

SWEDISH MATERNAL HEALTH CARE IN A MULTIETHNIC SOCIETY
- INCLUDING THE FATHERS

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PERNILLA NY

**SWEDISH MATERNAL HEALTH
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- INCLUDING THE FATHERS**

Malmö University, 2007
The Faculty of Health and Society

This doctoral thesis is dedicated to all my midwife-colleagues and physicians around the globe who have dedicated their professional life to maintain pregnancy and birth as a normal life event. By offering our professional knowledge and by being there during the moments of pregnancy, birth and family life, we can with our knowledge and expertise, prevent as far as it is possible, maternal and neonatal illness and death. By assisting the woman by good practice and simple hygienic methods we can prevent ill-health for both mother and child. We must not be tempted to introduce technology which can have negative effects on pregnant women without thorough research. This will only lead to suffering as well as less resources available for those women in need. We must also have realistic expectations on the medical staff. We can not prevent all death and suffering, but we can offer our support and clinical expertise in the purpose of practising evidence based care, for the sake of women and their unborn children. As Joy Phumaphi put it, “*The women of the world are waiting...*”

Pernilla Ny

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ABSTRACT

Preventive work in maternal and child health care has a long history in Sweden. Today, Sweden has achieved the lowest maternal and child mortality rates globally based on a maternal health care system regulated by national recommendations; offered to every woman, free of charge, on a continuity basis, by registered midwives at municipal clinics within the community with the purpose of being assessable for all women. Despite the availability of antenatal care, immigrant women living in Sweden often have a different pattern of utilising care and in some cases immigrant women have been shown to be at risk for a negative delivery outcome.

The overall aim of this thesis was to investigate differences due to country of birth and utilisation of antenatal care and the experiences of antenatal care, from the perspectives of the both the parents to be. Epidemiological design and explorative qualitative research has been used for the purpose of finding patterns of the utilisation of maternal health care as well as experiences from foreign born men and women concerning maternal health care in general, and maternal health care in the city of Malmö Sweden in particular. Qualitative research has been used to add depth and thereby attain a greater understanding in a social context.

In the study population, according to the definitions set in Studies I, IV, the main finding was that 28.3-48.7% of the women had unplanned visits to a midwife and/or to a physician at the delivery ward. Women born in Sweden and in Eastern and Southern Europe had a linear relationship with few planned visits to the midwife at the municipal clinic and more unplanned visits to a midwife at the delivery ward.

The women in Study II were positive to the individualised and professional care given at the MHC by empathic and professional midwives. They were positive to the increased involvement of their partner in the area of reproduction and family life since migrating to Sweden. According to the women, this may lead to an increased understanding by the fathers of the woman's situation during pregnancy,

birth and caring for the children as well as it could increase the fathers own emotional as well as practical involvement in their children. The foreign born men, in Study III, were positive towards antenatal care and to be able to take part as support to women at MHC, and during the delivery process. They experienced problems with their situation of being fathers, partners and, as men living in Sweden, due often to their being un-employed and the changed situation that their migration had brought about.

The health care system manager need to be aware of the fact that there are groups of women, in a low risk population, who tend to make contact with the maternal care system in a more of less unplanned fashion. By not utilising the planned care offered these women miss an opportunity to meet a midwife who is specialised in preventive care during pregnancy with the focus of treating pregnancy a normal health life event, while at the same time, ensuring the detection of eventual risk factors. A conversation with a midwife in a calm environment is beneficial to the pregnant woman. The immigrant groups need our special attention aimed at making the maternal health care system easily accessible for them, as well as making the maternity staff aware of their own attitudes towards preventive work involving pregnancy in a multiethnic setting. The organisation of care must also, in itself; offer such possibilities for both the staff and the women.

ORIGINAL PAPERS I-IV

- I: Ny P, Dykes A-K, Molin J, Dejin-Karlsson E. Utilisation of antenatal care by country of birth in a multiethnic population - A four-year community-based study in Malmö, Sweden. *Accepted for publication in Acta Obstetrica Gynecologica Scandinavica*
- II: Ny P, Plantin L, Dejin-Karlsson E, Dykes A-K. The experience of Middle Eastern men living in Sweden of maternal and child health care and fatherhood: focus-group discussions and content analysis. *Midwifery*. 2006 Nov 25; [Epub ahead of print]
- III: Ny P, Plantin L, Dejin-Karlsson E, Dykes A-K. Middle Eastern mothers in Sweden, their experiences of the maternal health service and their partner's involvement (*re-submitted*)
- IV: Ny P, Dykes A-K, Nyberg P, Molin J, Dejin-Karlsson E. Unplanned care seeking at the delivery ward in a low-risk multiethnic population - An obstacle for both the pregnant woman and the health care organisation (*re-submitted*)

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ABBREVIATIONS

World Health Organisation WHO

Maternal health care MHC

Gestational week g.w

Kunskaps, informations- och kvalitetsavdelningen (Knowledge, information and quality department) KIKA

Universitetssjukhuset MAS (Malmö University hospital) UMAS

Odds ratio OR

Confidence interval CI

DEFINITIONS OF TERMS

Maternal health care	MHC, Health care service during pregnancy, birth, the post partum period and 8-12 weeks post partum ¹ .
Multiethnic society	Ethnic derives from the Greek 'ethnikos', which refers to people or nation; A group of people that hold some degree of unity and solidarity aware of having a common origin ² . By multiethnic the author implies a society with people from different countries of birth.

PREUNDERSTANDING

The main author in all of the articles as well as the framework is a registered midwife with working experience from different multiethnic settings in urban- and rural areas in Sweden. Following an early interest in global health I have a Masters degree in International health including public health, women's reproductive health in low-income countries and a degree in governmental studies from countries of former Eastern Europe and other low-income countries. This education has introduced me to different settings in different countries as well as to different delivery clinics abroad, mainly in Egypt and in India, but also to Viet Nam and to the lives of rice farmers in the northern parts of that country. There I was able to participate and observe care given by midwives, traditional birth attendants and physicians as well as to meet women receiving some kind of perinatal care. The data collection related to in my thesis at Master's level in India (Ny P. et al 2006. Health education to prevent anemia among women of reproductive age in southern India. *Health care for Women International* 27, 131-144.), gave me a deeper knowledge in both methodological issues while performing data collection using an interpreter. However, maybe most important, being in India and Egypt gave me deeper knowledge and experience of being the 'odd one out'; the one not speaking the native language and not being from the main stream culture or country. This experience helped me in my encounter with foreign born women and men both in my clinical work in Sweden with regards to reproductive health, but also in the research situation, when performing the interviews and using an interpreter. Having had this experience made me aware of my own culture and attitudes which helped me when analysing the material as objectively as possible. It also helped me in conducting the quantitative studies since most of the experiences I had from other settings and countries were similar to here and due to my studies of government I was aware of the great transition that people of the former Eastern Europe had gone through since 1989 and how it might have affected them since having lived earlier in a totalitarian society.

Our pre-understanding includes anything and everything we understand and believe. We need to be aware of our pre-understandings, to guard against incorrect interpretation in order to be objective. This is vital for all types of research; otherwise our findings are only reflections of something that is already within our understanding.³

INTRODUCTION

Preventive work in maternal and child health care has a long history in Sweden. Sweden has the lowest maternal- and child mortality rates globally^{4,5} as well as a maternal health care system, regulated by national recommendations, offered to every woman free of charge, on a continuity basis by registered midwives at municipal clinics in the community with the purpose of being available and accessible for all women¹. Despite the availability of antenatal care, immigrant women in Sweden have a different pattern of utilising antenatal care^{6,7}. The reproductive health of migrants is one of the most important, but yet still unmet public health challenges globally⁸ since immigrant women can be at an increased risk of having a negative delivery outcome^{6,7,9,10}. Being foreign born has also been seen as an obstacle and hinder to receiving or seeking antenatal care¹¹. Migration is an important determinant of global health and has implications for the countries who host migrants and those countries health care systems⁸. In recent years, a multi-ethnic society has developed in many larger cities in Europe. Therefore reproductive health in the context of migration is a serious dilemma everywhere since more needs to be done to ensure that immigrant women actively participate in, and profit from, mother and child care services, especially antenatal care⁸. In this respect social and cultural aspects of reproductive health deserve attention.

The primary goal of antenatal care is to decrease the perinatal morbidity and mortality^{1,12}, and to ensure well prepared parents^{12,13}. The importance of antenatal care for improving maternal and infant health is unquestionable, but the potentials of the services remain insufficiently investigated such as the onset of care, the exact number of visits¹⁴ and the importance of involvement of family members. The use of unplanned visits at the delivery ward as a substitute for planned antenatal care at municipal clinics has several negative consequences. Pregnant women who do not attend planned antenatal care at municipal clinics lose the opportunity to meet midwives who are specialised in the preventative aspects of pregnancy and birth¹

including the provision of support for the woman and her partner¹⁵. Also, deviation from the recommended antenatal care regime puts strain on both the economic and staff resources of the delivery ward, where the primary purpose is to provide care for women giving birth or having emergency consultations.

Most westernised countries, as well as Sweden, have in the last decades changed from being a relatively homogenous to an ethnic heterogeneous population. Today these countries are home to people from many different parts of the world, socioeconomic levels as well as cultures and ethnic groups, all with different experiences of health care behaviour when related to maternal health care. Immigrant women originate from many countries that are suffering from war and conflicts that affect their health status. Further they bring with them their experiences of the available care and the traditions surrounding pregnancy and birth in their native country. The curative perspective in antenatal care, in for example the Middle East and former Eastern Europe is different from the preventive perspective in the Swedish health care system.

The need of patient involvement, as an interaction between patient and caregiver¹⁶, the involvement of the father in antenatal care and finally the women's opinion regarding the fathers' involvement needs to be addressed. The Swedish maternal health care system has encouraged the involvement of the father to be as early as the late 1960's. The gender equality politics that has pervaded within Swedish society since the late 1950's aims at not only involving women and women's rights, but also the involvement of men and thereby creating an active and equal parenthood for both parents¹⁷.

BACKGROUND

The purpose of Maternal health care

Sexual and reproductive health is integral parts of basic human rights. Access to sexual and reproductive health care is the gateway to health; not only because it is vital for our survival as a species but it also represents the most important steps toward gender equality. At the World conference on human rights, in 1994, 179 countries came to an agreement that empowerment of women and achievement of people's individual needs for health; including reproductive health was accepted as essential for sustainable economic, social and environmental development.¹⁸ The purpose of maternal health care is to enable the birth of as healthy babies as possible to well prepared parents^{12,13} and should consist of a number of scheduled visits to health care services in order to detect symptoms such as hypertension and deviation from normal foetal growth as well as offering psychosocial support and health education.^{19,20,21} The history of success in reducing maternal and newborn mortalities shows that skilled professional care during and after childbirth can be the difference between life and death, and have impact post partum²². In reality it is often not so that the medical check up can prevent a complication from happening, but may lessen the damage by earlier intervention^{1,23,24,25}. The purpose is also to deliver effective appropriate screening or prevention, or treatment intervention^{20,21,22,24,25} to assure and maintain and continually improve a high level of health care and to avoid out-dated and possibly harmful interventions^{26,27}.

With this improved understanding it is important that women have access to care during the critical period around labour, delivery and the post partum period coupled with the possibility of referral for the management of eventual obstetric emergencies. Several international studies have been done with the purpose of defining the optimal number of visits and also in describing the different kind of routine antenatal care that is offered and utilised in many different countries^{21,22,25,26,28}. There is still no worldwide consensus since the conditions for women vary widely

from the low-income countries where the assets might be lacking for women with no income, or further in countries where antenatal care must be paid for and then there are all the different European countries often with free care, but nevertheless in different forms that are related to the traditions and the medical staff performing the antenatal care.

Maternal health care services started in the United Kingdom and Ireland during the 1930's with the purpose of checking for eclampsia, a death threatening illness if left untreated¹⁴. The core of the models created are practically unchanged, but due to both increased technical and medical knowledge these programmes have since evolved^{20,21,22}. Some new components of technical and medical interventions have often been introduced without proper scientific evaluation. Greater effort is needed to improve the content and quality of the service offered. In addition, increased attention is required to ensure that particular groups of women, especially those living in rural areas, the poor and the less educated, obtain better access to antenatal services,²² which is of importance in all countries. Antenatal care has the advantage of enabling the creation of a long lasting relationship with both of the parents to be that can lead to empowerment, a feeling of respect and participation; Not only in the setting of parenthood and women's health, but also the feeling of being an accepted and worthy member of society as a whole.²⁹

Globally the midwife is the most cost effective and appreciated care giver for low-risk women during pregnancy and birth²⁸. By providing good antenatal care, dealing with unwanted pregnancies and improving the way society looks after pregnant women, it is possible to make pregnancy and birth safer.

In 2001 WHO concluded, that inappropriate perinatal care and technology continue to be practiced widely throughout the world. Therefore, they have proposed the ten "*Principles of antenatal care*" (p.202)¹² that recommend, in detail what activities should be abandoned and what forms of care can reduce the negative outcome of birth. The care for a normal pregnancy and birth should be de-medicalised and that less, rather than more, technology should be applied, likewise the antenatal care should be supported by best available research where possible and appropriate. Higher use of antenatal care will not only increase public expense but the avoidance of the possible negative physiological effects of the medicalisation of a normal life event may be more important. If the general attitude prevails, that pregnancy is a dangerous period this will set the stage for unnecessary medical examinations and interventions with the potential for iatrogenic injuries. Established procedures should be installed that are right for the individual person and at the right time.³⁰

Maternal health care should provide preparation for parenthood for the woman and her partner and recognise that fathers have their own needs as individuals. The world health organisation also emphasises the importance of involving men in reproductive health^{31,32} by also recognising the role of gender inequality where men actually can function as gatekeepers of women's health as well as men's importance in as much as they have an influence on women's health.

Maternal health care worldwide

Not all women globally receive antenatal care¹⁴. In the industrialised countries, 98% of the women have at least one visit to antenatal care, in some of the low income countries about 68%. Southern Asia has the lowest levels with 54% and Lebanon and Iraq 87% versus 78%. Urban women are twice as likely to report at least four antenatal visits and educated women are more likely to have four or more visits. Wealth distribution seems to be an important determinant of the use of antenatal care and women who attend one visit are more likely to have a second⁵. Many women in Lebanon, Iraq and the sub-Saharan region have no tradition of receiving antenatal care and the majority of care-givers in these countries are physicians¹⁴.

Access to sexual and reproductive health services is central to achieving maternal and child health. It also engenders a sense of wellbeing and control over one's life, along with an ability to enjoy the basic human rights. These key areas are still largely missing in many countries in the Eastern Mediterranean Region.³³ The failure of governments also in many Middle Eastern countries to provide comprehensive healthcare services has led to health care being taken over by market-forces. This has transformed it into a commodity with a curative, rather than preventive, orientation.³⁴

Health professionals and their organisations have failed to place health on the public agenda. They have also contributed to medicalising health systems and policy thus making it so that preventive approaches based on rights and social determinants are excluded.³⁵ The antenatal care in Lebanon is offered in absence of standard guidelines or evidence practise; it is often highly medicalised, expensive and performed in urban areas by physicians.³⁶

The standard model that is currently used in many developing countries is 12 visits³⁷ and the four-visit antenatal schedule appears to be the minimum that is offered to low-risk women³⁸. According to the recommendations, the postpartum visit is highly recommended and should take place within a week after delivery³⁹.

Maternal health care in Europe

In the EU, 20 of the member states have recommendations regarding antenatal care. The number of tests offered differs among the countries as for example the countries of the Eastern block recommend up to 37 different tests during pregnancy (as for example breast examination, foetal movement count, full physical examination, formal risk scoring, vaginal ultra sound) compared to Sweden who has 25 test.²⁷

A questionnaire filled out by 13 EU representatives regarding the organisation of antenatal in their countries care found 13 different systems each with a different organisation regarding the provider, continuity of care and financing. However, as a rule, antenatal care is planned and not built upon spontaneous care seeking and is often provided free of charge or at low cost.⁴⁰ Initiatives to promote participation on prenatal care have been established in the EU for many decades, even though barriers exist. A case-control study (in 2001) was performed in ten European countries. Women with inadequate care were likely to be of foreign background, unmarried and have an unplanned pregnancy, less education and no regular income⁹. An older study conducted in 1999 compared antenatal care attendance from five national registers in the EU, and Hungary and Norway. The median number of visits varied from seven in Greece to 14 in Finland. Women not receiving any prenatal care at all differed 0.5%-2.6% and late care 3.1%-29.2% with the highest frequency being in Ireland and the lowest in Finland.⁴¹

In the United Kingdom the recommendations introduced in 1993 are in the process of being updated.⁴² The present recommendations for the health of pregnant woman are practised by midwives and general practitioners on a continuity of care base and care is to be easily accessible for all women within the community. For a non complicated pregnancy, ten visits is the recommendation

Political and socio-economic instability in and around the EU has increased the number of refugees and asylum seekers arriving in European countries. Already in 1995-96, 19.6 million foreign national were resident in Western Europe. Immigrants bring with them a range of background factors and because poverty and the desire to search for better economic opportunities are two of the main factors that promote migration, immigrants tend to originate from poorer backgrounds often including inadequate access to health care. Due to their limited experience with health care services they might find it difficult to relate efficiently to local health care service providers¹¹. Countries in Europe who belonged earlier to the former Eastern block consist of a diverse sample of countries both in regard to their populations and their health care organisations. These countries have gone through the

change from a totalitarian system of government to a democracy.⁴³ The care offered to pregnant women there was earlier focused on risk as well as the attitude that the more visits the better and the care was traditionally physician directed rather than family centred, so family members were not invited to be involved in the care of their own. The former Soviet system regarded pregnant women and women in birth to be potentially ill persons who posed a potential risk for her baby. A normal low risk pregnant woman might have around 30 visits to the antenatal clinic. Continuity of care was not offered and neither was other family members invited to take part in the care. In Russia the midwives had an independent role and had the responsibility for the delivery situation of low-risk pregnant women.⁴⁴ Today, after the integration of the former Eastern Europe into the western block, women from e.g. Eastern Europe have become a vulnerable group; they are often younger and are smokers and they are reported to a higher degree of poor self-reported health and psychosomatic complaints.⁴⁵

The recommendations regarding MHC in other Scandinavian countries^{46,47,48} differs somewhat from those of Swedish¹ both in number and in who performs the care. Physicians, nurses and midwives are involved in the care of low-risk pregnant women. The number of scheduled visits is somewhat higher than in Sweden however all countries highlight the importance of offering the post partum visits (Denmark offers three visits).

Maternal health care in Sweden

Within the field of maternal health care system in Sweden lies the women's rights to her sexual and reproductive health including, prevention of unwanted pregnancies and- sexually transmitted diseases, cell specimen taking for gynaecological purposes, as well as care during pregnancy and birth¹. In 2006 an updated description of the requirements of the Swedish midwife was introduced thus upgrading the role of the midwife and her professional competence level, thereby contributing to safer care. The professional field of the registered midwife lies within sexual and reproductive health care. The midwifery-degree in Sweden (90 ECTS Advanced level) is based on a Bachelors degree in nursing (180 ECTS). The midwife shall have the ability to independently take care of a normal pregnancy, delivery and the postpartum care and be able to complete a delivery with a Vacuum extractor. She should have knowledge of contraceptives and their use.⁴⁹

The national recommendations are currently being revised, but those published in 1996 recommend 7-8 visits to the midwife for multiparaous and 8-9 visits for primiparaous (including a visit in gestational week 41) (some counties offer also

one visit to a physician) and a postpartum check-up 8-12 weeks after the delivery, free of charge¹. The section under the heading “setting” describes the care more in detail.

In Sweden the health hazards related to pregnancy and delivery have decreased dramatically during the last hundred years. Extra concern needs to be taken concerning immigrant women, since earlier studies in Sweden show that they do not avail themselves of the antenatal care provided to the same extent as Swedish born women do^{6,7,10} and a one barrier to seeking care might be immigrant status as well as that of being young and of single status⁶.

In 1991 Sweden had the highest mean number of visits to the midwife among several westernised countries, 13 per pregnancy due to a close adherence to the existing recommendations and early booking of the first visit, before g.w 15¹⁹. In 2004 the national mean for primiparous women was 9.1 visits (in the region of Skåne, range 8.4-9.1) and for multiparous women 8.4 (in the region of Skåne, range 7.2-8.6).⁵⁰

A reduction of the number of visits was made in an intervention in the city of Västerås Sweden, during 1991 due to a reduction of recourses (from 14 visits to 8). This reduction in number of visits resulted only in a very few additional visits initiated by the women themselves, most were in fact initiated by the midwives. Contact with a physician was mostly initiated by the woman and concerned most often a wish for being granted sick-leave. This reduction of care did not result in an increased demand for extra visits or referrals to special consultations or emergency care. Self referrals were mostly influenced by symptoms. With a reduced routine programme the available surveillance became better apportioned to obstetric risk.⁵¹

Women's experiences of maternal health care

The strategic approaches from *Making Pregnancy Safer*, WHO¹⁴ highlights the need of empowerment of individuals, families and communities to increase the control of maternal and neonatal health, but there are few studies focusing on immigrant women's views on maternal health care in Sweden. One study showed that women stated that they felt safe when they had knowledge of the Swedish health care system. Being able to ask the professional and knowledgeable staff made the women feel safe since most of them did not have a female network in Sweden. Being prepared created a sense of security for the women and they were positive towards participating in the parental education offered. Further more they felt positive about the fact that the husband was invited to participate.⁵²

A national cohort of 2746 Swedish speaking women, 1999-2000, showed that the majority were satisfied with the antenatal care; however, 23% were dissatisfied with the emotional aspects and 18% with the medical aspects. The dissatisfaction was that the midwives were not supportive and had not paid attention to their partners' needs.⁵³

In the UK in 1996, a reduction of the number of visits, (13 visits to 6-7 including low-risk women) was introduced in an ethnically diverse area. The visits were still as clinically effective, but the reductions lead to reduced psychosocial effectiveness and dissatisfaction from the woman's point of view⁵⁴. A study in Lebanon revealed women's satisfaction in both rural and urban settings. The most important, for the women in the Lebanese study, was the time spent and the communication, empathy and skills the staff provided, both during their pregnancy and delivery. By being encountered by someone they liked they felt their pain was reduced.³⁶

Migration

Today 94.5 million migrants globally are women.⁵⁵ In 2005, 336 000 people applied for asylum in 50 of the industrialised countries, mostly in North America and Europe. Migrant women have received little attention but it is of importance to hear their voices.⁵ Migration has also implications for those countries who host migrants and their health care systems⁵⁶.

For many women, migration opens doors to a new world of greater equality. Being exposed to new ideas and social norms can promote their rights and enable them to participate fully in society. For both the countries of origin and the receiving countries the contribution of women migrants can transform the quality of life. Not only positive effects emerge from migration. Immigrants are also victims of discrimination which makes it impossible for them to work and function in their new countries.⁵⁷

Migration to Sweden and Malmö

Sweden was earlier a nation whose people emigrated. During the 19th century one million Swedish men and women immigrated to America due to the inability for them to feed their families. After World War II the economical situation in Sweden improved therefore, during the 1960's, the labour force immigration began, mostly it was young men from e.g. Yugoslavia, Albania and Pakistan who came and were offered employment in Swedish industry. During the 1980s refugees from Iran and

Iraq came to Sweden, as well as people from the Lebanon. In the 1990's it was mainly people from Somalia, Bosnia, Kosovo and Iraq who came, often because of conflicts in these areas. Today many immigrants in Sweden have limited ability to converse in Swedish which is one of the greatest obstacles for integration as well as one of the reasons that segregation exists, according to Roald⁵⁸.

Malmö has a population with 270 700 inhabitants of which 26% are foreign-born. There are citizens of 169 different countries and the most common groups are people from Yugoslavia, Denmark, Iraq, Poland, Bosnia and Herzegovina and Lebanon. The city of Malmö is divided into ten districts and the distribution of foreign-born inhabitants is somewhat imbalanced, 11-59%, in the different city districts.⁵⁹

In the statistical analysis made each year reviewing the status in the different city districts in Malmö it shows that there are differences in health due to income, level of education, sex and ethnicity of the citizens as well as smoking habits. Foreign born citizens also have the most difficulties in getting into the labour market.⁶⁰

Migration and healthcare in Sweden

All new immigrant arrivals have the right to a medical examination, maternal health care (including care during the delivery) as well as some other forms of medical care⁶¹. In the city of Malmö, health care is offered to asylum seekers at *Flyktinghälsan* (Refugee Health Centre) situated in the centre of the city, which offers medical as well as psychosocial care by child health care nurses, nurses, social workers and physicians.⁶² Different support groups are available to women in the asylum process, but not for men. Pregnant asylum seekers are referred by *Flyktinghälsan* to the different MHC-clinics within the city of Malmö.

In Sweden, the general health status is now worse than it was 20 years ago as well as a different health status among different groups. Immigrants have worse health than the Swedish born population which is evident especially in the segregated areas. Peoples who have immigrated to Sweden have a greater risk of having ill-health than the Swedish born population and utilisation of health- and medical care by the immigrant population is higher. A cross sectional survey created from data from the Swedish Survey of Living Conditions and Immigrant Survey of living conditions 1996 showed that foreign born residents were more likely to have a higher rate of seeking a health consultant. This was primarily explained by there being a less satisfactory self reported health status among immigrants when compared to Swedish born residents.⁶³ Consequently, the Swedish Parliament made a decision about new goals for the public health in 2003 (2002/03:35 *Mål för*

folkhälsan) stating that integration is an important political area and needs to be considered in the field of health care. A doctoral thesis performed in this region of Sweden⁶⁴ showed that immigrant women from the horn of Africa had an increased risk of perinatal mortality due to pregnancy strategy practises in combination with sub-optimal utilisation of Swedish perinatal care services.

Acculturation

Migration is a process of social change. It is a process where a group selects portions of a dominant or contributing culture that fit their original worldview and at the same time strives to retain what's left of their traditional culture. Any such event that means leaving the social networks behind creates a sense of dislocation, alienation and isolation⁶⁵. There are both physical and psychological aspects related to health, but experiencing a sense of coherence is of great importance for health. Migration in it self adds to loss of coherence. One reason for this can be discrimination regarding both housing- and the labour market. Other reasons can be, how one lives, the reasons for migration, experiences from a traumatic background and earlier conditions when living in the native country⁶³. At a socio-cultural level trans-national immigration has created significant economic, health and social-psychological problems in societies and nations where similar problems haven't been seen earlier. Immigrant masses have left their communities of origin in search for change as they look for acceptable political climates, improved economic conditions, and the protection of their beliefs and values. How individuals and groups deal with this is an important research question and acculturation has become an important concept in trying to explain the different experiences of minorities such as international migration, in the creation of multicultural societies. Adaptation and change are important components and instead of assimilation one should consider that there are many options available to individuals interacting with a new culture.⁶⁶

Transition, in the perspective of maternal health care

By transition the author implies the effects of migration and what a change of society can have on parenthood. Migration has become one of the most important determinants of global health and social development and reproductive health is one of the most important and often unmet public health challenges in relation to migration. Migration often means isolation and separation of spouses⁸ plus the act that the former female network can be lost⁶⁷. At the same time the migration proc-

ess can lead to new customs for the parents to be, such as the greater participation of the male partner in pregnancy and birth.

Few studies have focused on immigrants' views of the maternal health care in Sweden and their views on becoming parents in Sweden. The foreign born parents, or parents to be, will encounter a totally different world view regarding parenthood and gender equality in Sweden^{68,69}. The formal attitude in Swedish society is that men should take equal responsibility for the household and the upbringing of the children, as well as the woman/mother is expected to work in paid employment after having children.⁷⁰

Somalis living in Sweden expressed both positive and negative feelings about being an immigrant. The reasons for the father to be entering the female arena of pregnancy and childbirth were because the woman did not speak the new language, she was lonely. Some said it was because he wanted to, motivated by responsibility towards his family. He acted as the spokesman for the woman⁷¹. Globally, women seem to share the attitude of the importance of having the partner present in pregnancy and birth. Many women also mentioned the importance of the psychosocial support provided by the husband during pregnancy.^{36,72}

The encounter with the midwife

A friendly and understanding attitude from the host country was the main factor in promoting the health of the refugee families in Sweden.⁷³ Maternal health care could be seen as a major success story, but more can be done by emphasising effective interventions. It is important to empower women and families to recognise dangers early and to get professional help when difficulties arise^{26,74}. In being able to do this the midwife must be aware that her attitude affects the encounter and the communication with the parents to be.

A caring midwife communicates with the woman who in turn makes her feel secure, at ease and able to be herself and feel connected to the midwife. It is important with competence, knowledge and skills as these create a feeling of trust⁷⁵. However, studies performed in Scandinavia did show a somewhat contradictory result in this area. It was found that the midwife could be experienced as both empowering as well as uncaring^{76,77}. From the perspective of the professional midwife it is of importance that she invites the involvement of significant others as they can have a positive effect of health outcome,^{78,79} On the same subject a British study including 837 men stated that midwives did not always meet men's needs for information and support. In spite of this, midwives were considered better than other professionals as they did listen to the men and made it possible for them to

ask questions. However, men wanted to be more involved in their partner's pregnancy and care. Men are important for the support of their partners in this exclusive time in life, but it is important that the midwives see them and their individual needs as well⁸⁰.

Women who were offered health communication by someone they knew and together with the presence of people familiar to them seemed to get to know more about a health promoting action⁸¹. From a midwife's perspective it is also necessary that the communication flows smoothly and creates a sense of security for the women⁸². It is important to note that the receiver is dependent on the sender's communications skills. If midwives and physicians receive training in communication skills they can improve their way of giving information.⁸³

Being a mother and father in a new country

This can be experienced as being most difficult as well as most rewarding. Immigrant women have priority needs in the area of reproductive health, but legal, cultural or language barriers mean that many have difficulties in accessing information and services⁵. Women who migrate to a new country can be confronted by a complex set of problems related to social deprivation and conflicting value systems. Many migrants come from traditional cultures and remain living in families that continue to prize and respect traditions, even though they might be expected to live and work in post-industrial settings that do not value these same traditions¹¹. A study in Australia showed that ethnicity of their husbands played a significant role in their motherhood role and in the ways they mothered their children. The immigrant woman thought that involvement of the man made him appreciate the tasks of motherhood as well as improving the connection between the father and the child which would have positive effects on the children when they grew up and maintained a close connection with the father⁸⁴. The immigrant man's cultural identity is being challenged by the host country. While employment can be the key to increased independence, the husbands may face downward mobility and find themselves in lower-skill jobs due to their immigrant status. For many men the meeting with the Swedish culture and the views of gender here has been traumatic. The roles have changed, and challenged the fathers' position⁸⁵. Their experiences of immigration are a result of the complex combination of the individual's socio-economic and cultural background in the country of origin versus their status in the new country. Immigrant women, on the contrary, have experiences that they have increased resources available in Sweden. These changes of perspective of power can probably give a better understanding of the conflicts that exist in immigrant fami-

lies instead of trying to explain them in the context of culture⁸⁶. When becoming a parent you tend to rely on your former experiences of family life. For many immigrant families this situation has changed both due to immigration, lack of social network and the influence of the new country.⁸⁷ Life can be totally different in the new country, but positive effects can also result from this. As one Somali woman stated, she and her husband has started to talk to each other since they now have no one else.⁷¹

Some men openly question the western gender equality, but they acknowledged that the move to the western orientated societies had made it possible for them to have an increased involvement in their children in many ways. From being used to live in cultures where motherhood is nurtured, valued and supported during this period in life immigrant women loose their family and friends, familiar practices of giving birth, traditional care providers and patterns of care.. These women can get socially isolated in their new country, within a, for them, alien health care system and separated from their native birth customs.^{88,89} As men gradually take more responsibility for the children and participate more in domestic duties they become more family oriented⁸⁷.

It is important to investigate foreign born women and their partner's experiences of the Swedish maternal health care and the involvement of the male partner in the maternal health care. Women from the Middle East were the largest group of women giving birth during the study period; as well as one of the largest immigrant-groups living in Malmö during the study period. Two explorative cross-cultural studies have been made using focus groups discussions and individual interviews in the respondent's native language together with interpreters. Antenatal care and parental education not only offer information and communication about the birth experiences, but focus also on partner support, empowerment of women to be involved in their own birth experience, to breast feed as well as giving information about the health care seeking practice in Sweden regarding pregnancy and birth.

Thus it is important to investigate patterns of health care utilisation among different groups as being foreign born has been shown itself earlier to be a barrier to health care. Little research has been done on antenatal care utilisation in the context of migration and targeting on the both planned an unplanned health seeking patterns. Being an immigrant puts the woman and her family in a more difficult situation since often she cannot handle the native language. This means that all contact with the health sector including gaining knowledge and understanding of the health care system, becomes more difficult. The utilisation of care in the native country might affect their health seeking behaviour in the new country. Although

immigrant women have the same rights to the Swedish MHC services as Swedish born women do, the present health care system administration may not suitable address the immigrant women's need for information regarding how to approach the system.

To examine acculturation in a family context opens up rich opportunities toward understanding the multidimensional nature of this construct. Acculturation affects not only the entire family, but also the marital and parent child subsystem as well as individual family members functions within the family.

AIMS

The overall aim of this thesis was to investigate differences due to country of birth and utilisation of antenatal care and the experiences of antenatal care, from the perspectives of both the parents to be.

The specific aims were,

To investigate differences in the use of maternal health care in a multi-ethnic population in Malmö, Sweden, over a four-year period.

To investigate characteristics of low-risk pregnant women's unplanned utilisation of maternal health care at the delivery ward.

To explore how men from the Middle East experience Swedish maternal health care, and their experience of being a father in Sweden

To explore how women from the Middle East experience Swedish maternal health care, and the involvement of the fathers to be in the maternal health care.

METHODS

Design

Epidemiological design and explorative qualitative research has been used in this thesis for the purpose of finding patterns of the utilisation of maternal health care as well as experiences from foreign born men and women concerning maternal health care in general, and maternal health care in the city of Malmö in particular. Qualitative research has been used to add depth and thereby attain a greater understanding in a social context⁹⁰ by using a non-positivist way of inquiry and content analysis⁹¹.

The first author of the four articles (PN) was the creator of the different aims for the the articles as well as the main aim of the thesis. PN was mainly responsible for the design of studies II, III. PN was responsible for the design of study I, IV together with the two advisers (A-KD, ED-K). PN performed all the interviews as well as all the statistical analysis, the latter under the supervision of statisticians and co-authors. PN has written the four manuscripts as well as the framework with helpful assistance from the tutors, co-authors and statisticians.

Table 1: Overview of studies (Study I-IV).

Study	Study I	Study II	Study III	Study IV
Participants	5373	16	13	5373
Gender	Women	Men	Women	Women
Design	Epidemiological design	Qualitative explorative design	Qualitative explorative design	Epidemiological design
Method of analysis	Logistic regression analysis, Chi 2-test for differences	Focus group discussions, individual interviews	Focus group discussions, individual interviews	Logistic regression analysis, Chi 2 test for differences, Linear-by-linear associations for trend, Kruskal Wallis and Mann-Witney U-test for comparisons between groups and goodness of fit of the model with Hosmer and Lemenshow test
Type of data Variables	Register Country of birth, age, parity, co-habiting status, use of interpreter and tobacco-use	Interviews	Interviews	Register Country of birth, age, parity, co-habiting status, use of interpreter and tobacco-use.
Outcome	Use of lower or higher antenatal care at municipal clinics	Experiences of maternal health care from the perspective of a father	Experiences of maternal health care, and the involvement of the father, from the perspective of a mother	Use of unplanned antenatal care at the delivery ward
Geographical covering	Five municipal clinics in Malmö, under the regime of the Women's health department at Malmö University hospital (UMAS)	The Region of Skåne	The Region of Skåne	Five municipal clinics in Malmö, under the regime of the Women's health department at Malmö University hospital (UMAS)

Setting

Malmö is a city located in the south western part of Sweden with 270 000 inhabitants, 26% of which are foreign born⁵⁹. The maternal health care is provided out in the community in six different Midwifery clinics (five during the study period) under the regime of the Department of Obstetric and Gynaecology at Malmö University Hospital. They offer planned antenatal care performed by midwives (to low-risk pregnant women). Women with pregnancy complications and those who need continuous care from obstetricians will be referred to the Specialist antenatal clinic, but will continue to visit their midwives at the municipal antenatal clinic. General Practitioners are not involved in care of the pregnant women in the Region of Skåne, but can be offered care in other settings in Sweden. Standardised charts are used for recording information during the perinatal and postnatal period. At Malmö University Hospital the delivery ward takes care of unplanned emergency consultations by both midwives and physicians for pregnant women, outside normal office hours. These consultations can be initiated by the woman herself. Every visit to a midwife at the municipal clinic in Malmö is calculated to take 30 minutes, the registration visits 1.5 hours and a visit to a physician 20 minutes.

The number of deliveries has increased over time at the Women's department at Malmö University hospital. In the beginning of the study period, year 2000-2004 (3261-3707 births) followed by 3837 (2005) and 4057 (2006).

The number of pregnant women per full time midwife in the Region of Skåne, in general, 2004, was 80.9-93.3 women, and has not changed since the year 2000⁵⁰. In 2005 the mean was 95.7 and the part of Skåne with the most pregnant women per fulltime midwife had increased to 117.2 women. The number of fulltime employed midwives in Skåne ranges within 17.4-38.2 in the five districts.⁹² None of the MHC clinics in the city of Malmö has other supportive staff to take care of appointment bookings answering the phone or taking care of women who drop in. It is up to each of the midwives to perform this between appointments, which involves waiting time for the visitor.

In Malmö, Sweden antenatal care is conducted in accordance with the Swedish national recommendations introduced in 1996¹ and are offered free of charge. Seven to nine visits are offered (including a visit in gestational week 41) and a visit 8-12 weeks postpartum for follow-up after the delivery and for information regarding use of contraceptives. Care is based on continuity of the midwifery care given during pregnancy. Every couple (with focus on women being pregnant for the first time) is offered parental education 3-4 times which aims at empowering women together with her partner to prepare for birth, breastfeeding and parent-

hood. Relaxation courses are offered at some municipal clinics. Special meetings are offered to teenage mothers/couples as well as parents of twins; most courses are performed in Swedish. One municipal clinic in Malmö city performs parental group education in Arabic. It is recommended that the first visit should take place between gestational weeks 8-12. One ultrasound scan is offered in gestational week 16-18, which is performed by a midwife. The purpose being to determine the expected delivery date as well as to detect any foetus malformations. In the Malmö an extra ultra sound scan is offered in gestational week 32 with the purpose of detecting a foetus that is small for its gestational age.

Data collection

Retrospective community based register study Study I, IV

This is a retrospective analysis of a computerised obstetric data set (KIKA - Journalen©), containing data regarding pregnancy and deliveries that took place at the Department of Obstetrics and Gynaecology at Malmö University Hospital. Information about pregnancy and the utilisation of care during pregnancy is based on midwives' and physicians' documentation during pregnancy and delivery. The patient records in the database consist to a large extent of well-defined input variables and are validated repeatedly by a quality audit.

Additional strengths are the totality of the obstetric population whereby almost 100% of the low-risk women who participated in the antenatal care during the study period were included insofar as the documentation by midwives and physicians is made 'online' and repeatedly validated by a quality audit. Before use, all data was de-personified.

The quality of the data is controlled in four different ways. Registration of data is an interactive process, where tools have been developed for "on-line" quality control of the data itself and decision support, as a means of eliminating as many possible pitfalls as possible during data entry. For instance, the system questions your data input if you register a birth weight of more than 6.000 g. Apart from the electronic database, a ledger is kept with a few variables from every delivery, and a monthly check is made to ensure that the database and the ledger contains the same data. A comprehensive data set is exported yearly to a regional database in southern Sweden; Perinatal Revision South, where tools are used to confirm the reasonability of the data received. Lastly, on a local level the database is continuously monitored, both regarding data quality and lack of data. When evaluating

data from the years of this study, it could be noted that 81 newborn babies lacked a proper diagnosis, which was the variable monitored that had the highest lack of data. No mothers lacked delivery diagnoses and no babies lacked information of gender or birth weight. A retrospective study makes use of historical data to determine exposure. The amount of data can often be quite extensive for a low cost⁹³. Sweden has an international reputation concerning the good quality of the different medical registers that are available for research in Sweden. The prerequisite for full coverage registers the unique personal number system that exists in Sweden which makes it possible to follow individuals over a long period of time. Today the registers available in Sweden are the base for information and knowledge to describe the prevalence of illness and risk factors for serious illness and for early death. The advantage of register based research is that it is a relatively cost effective way of doing research within a limited period of time compared to other forms of data gathering.⁹⁴

Focus group discussion, individual interviews and cross cultural research Studies II, III

Triangulation⁹⁵ with focus group discussions, individual interviews, interviews in the participants' native language and in Swedish, was used in this exploratory research. There was no requirement that the participants should be able to read or write either in Swedish or Arabic.

Focus group discussion is a method suitable for exploratory research^{96,97}. The goal is to discover new ideas and insights that can help people to explore and clarify their views⁹⁸. The number of participants, 2-4 per group-discussion was suitable due to the need for an interpreter and cross-cultural research⁹⁹. To follow up the focus group interviews with individual interviews gives the possibility to gain deeper insight into certain aspects of the chosen topics^{100,101}. The interviews in the focus groups were audio taped and transcribed verbatim into English from Arabic by the interpreter; the individual interviews were audio taped and transcribed verbatim into Swedish. Extensive notes were taken both during and after the interview to act as a reminder when reading the transcribed texts and also as a backup.

Each focus group discussion took two hours to 2.5 hours, and was conducted by the same moderator PN and same interpreter (a male interpreter for the men and a female for the women). The individual interviews took between 45 min- 1h 20 min and were conducted by PN using Swedish, all except one individual interview that was conducted in Arabic. The interviews were conducted during 2004-2006.

Cross-cultural research that crosses both cultural and language barriers needs special consideration and this study was performed with close contact to bilingual community workers and health staff from the Middle East in order to minimise both linguistic and cultural misunderstandings. Therefore the interpreter should translate as verbatim as possible⁹⁵ which requires time. By not excluding people who do not speak Swedish it gave a unique possibility to take part in their experiences, which can be different from those of Swedish speaking people due to their often different background¹⁰². This study concerned men and women who had immigrated. The reasons for their immigration were not investigated.

The interview guide concerning the fathers in the focus-group discussions focused on topics regarding the men's experience of maternal health care for pregnant women, their participation in the care, the communication between midwife and the father to be and around the situation of being a father in Sweden. The interview guide for the women explored areas regarding the women's experience of the MHC and the involvement of the father to be in MHC. The questions were developed by the research team and the two interpreters, both born in Iraq and are members of the Arab community, also by a health professional with a foreign born background working in a multiethnic city district and one of the researchers (PN) who earlier worked as a midwife in a multiethnic city district. The guide was tested¹⁰³ by PN in three interviews individually with Swedish speaking men and women from Iraq living in Sweden, and the topics were found culturally acceptable and relevant. Each topic was presented to the participants with a short introduction.

The individual interview guide was extended with more focused questions regarding advice given and the encounter with the midwife. All participants filled in a short questionnaire regarding demographic data before participating in the interviews and gave their written consent to participate in the study. Before the interviews, all participants were informed about the purpose of the study and that their participation was voluntary.

Participants

Study I, IV:

During the study period 2000-01-01—2003-12-31 (4 years) 14011 deliveries took place at the Women's department at the Malmö University hospital. Women who suffered foetal death (n=91) and had twin pregnancies (n=406) were excluded from

the population, as well as 6342 women who were not registered at the municipal clinics in Malmö (but might have had antenatal care elsewhere in the Region of Skåne or had private antenatal care). This gave a total of 7142 singleton primiparous and multiparous women who utilised the antenatal care services at five (later six during year 2006) different municipal clinics under the supervision of the Malmö University hospital. These women were registered at the KIKA-Journalen © from their first registration visit at any of the municipal clinics in Malmö. Among these, 44% were foreign born. The mean age was 28.6 years. In order to obtain a low-risk categorisation of pregnant women, women with pre-term birth (n=281), post-term birth (n=404), women registered at the specialist antenatal clinic (n=1084) were excluded and a further 30 individuals were excluded from the calculations due to inadequate registration. This formed a final study population of 5373 low-risk singleton pregnant women. Swedish-born women were used as a reference group due to their large number as well as their assumed familiarity with the antenatal programme in studies I, IV.

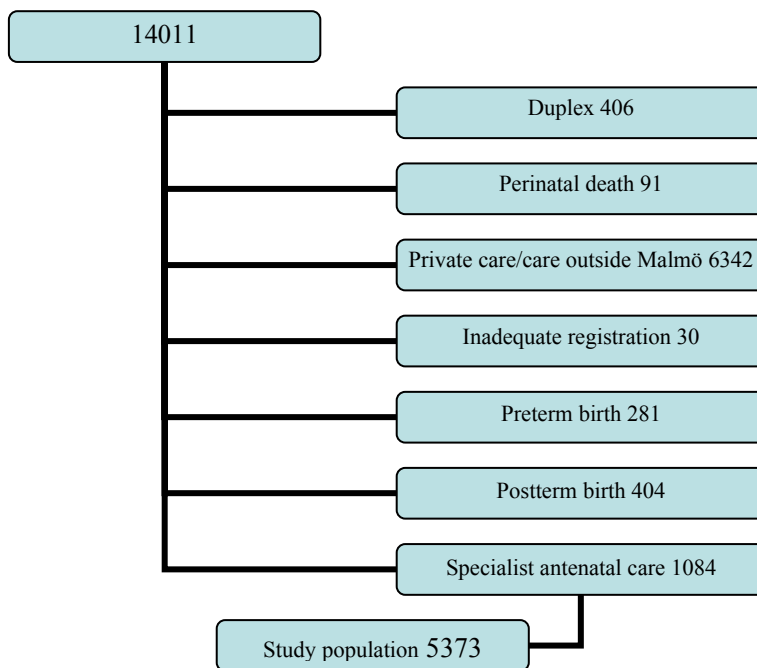


Figure 1: Study population.

Study II:

Women from Iraq and Lebanon were the largest group who gave birth during the study period 2000-2003 therefore men and women from the Middle East were included in the interview studies. A total of sixteen men were interviewed and twenty five were asked to participate in this study according to the inclusion criteria. The reasons for not wanting to participate were other priorities. The inclusion criteria were men originating from the Middle East with Arabic as their mother tongue, living together with a partner who had participated in the Swedish maternal health care and also originating from the Middle East with Arabic as the mother tongue. Ten men accepted to participate in three focus group discussions using Arabic, and six other men accepted being individually interviewed using Swedish after being purposefully sampled by a member of the Arabic speaking community and a teacher at a school for immigrants. The men were asked to participate by their teacher. Previously the whole class had been introduced to one of the researchers who explained the purpose of the study. Thereafter a time schedule was proposed and those who were interested attended an interview.

The first (A) and the last group (C) consisted of men who had lived in Sweden for more than 5 years while the second group (B) had only lived in Sweden for 1-3 years. The participants in the individual interviews had lived in Sweden between 10-15 years. Their children's ages varied from 2-28 years among those attending individual interviews and from 3 weeks till 17 years for those attending the focus groups. Participants with younger children also had grownup children living at home. Two of the wives were currently pregnant. Three men had a university degree and seven men were unemployed. Two of the wives were working outside the home (interview B and 6).

Study III:

A total of 25 women were invited and 13 agreed to participate. The inclusion criteria were immigrant women born in the Middle East having Arabic as their mother tongue, had participated in the MHC in Sweden and were living or had lived together with a male partner from the Middle East. The women were a heterogeneous group of immigrant women from Turkey, Syria, Iraq and Lebanon. Eight women accepted to participate in three different focus group discussions in Arabic, and five other women accepted being individually interviewed (one with an Arabic interpreter) in Swedish after being asked by a member of the local Arabic speaking community, or by a midwife at an antenatal clinic in a multiethnic area or by a teacher working at a school for immigrants. The women at the antenatal clinic

were asked by the midwife, after conducting the postpartum check-up if they were interested in participating in this study. If the woman said yes, she gave her permission to the midwife to pass on her phone number to one of the researchers (PN). The researcher called the woman and, using a female interpreter, she explained the purpose of the study and asked if the woman was interested in participating. If the woman could converse in Swedish she was asked to participate in an individual interview. One week later the woman received a letter of invitation written either in Swedish or Arabic containing the purpose of the study, the practical arrangements regarding time and place of the interview and their right to decline participation at any time. None of the interviewed women were in any way dependent on personal care from the midwife. Two of the women chose to be interviewed in their home. The women who were asked by their teacher, following the whole class having been informed, were introduced to one of the researchers who explained the purpose of the study. Later a time schedule was proposed and those interested attended an interview with the researcher.

The reasons for their immigration were not investigated. The age of the women varied from 23 to 41 years of age and they had children ranging from 2.5 month up to 21 years of age. The length of time since they had participated in the Swedish MHC was 3 month to 8 years. Some women with younger children also had older children and the number of children per women was 1-6. Two of the women had given birth both in their native country and in Sweden. The rest had participated in the Swedish MHC and given birth in Sweden. Their length of domicile in Sweden ranged from 4 to 19 years. Their level of education was between six years of elementary school and up till university level. One woman was working professionally in Sweden. About half of the total group were living on social welfare, two women were divorced and eleven were married and living with a partner originating from the same area as themselves. Their ability to communicate in Swedish varied considerably.

Focus group (A) and (B) were a mixture of women who had lived in Sweden for 5 to 13 years, while the last group (C) consisted of women who had lived in Sweden for more than 18 years. Women who were currently pregnant were represented in all three groups and all the women had participated in the Swedish MHC.

Definitions and variable description

Low-risk pregnancies

In studies I, IV the concept low-risk singleton pregnant women has been introduced for the purpose of studying care utilisation during pregnancy, before birth. The classification of a low-risk population might not have excluded all patients with the need of extra care, but those of need of regular extra care. The final study population comprised of 5373 low-risk singleton pregnant women. Pre-term birth is defined as birth before 37 weeks of gestation, and post-term is defined as birth after 42 weeks of gestation. Both Drooger et al¹⁰⁴, Ibison¹⁰⁵ as well as Sikroski et al⁵⁴ excludes women giving birth pre-term. Women registered at the Specialist antenatal clinic in Malmö represent those who might suffer from a chronic disease (such as hypertension, Diabetes Mellitus, heart or renal disease, HIV) before pregnancy as well as diseases/events developing during the pregnancy as for example hypertension, preclampsia, Gestational Diabetes Mellitus and Intra Uterine Growth Retardation (<22%) detected in gestational week 32. This can be compared to case where the diagnosis has been excluded in both Cleary R et al¹⁰⁶, Drooger et al¹⁰⁴, Ibison¹⁰⁵ and Sikorski et al⁵⁴. The reason for excluding post-term women is based on the National recommendations for the standard low-risk pregnant woman in Sweden which recommends the last antenatal visit at the municipal clinic to be in gestational week 41¹. Thereafter she is cared for at the delivery unit at hospital level, with follow up visits after g.w 42+0. Excluding duplex from the standard population is also performed in several studies^{54,105,107}. The standard primiparous woman is a subset of the obstetric population that has relatively low risk or low interventions and of adverse outcome. By having this standard population it is easier to make comparisons between different studies more reliable¹⁰⁶.

Country of birth

Studies I, IV included background factors as a self-classified country of birth which is confirmed at the first registration visit at the municipal clinic and entered into the database using well defined input variables following classification according to the of the National Board of Health and Welfare.¹⁰⁸ In the current two community based register studies six country groups, were defined, with Sweden as the reference group. Iraq and Lebanon are extracted from the Asian group due to the large number of women coming from these two countries being present during the study period.

The country groups were divided as follows^{108,109}: Western Countries/Westernised countries including *Northern Europe* (Norway, Denmark, Estonia, Finland, Ireland, Iceland, Lithuania, Great Britain and Latvia), *Western Europe* (France, Netherlands, Germany), North America (USA) and Australia. Eastern- and Southern Europe (Bulgaria, Poland, Rumania, Russia, Czech republic, Ukraine, Hungary, Belarus, Slovakia; Albania, Bosnia-Herzegovina, Greece, Yugoslavia, Croatia, Macedonia, Portugal, Slovenia, Spain, Italy and Kosovo) Africa including *Northern Africa* (Libya, Algeria, Egypt, Morocco, and Tunisia), *Western Africa* (Ivory coast, Eritrea, Ethiopia, The Gambia, Ghana, Liberia and Nigeria), *Eastern Africa* (Kenya, Somalia, The Sudan, Tanzania and Uganda), *Central Africa* (Congo), Iraq and Lebanon, Asia including *Western Asia* (United Arab Emirates, Georgian, Israel, Jordan, Saudi-Arabia, Syria, Turkey, Yemen and Kuwait), *Eastern Asia* (China, Japan and Taiwan) *Southern Central Asia* (Afghanistan, Bangladesh, India, Iran, Pakistan, Sri Lanka and Uzbekistan), and *Southeast Asia* (The Philippines, Indonesia, Cambodia, Malaysia, Thailand and Vietnam), *Western Asia* (Azerbaijan) and South America and Central America (Bolivia, Brazil, Chile, Colombia, Peru, Uruguay; El Salvador, Mexico and Guatemala).

Western Countries/Westernised countries including *Northern Europe* and *Western Europe*, North America (USA) and Australia were included into one group due to their somewhat similar attitude toward preventive care, with respect to the subgroups suggested by the Swedish Board of Health and Welfare and the UN. There were few Women from the Baltic States in the data material.

In study II & III men and women born in the Middle East with Arabic as their mother tongue were included also men and women from: Iraq, Lebanon, Turkey, Syria, and Jordan were represented.

Background factors

Maternal age was divided up as <25, 25-30,>30, parity as primiparous or multiparous, *cohabitation status as Cohabiting or Single at first registration visit*, *Use of interpreter as No or Yes at the first registration visit and the Use of tobacco was No or Yes, or Non-user or User.*

Planned care

The National recommendations in Sweden as well as local praxis at Malmö university hospital offer low-risk pregnant women 7-9 planned visits to a midwife at a municipal clinic in the woman's neighbourhood and a post partum visit 8-12 week

after the delivery. The first visit is suggested to take place in g.w 8-12 and the last planned visit, at g.w 41+. Thereafter the delivery ward takes over the responsibility for the care. The first visit is based on the last menstrual period estimated from the first day of the last normal menstrual period or an ultrasound examination performed in gestational week 16-18. Ultrasound visits only, are not included in this study. A planned visit to a midwife at MHC is defined as a planned visit for checking pregnancy related health concerns, takes place during working hours and on working days. Planned visits to a midwife at an antenatal clinic were divided into <7, 7-9, >9 and as 1-3, 4-6, 7-9, >9. The first visit to an antenatal clinic was divided into 12 g.w, 12-15 g.w and >15 gestational weeks. Planned visits to a physician at an antenatal clinic were registered as No or Yes and as 1-2, 3-4, 5-9.

Several regions in Sweden, as well as Skåne have adopted the recommendation that low-risk pregnant women do not have a scheduled visit to a physician during pregnancy¹¹⁰. Figure 2 describes the care utilisation in the study population below according to the definitions.

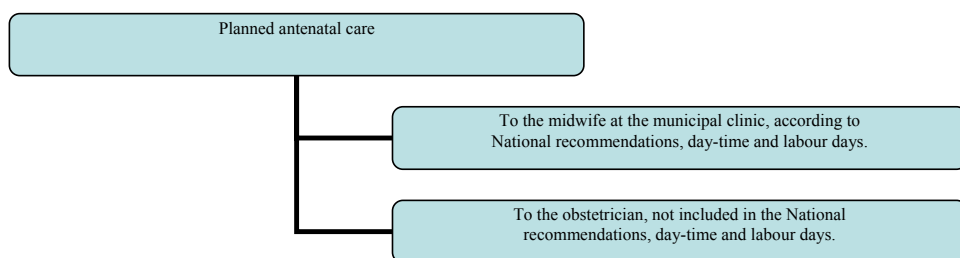


Figure 2: Planned antenatal care.

Unplanned care

The midwife in Sweden has the independent responsibility to care for women in the normal process of pregnancy, birth and the time post partum⁴⁹. Unplanned care is defined as care, by a midwife or obstetrician voluntarily requested by the women, and takes place at the delivery ward and is available for women before giving birth between g.w 37+0--42+0, according to the exclusion criteria. In Study IV the outcome that was of interest was the unplanned visits for antenatal care during pregnancy, either to a midwife or physician at the delivery ward vs. any other care. The delivery ward is open round the clock, every day all year round

(Figure 3). All women seeking unplanned care at the delivery ward will be assessed initially by a midwife. If she considers it necessary, according to local guidelines, for the woman to meet an obstetrician, the visit will only be recorded as an unplanned visit to an obstetrician. Those women that according to local guidelines are handled only by midwives are recorded as an unplanned visit to a midwife. Women being cared for by a midwife due to an unplanned visit are mainly women seeking care due to contractions before the planned visit in relation to the delivery. Women are encouraged by the midwife at their first registration visit at the MHC to seek unplanned care at the delivery ward between g.w 22+0 – 42+0 (in this study population g.w 37+0 – 42+0) if they are bleeding, notice decreased movement of their foetus or if the birth water is released. This is in accordance with local guidelines.

Care could be initiated by the woman herself and she will then attend the delivery clinic without an appointment. The visit could be initiated by the midwife at the MHC, but those women being referred by the midwife only include emergency visits and are recorded as an unplanned visit, in this study. (Women in need of specialist antenatal care are referred to the Specialist antenatal clinic and are not included in this study population.)

The number of unplanned visits to a physician was registered as 0 and 1-9, or Yes or No and 1-2, 3-4, 5-9. Unplanned visits to a midwife at the delivery ward were registered as No or Yes and 1-10, or 0, 1-2, 3-4 or 5-10. The Post partum visit was registered as Yes or No.

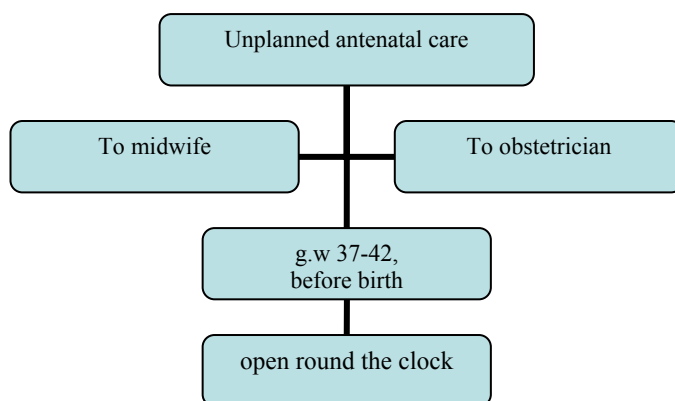


Figure 3: Unplanned antenatal care.

Lower- and higher utilisation of MHC

In study I the utilisation of antenatal care was calculated as odds of lower versus higher utilisation of antenatal care vs. any other utilisation of care. Lower utilisation of antenatal care is defined as: less than 7 planned visits to the midwife and/or a late planned first visit to the midwife (>15+0 gestational weeks). The definition of few visits is supported by the national recommendations¹ and a late first visit after 15 g.w is also used by others^{9,29,41}. None of the women who gave birth during the study period had less than 1 antenatal visit before birth. Higher utilisation (Study I) of antenatal care is defined as: more than one unplanned visits to a midwife or a physician at the delivery ward before birth and/or any planned visits to physician at the antenatal clinic.

Mode of delivery

Mode of delivery was divided as Normal vaginal delivery, Instrumental vaginal delivery, Emergency caesarean section, and Elective caesarean section. A normal vaginal delivery includes a non interfered vaginal delivery, not induced, but could be supported by external pressure on the uterus, episiotomy and the use of Oxytocin as a stimulator of uterine contractility, ICD-code O80- O80.9¹¹¹. An instrumental vaginal delivery is a vaginal delivery assisted by vacuum extraction or forceps and could be supported by external pressure on the uterus, episiotomy and the use of Oxytocin as a stimulator of uterine contractility, ICD-code O81-O814.X¹¹¹.

Analysis

Statistical analysis

Study I & IV:

For categorical variables the Pearson chi-square test, and when applicable, Fischer's Exact Test were used to analyse the differences between Swedish born women and women born elsewhere, regarding background variables and utilisation of antenatal care. To avoid the risk of mass-significance regarding multiple comparisons, a Bonferroni correction was used implying that differences with a p-value $\leq .008$ were regarded as significant. For continuous variables, Chi-square for trend was calculated in order to investigate linear relationships between planned and unplanned visits to a midwife. For comparisons between groups regarding variables not judged as normally distributed the Kruskal-Wallis and Mann-Whitney tests were used. Each country of birth was individually analysed using the Swedish group as the reference group. Calculation of crude/bivariate odds ratios and 95% confidence interval (OR; 95% CI) were used to analyse the association between country of birth and lower- and higher utilisation of care, and country of birth and unplanned care, according to recommendations for antenatal care in Sweden. Multiple logistic regression analysis was performed in order to investigate the potential influence of possible confounders such as age, parity, cohabiting status, use of translator and tobacco-use. Interaction between age and parity was calculated. The goodness-of fit the final model was tested using the Hosmer and Lemeshow test. All analyses were performed by using SPSS for Windows 12.0. The co-authors making the analysis each came from different disciplines.

Content analysis

Study II & III:

Content analysis is a suitable method for cross linguistic studies⁹⁷ and is used to determine what is significant⁹⁵. The text was analysed according to the content analysis method by Burnard¹¹² and divided into codes, subcategories and categories. Key illustrative verbatim narratives reflecting the different sub categories are presented, both as individual quotes and as dialogues. First the texts were read through several times individually by the authors to provide a sense of the whole and to achieve an understanding of the different themes in the text. Thereafter, during the analysis, meaning units referring to the same content were divided, into the same codes and into subcategories. The result of the content analysis was discussed with the translator with the purpose of excluding misinterpretations of the

content due to the cross-cultural and cross-linguistic context. In order to ensure consistency in the translation, parts of the audiotape were translated from Arabic into Swedish by two independent translators^{113,114} from the Middle East with Arabic as their native language but who themselves were not involved in the study.

In Studies II, III the authors took their pre-understanding (midwifery, specialisation both in delivery care and antenatal care, and sociology) and the study purpose into consideration, discussed the findings and agreed on the four main categories of the text. Reflection is best carried out in interaction with others and by being open to our own bias we can be more open to our findings¹¹⁵. The authors involved in the analysis of studies II & III had different lengths of work experience as well as different specialisations in midwifery. One of the midwives is also an Ass. Prof. (A-KD) and involved in research at the university. The sociologist (LP) came from a different research field also with a long experience of working as a social worker at a Youth surgery as well as being a lecturer at the university.

Ethical considerations

For conducting the two community based register studies (Study I, IV) an ethical approval has been given by the Regional Ethical Review Board in Lund at Lund University No: LU 348-03. The two interview studies (study II, III) regarding experiences of the maternal health care in Malmö, Sweden has been deemed to fall under the new Swedish legislation regarding non invasive studies considered not to be of harm to the participants. From the 1st January 2004 the new law (2003:460) regarding ethical review permits for research with reference to humans applies¹¹⁶.

None of the women or the men involved in Studies II or III were in any way dependent on the midwifery organisation regarding the current or earlier pregnancies. The researcher conducting the interviews (PN) was not currently working at the maternal health care centre in question.

Informed consent was made possible by using an invitation letter written in Arabic that was sent to all participants in advance stating the purpose of the study and that participation was voluntary¹¹⁷. On arrival at the focus group discussion or individual interview the purpose of the study was once again explained, that participating was voluntary and that the material would be handled according to the legislation governing the use of research material; thereby taking into consideration those who were not able to read Arabic. Before beginning the interview all the participants completed a short questionnaire, in Arabic, with the help of an interpreter, covering any background factors of interest for the study.

RESULT

The results from each individual paper have been organised into the text below with the following order, Studies I, IV and Studies II, III. The descriptions contain the main results whereas further detailed information may be found in the individual papers.

Studies I, IV

The first retrospective study discovered the pattern of utilisation of antenatal care both lower and higher, in a multiethnic setting in Sweden. The results reveal a differential pattern of antenatal care utilisation in this low-risk population where nearly 90% of all women had vaginal deliveries and just about all children had an Apgar score at 5' of more than 7 (99.3%). There were significantly increased odds for lower utilisation of planned antenatal care among some groups of foreign born women (Study I). Women born in Eastern and Southern Europe, Iraq and Lebanon and Asia had fewer numbers of visits than recommended and most foreign born women (except for women born in Iraq and Lebanon and South and Central America) had a late first visit compared to Swedish born women.

The second study (Study IV) focused on women using unplanned antenatal care at the delivery ward. A large proportion of low-risk pregnant women made unplanned antenatal visits to the delivery ward. There was a linear association between few planned (1-3) visits to the municipal clinics and more unplanned visits (5-10) to a midwife at the delivery ward for women born in Eastern & Southern Europe and women born in Sweden. Women who adhered to the recommendations had the least number of unplanned visits at the delivery ward. In Study IV a significant association was seen regarding the fact that more women had a non-normal delivery outcome related to unplanned visits to either a midwife or physi-

cian ($p < .001$) compared to those making no unplanned visits. Predictors of excessive care seem to be younger age, multiparous status and country of birth.

Backgrounds factors

The study populations in Studies I, IV included 5373 women, both primiparous (51.7%) and multiparous (48.3%), with singleton pregnancies, of which 45.4% were foreign born and the mean age was 28.4 years. Women from Eastern and Southern Europe, Iraq and Lebanon and Asia comprised of a higher proportion of women who gave birth before the age of 25 years compared to Swedish born women. A significant difference was found in the distribution of parity among women born in Sweden and women born in Eastern and Southern Europe, Africa, Iraq and Lebanon and Asia.

Nearly one fourth (23.4%) of the women born in Africa stated that they were not cohabiting. Almost two thirds of the women from Iraq and Lebanon required the use of an interpreter at their first registration visit. Women born in Eastern and Southern Europe smoked to a greater extent, but not significantly when attending their first antenatal visit and only Swedish born women used moist snuff. Women born in Western countries/Westernised countries, Africa, Iraq and Lebanon and Asia smoked significantly less than Swedish born women.

Care utilisation

No more than 403 women (7.5%) in this low-risk population ($n=5373$) used planned antenatal care solely in accordance with the Swedish national recommendations (7-9 planned visits); of those 99.4% ($n=400$) women had a normal vaginal delivery. The mean number of planned visits varied: visits to a midwife at the antenatal clinic 8.3 (range 1-28) and visits to a physician at an antenatal clinic 1.7 (range 1-10). Significantly fewer women from Eastern and Southern Europe, Africa, Iraq and Lebanon made post partum visits, compared to Swedish born women.

All foreign born women, except for women born in Western/Westernised countries, and South and Central America, had significantly increased odds for lesser use of antenatal care than recommended (<7 visits). In the main effect model, adjusted for age, parity, cohabiting status, use of interpreter and tobacco-use, the odds ratio decreased and remained statistically significant for women born in Eastern and Southern Europe, and Iraq and Lebanon and Asia.

In the crude analysis the odds for having care later than recommended (>15 gestational weeks) were significantly increased for all foreign born women except for women originating from South and Central America, compared to Swedish born women. In the main effect model, when potential confounding factors were added to the analysis, the odds for late first visits remained statistically significant for all foreign born women, except for women born in Iraq and Lebanon and South and Central America.

Unplanned care

In the study population approximately, 30% of the pregnant women had an unplanned visit to the delivery ward to a midwife and 50% to a physician. The unplanned care visit to a midwife ranged from 1-10 visits (mean 1.5) and to the physician 1-9 visits (mean 1.8). Women born in Sweden, and Eastern and Southern Europe had a significant trend ($p \leq 0.008$) towards fewer planned visits to a midwife at the municipal clinic (1-3) and more unplanned visits (5-10) to a midwife at the delivery ward. Among these, significantly more women born in Southern and Eastern Europe were younger than 25 years old. Women from Africa, Iraq and Lebanon and Asia were more often multiparous, compared to Swedish born women ($p \leq 0.008$).

During the study period there were a total of 6906 unplanned antenatal visits to the different care services, range 0-12 visits per women with a median of 1 and mean of 1.28.

Nearly fifty percent ($n=2500$) of the women utilised unplanned visits to a physician at the delivery ward. Among these, significantly more women born in Eastern and Southern Europe and Iraq and Lebanon were younger than 25 years old. Women from Africa, Iraq and Lebanon and Asia were to a greater extent multiparous compared to Swedish-born women. There were more single women in the African group. Asian-born women made fewer unplanned visits (3-4, 5-9) to a physician at the delivery ward compared to Swedish-born women ($p \leq 0.008$).

Reasons for seeking unplanned care

In the current study population women consulted the delivery ward unplanned and 1362 women were classified as having uterine contractions ICD-code O479. Of those, 53 were considered being in need of some kind of action before leaving the delivery ward. Other classifications for women visiting the delivery ward and the midwife unplanned were 'Protein detected in urea, $\geq 3\text{g}/24\text{h}$ ' ($n=24$), and 'other un-

specific complication' (n=22. Among the most common registrations following visits to the obstetrician were for example, 'Anemia', <100g/L (n=291), 'abdominal pain' (n=259) and 'bleeding' (n=177). (All ICD-codes are from the Swedish version of the International Statistical Classification of diseases and related health problems, ICD- ten).

New data not shown elsewhere showed, taken from a three month period at the delivery ward in Malmö at the University hospital in 2005 (2005-06-01--2005-09-01) the four most common reasons and timing for women seeking unplanned care at the delivery ward during any 24 hours were (women who also gave birth were included in this data):

- Related to "uterine contractions", 191 women, between 08:00 and 16:00 and a further 475 women between 16:01 and 07:59.
- Related to the "suspicion that the membrane had ruptured", 64 women between 8:00 and 16:00 and a further 112 women between 16:01 and 07:59.
- Related to "decreased movement of the foetus", 55 women between 08:00 and 16:00 and a further 30 women between 16:01 and 07:59.
- Related to "bleeding", 18 women between 08:00 and 16:00 and a further 29 women between 16:01 and 07:59.

Delivery outcome

There were significantly more women who had a non-normal delivery outcome related to unplanned visits to either a midwife or a physician ($p<.001$) compared to those making no unplanned visits. Women from Iraq and Lebanon differed from Swedish-born women in that they had significantly more normal vaginal deliveries. Women from Western/Westernised countries and from South and Central America had 10% and 9.6% emergency caesarean section, respectively. Almost all women gave birth to children who had 7-10 Apgar points at 5' (99.3%).

Studies II, III

The men and women in these studies described their experiences about taking part in the Swedish maternal health care using their native language as well as Swedish. They were all asked the same introductory question. "*What are your experiences of taking part in the Swedish maternal health care*". The approach was inductive with the purpose of letting the participants express themselves freely in relation to

the purposes of the studies. The questions only served as a guide or a help if the discussions/conversation faltered

Maternal health care

The main result of Study III was that immigrant woman could develop trust in the midwife working within the maternal health care services, based on the midwife's knowledge, empathy and her way of imparting it. It was not vital for the midwife to know the woman's native language or her culture. This interesting finding requires further research. The women also gave their views regarding the content of the Swedish recommendations of care for pregnant women. The need for more visits in the first trimester seemed to be important, not only for the individual woman but also in an attempt to avoid spontaneous visits to the delivery ward. Women expressed a need for someone knowledgeable to talk to in this tumultuous period in life, since she lacked the female network she had in her native country. Both men and women had experiences of their encounter with a midwife. According to the men, health information from the staff, and that the staff took time to answer questions based on the individual woman's needs, seemed to be important for them. This is the period in the pregnancy when many women suffer from different pregnancy related health hazards. Often, at the same time there is a great change going on both physically and, therefore there is a need for communication with the midwife. If this need is not satisfied some women said they might feel the need to seek care elsewhere. Several of the men stated that 'too much' information and information regarding risk could lead to anxiety.

Women declared that information, advice and the possibility to discuss their own health situation and the status of their unborn child was of the greatest importance. At the MHC, when meeting their midwife, they received advice concerning those health hazards that are common during pregnancy such as constipation, sickness, tiredness, backache and how to help their situation. One woman stated that the midwife both gave advice and listened, but then it was up oneself to make the decision what to do.

To be informed in a group was considered positive among all of the women, but not all needed information since they had friends and family with whom they could talk. Also the women's opinions about the participation of the men differed. Some women thought that the woman would be inhibited. If their male partner was present, they could not talk about breastfeeding, how to position the baby at the breast or other more intimate matters. On the other hand, other women said that these things were natural and nothing to be ashamed of.

Among the men, talking about risks threatens their desire for “keeping it natural”. Not all of them had participated in the parental education that was offered to them but all had opinions about it. To receive information in groups was considered by most men to be positive, but could also be experienced as frightening by the men if other participants discussed bad experiences. All of the men stated that the knowledge of Swedish is of great importance when taking part in group education, since most of the education is offered in Swedish. One solution, suggested by the men, could be to have different groups in different languages or use an interpreter which would make it possible for the participants not only to understand, but also to take an active part in the discussions.

If the staff is knowledgeable and well-informed regarding the health of the pregnant and the child it could lead to a sense of security for the fathers. The men made comparisons from their experiences from their native countries where they discussed the lack of control often found in the health care services in their home country. To take part in the care of the delivering woman, seeing that she and the small child were met with kindness and that there were medical resources available, increased the men’s feeling of respect and understanding for her in her situation. The fathers said that it is important that there were such recourses both empathy and medical technology. Meanwhile the pregnant woman felt the midwife to be trustworthy as she had the knowledge and education required. The same feeling was expressed regarding the different physicians that the women had met. The difference in getting advice from your mother or a friend compared with a midwife is that your mother has only experience, but a midwife has both experience and education. Being met with kindness by someone who shows an interest in your situation was regarded as most important and was also expressed by all of the women. Some of the women remarked on the kind approach of the staff in relation to her questions as well as the individualised care. She could see that they also care about the small details which had not been her experience in her native country.

The men’s involvement

Several men responded by saying that participating in the pregnancy and delivery opened up a new world for them. They followed their women to both the midwife and often acted as interpreter. In a way it restrained the women since they became more dependent on their husbands, even more so than when in their native country. In their country of origin it was the female network with the mother in law in charge that helped and took care of the pregnant and delivering woman. All women expressed being positive to their man being invited to partake in their care

and maybe this could make them more involved in the practicalities surrounding the care of the small children. Not all men managed to do this and this left the women in a vulnerable situation having also to manage the household, the care of the children and trying to find employment in Sweden.

The men were very positive towards being invited to take part in the care concerning the pregnant woman and how to make her situation better during her pregnancy, how to care for small children and to be able to take part in the delivery. They considered this an important event in their lives.

The involvement of the father to be, in maternal health care was expressed as supportive; in the results from both Study II and III. The women expressed that the involvement of the father to be, in antenatal care, the delivery process and the care of the small children could have positive effects also for the man himself. By getting involved early in the process helped him to get a closer contact with his children once they were born. The fathers themselves expressed their role during pregnancy and birth as being a support to the women, taking care of them and helping them with practicalities such as translations. At the same time many of them also encouraged the women to be independent and manage the contacts with the health care system by themselves "*you have to be strong to be independent*".

Due to migration the relationship within the family had altered. The experience of motherhood remained stable, but there was a great need for involvement and support by the father in the perinatal period, such as caring for older children and with household chores since the mother's earlier female network was often lost. It has also offered, from the men's perspective, knowledge about immigrants views of fatherhood in Sweden and how different social structural problems such as unemployment, bad economy, the inability to speak Swedish and the upbringing of children who are in-between two different cultures, affect them. The men emphasised factors affecting them in their ability to handle their view of themselves as men which in turn affects how they behave as fathers and partners. According to the women, not all men managed to give support which often placed the woman in a stressful situation after the birth.

All the women except one described in a positive way, the presence of their husbands both at the MHC and during the delivery. Most of the men had been supportive to their wives. Some of them had been actively involved in the conversation with the midwife, but some had stated that they were there as support only because it concerned the woman's body. Being able to seek and utilise the MHC services by herself made the woman feel less dependent on her husband.

But not all men joined the women and their children to MCH. The reasons for not doing so could be that the woman preferred a female friend. One man in a

group did not want to join his wife at the delivery since she was also accompanied by a female relative or friend and according to the man this was something that they had agreed upon.

According to the women, their own mother is an important person for them. Due to the restrictive legislation regarding entry permits into Sweden on the grounds of family ties, not all the women's mothers living outside Sweden were allowed to visit their daughters during the perinatal period. A mother has both experience of pregnancy and childbirth and would normally be a support during her daughter's confinement. Many women noted that since coming to live in Sweden they had no available relatives or family except for their husband, which made the raising of their children harder. Nearly all the women said that giving their husband the chance to take part in what was formerly considered to be a 'woman's world' gave him the possibility to see her efforts during delivery and also a chance for him to get an earlier and closer contact with his child.

Being parents in Sweden

For immigrants, life in Sweden was most often quite different compared to life in their native country. Some women expressed a wish to be able to continue taking the main responsibility for their household. Among those women who did not work, all of them expressed concern as to how they should be able to take care of their family and children and work professionally at the same time. They also stated that it is difficult, nearly impossible, to provide for a family on only one salary living in Sweden.

The women expressed that when living in Sweden there is a need for mutual understanding within the family concerning the division of labour, since most often the couples are living on their own without the larger family circle common in their countries of origin, they have to help one another. Some of the women could also see this new situation, without the involvement of the extended family, as being positive. Two fathers stated that it is difficult for them to find their role as a father in Sweden and that one doesn't feel the responsibility for being a father here, but it is important that you take that responsibility. The personality of the father and how society looks upon the role of the person effects how a person acts as a father, both in their native country and also in Sweden. The women, on the other hand, felt confident that that they as a mother are the best and most central person for their children. The mother is the one who takes care of all the practical things, but also the one to whom the children want to talk to about things that are important to them. Her role is to be responsible for the children's upbringing and their

progress in school. The reason for the importance of the mother was that she had more patience than the father and this commitment to her children was something that women are born with.

Being in transition caused several of the women to make comparisons between motherhood in their native country and in Sweden. According to the participants the ability to be a mother was something women had in them: and it remains stable. In the move to a new country the external conditions could be different, such as the division of labour within the family as well as different housing conditions, but not the motherhood in itself.

Several of the men stated that being employed makes it possible to take part in society. As a foreigner you have to learn the laws and language of the country you come to, but neither of these things are possible if you do not have a job. Being without employment makes a man feel isolated and that he is not pulling his weight. The social situation becomes different when the man was without a job since, as some of the men stated, in this situation the man has no status and the woman was as well off without him.

The men were questioned if the length of their residence in a country would affect their ability to integrate? It is rather based on the conditions one has, like the status of the area you live in, the school you go to and your own ambitions. Becoming integrated can be difficult because of structural social problems such as isolation within segregated areas, crowded housing and no possibility to get employment. This is what many immigrants suffer from, according to the men. Also being the sole provider for the family was also hard for the men both in their relationship with their wife and also with their children. It is difficult to be a good role model if you cannot show your children that you can take care of them economically. A better economic situation makes it possible to save money, buy things, go on vacation and have a better living standard.

DISCUSSION

Criticism of methods

Studies I, IV:

The target population, in these studies, consisted of singleton pregnant women participating in the municipal antenatal care in Malmö Sweden, who gave birth within gestational week 37-42, who were not registered at the Specialist antenatal clinic and gave birth to their children at the only existing delivery clinic at Malmö University Hospital. This was performed with the purpose of finding an obstetric population with no obvious reasons for utilising both planned antenatal more often than the national recommendations. Swedish-born women were used as a reference group due to their larger number as well as their assumed familiarity with the Swedish antenatal programme. The visits in relation to birth are not included.

During the study-period 6342 other women gave birth at the Malmö University Hospital, but these women had attended either private antenatal care or other municipal antenatal clinics outside the city of Malmö. There are good reasons to believe that almost all foreign born women living in Malmö have participated in the municipal antenatal care in Malmö as normally, women visiting private antenatal care are usually Swedish born, 97%.¹¹⁸ Therefore, if a selection bias was in operation, this would promote an underestimation of the relationship between country of birth and the lower utilisation of antenatal care.

In order to study a group of low-risk pregnant women, women categorised as high-risk were excluded which is similar to other studies; 75% of the women registered for antenatal care in Malmö during the study period were included in the low-risk categorisation. Nationally, during 2004, 75% of women registered for antenatal care were considered low-risk⁵⁰. This could have created a selection bias if the wrong cut-off points were chosen, either too many or too few or the wrong type of women would then be included. The women in the low-risk group had significantly more vaginal deliveries ($p < .001$) and 99.3% delivered a baby with 5'

Apgar score between 7-10 p. Women who have not delivered until gestational week 42+0 are offered regular visits at the delivery clinic until birth according to local praxis. Women registered at the Specialist antenatal clinic also have a valid reason for visits over the recommended number possibly due to some illness. The classifying of a low-risk population by excluding women in need of specialist antenatal care might not have excluded all patients with the need of extra care, but at least those in need of regular extra care. There is a hypothesis that women giving birth pre-term might have had conditions which might have affected them in their utilisation of care.

Women in need of obstetric care during nights and weekends are forced to seek unplanned antenatal care directly at the delivery ward; thereby a misclassification might be possible for the group; as well as unplanned care seeking due to the inability to determine the timing of the visit both in pregnancy and due to time. The municipal clinics do not have the services of secretaries; therefore the daily telephone hours are limited to 1-1.5 hour with the possibility to leave a message for the responsible midwife who will then phone back during the same day.

Although the variable 'country of birth' was classified according to specific guidelines and recommendations the grouping of the foreign born women into six different country groups, including various nationalities as well as ethnic/cultural groups, was heterogeneous. The reason for excluding women born in Iraq and Lebanon from the Asian group in Studies I, IV was due to the large number of pregnant women from these two countries. Alternative ways of classifying due to country of birth could be 'use of similar antenatal care systems'. We know for example that women living in countries in the former Eastern Europe were offered up till 30 visits per pregnancy in a medically risk oriented antenatal care system⁴⁴. All of the women self-classified their country of birth at the first registration visit to the antenatal clinic in early pregnancy and the responsible midwife recorded this on-line using a well-defined variable according to the same categorisation used in Studies I, IV. This might have limited the misclassification of the variable country of birth.

Age⁵⁰, parity^{119,120}, cohabiting status⁶, use of interpreter⁶ and tobacco-use¹²¹ might be confounders of the association between the country of birth and utilisation of lower and higher use of antenatal care. Other factors might have had greater effect in the logistic regression models and be of greater importance for women in their utilisation of care. These factors might be, a former miscarriage¹¹⁹, earlier intrauterine death¹¹⁹, length of time of living in Sweden, educational level in Sweden and in the former home country.

In the analysis in Studies I, IV, logistic regression analysis is used, interpreted as odds ratio. An odds ratio will always over estimate the results compared to relative risk (meaning a odds ratio smaller than 1 is always smaller than the relative risk and the opposite with odds ratios bigger than 1), but the qualitative judgments based on interpreting them as equal are unlikely to be seriously in error. In the result section this has been taken into consideration and the OR are mainly described as increased odds (above 1) or a decreased odds (below 1) and the interpretation is not described in percentage.

Studies II, III

“The goal is to gain maximal awareness and to recognise without being led” (p. 27)¹²². Trustworthiness is important for qualitative research and includes concepts such as stability and credibility, but the more main stream definitions such as validity and reliability can also be used¹²³. The authors have analysed the data separately in order to secure that the descriptive categories are in accordance with the interview material to secure reproducibility (inter coder reliability)¹²⁴. The text was read multiple times, to achieve stability^{125,126} and discussed by the researchers to strengthen the credibility^{100,125} which also reduced the risk of researcher bias and enhanced validity; the risk of the latter was also minimised by using triangulation - a combination of methods⁹⁵. In the analysis it is important illuminate patterns, but also the things that does not follow the patterns¹²⁷.

To enhance trustworthiness of the data it is important to hold interviews in the first language of the participants⁹⁹ and use the same interpreter throughout all of the interviews⁹⁷ as was done in all focus group and one individual interview. It is important to be very clear about the moderators position, that person is there as a researcher and the group must feel that they are allowed to say anything. In this context the researcher (PN) was, in one of the interviews, first regarded as the moderator, but when the discussion went on and subjects such as women’s role in society and in Sweden were discussed among the participants. The researcher was suddenly regarded as Swedish born women and the participants wanted her comments regarding her views on Swedish women’s position in the Swedish society. In this situation it is very important to keep a distance in order to get back to the study purpose.

One limitation was the non response by 12 women and nine men who due to personal reasons could not participate after accepting to be part of the study. The first author spent considerable time, together with the interpreter, finding women who were willing and had the time to participate. Similar difficulties are mentioned

by others¹²⁸ when doing research among other immigrant groups. This is a dilemma connected to the transferability of the result¹²⁹ and must be considered when translating the result; the views that will be expressed will be a sub-set of those that exist in the community.¹³⁰

The numbers of participants per group, 2-4 were found suitable depending on the explorative and cross-cultural character of the study and the use of an interpreter. This is also the experience of Twinn⁹⁹ who conducted a content analysis of transcripts in English translated from Chinese. By having small groups we eliminated the risk of frustration when the participants do not have enough time or a possibility to express themselves due to large groups. We followed the concept of 'higher involvement' where the participants were seen as the experts⁹⁸.

The credibility of the result increased due to the fact that several focus group discussions were conducted, also mentioned by Sim¹³¹. The reason for not using the same informants in focus groups and individual interviews was the desire for variety⁹⁷, since finding common patterns in a heterogeneous group of people are of particular interest⁹⁵. The participants in this study were both geographically and socially separate; however they had a shared view of the field of interest. The women came from four different countries from the Middle East and had lived in Sweden different lengths of time. It is possible to identify consensus across groups in terms of the range of issues concerned even if it is not possible, or even desirable to identify consensus within groups. If they can not be generalised the results can at least be transferred to other settings which are similar¹³¹.

The women taking part in this study have experienced seeing other women suffer during pregnancy and birth, in their native countries, often due to war and economical restraint and through being treated by medical staff who work constantly under poor conditions such as shortages of water, poor sanitation and bad hygiene. In Sweden, care is given by professional caregivers with large medical resources and the care is offered free of charge. Therefore it is not surprising that women who participated in this study were grateful for the maternal health care offered to them and the way in which it is administered This was also recognised in a study of immigrant women from the Middle East living in Australia¹³².

One disadvantage of focus group interviews could be that one person will dominate the group⁹⁸. This was the case during the set-up of group A (men) and in one of the women's groups (B), but since the moderator was well informed she focused on involving the other members of the group. Another disadvantage can be the difficulties for the moderator to keep the group focused⁹⁹ without losing the inductive character of the study. This was the case in groups A and C at some points (Study II), but after explaining the purpose once more the participants became focused

again, and after a while the members reminded each other to stay focused. This is one key obstacle in inductive research, when to know that the participants are still focusing on the question rather than talking about something of great concern to them.

Conducting interviews in the interviewee's mother tongue seems to be important. Even though the participants in the individual interviews had lived in Sweden for several years their ability to talk about personal matters in Swedish were limited. This might have limited the outcome in the interviews performed in Swedish and might not have made it possible for the participants to fully express their true meaning, which should be taken in consideration while interpreting the results¹¹⁴.

Conducting the analysis from the Arabic transcripts would have increased the trustworthiness of the study¹³³, but at the time of the study there was no one available who was bilingual in Arabic and Swedish and familiar with the content analysis method. It is also important for the researcher to be aware of their own racial identities and cultures when interpreting data¹³⁴ as well as their own pre understanding.

The participants' perception of the recruiter plays a significant role. Having recruiters who are known within the community probably played a major role in reaching as many participants. This person takes on a special 'bridging' role since they need a good understanding of not only the different languages, but also the different cultures and then be able to connect the two¹¹⁴. By involving one person with the same background as the participants in the process of developing research questions, we also tried to get the approach correct¹¹⁴ as well as pilot testing the questions¹⁰⁰. After the interviews the men seemed positive towards discussing the subject of this study. One man stated "*this is something that all men should do*" (B), another man stated that "*the questions were very clear and important*" (A) and in focus group C the men stated that "*if you live in this country these are things you need to know*". The women expressed delight in being able to recapitulate this often happy and important event in life.

The dialogue differed between the groups, among the men, but most obvious was the difference between group B and C. Group B were still in the first phase of their immigration and trying to understand their new country⁶⁵ the way of living and the Swedish MHC, since their children were small and/or their wives pregnant. The realities were different in many ways. For Group C it was being able to take part in the woman's world, and because they had been in Sweden for a longer time than group B they had more possibility to reflect on their overall situation in Sweden and how it had turned out. This was also found in Samarasinghe & Arvidsson⁷³ who saw differences in the status of the immigrant families based on their

length of stay in the host country. Because of their older children they were keener on discussing matters regarding the upbringing of children in a different country and how their socio-economic situation affected them as fathers. Due to their longer stay in Sweden, the participants in the individual interviews had already made reflections about how it had all turned out, but had different experiences of the Swedish MHC, and fatherhood due to the different ages of their children. The women had lived longer in Sweden, but even taking their different lengths of domicile and their level of education, the women shared the same views.

Result discussion

Due to the retrospective character of the studies (Studies I, IV), the exclusion criteria and the outcome of birth and status of the new born baby (Apgar score) a low-risk population has been studied, even though in clinical practise one should always be prepared for the fact that emergency events can occur even in low-risk women. This thesis has shown that young age, multiparous status and country of birth have an association with unplanned care seeking during pregnancy. Women who made their visits in accordance with the national recommendations had less unplanned visits. The utilisation has been studied using the National recommendations as the definition of normal care (7-9), in a low-risk population, but use of phrasing as 'under' -and 'over' utilisation has been avoided due to the somewhat charged value related to the meaning of these words.

The experiences of foreign born men and women from the Middle East has shown that maternal health care as performed by midwives in Sweden, caring for pregnant women and women at birth, is highly appreciated by both men and women from these countries. They encounter empathic and knowledgeable – professional - staff. It is positive from both the perspective of the pregnant woman and the father that the father is involved in the care of both mother and child. This might, from the woman's perspective lead to a greater involvement by the father in family life in a situation that has possibly been altered since immigrating to and living in Sweden Further, from the father's perspective involvement opens up new possibilities for them to engage themselves in a new area.

There are three groups that will receive special attention in the discussion section, Swedish born women, because they are used as the reference group in Studies I, IV and that they show a somewhat unexpected pattern of utilising planned as well as unplanned care to the midwife. The second group are the women born in Eastern and Southern Europe due to their similar behaviour as the Swedish born

population when utilising the MHC (few planned and more unplanned visits). The third group are the women born in Iraq and Lebanon due to their different pattern of utilisation compared to the groups mentioned above.

The foreign born women in this study population need to be put in a transnational perspective in order to be able to understand their ways of seeking care. Their former experiences concerning pregnancy and birth will probably affect them in their new country, in this case Sweden⁶⁵. The attitudes towards health care, brought by immigrants from their former country, are they curative or is there a preventing perspective as in Sweden?

Health care utilisation-behaviour

The unplanned care utilisation can be discussed as follows (Figure 4): A woman has ill health during pregnancy (A) that requires a visit to the emergency ward prior to birth and she turns to the delivery ward, and will meet either a midwife or an obstetrician depending on the character of her problem. This would be the optimal situation. In article IV an association was revealed regarding the fact that significantly more women had a non-normal delivery outcome related to unplanned visits to either a midwife or a physician ($p < .001$) compared to those making no unplanned visits. These women might be those who suffered ill health during pregnancy and needed an intervention for the purposes of improving the outcome for herself and her child, or she went to the wrong level of care. Those women seeking care of ill health are, we might assume, handled correctly and interventions are performed according to the correct guidelines. Further research needs to cast light on the matter, as the relationship between intervention and reason for health care seeking does need further research.

In the current study population women consulted the delivery ward unplanned and 1362 women were classified as having uterine contractions. Of those, 53 were considered being in need of some kind of action before leaving the delivery ward. To study the outcome was not the aim of this doctoral thesis, but needs further research. Other classifications for women visiting the delivery ward and the midwife unplanned were 'Protein detected in urea, $\geq 3\text{g}/24\text{h}$ ' ($n=24$) and 'other unspecific complication' ($n=22$). Women in the latent phase of the delivery appear to be a large group of women being in need of care by the midwife at the delivery ward. Those women not in the active phase of delivery are normally sent home and asked to come back later when the contractions has increased, i.e. the number of contractions has reached 2 per ten minutes and the woman should feel strongly affected by them. Little interest has been shown in women in the latent phase of the delivery.

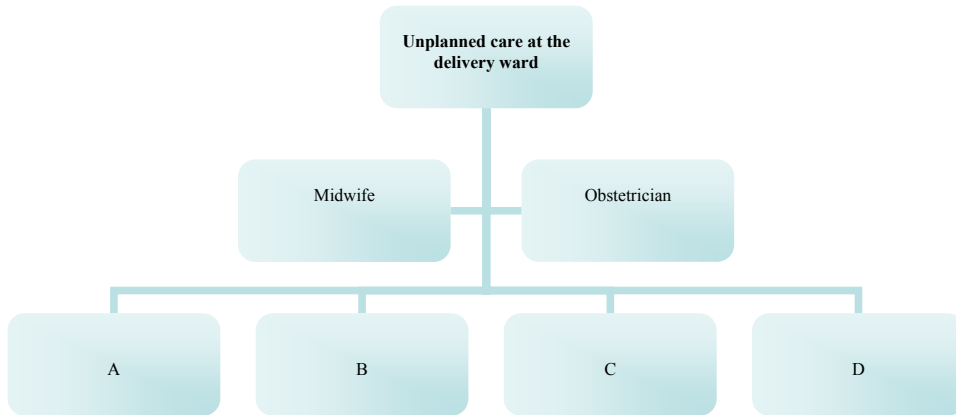


Figure 4: Unplanned care seeking at the delivery ward

A second alternative (B) might be that the woman needs to get in contact with her midwife at the municipal clinic due to feeling concerned and/or non-complicated pregnancy related matters. After 16:00 on working days and at weekends, the municipal clinic is closed. The duty midwife at the municipal clinic has a planned schedule and for some it might be a real problem since the possibility for a non scheduled visit in short notice is hard to meet at the municipal clinic. None of the municipal clinics in Malmö have supportive staff to take care of booking appointments, answering the telephone or dealing with people who turn up at the clinic. All such administrative work must be performed by the midwives on duty.

The Swedish born women were chosen to be the reference group in Studies I, IV due to their large number, their presumed acquaintance with the Swedish maternal health care system, as well as the fact that they are living in a familiar environment with the knowledge about how to seek care. Also they possible have a better social network than their immigrant sisters. Among the Swedish born women there is a linear association between having few planned visits to the midwife at the municipal clinic and more unplanned at the delivery ward to the midwife as well as there were significantly more normal vaginal deliveries among women from Iraq and Lebanon than among Swedish born women. Thereby more research is required regarding the Swedish born women, what background do they have and what socio-economic resources do they have? Could we improve their accessibility to midwifery care, maybe by offering support via the internet since studies show that women, at least from the lower socio economic levels, use the internet as an infor-

mation source and a chat forum¹³⁵. A lack of a social network might affect women in their situation and also the support from significant others that has shown to be positive in health preventive actions^{78,79}.

The Swedish born women were more often primiparous and only a fifth of them could be defined as young women. Are the Swedish born women more worried about pregnancy and birth since Sweden has many regulations just for safeties sake? Do women think that pregnancy and birth is totally safe and that the Swedish health care organisation should be able to give guaranties that nothing negative will happen and therefore they seek help at the delivery ward even just to confirm that every thing is all right without realising that they thereby expose themselves to a greater risk of interventions?^{37,136}. Hildingson (2002)¹¹⁹ noted in her study including Swedish speaking women, that they were content with the number of visits but had unrealistic expectations of what antenatal care can actually prevent. The antenatal care cannot entirely prevent mortality and morbidity, but make the possible damage by detecting ill health early in the pregnancy¹.

The woman might not get her worries confirmed by a midwife at the municipal clinic since her experience is that the MHC offers investigations such as ultra sound, screening tests as well as foetal investigations, 'just to be on the safe side'. As this is the case it would seem impossible for her to consider pregnancy and birth as something natural and low-risk, since so much need to be tested for in order to be prevented. These "double messages" (p. 225) can create worry and contradictory feelings among parents to be^{137,138}. This being said, the antenatal care in Sweden continues to focus on the individual woman's needs during the pregnancy. A more appropriate action to take would be is to have an increased preparedness, keep the woman involved and informed regarding any symptoms that should be observed¹ and keep in mind to assure the pregnant woman that despite the measures taken to prepare for all eventualities, pregnancy and birth are natural processes and not illnesses.

The professional roles of both midwives and physicians have changed due to increased patient involvement and that might not always be positive. This might lead to a feeling of uncertainty and an attitude that "the customer is always right" (p. 1884)¹³⁸. According to the Principles of perinatal care, WHO¹² we must never be tempted to abandon evidenced practices due to desire of the patient to have something else.

A third alternative (C) might be that the woman is ignorant of the health care system and/or with personal matters that makes it impossible for her to seek care daytime. In this study population being young and being multiparous were associated with few planned visits at the municipal clinic. Young women with more chil-

dren might need other forms of care, more related to their conditions and making it possible for them to bring their other children or at times when someone else can look after the children.

Political and socio-economic instability in and around European Union has increased the number of refugees and asylum seekers arriving in European countries. In 1995-96 19.6 million foreign national residences lived in Western Europe¹¹. Therefore, an interesting finding is to be found among the group of women born in Iraq and Lebanon. Women living in these countries do not have the same experiences of the MHC as Swedish born women do since most of the care given in their native countries during pregnancy is given ad hoc by physicians with a more curative than preventive aspect of health and with no national guidelines regarding antenatal care^{35,36}. One study performed in Lebanon showed no differences concerning the number of visits between low-risk compared to high-risk pregnant women¹³⁹. Many women in Lebanon, Iraq and the sub-Saharan region have no tradition of receiving antenatal care and the majority of care-givers in these countries are physicians which are mainly due to a lack of trained midwives¹⁴. In spite of this, when arriving to Sweden these women have few unplanned visits and most women have the recommended number of planned visits to the municipal clinic with a non complicated delivery outcome. This in spite of their having language problems as stated both by the interviewed men and women from the Middle East. In the focus groups interviews the fathers were asked if they thought that the time they lived in a country had implications for their ability to feel integrated. The men all shared the same view. Length of stay was not critical, rather it was the surroundings one lived in and the possibilities one was given that mattered. Young Y K¹⁴⁰ writes that the process of acculturation is a process in time, but it also depends on the level of stress as well as the ability for adaptation.

The fourth option (D) might be that foreign born women have different experiences of healthcare seeking during pregnancy in another country and that the delivery ward at the hospital in that country seems like the best alternative for the woman. Due to the limited experiences with health care services they might find it difficult to relate efficiently to local health care service providers^{11,141} in Sweden.

Women coming from countries with less developed primary health care might expect hospital referral¹⁴². This as well as having no knowledge of the health care system and no knowledge of the main language can be barriers to health care¹²⁰. Therefore immigrant women coming from settings with a more curative rather than preventive aspect towards health care might not give the time or resources to seek preventive MHC until she has a problem¹⁴³. Exposure to Western medicine and health practices could actually assist in the pattern of utilising preventive

health, since acculturation appears to change beliefs, attitudes and values regarding the medical system as well as health beneficial behaviour. In the Swedish health care system patients are entitled to care in accordance with the country's national health and welfare regulations¹⁶. This is a shift in both thinking and attitude toward the position that the patient becomes involved and takes part in choosing their health interventions. Migrants' beliefs influence their help-seeking behaviour⁶⁵. Countries in Europe earlier part of the former Soviet union consist of a diverse sample of countries regarding both their health care organisations as well as their population. These countries have gone through a change from a totalitarian system of government to democracy⁴³. In Study IV nearly 25% of the women who came from Eastern and Southern Europe were smokers at their first antenatal visit. The level of the number smokers also differs between the different city districts in Malmö. Women from Eastern and Southern Europe are a vulnerable group; often younger and smokers, and they reported a higher degree of poor self-reported health and psychosomatic complaints⁴⁵. These women would benefit from being involved in planned care at the MHC since smoking has well known negative effects on the foetus. It would help to prevent and encourage women to stop or decrease their smoking while pregnant and is one important task for the MHC. Women who smoke during pregnancy has an increased risk of having SGA's (small for gestational age children). More than 10% of the pregnant woman that smoked regularly did not participate in the parent education classes offered in Sweden during 2004 and it was noted that smokers breastfed to a lesser degree. The range of women smoking before pregnancy, in the region of Skåne during 2004, was 15.1-24.6 percent⁵⁰. Other groups of pregnant immigrant women are exposed to increased risk when giving birth in Sweden; Risks such as "caesarean section"¹⁴⁴, negative perinatal outcome¹⁰⁷ and for "small for gestational age children"⁷.

Studies I and IV show an association between few visits as well as late entry by some foreign born, young and multiparous women, into the MHC. The same result was seen in an Australian study where the authors discussed whether traditional beliefs, being young having unplanned pregnancies and the lack of information regarding MHC could be an explanation for late entry into the MHC. Being multiparous also made women more confident because of their experiences as well as it might be harder for them with child care¹⁴⁵, however difficulties may arise regarding care when there are several children. Foreign born women had lower prevalence of utilising the postpartum visit which is included in the Swedish national recommendations and should be take place 8-12 weeks after the delivery. This visit offers the woman the opportunity to discuss her delivery experience as well receive advice on contraception. Contraception is an important factor enabling

the woman to have the control over her own reproduction¹⁸ in accordance with the Cairo conference in 1994¹⁴⁶.

Individualised care by professional caregivers in a multi-ethnic context

In Studies II, III neither the men nor the women from the Middle East asked for 'culture congruent' care since for them the most important, as they expressed it, was the professionalism shown by the staff, since they had the ability to be both empathize in their encounter as well as being knowledgeable. The participants highlighted the way the professionals saw them as individuals, at meetings at the municipal clinic as well as on the delivery ward. Further, a study made in Lebanon, showed that the most important aspect in the process was the time the staff offered and the communication, empathy and skills the staff provided, both during pregnancy and delivery³⁶.

Several studies have emphasised the need for culturally congruent care, in the meaning that health professionals should be able to care for, and communicate with patients who belong to varying culture^{133,147,148,149,150}. Earlier it was probably necessary to compensate for our lack of knowledge regarding how to encounter people from a culture different from our own, in relation to maternal health care, but many of the larger cities in Europe, US and Australia have now become multi-ethnic communities for a longer period of time¹⁵¹. Therefore there is a greater need to see beyond culture and ethnicity and encounter women and their partners as individuals and offer them a holistic view of health care and thereby giving care that stresses the importance of recognising differences, also on an individual level, as well as creating trusting relationships between the parents and staff.¹⁵² By doing this we increase cultural awareness and openness in an attempt to acknowledge multiplicity. This then opens the way for the medical staff to also focus on what we as health staff are good at, being professionals in a professional way means having knowledge and imparting it with empathy focused on the individuals needs - otherwise there is a great risk of generalisation, stereotyping and failure to recognising cultural differences at all. The woman and her partner must be seen in their individual context since it is within this context that they make their choices regarding health, which is also stressed in Midwifery praxis in Sweden⁴⁹. According to the women in this study, information and communication are central issues. Professionals should aim at imparting knowledge based the individual woman's needs within a safe environment together with people she trusts⁸¹. This has shown to be effective when communicating health matter. Further it increases the woman's involvement in and control over her own care⁸³. The experience of the

women in this study was that midwives in Sweden give both advice and recommendations, but they leave it to the individual woman to make her own decision. This is a quite different experience than the feeling of being pressured into action¹³², or a feeling of ignorance¹⁵⁰. According to Dreher and MacNaughton¹⁵³ there is doubt whether cultural knowledge translated into culturally specific care necessarily improves clinical outcome or a reduction of health disparities. Instead, care providers should be able to develop interpersonal relationships, by being respectful of differences in values and beliefs¹⁵⁴.

Stable motherhood and unstable fatherhood, within the area of reproductive health

Women and men who immigrate to Sweden encounter attitudes of gender equality that has developed to be attributed to Swedishness. Historically, the Swedish government began to take an active part in the upbringing of children by providing day care centres. This, together with two other important factors, that is to say, the liberation of women in Sweden through control over of their own fertility by the right to free abortions and the use of contraception⁵⁸. Maternal mortality in Sweden is one of the lowest in the world. Further, women's situation within society was in 2007 ranked to be the highest in the world^{14,5}. Seen in a global perspective maternal mortality is an indicator of disparity and inequality between men and women and it is a sign of women's position in society and their possibilities for access to social, health and nutrition services and to economic opportunities¹⁵⁵.

The arena the immigrants enter and are required to take a standing on and the process of acculturation starts with their encounter of the new society. This might bring many surprises and shake up their previous taken-for-granted concepts and collective ethnic identity¹⁵⁶. To examine acculturation in a family context opens up rich opportunities to understand the multidimensional nature of this construct.

The fathers born in the Middle East spoke about fatherhood in relation to society. They were affected by how society looked upon them as fathers, and the possibilities and demands the society offered. Women originating from the Middle East, on the other hand, talked about being mothers in relation to their children, not in relation to the society. For many women migration opens doors to a new world of greater equality; being exposed to new ideas and social norms can promote their rights and enable them to fully participate in society⁵⁷. Their partner's behaviour had effects on how they managed their work load, but never on motherhood in itself. It was something women were born with. Since the men experienced their role as fathers to be strongly connected to the 'breadwinner' position in

the family (this can be described as the traditional way of looking upon fatherhood)¹⁵⁷. They felt they had the responsibility to support the family and expressed that they were not able to be suitable role models for their children in Sweden since most of them were unemployed. The men that were employed stated very clearly that it had affected them positively. They now considered themselves being worthy members in society since they paid taxes and thereby also took part in society. With their new status they were able to fully understand and accept the different views of gender within Swedish society compared to their native countries and interact with these views without experiencing it as a threat.

The women never discussed parenthood in relation to being an immigrant; neither did they express negative views of immigration. They did however state how they had difficulties living without their female network, and that it was difficult when they had to work fulltime. This made it hard for them to take care of their children and their household in a way they wished to. Some of the women who had a university degree from their native country said that it was the mother who created family life by her presence and that the children experienced a family when their mother was present. Some women stated that in her it was easier being a mother since the man worked fulltime and she could work part time work and thereby spend much time with her children. One of the women also expressed that she found it better to be a mother in Sweden since she and her husband were equally responsible for their children and how they lived their lives and they did not have to consider the views of family and friends. This is quite the opposite to the hypothesis that when people from socio-centric societies migrate to egocentric societies they may feel more alienated⁶⁵.

The women explained that their men only 'helped out' with household duties and the care of the children, but it was the woman who had the full responsibility for these things. They talked about how men were accustomed to this from their native countries and this traditional advantage was something they were not willing to give up, even though most of them were unemployed in Sweden. Some of the men, on the other hand, stated that living in a country with a different attitude toward gender equality where the household work was divide and shared opened up possibilities for the men to enter the female arena. No one looked strangely upon a man who did the laundry. It was not considered a strange thing or something odd that a man could not do. Immigration may seriously challenge the father's role and some may experience this as a possibility and some as a threat⁸⁵. Therefore, as several of the men expressed, one has to admit that there are different laws and traditions in a new country and one had best adapt to them. On the other hand there were younger immigrant men who had lived in Sweden since they were teenagers

who stressed the importance of keeping such cultural values as their religion and thereby having rules for how girls and boys should behave. One father gave an example that he was very proud of his daughter since she was very serene, quiet, and timid and for him this was a preferred way for how a girl should behave. At the same time he stressed the importance of the children having a choice if they wanted to be religious or to wear religious attributes.

In maternal healthcare the relationship between the midwife, the pregnant woman, the unborn child and her partner may be explained as in Figure 5. The pregnant woman and the unborn child are in focus they are supported by the MHC which offers professional care and the father to be, who offers support. All the men and women in the study stated that the most important characteristic of the MHC was to have control over the health of the unborn child and the pregnant woman. None of the men experienced being involved for their own sake as fathers to be, nor did they express any need for this. According to the participants, the midwifery profession, described as an ellipse around the couple, acted as the guide between the health and well being of the pregnant woman, her unborn child and the partner. Both parents are in the midwife's focus, but the man is a little bit more in the background as his role is to be supportive and protective (Study II).

Maternal health care has a delicate assignment in getting fathers more involved for their own sake as fathers, without losing the focus on the pregnant woman and her need in this delicate moment in life, when she actually puts her life at risk in order to give another life. Therefore, the medical preventive aspects of the care are vital, but these have to be offered in a package made suitable for our demands for equality in family life. The father should be seen as a resource as he can be a motivator⁷⁸ and he needs to be considered when designing a perinatal care system. Much emphasis should also be put on the way care is performed to avoid those uncaring encounters that are expressed in two Scandinavian studies^{76,77}.

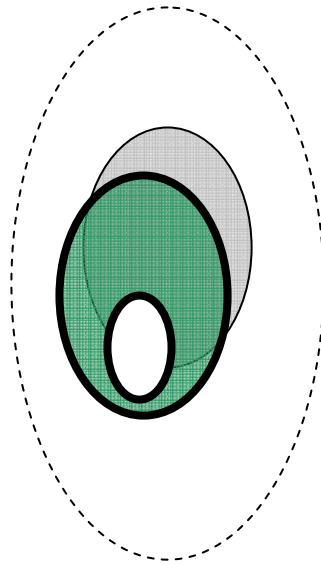


Figure 5: Maternal health care, in the perspective of the woman, her unborn child and her partner.

The men related that they had taken the place of the woman's former female network which they thought made the woman more dependent on the man when living in Sweden compared to their native country. A similar situation could be seen in a study of Somali men and women living in Sweden. The male partner acted as the spokesman for the woman in the maternal health care setting⁷¹. In many socio-cultural systems rituals, taboos, religious convictions regulate individual and group efforts. There is no doubt that when two or more intact groups come into contact conflict is one predictable result. How individuals and groups deal with this is an important research question and acculturation has become an important concept in trying to explain the different experiences of ethnic and cultural minorities.

Acculturation involves change not only on an individual level but also on a socio-cultural level, and it is not possible to ignore the influences of social and environmental changes on an individual's beliefs and behaviour. Adaptation and change are instead important components and instead of assimilation one should consider that there are many options available to individuals interacting with a new culture.⁶⁶

The women could see positive side effects in the early involvement of the man here in Sweden since it makes him aware of the heavy work she has during pregnancy, delivery and with household matters. The men also expressed that by being present they learnt to understand her efforts which gave them a respect for the woman and her situation. One idea was that as men gradually take more responsibility for the children and participate more in traditional household duties they become more family oriented⁸⁷. The women discussed that this might also have a positive effect on the bonding between the father and the child; if he was present from the beginning.

The midwives role in the MHC is to enable the woman's partner to take part in the pregnant woman's situation, for the sake of the whole family, as this can create a feeling of security following the birth- "*affinity within the family*" (p.56)¹⁵⁸, being two taking care of their new born baby.

CONCLUSIONS

The purpose of this doctoral thesis was to retrospectively investigate patterns of utilisation of both planned and unplanned care during pregnancy in a low-risk group of women. Foreign born people with limited ability to converse in Swedish have been involved in focus groups discussions and individual interviews conducted in their mother tongue using an interpreter. The purpose of this study was moreover to describe foreign born men's and women's experiences of taking part in the MHC in Sweden and the women's' experiences of the participation of the fathers to be in MHC.

In the study population, according to the definitions set in Studies I, IV, the main finding was that 28.3-48.7% of the women had unplanned visits to a midwife and/or to a physician at the delivery ward. Women born in Sweden and in Eastern and Southern Europe had a linear relationship with few planned visits to the midwife and more unplanned visits to the midwife at the delivery ward.

In Study II women were positive to the individualised and professional care given at the MHC by empathic and professional midwives. They were positive to the increased involvement of the partner in the area of reproduction and family life when living in Sweden. This according to the women may lead to an increased understanding of the woman's situation during pregnancy, birth and caring for the children as well as it could increase the fathers own emotional as well as practical involvement in their children. The foreign born men, Study III, were positive toward antenatal care and to be able to take part as support to women at MHC, and during the delivery process. They experienced problems with their situation as being fathers, partners and as men living in Sweden, often due to their becoming unemployed and the changed situation that migration brought about.

FURTHER RESEARCH

This thesis has raised many questions. The number of visits recommended according to the Swedish national recommendations is mainly based on a medical perspective, but several local guidelines at different MHC's in Sweden have added a programme aiming at highlighting psycho-social factors. Therefore it is of interest with regard to future research to explore the most appropriate number of medical visits to offer women during pregnancy and thereby be able to maintain a flexible attitude when offering those in need, more visits or other types of support. The reasons why women born in Sweden, as well as those born elsewhere, choose to seek unplanned care at the delivery ward and utilise less than the recommended number of visits to the municipal clinic in a low-risk population requires further research. The attitude of the staff as well as their working conditions needs further investigation since this can be a gatekeeper to more spontaneous care seeking, or care initiated the same day at the municipal level.

Pregnant women having 10-28 planned visits to the midwife at the MHC as well as the care of women seeking unplanned care at the delivery ward is also of further interest: how many of the latter women are in the latent phase of the delivery and how do they experience the care they are given? How is the care organised, which interventions are performed and by whom? The social network surrounding these women needs to be further explored: to what degree are their partners feeling involvement and how do the women experience the support from their partner? What motivates women to seek unplanned care and what prevents them from seeking planned care? The goal of antenatal care in Sweden should not only aim at physical and psychosocial care for women and their unborn babies. It should also aim at giving everyone the possibility to have access to care, and be given the opportunity to make an active decision regarding health actions suggested according to those prerequisites that exist in reproductive health care in Sweden today. To

understanding health behaviour in a multiethnic context is an important factor for making it possible to provide cost-effective interventions¹⁴¹.

CLINICAL IMPLICATIONS

In Malmö there is a different pattern on the subject of utilisation of antenatal care related to country of birth and immigrant women and men born in the Middle East had positive experiences from the care given by midwives. We require systems that enable us to communicate with the care seekers regarding how and when and where to seek care. We must also be able to communicate in order to inform what our intentions are with the care offered in general and specifically what we can offer the pregnant woman and her partner. The care offered is based on a preventive attitude rather than a curative perspective, and the woman and her partner in antenatal care should be encouraged to get involved in her personal health situation in an empowering manner.

We have to be aware of that there are groups of women who tend to have contact with the care system in a more or less planned fashion. These women miss an opportunity to meet a midwife who is specialised in preventive care during pregnancy with the focus of keeping pregnancy a normal health life event, as well as detecting risk factors. Such a conversation in a calm environment is beneficial to the woman. These immigrant groups need our special attention towards making the MHC accessible as well as making the staff being aware of our own attitudes towards preventive work during pregnancy in a multiethnic setting. The organisation of care must also, in itself; offer these possibilities for both the staff and the women.

We must have a flexible attitude towards preventive healthcare and understand and act upon the notion that women need encouraging and individualised care. We must ask them what their needs are, not serve them ours.

Populärvetenskaplig sammanfattning

Avhandlingens titel är *'Mödravård i ett multietniskt samhälle - inkluderande fäder'*. Den handlar om studier som dels fokuserar på mönstret av nyttjande av mödrahälsovård i en lågrisk grupp av gravida kvinnor med olika födelseland i Malmö under 4 år, 2000-2003. Påverkande faktorer som kvinnans ålder, antal barn, civilstånd, användandet av tolk samt rökning har studerats. Dessutom har män och kvinnor födda i Mellanöstern och deras erfarenheter efterfrågats med hjälp av både fokusgruppintervjuer på arabiska med tolk samt individuella intervjuer på svenska och arabiska.

Flera av Europas stora städer har en växande multietnisk befolkning som är i barnafödande ålder och därmed i behov av mödravård vars mål är att minska sjuklighet och dödlighet samt förbättra hälsa för mor och barn. I flera länder har det visat sig att emigranter har svårare att nyttja mödravården fullt ut och att de kan i större mängd drabbas av komplicerat förlossningsutfall. Trots fri tillgång till svensk mödrahälsovård, enligt ett svenskt nationellt basprogram (7-8 besök till en barnmorska/graviditet, samt ett efterkontrollbesök 8-12 veckor efter förlossningen) visar kvinnor födda utomlands ett annorlunda nyttjandemönster, än svenskfödda kvinnor. Risker är att preventiva besök och åtgärder minskar och att akuta besök och medicinska åtgärder ökar. Fäders deltagande i graviditet och förlossning följer ofta kulturella mönster vilka kan förändras i samband med migration. För att kunna stödja blivande och nyblivna föräldrar från en annan bakgrund är det nödvändigt att få en djupare förståelse för både moderns och faderns upplevelse och behov i samband med graviditet och barnets födelse.

Resultatet från Studie I visar att kvinnor födda i Öst- och Syd Europa, Irak och Libanon samt Asien hade färre besök än rekommenderat, dvs. färre än sju besök, till mödravården. De kvinnor som hade ett sent första besök efter graviditetens 15:e vecka, var till största del utlandsfödda (förutom kvinnor födda i Irak och Libanon samt Syd- och Central Amerika). En andra registerdatastudie (Studie IV) fokuserar på det oplanerade vårdsökande på förlossningen före besöket före födelsen. Där kunde det konstateras att det är mellan 30-50 % av de gravida kvinnorna som har ett eller fler oplanerade besök till barnmorska eller läkare. Kvinnor som var födda i Sverige och Öst- och Syd Europa visade ett intressant mönster då det fanns ett samband mellan att gå få planerade besök till barnmorskan på mödrahälsovården samt fler oplanerade besök till barnmorskan på förlossningen. De kvinnor som följde de nationella rekommendationerna i denna lågrisk grupp hade lägst antal oplanerade besök.

Resultatet från de två intervjustudierna (Studie II, III) utgår från tio män som deltog i tre fokusgruppintervjuer med tolk samt sex män som talade svenska och intervjuades individuellt. Alla män fick berätta om sina erfarenheter av att deltaga i den svenska mödravården tillsammans med sin partner. Tre huvudkategorier utvecklades: *Att möta empatiska professionella* – männen uppmuntrades till engagemang genom barnmorskans empatiska förhållningssätt; *Att finna nya positioner inom familjen* – kvinnan var beroende av mannens hjälp och han fick ersätta det kvinnliga nätverket från hemlandet; *Att uppleva sociala krav* – ibland arbetslös och inte längre en rollmodell för sina barn.

Det tredje delarbetet bygger på resultatet från tre fokusgruppintervjuer, med tolk, och fem individuella intervjuer på svenska med totalt 13 kvinnor från Mellanöstern. Fyra huvudkategorier växte fram efter det att samtliga kvinnor fick berätta om sina erfarenheter av att deltaga i den svenska mödrahälsovården, samt hur kvinnorna såg på att deras partners blivit inbjudna: *Tillgång till den professionella barnmorskan* – innefattande tillit, kunskap och kompetens var värdefullt i rådgivningen; *Det stabila moderskapet i transition-* att vara mamma upplevdes likartat oberoende av vilket land man bodde i, dock kunde förutsättningarna vara olika; *Att vara familj i en annorlunda kontext* – familjens behov av stöd och engagemang från fäder var påtagligt då nätverket av kvinnor saknades.

Slutsatsen är att eftersom utlandsfödda kvinnor från vissa länder, samt svenskfödda kvinnor, inte nyttjar den organiserade mödrahälsovården fullt ut utan gör oplanerade besök, hos främst barnmorskan på förlossningsavdelningen, bör information och stöd till gravida kvinnor och deras partner förändras så att de kan tillgodogöra sig den preventiva mödrahälsovården. Det bör även inkluderas kunskap kring vårdstrukturen. Att känna sig väl bemött av en professionell och empatisk individorienterad barnmorska har betydelse såväl för den blivande modern som för den blivande fadern, i synnerhet i en främmande kultur. För att information och rådgivning skall förstås på ett rätt sätt behöver behovet av tolk alltid tillgodoses. Mödravårdens tillgänglighet i förhållande till olika människors behov behöver också ses över.

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