checks my blood and that everything is okay with me and the baby. With the midwife, there are more questions... and a few more... Yeah (...) Seeing a midwife is more of a process, to put it that way." (Haba)*

#### *The importance of continuity of care and of sharing commonalities with the caregiver*

The women explained that continuity of care was a key element in establishing trust in their midwife or RGP: they also divulged

how sharing similarities with the caregiver encouraged them to open up and motivated them to attend antenatal appointments. While some women preferred their care to be provided primarily by a midwife, or split between their RGP and a midwife, others stated that they preferred their RGP: one reason offered for this preference was that the women had actively chosen the RGP themselves, whereas the community midwife was assigned to them based on their address. While most of the Somali women considered it crucial that the main caregiver was female, others found it more important to choose caregivers with similar cultural or religious background to themselves. As one woman, who said she preferred her male RGP over a community midwife, explained:

*"I felt safer with my doctor. I've had the same doctor since I was a child, so it was much easier for me. He was also a Muslim, so it was easier." (Mina)*

For some of the women, it mattered less whether it was the midwives or the RGPs who were the source of relevant information; the availability of the caregiver and the respect they showed were considered to be far more important than their professional status. Indeed, some of the women, with limited or no social networks, explained how they appreciated caregivers who functioned beyond their professional role. One woman described how she missed her mother in Somalia and how her teacher became her most important source of care and information:

*"I kept thinking of my mother (...) I felt nauseous and I felt strange and I cried... and everything that I ate, I just threw up. It was my first pregnancy, but I was also lucky in a way... because I went to school - second year in high school - and it was easy talking to my teacher. She was also an educated nurse and she was kind and she gave me advice on eating fruits and such..." (Vilma)*

#### *A need for accessible information, specifically tailored to the needs of Somali women*

All the women in our study reported a need, when pregnant, for accessible information, specifically tailored to their particular needs. Several of the women explained that they, initially, did not know where to go for antenatal care or what their rights were. One woman was a health care professional herself and even she stated that finding information about where to go was a complicated process. Although they all expressed an interest in knowing as much as possible about how to take care of themselves during pregnancy, the women felt the information provided by health care professionals was inadequate or too complex. One first-time mother put it like this:

*"It wasn't always easy to understand. Can't they just explain it to me? Instead, I had to read about it and learn it on my own." (Mina)*

Women who did not speak Norwegian when they became pregnant explained that they had trouble obtaining enough information and felt that antenatal care was of little use to them. Some explained that they came to Norway as refugees and settled in areas with few immigrants. They found no information in languages other than Norwegian at the local health care centres; some said that the health care professionals seemed unprepared for immigrants with a limited knowledge of Norwegian. Some participants observed that Somali women often missed out on antenatal care due to language barriers, not knowing who to contact or where to find information.

Some of the parous women had attended different antenatal clinics over the years and reported that, although some of these clinics supplied literature in a range of community languages, others did not provide multilingual information. Despite the fact that

some of the women struggled with language during their first pregnancy, several of them were content with their antenatal care during later pregnancies. They all said that understanding the language was a major issue, in terms of their ability to make use of the care provided. As one parous woman elucidated:

“You know, I know one thing. Women who speak Norwegian often don’t have those kinds of problems with communication between the midwife and the pregnant woman.” (Haba)

The women explained that there was not always an interpreter available when they needed one: this often led to misunderstandings and difficulties interacting with the midwife or RGP. Some of the women felt that having someone they knew and trusted to translate was safer, while others preferred to communicate through an interpreter. The use of a professional interpreter made some of the women uneasy because they were feared that the interpreter might not adhere to the principles of confidentiality and could divulge personal information about them within the Somali community. As this parous woman observed:

“It is not the same when they use an interpreter (...) They don’t address you in the same way, like, they don’t translate all of the words and they don’t understand about the principles of confidentiality and so on...” (Fariido)

*Culturally insensitive caregivers had a negative impact on the quality of care*

Most of the women we interviewed explained that they felt their background as a Somali woman had influenced the quality of the antenatal care they received from midwives or their RGP. Several of the women described how they felt they had been treated with condescension for wearing a hijab or traditional clothing. Some shared that they felt stigmatized when the health care professional presumed they did not understand the Norwegian language simply because of the way they were dressed. Several of the women asserted that they felt rejected by health care professionals and found contact with them to be unpleasant. One Somali woman even described her caregiver as mean, adding:

“When she (the midwife) was talking to me, I felt like there wasn’t a great deal of respect. I felt as though she was thinking “you stupid Somali mothers”.” (Fatima)

The women sometimes felt caregiver’s comments, such as “we will see you again next year when you are pregnant again”, to be spiteful. One of the women repeated an ignorant and hurtful remark from her midwife: “Four, five or six kids? Oh, my goodness, why?”

Most of the interviewees had lived in Norway for several years and therefore spoke fluent Norwegian when they became pregnant. As a result, they, in the main, felt that they belonged to Norwegian society and so struggled to understand why the midwife was broaching subjects that they felt were unrelated to their pregnancy. The women reported that they were asked several questions about where their husband was, what their domestic situation was like and why they had chosen to have so many children: because of such intrusive questioning, they stopped sharing intimate details with their midwife or RGP. Even though some of the women did not experience challenges directly related to their culture, several of them felt cultural differences to be an important determinant of the kind of care they received. One of the women explained that she felt Norwegian caregivers lacked knowledge about Somali women:

“I think it’s important to have patience and try to understand each other. People from Norway don’t know what I, as a Somali mother, am going through.” (Fatima)

Women who did not have family in Norway said that they missed their family back home and expressed feelings of loneliness during pregnancy. A few women revealed that they had suffered depression during their pregnancy. One woman explained that she received positive help from her midwife to prevent the depression from returning during her next pregnancy, while another affirmed that she had not received help from her RGP, explaining that they never once asked how she was. One parous woman described her feelings of loneliness as follows:

“I only had my husband (...) No friends. I felt lonely.” (Vilma)

Several of the women raised differences between Norwegian and Somali family cultures, describing the Norwegian society as closed and difficult to participate in. Women who were encouraged to join organized groups of Somali women explained that joining helped them cope during pregnancy; those belonging to such groups indeed confirmed that participating made them feel less ostracized and lonely. With limited support from family and friends, they imagined being pregnant and having many children to be more exhausting in Norway than if they had lived in Somalia. Although the women spoke of loneliness, they also expressed strength, hope and a willingness to take responsibility for their situation, as this woman’s account makes clear:

“I was so exhausted. I had a couple of relatives, but I was alone most of the time, you know. You don’t get much help, so the best thing to do is just set your mind to it... You need to decide and to be strong and know that things will get better.” (Fatima)

## Discussion

The issues raised by the Somali women included the necessity of trusting the health care system in order to access and avail themselves of its services, the importance of receiving continuity of care and of identifying common ground with the caregiver. They also identified the need for accessible information, specifically tailored to the needs of Somali women. Moreover, participants considered it vital that those entrusted with their care display cultural sensitivity.

In order to make use of antenatal care, trusting the health care system was, the Somali women maintained, crucial. This finding is supported by a recent systematic review, emphasizing that women’s participation in antenatal care, in general, is dependent on their perception that engaging with the care offered will prove a positive experience (Downe et al., 2019). Our findings therefore suggest that improving care, by enhancing a pregnant woman’s trust in her caregiver, is not unique to Somali women. Continuity of care and individualized care, similarly, are practices which potentially enhance the health care experiences of women from both immigrant and non-immigrant backgrounds (Renfrew et al., 2014; Small et al., 2014, 2002). Even though continuity of care may benefit the majority of women, however, it is likely that both Somali women and their caregivers will find it particularly challenging to overcome language and cultural barriers in order to establish mutually trusting relationships. In a Swedish study, midwives recognized the challenges uniquely experienced by Somali women, explaining that midwives often lacked appropriate resources in their encounters with Somali women in antenatal care (Ahrne et al., 2019).

We found that sharing commonalities, such as gender or religion, with the caregiver was an important factor in enabling the women to be able to establish trust in the health care offered. Other studies have found that cross-gender interactions may be uncomfortable for some Somali women and the presence of a female health care professional may be more acceptable (Balaam et al., 2013; Carroll et al., 2007). For Somali women,

the decision to seek health care can depend on whether or not a female health care professional is available (Carroll et al., 2007) and female immigrants of non-Western origin might not consent to a gynaecological examination performed by a male RGP and may even object to being alone in a private room with a male RGP (Småland Goth and Berg, 2011). Gender can also be an important consideration for health care professionals: indeed, a Finnish study revealed that the communication with Somali women can be especially challenging for male caregivers (Degni et al., 2012). However, some of the women we interviewed had male RGPs and expressed their satisfaction with them: these highly-appreciated RGPs had developed a trusting relationship with the women prior to their pregnancies. In Norway, people can choose their RGP (Helfo, 2017), while a midwife in the public health care system is assigned to pregnant women upon request, according to the individual woman's home address. Finding common ground with the caregiver was important to the Somali women in our study. Whether a caregiver shares the gender or religion of a pregnant woman is, of course, beyond their control; however, policymakers can perhaps display greater flexibility to in the design of Somali women's care than is currently exercised.

Some of the women we interviewed experienced misunderstandings and communication difficulties due to insufficient use of interpreters. This confirms the findings of other studies (Ali et al., 2004; Carroll et al., 2007; Glavin and Sæteren, 2016), which suggest that Somali family and friends are often used to translate. The right to receive information suited to age, language and culture is protected by law in Norway (Ministry of Health and Care Services, 2001) and the use of professional interpreters are recommended in national guidelines (The Norwegian Directorate of Health, 2011). Nevertheless, some of the women in our study stated that they were not offered professional interpretation services, or expressed a preference for the use of family or friends to perform this function. Interpreting services are underused by health care professionals in Norway and the use of non-qualified, informal interpreters, such as family members, is widespread within the health care system (Ministry of Children and Families, 2014). A Norwegian report suggests that the reason provided by health care professionals for failing to use professional interpreters is because they perceive their services to be time-consuming and impractical (Kale, 2006). Moreover, it should alert clinicians and policymakers when Somali women explain that they struggle to find where to go for antenatal care or do not know what their rights are. Our findings reveal a need to re-evaluate and strengthen information given to pregnant Somali women, and the interpretation services available to them.

Cultural differences, and a lack of family and close friends, for most of the participants resulted in feelings of loneliness. While some of the women felt well cared for during pregnancy, others felt alone and insecure. A review paper (Balaam et al., 2013) describes how immigrant women, missing their family members, are at particular risk of physical and mental health problems, such as depression, feelings of loneliness and isolation. Helping Somali women cope with loneliness by facilitating and encouraging them to join together in groups with other Somali women might make a positive contribution to their overall wellbeing. Group antenatal care has also been suggested as a mean of empowering Somali parents in a recent Swedish study (Ahrne et al., 2019). Some women in our study also felt poorly treated, stereotyped or discriminated against on the basis of their cultural background. While our research does not address the question of how widespread such experiences are, a Swedish study confirms that some Somali parents experience discrimination and are met with stereotypes in antenatal care (Ahrne et al., 2019), and a Norwegian study argues that Norwegians frequently conceptualize Somali women as 'victims' simply because they wear a hijab or because they might be cir-

cumcised (Fangen, 2006). Nonetheless, a US study exploring challenges in obstetrical care for Somali women, found that caregivers do not consider circumcision a barrier in itself, rather difficulties with communication and a lack of formal training in handling circumcised women (Lazar et al., 2013). While circumcision was not a main topic in our study, our findings do suggest a need for improving both clinical and cultural skills in midwives and doctors caring for Somali women.

Some women in our study withdrew from antenatal care services after negative experiences. This finding is supported by a recent American study, which describes how pregnant Somali women may intentionally not seek antenatal care, refuse care, change hospital or care provider, or delay hospital arrival during labour if their needs are not met (Agbemenu et al., 2019). In line with Fangen (2006), the women in our study stressed that Norwegian-born health care professionals do not always acknowledge or understand Somali women's familial needs. However, recognizing their needs may also prove challenging for health care providers, for instance when some Somali women attend scheduled appointments late and thus delay subsequent patients (Degni et al., 2012). Our results are supported by the findings of a recent Swedish study emphasizing the importance of accessible care and flexible routines in order to care for pregnant Somali women (Ahrne et al., 2019).

#### *Study limitations*

Conducting cross-cultural and cross-language research can be challenging, and the person interviewed might not trust a stranger or worry about the confidentiality of the interview (Wallin and Ahlström, 2006). Moreover, barriers related to culture or language may constrain an interviewer in the encounter with a person with an immigrant background (Tsai et al., 2004).

The eight women participating in this study represent a relatively small sample. However, Malterud et al. (2016) claim that the more study-relevant information provided by the sample, the lower the number of participants needed. The Somali women included had experiences from 21 pregnancies and they lived in three different cities. Hence, the women represent a wide range of knowledge and experiences related to antenatal care in Norway. Notably, using a different sampling strategy than snowball sampling may have added to the understanding of the needs of Somali women in antenatal care.

#### *Implications for practice*

Somali women are a diverse group who present challenges which health professionals must address. Our results suggest a re-evaluation of the services currently available, including strengthening interpretation services and making sure practical information is available to Somali women at an early stage of planning a pregnancy. Such early efforts may promote a trusting relationship between Somali women and their caregivers in antenatal care, contributing to Somali women's experiences of safe pregnancies in Norway and similar settings. In addition, helping Somali women come together in groups, consisting of other Somali women, might make a positive contribution to their overall health and wellbeing during pregnancy. Suggestions for future research include investigating Somali women's experiences of other aspects of maternity care, such as group antenatal care especially tailored to Somali women.

#### **Conclusion**

The Somali women in this study were grateful for the care provided, although they acknowledged that the quality of antenatal

care did not always meet their needs. This study should serve as a reminder of the importance of establishing trust between the pregnant woman and the caregiver. The findings further suggest that antenatal care may be improved for Somali women by offering continuity of care, providing accessible information specifically tailored to their needs and improving clinical and cultural skills in clinicians.

### Authors' contributions

The interviews were conducted and transcribed by the first and second authors, as a part of their master's degrees in Midwifery. The three last authors are teachers and supervisors at the Midwifery education programme. All authors took part in the planning and analysis of the material. The first and second authors wrote the first draft of the paper and the last three authors made additional contributions prior to the submission of the final manuscript to the journal.

### Ethical approval

The study was approved by the Norwegian Social Science Data Service (NSD; 56,657) and assessed by the Regional Committee for Medical Research Ethics (REC), but considered to be outside the remit of the Act on Medical and Health Research (2017/1262).

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### Declaration of Competing Interest

None Declared.

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### Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:[10.1016/j.midw.2020.102656](https://doi.org/10.1016/j.midw.2020.102656).

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