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Antenatal care for Somali-born women in Sweden: Perspectives from mothers, fathers and midwives

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ABSTRACT

Objective: To explore Somali-born parents' experiences of antenatal care in Sweden, antenatal care midwives' experiences of caring for Somali-born parents, and their respective ideas about group antenatal care for Somali-born parents.
Design: Eight focus group discussions with 2–8 participants in each were conducted, three with Somali-born mothers, two with fathers and three with antenatal care midwives. The transcribed text was analysed using Attride-Stirling's tool "Thematic networks".
Setting: Two towns in mid-Sweden and a suburb of the capital city of Sweden.
Participants: Mothers ($n = 16$), fathers ($n = 13$) and midwives ($n = 7$) were recruited using purposeful sampling.
Findings: Somali-born mothers and fathers in Sweden were content with many aspects of antenatal care, but they also faced barriers. Challenges in the midwife-parent encounter related to tailoring of care to individual needs, dealing with stereotypes, addressing varied levels of health literacy, overcoming communication barriers and enabling partner involvement. Health system challenges related to accessibility of care, limited resources, and the need for clear, but flexible routines and supportive structures for parent education. Midwives confirmed these challenges and tried to address them but sometimes lacked the support, resources and tools to do so. Mothers, fathers and midwives thought that language-supported group antenatal care might help to improve communication, provide mutual support and enable better dialogue, but they were concerned that group care should still allow privacy when needed and not stereotype families according to their country of birth.
Key conclusions: ANC interventions targeting inequalities between migrants and non-migrants may benefit from embracing a person-centred approach, as a means to counteract stereotypes, misunderstandings and prejudice. Group antenatal care has the potential to provide a platform for person-centred care and has other potential benefits in providing high-quality antenatal care for sub-groups that tend to receive less or poor quality care. Further research on how to address stereotypes and implicit bias in maternity care in the Swedish context is needed.

Introduction

Few measures have been taken in Sweden to ensure high quality antenatal care for migrant women in Sweden, despite their higher risk of adverse pregnancy outcomes in Sweden and other high-income countries (Almeida et al., 2013; National Board of Health and Welfare 2016; Almeida et al., 2014b; Small et al.,

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2014; Bakken et al., 2015b; Belihu et al., 2016a; Belihu et al., 2016b; Gagnon et al., 2009; Urquia et al., 2010; Malin and Gissler, 2009; Urquia et al., 2015; Esscher et al., 2013; Almeida et al., 2016). Underlying social determinants of health pre- and post-migration (National Board of Health and Welfare 2016; Rowe and Garcia, 2003; Bakken et al., 2015a) including loss of social support (Almeida et al., 2013) and sub-optimal care (Boerleider et al., 2015; Bredström and Gruber, 2015; Binder et al., 2012; Krupic et al., 2016; Almeida et al., 2014a; Esscher et al., 2014; Robertson, 2015; Essen et al., 2002; Essen et al., 2000) contribute to the unequal distribution of health, access and utilisation of health care services for migrant women.

A review from five high-income countries showed that migrant women were less happy with maternity care but had similar expectations of care as non-migrants: safe, high quality, attentive and individualised care with adequate information and support (Small et al., 2014). Communication problems, lack of familiarity with care systems, perceptions of discrimination, disrespectful care and being met with stereotypes impacted negatively on migrant women's experiences (Small et al., 2014; Jacoby et al., 2015) as did lack of awareness of services and discordant expectations (Higginbottom et al., 2015). In general, migrant women in Sweden have lower attendance at check-ups (Fabian et al., 2008; Ny et al., 2007a; Rassjo et al., 2013) and in childbirth and parenting classes (Fabian et al., 2004; Fabian et al., 2006) and lower compliance with recommendations (Small et al., 2008). Somali-born women have demonstrated higher risk for some adverse pregnancy outcomes compared with non-migrant and other migrant women (Bakken et al., 2015a; Small et al., 2008; Wahlberg et al., 2013) and later registration for ANC than recommended, fewer ANC visits than Swedish-born women, higher rates of anaemia, insufficient weight gain and are more likely to give birth to infants small for gestational age (SGA) (Rassjo et al., 2013).

Somali-born women constitute a growing proportion of mothers giving birth in Sweden. The number of women of childbearing age (15–44 years) has increased from approximately 4500 to 22,000 between 2000–2017 (Statistics Sweden). Many have relocated to Sweden as refugees because of war and conflict (United Nations High Commissioner for Refugees (UNHCR) 2019). Somali-born women's ANC experiences in Sweden have rarely been explored. In the late 1990s Somali women's inadequate health literacy concerning pregnancy and birth (Essén et al., 2000) and Somali-born men's contradictory feelings to enter the "female sphere" of childbirth were reported (Wiklund et al., 2000). One study from 2002 reported communication difficulties between Somali women and their care givers and lack of guidelines on female genital cutting/mutilation (FGM/C) (Widmark et al., 2002) and another identified health professionals' FGM/C knowledge as central for a positive experience (Widmark et al., 2002; Berggren et al., 2006; Widmark et al., 2010). More recently, the need for clarity about routines and content of care and the importance of trustful relations between midwives and Somali-born mothers when communicating about violence in ANC has been highlighted (Byrskog et al., 2016; Byrskog et al., 2015).

The need for antenatal care to be more responsive to, and better address health inequalities was the starting point in developing a care model that could enhance ANC experiences and birth outcomes for migrant women in Sweden, initially for women of Somali origin, leading to the Hooyo project (Somali for mother). One promising care model is group antenatal care (gANC), which has been implemented in Sweden and elsewhere to empower women, to improve health literacy, strengthen social networks and increase ANC attendance (Catling et al., 2015; Andersson et al., 2013; Andersson et al., 2012; Dowswell et al., 2015), also for fathers-to-be (Andersson and Small, 2017). gANC incorporates pregnancy assessments and group sessions for education, support and dialogue in a group of pregnant women at about the same gestational week and their partners. Migrant parents-to-be with limited Swedish proficiency have sometimes been excluded from group care due to communication difficulties. Whether this model would be attractive, acceptable and effective for migrant families requires more testing and research, and ideally should be developed in collaboration with those receiving and providing care. This study therefore aimed to begin by exploring Somali-born mothers' and fathers' experiences of antenatal care in Sweden, antenatal care midwives' experiences of caring for Somali-born parents, and their respective ideas about gANC for Somali-born parents.

Method

Design

A qualitative study with eight focus group discussions (FGDs) with Somali-born mothers and fathers and Swedish ANC midwives was conducted (Polit and Beck, 2015). Openness and dialogue were guiding principles (Halcomb et al., 2007), and challenges such as group dynamics and confidentiality were addressed through involvement of Somali speaking research assistants, interpreters and facilitators throughout the study.

Setting

In Sweden, women with a normal pregnancy attend midwifery-led ANC free of charge, including eight to nine visits, with referral to an obstetrician if complications occur. The content of ANC is regulated by national guidelines and includes checking the health of the mother and unborn child, health information, preparation for labour and birth, and parenting advice (The Swedish Society of Obstetrics and Gynecology (SFOG) 2016). In addition, childbirth and parenting education in groups is offered, also free of charge, but mainly for nulliparous women. Fathers/partners are encouraged to be engaged throughout pregnancy, labour and birth.

The study was conducted in three different locations between December 2016 and May 2017. In two locations a developed gANC is underway; one is a suburb to the capital city with a long history of receiving migrants and one is a small town (approx. 50,000 inhabitants) in mid-Sweden where Somali migrants have settled since the beginning of the 2000s. A third location was chosen for the recruitment of midwives because of their experiences from providing gANC to Somali born women.

Recruitment and participants

Purposeful sampling was used to recruit focus group members with as varied characteristics as possible and was conducted consecutively until the data were considered sufficiently rich to answer the research questions. Recruitment of midwives ($n = 7$), all female, was done at the three ANC clinics. The inclusion criterion was to have several years' experience of ANC.

Recruitment of parents took place through existing networks within the Somali diaspora, public preschools and Child Health Centres. The inclusion criteria were to be born in Somalia and to have a child under the age of two, in order to have recent experience of ANC. One female participant was born in Sweden but of Somali background and was included because she wished to participate. The female participants ($n = 16$) had from one to six children, the male participants ($n = 13$) had from two to more than ten children and their length of residence in Sweden ranged from four to more than 20 years. The level of education and profession varied widely between participants, as did marital status. The mothers and fathers who participated were not recruited as couples. They had attended a range of ANC clinics, not necessarily the clinics

where midwives were recruited. The study was carried out in accordance with the Helsinki Declaration and approved by Stockholm Ethical Review Board (2015/1703-31/1). Oral and written information about the study, its voluntary nature and confidentiality was provided in Swedish and Somali before the discussions started and written consent was given by all participants.

Data collection

Mother FGDs ($n=3$) and father FGDs ($n=2$) were held in community facilities and lasted for 1½–2 h and coffee/tea or lunch/dinner was offered. These FGDs were conducted by co-authors MA, UB and RS in Swedish and Somali, assisted by a female interpreter/facilitator in all but one FGD, in which a man interpreted. Not all participants needed an interpreter. Children were present in some groups. Midwife groups ($n=3$) were held in the respective work place and conducted by co-authors MA and UB. A Somali-born research assistant was present in one of the midwife FGDs. Two clinics were large, centralised clinics in hospital settings and one was a small clinic, located in a "Family-centre", with other services for families under the same roof.

A topic guide supported the discussions, with four general questions phrased slightly differently for the mothers, fathers and midwives respectively: 1) What works well with present ANC? 2) What works less well or poorly? 3) How could ANC be improved? and 4) What are your experiences (midwives) /your ideas (parents) of gANC for Somali born parents? Follow up questions included specific and open-ended questions for clarity to encourage a creative dialogue.

At the end of each FGD, emerging themes were highlighted by the researcher and crosschecked with participants for accuracy. This approach was utilised to encourage engagement and to secure accurate understanding of the key issues raised by participants (Lionis et al., 2016; Johnson et al., 2009). The discussions were recorded, FGDs in Somali were translated orally to Swedish by a Somali interpreter, and transcribed verbatim by MA.

Analyses

The data were coded and analysed using Attride-Stirling's tool "Thematic networks" (2001). Thematic analyses seek to reveal salient themes in texts at different levels, and thematic networks facilitate structuring and description of these. The lowest-order unit constitutes a "basic theme". Categories of basic themes are merged into "organising themes" to summarise more abstract principles; and "global themes" are super-ordinate themes embracing the principal metaphors in the text as a whole (Attride-Stirling, 2001). The first and last author listened to all digitally recorded data and read each transcript several times.

The four general questions asked in the FGDs were used as an initial coding framework to dissect text. Text segments were coded close to the text, and then basic themes and organising themes were identified and summarised in an overarching global theme. Author EA read all transcripts and coded the material independently and the coding was cross-checked to increase validity. The different themes were discussed and cross-checked with the other authors, and thereafter refined and organised in a network model.

Results

Similar themes came up in the parent and midwife FGDs, but from different perspectives (Fig. 1). In the FGDs with mothers and fathers, the experiences and thoughts varied more between individuals than between genders, therefore we refer to "parents" when possible and to mothers and fathers specifically when their responses differed. Parents and midwives were *striving for optimal antenatal care*, which constitutes the global theme. Optimal, high quality and safe ANC could be facilitated through both the midwife-parent encounter and health system characteristics. Two organising themes; *Challenges in the midwife-parent encounter* and *Health system challenges* with nine sub-themes comprise the challenges that were described in all FGDs. In addition, whether gANC might be a way forward was discussed.

Challenges in the midwife-parent encounter

The first organising theme included five intertwined basic themes describing challenges in ANC encounters: *Tailoring care to individual needs, Dealing with stereotypes, Addressing varied levels of health literacy, Overcoming communication barriers* and *Partner involvement.*

Tailoring care to individual needs

"To be seen as an individual" and "to see the individual" were central to parents and midwives respectively. The midwife's approach and attitudes, such as kindness, curiosity, commitment, and a warm and welcoming encounter, were essential for whether parents experienced care as tailored to their needs or not. Attitudes were sometimes conveyed in subtle ways.

> *You can understand from a person's facial expression and from how that person cares for you, if somebody is sort of distanced – even though that person is supposed to be there to help you… in Somali you say that an open face is like an open door. (Father 2 FGD 3)*

Parents expressed that their need for ANC support was not linked to their migrant status, rather to their individual background, with the exception of communication difficulties and to some extent FGM/C (female genital mutilation/cutting). The heterogeneity within the Somali diaspora entailed individually tailored support.

> *It's a very big difference… there has to be a difference- between a Somali man who has been in Sweden for 30 years, knows the language, knows about society…and a father who came from a refugee camp one year ago. (Father 1 FGD 4)*

Concurrently, midwives described how they strived to get to know each patient to be able to actively tailor care for them.

> *I always ask - not just women from Somalia - how many years of education they have. Because that really says a lot about at what level to start. And that is the exciting part! Because you can't give the same information to everyone, that doesn't work, you have to find out what level people are at. (Midwife 2 FGD 5)*

Dealing with stereotypes

The parents described positive midwife encounters and satisfaction with many aspects of the ANC provided, as in the following quotes:

> *I had a very good midwife. I have nothing negative to say (Mother 5 FGD 2)*

> *We are so happy, 100%, with the maternity care here (Father 2 FGD 3)*

Nevertheless, parents also described episodes of discrimination and being met with stereotypes in ANC and later when giving birth. Participants described feelings of always having to be on one's guard. Negative comments related to number and spacing of children was a reoccurring experience, which could result in reluctance to visit ANC.

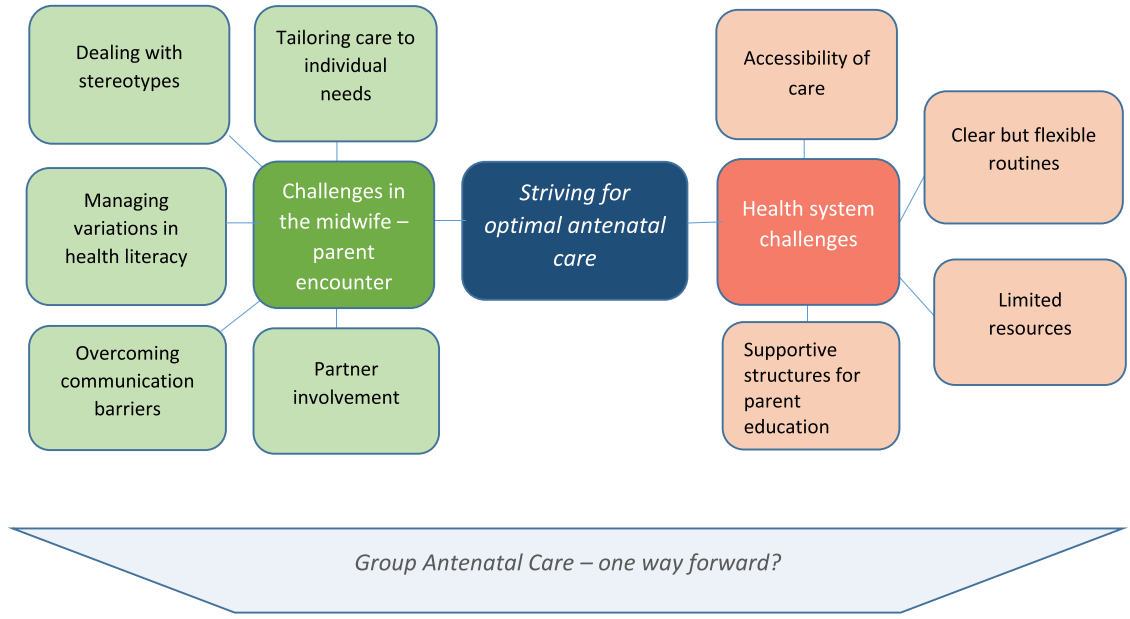

Fig. 1. Global, organising and sub-themes illustrating parents' and midwives' challenges in striving for optimal antenatal care – aspects that need to be considered in standard care as well as in the development of care models aiming at improving outcomes for Somali-speaking families.

"Why do you have another child? It would be better if you finished breastfeeding first, so that the children are not so close." I can't put up with such information. I refuse to listen to it. That's the reason I don't want to go there… (Mother FG 1)

One mother described an episode related to advice about iron supplements:

I have never needed iron supplements, and then she (the midwife) *checked my iron value and said: "You need iron tablets, but you guys won't take that". I didn't have a clue what she meant by that, I just: "What do you mean?" "Well, you say they contain gelatin so you don't take them." (Mother 1 FGD 2)*

A fine line between giving/receiving advice versus expressing what could be perceived as subjective values and norms was described by both parents and midwives. Good intentions and concern from the midwife, such as suggesting birth control to grand multiparous women, could be perceived as patronising if not carefully expressed. Parents suggested that such important health and family issues should preferably be discussed in other forums and not necessarily with the midwife.

A recurring stereotype, with positive connotations for the midwives, was that Somali-born women have a natural approach to pregnancy and childbirth, and high levels of trust and confidence in their capabilities: to manage labour pain, to give birth, to breastfeed and as mothers.

They are calmer, comfortable with this, having children, giving birth… not as scared as many others, many Swedes. (Midwife FG 7)

However, this approach was not reflected in the parent discussions. Further, the tendency to generalise and make assumptions based on preconceived ideas was also apparent when midwives described challenges and the efforts made to understand cultural differences. If communication barriers prevailed, this tendency was accentuated. Midwives expressed feelings of frustration and worry when women/couples did not comply with their advice and they wanted to learn more about the issues they felt they did not understand.

I think it is frustrating when we don't understand, why don't they comply with our recommendations? And this is a pretty complicated issue, this issue of women who shouldn't get pregnant again but they do. But this applies to other smaller things as well like coming late and this issue of [not taking] iron tablets… (Midwife 1 FGD 7)

Addressing variations in health literacy

Different aspects of health literacy came up in all the FGDs. Some parents described or revealed knowledge gaps related to, for example pain relief during birth, immunisation or postpartum health problems, gaps that would optimally be addressed during pregnancy.

I believe there is so little information about what happens after birth. I had not heard almost anything. I didn't know about contractions after labour, the pain, everything… breast feeding… I didn't have a clue. (*Mother 5 FG 2)*

Parents emphasised the need to understand their rights to be able to make informed choices or ask for a second opinion, to stand up to poor staff attitudes, to have confidence in receiving the right care and to know how to make formal complaints. Another aspect of health literacy was varied awareness about the usefulness of ANC and preventive care, which one of the fathers confirmed in a reflection:

You don't get so much really. They [the midwives] *are not doctors, you don't go there to get treatment for a disease. It is more dealing with "your everyday life"… they measure some things and then: " you can…"* [give advice etc.] *(Father 6 FGD 4)*

Similarly, midwives saw a need for parents to understand Swedish society in general and described how they provided information about the law against FGM/C, the Convention of the Rights of the Child and gave support on general issues, such as housing. The midwives also described challenges when responding to parents' diverse levels of education and health literacy, which affected the understanding of information provided. Translated material about for instance anatomy or fetal screening was not sufficient if health literacy was inadequate.

This issue of fetal screening…there is information perfectly translated to Somali, and films – but the information is rather complicated. If you read it for yourself in Swedish and you think of someone with two years of schooling… What is a cell for instance? Not to mention a chromosome? (Midwife 2 FG 5)

Overcoming communication barriers

Communication barriers included aspects of language and interpreting, as well as complexities beyond language. Critical situations were described when misunderstandings had constituted a serious patient safety risk, typically conversations over the phone without an interpreter. When Swedish proficiency increased it became more difficult in fact for midwives *and* parents to decide if a professional interpreter was needed. Limited Swedish proficiency could be overcome through face-to-face or telephone interpreters and positive experiences of both were described. At one site, telephone interpreting was considered more confidential and preferred by both midwives and parents.

Complex communication scenarios were described, also when language was not an issue. Parents described situations when they had not been informed or asked about important issues, for example related to FGM/C. Midwives described similar situations when information had been left out during history taking or when pregnant women refrained from asking questions or were perceived as not interested in information, which could be interpreted in different ways.

You can wonder what it stands for, this thing that they don't want so much information. Either they are already well informed, because they have siblings, perhaps they have even been present when their siblings were born. But I also think it's a cultural thing. That you don't question things, you don't engage to the same extent in your own care as we here in Sweden very much like to do. (Midwife 1 FGD 7)

These aspects of communication failure were considered by all categories of informants and included aspects of communication style, attitudes, confidence, trust, parents' health literacy, midwives' understanding of health literacy and midwives' communication skills.

Partner involvement

In general, father's participation and involvement during ANC visits was desirable. Fathers described a number of reasons to accompany their partner, such as sharing the joy, learning new things, being supportive, helping with language and also challenges, such as difficulties in being away from work. However, mothers described how fathers sometimes remained in the waiting room due to a mix of midwives' sometimes ambivalent attitudes, not knowing what was expected and struggling with traditional social norms that previously had excluded men from pregnancy and childbirth.

In contrast, midwives' perception was that Somali-born fathers engaged to a lesser extent in pregnancy related concerns than non-migrant fathers. The midwives' views differed however, regarding to what extent fathers' involvement should be the responsibility of the midwife to facilitate and promote, and on how often fathers should come.

The woman comes for the check-ups, but the man comes primarily to get information. And then, if he has already come during a previous pregnancy, I can understand if he doesn't feel that he has as much reason to come. (Midwife 1 FGD 7)

Health system challenges

The second organising theme encompasses health system challenges, presented in four interlinked themes: *Accessibility of care, Clear but flexible routines, Limited resources* and *Supportive structures for parent education.*

Accessibility

Accessibility was important for an optimal ANC experience and was made easier through for example drop-in hours with interpreters available. Reaching the midwife for questions or to make appointments could be complicated, requiring several attempts. Transport and distance could also constitute barriers. Taking time off work could impose difficulties when being new on the labour market, especially for fathers.

My wife, I remember that she used to get these odd appointments, either really early in the morning, or in the middle of the day, and then you have other obligations. (Father 3 FGD4)

Clear but flexible routines

Routine appointments for women throughout pregnancy were appreciated. Although parents acknowledged the need for routines and care protocols, for instance in relation to check-ups and information transfer between the ANC clinic and the delivery ward, which was they experienced as sometimes inadequate; they stressed the importance of flexibility and adjustments to individual circumstances.

Rules are there to be obeyed, but sometimes they need to be bent…I understand that they (the midwives) *have to tackle this all the time… always having to bend the rules, but still… (Mother 2 FGD 2)*

Being asked routinely about FGM/C was reported positively by women, and the midwives did so. Midwives also described a positive shift in recent years from protocol-driven care towards more individually tailored care. This allowed and encouraged more flexibility.

Limited resources

Parents and midwives discussed limited resources in terms of money, staff and time. The physical environment was regarded as a 'pull' factor, enhancing a positive ANC experience and affecting the parents' choice of ANC-clinic. Some midwives believed that socio-economically disadvantaged areas did not receive enough resources to provide high quality care, and that collaboration with other health and social service providers could optimise holistic reproductive care.

We recently talked about initiating collaborative projects with some other stakeholders… we do collaborate, but we actually don't have any time allocated for it, or resources… (Midwife 1 FG 5)

Appointments with interpreters are time-consuming, but the clinics were not compensated for this. Resource limitations could force clinics to exclude recommended ANC components, such as early healthy lifestyle information in gestational week 6–8.

Structures for parent education

Parent education (PE) in groups was mainly offered to nulliparous, Swedish-speaking women/couples. Less fluent Swedish-speakers generally received PE one-to-one during the routine visits. Parents considered PE in groups as a way to access additional information, support, and to network, particularly for first-time parents, but the demands and interests varied. Even though one-to-one information allowed for flexibility, the midwives concluded that non-Swedish speaking couples received less PE than their Swedish-speaking peers, in time spent and in content, due to limited resources, lack of routines, or because they felt that parents were not eager to receive information.

For Swedish speakers we have parent education [in groups], *yes. Not for non-Swedish speakers, then we give education individually, in the consultation room. And it becomes shorter, and not the same amount. (Midwife 1 FGD 7)*

Group antenatal care – one way forward?

To provide input for developing an appropriate intervention to improve ANC, group antenatal care (gANC) was described to the focus group members as a series of 1–2 h group sessions integrating parental education and birth preparation with individual checkups and controls, where partners are also invited, and with language interpretation if needed. The researchers did not present a fixed concept of gANC as the FGDs provided an opportunity to receive input on the design of the future intervention. Focus group members were asked to reflect on whether they thought gANC for Somali-born parents might have the potential to improve ANC. The parents did not have prior experience of gANC so the question was hypothetical, but some had attended PE in groups and could relate to those. Both women and men saw benefits especially if Swedish proficiency or knowledge about the health care system was lacking, and if gANC involved receiving information in their native language.

However, mixed groups could be a way of meeting people from different cultures and to practice Swedish. Parents with adequate Swedish saw no personal need for groups for Somali-born parents and preferred mixed groups, or groups based on other factors, such as being a first-time parent. Some parents thought it would be tiresome to attend sessions interpreted for different languages. Fathers pointed out that the lack of female relatives in a new country could be difficult for some women and thought that gANC might have the potential to compensate for that.

The midwives who had experience of gANC specifically for migrants, including Somali migrants, considered their small-scale attempt successful. Important for success were the midwives' commitment, enthusiasm, flexibility and patience. Additional success factors were two midwives in each group who were perceptive about what the group wanted, and continuity of midwives and interpreters. On the down side they had experienced high absence rates, dropouts and coming late for group sessions, and few fathers attending. Suggested explanations were that the content and form had not been attractive enough, that parents, especially fathers, did not have the time or that cultural norms might constitute a barrier for some fathers. The midwives also raised concerns about tailoring "too much", which could result in migrants receiving poor or less information, and described how they tried to manage this.

We use exactly the same Power Point as we do with our Swedish parents, the same videos. Really, we thought that part was important, that no one shall start to wonder…. or feel that they have received different information, just because they are from Somalia, or that "if I come from Syria I get different information". It must be equal. And then we thought…well, of course we tailored some of the information…as we thought was proper…based on the background of the participants. (Midwife 1 FG 6)

Midwives without prior experience considered gANC for Somali-born parents as an opportunity to achieve a deeper understanding of individual needs through a richer dialogue than in the one-to-one encounters. Midwives also thought that unasked questions or misunderstandings that might go unnoticed in individual encounters were more likely to be picked up in the group setting. Also, it was foreseen that education or information could more easily be tailored to the needs of a certain group according to degree of Swedish proficiency and health literacy. Midwives mostly offered migrant women with limited Swedish one-to-one education during routine visits, which some midwives considered resulted in less parent education for these women. The clinic size and patient base had some significance for how the midwives visualised gANC as a possible care model at their clinic. Large clinics may have greater possibilities to organise groups for particular sub-populations. In one setting, the midwives were hesitant about gANC for particular language groups, and felt that integrating parents of different language backgrounds was more important, even if Swedish proficiency was elementary. In another setting, midwives believed that non-migrants would not be interested in being in mixed groups with non-fluent Swedish speakers, at least not if interpreting was needed.

I don't think Swedes would be interested in spending more time with the antenatal care group if there was a need for interpreting… (Midwife 1 FGD 7)

Finally, concerns were raised in all groups about discussing sensitive or private issues in group sessions and that it might be especially difficult for a woman without a partner or for a solitary man in a group of women. Some mothers thought that male presence in a hypothetical ANC group might hamper the dialogue and suggested that men should only be invited for certain parts. However, in general, the opinion among both parents and midwives was that male participation should be encouraged.

Discussion

The Somali-born mothers and fathers in this study reported barriers to receiving optimal care even though they were happy with many aspects of current ANC. Midwives identified the same types of challenges as the parents did, but sometimes lacked the support, resources and tools to address them. Challenges in the midwife-parent encounter were related to receiving care according to individual needs, dealing with stereotypes, addressing varied levels of health literacy, overcoming communication barriers and enabling fathers' involvement. Health system challenges related to accessibility of care, limited resources, and the need for clear but flexible routines and supportive structures for parent education.

The general attitude among parents and midwives to gANC targeting Somali-born parents was positive, although some concerns were raised.

Despite Sweden having been a migrant receiving country for decades, migrant women and their families appear to face many of the same challenges in antenatal care today as in the late 1900s and 2000s. Communication barriers (Small et al., 2014; Binder et al., 2012) and interpreting challenges (Larsson et al., 2016) are well known but seem not to have been adequately addressed. Women's knowledge gaps on issues related to pregnancy and childbirth, the health care system and rights described in our study have all been reported previously (Rassjo et al., 2013; Essén et al., 2000; Wangdahl et al., 2014). Further, the need for parent education for couples with limited Swedish was inadequately responded to, which is consistent with previous literature (Fabian et al., 2004; Fabian et al., 2015). Altogether, this indicates an urgent need for measures that can alleviate inequalities in antenatal care, such as interventions to improve quality of care or developing alternative care models that can address barriers and facilitate delivery of optimal care.

Dealing with stereotypes was a key finding, previously highlighted in other settings than in the Swedish (Small et al., 2014; Bredström and Gruber, 2015; Almeida et al., 2014a; Malmusi et al., 2010; Groglopo and Ahlberg, 2006). One example of stereotyping was the midwives' perception of Somali-born parents as generally embracing a non-medicalised, natural approach to pregnancy and childbirth. As a consequence, certain elements of information were sometimes not provided, and women may have been left un-

informed about, for instance, pain relief. For example, if a Somali-born woman does not want information about pain relief it can be interpreted as if she prefers to give birth naturally, which in turn can be seen as positive by midwives. Other possible explanations for women's reluctance to receive information, including inadequate health literacy, may thereby go unnoticed. Migrant women in Sweden have been shown to use less epidural analgesia (EDA) during labour than Swedish-born, and in contrast, the need for better information about different pain-relief methods has been identified (Ekeus et al., 2010). Generalisations and stereotypes may affect the quality of care provided and caregivers' ability to tailor care to individual needs, subconsciously, through implicit bias (Matthew, 2015). Insufficient dialogue is one factor that may underpin stereotypes. Our findings suggests that stereotypes and preconceived ideas need to be addressed in the clinical encounter as well as at the health system level (Groglopo and Ahlberg, 2006), particularly when developing more responsive and equal antenatal care for migrant women. In a Danish intervention study, the argument that migrant pregnant women do not have more in common than non-migrant pregnant women, and that targeted care could be stigmatising, were raised (Villadsen et al., 2016). However, there are successful examples of cultural tailoring at group level for specific groups of migrants in Sweden, for example related to parenting support to Somali parents (Osman et al., 2017). Tailoring care at group level targeting specific ethnic or language groups requires knowledge and reflection to avoid unintended consequences such as sustaining segregation or, as found in our study, affecting the quality of the parent education or quality of care negatively.

Group Antenatal Care may have the potential to overcome some of the challenges in standard, individual care for Somali-born parents. Studies show that gANC may empower women, increase the time spent with the midwife, serve as a platform for the midwife and mother/couple to get to know each other, improve dialogue and communication and provide a forum for social support from peers (Andersson et al., 2013; Heberlein et al., 2016; Novick et al., 2012; Riggs et al., 2017). Midwives in our study believed gANC could provide a better environment for them to get to know the women and their partners, which could facilitate seeing the individual and counteract generalisations through an active group dialogue. In a recent feasibility study from the UK, gANC for migrants enabled midwives to build more meaningful relationships with women. The midwives themselves were more satisfied with the way care was provided and believed that gANC empowered women and enhanced care, but expressed a need to be adequately supported and trained in group facilitation. Sticking points were a perceived lack of privacy in the groups and involving partners (Hunter et al., 2018). Taken together, it seems like gANC may offer more comprehensive ANC to women and couples who are at risk of receiving sup-optimal care and of being excluded from parent education.

The finding that parents desired individually tailored care, and that midwives tried to respond to that request, corresponds well to the concept of person-centred care during pregnancy (de Masi et al., 2017). Individually tailored and person-centred care may seem contradictory to gANC. However, at least one previous study has shown that women have felt more seen and confirmed as individuals in gANC than in standard individual care (Andersson et al., 2013). Feelings of trust and empathy (Byrskog et al., 2016; Byrskog et al., 2015; Ny et al., 2007b) and person-centring (Jones et al., 2017) are central for a positive care encounter. Person-centring and strengthened interpersonal communication skills have also been suggested as an approach to counteract generalisations and stereotypes (Byrskog et al., 2015) and as a way of addressing provider bias and provide tools for more equitable and non-judgmental care (Diamond-Smith et al., 2018). It may be challenging to provide person-centred care when health care providers perceive a norm conflict (Bredström and Gruber, 2015; Arousell et al., 2017), which was described in our study when midwives felt frustration about non-compliance and differing views. It may also be challenging to provide person-centred care in groups, but if a care model aims at empowering women, is person-centred, focused on dialogue, offers more time with the midwife as well as integrated interpreting for those with limited Swedish and peer support and in addition is inclusive of fathers – then it could be a model worth testing for sub-groups, such as recent migrants.

Somali-born fathers were generally positive to engaging in antenatal care but were perceived as less engaged than their Swedish-born peers by the midwives. The uncertainty about what was expected from them in ANC and lack of clarity about this issue from caregivers has been described previously (Widarsson et al., 2015; Xue et al., 2018) and might be more pronounced for Somali-born fathers, as they were perceived as less engaged by health professionals and because both mothers and fathers expressed that traditional social norms may constitute a barrier for some. Inclusion of fathers in group *and* individual ANC has been weak (Andersson and Small, 2017) and inclusion needs to be taken into account when developing gANC so that it corresponds with women's and men's needs (Andersson et al., 2012; Andersson and Small, 2017).

Study strengths and limitations

Pre-understandings during the interviews were minimised as the first author (MA) is not a midwife or of migrant background. Further, trustworthiness was strengthened through the involvement of both Somali-born parents and Swedish midwives which generated varied perspectives on ANC. In addition, health professionals with Somali background acted as advisors, research assistants and interpreters (Halcomb et al., 2007), and the research team included midwives and researchers experienced in qualitative research with the participant groups. Rich data was achieved through encouraging an open, supportive atmosphere during FGDs, and through a participatory learning and action approach in the FGDs (Lionis et al., 2016), where the researchers regularly checked their perceptions of emerging themes during the discussions.

One weakness was perhaps the dual aim of investigating experiences of current, one-to-one ANC *and* wanting reflections on the idea of gANC. The midwives were aware of the proposed intervention as a response to poorer outcomes and ANC attendance issues among Somali-born women, and this may have coloured their reflections. A hypothetical question is difficult to answer so the results on parents' ideas about gANC must be interpreted with some caution (Sudman, 1996).

Conclusions

ANC interventions targeting inequalities between migrants and non-migrants may benefit from embracing a person-centred approach, as a means to counteract stereotypes, misunderstandings and prejudice. gANC could serve as a valuable platform for person-centred care because it has potential to improve communication, allow more time for dialogue between midwives and women and enable peer support where the quality of usual care may be compromised for migrant women. Caution is required in the formation of groups however, to avoid potential unintended consequences, such as reducing privacy for individual women or reinforcing stereotypes by grouping people according to country of birth.

Conflict of interest

None declared.

Ethical approval

Ethical approval was obtained from Stockholm Ethical Review Board (2015/1703-31/1).

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