Title page

Middle Eastern mothers in Sweden, their experiences of the maternal health service and their partner's involvement -focus groups discussions and individual interviews

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Abstract

Background: Traditional patterns relating to how to handle pregnancy and birth are often challenged due to migration. The purpose of this study was to describe Middle Eastern mothers' experiences of the maternal health care services in Sweden and the involvement of their male partner.

Methods: Thirteen immigrant mothers from the Middle East who had participated in the maternity health services in Sweden were interviewed using focus group discussions and individual interviews. These were taped, transcribed and analysed according to Content analysis.

Results: The four main categories that developed were,

- Access to the professional midwife
- Useful counselling
- Stable motherhood in transition
- Being a family living in a different culture

Conclusion:

According to the respondents in this study, the requirement, as a midwife, to understand the woman's native language or her culture was not vital. Instead the immigrant woman developed trust in the midwife at the maternity health care centre based on the knowledge and the empathy the midwife imparted. This interesting finding requires further research.

The need for more visits during the first trimester seemed to be important, both for the individual woman and also in an effort to avoid spontaneous visits to the emergency clinic. Due to migration the relationship within the family had altered. The experience

of motherhood was stable, but there was a greater need for involvement and support by the husband during the perinatal period, such as caring for older children and doing household chores since the mothers' earlier female network was often lost. According to the women interviewed, not all men managed to give this support which often created a stressful situation for the woman following the birth of her child.

Clinical implications

There is a need to involve immigrant parents in the available parental education in order to prepare them for the realties of parenthood in their new country as well as to explore their altered family situation. Collecting immigrant women and their partner's experiences of MHC, offers a possibility to improve the existing care, both in content, access and availability, where also the timing of visits and content require further evaluation.

Background

Traditional patterns relating on how to handle pregnancy and birth are often challenged due to migration [1, 2]. An earlier study showed how Middle Eastern men living in Sweden changed their traditional roles and took part to a greater extent in what was for them a 'woman's world' by giving support to the woman during pregnancy and childbirth [3]. The midwife has an important role in not only caring for and meeting the mother to be, but also in inviting the father to take part [4]. 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 a different culture. [5]

Being born abroad with subsequent language difficulties can be perceived as a barrier to obtaining health care [6, 7]. Fabian et al [8] could see that not speaking Swedish was related to non-attendance to parental education and some groups have adverse perinatal outcome [9, 10]. Some immigrant women utilise the maternal health services [MHC] less during pregnancy than Swedish born women do and they come later for their first visit [11). Involving their men in their pregnancy and birth enables the woman to receive support which is important both in transition to motherhood as well as in attitudes to health preserving actions [12, 13]

The Swedish maternity health care is handled by midwives on a continuity basis at municipal clinics in accordance with the National recommendations. All parents are offered parental education, which is also provided by midwives. [4]

Immigrant women who are not fluent in the language of their adopted country are often excluded in research due to the lack of the use of interpreters as well as an unawareness of the experiences of minority groups of immigrants. Including them offers a unique possibility to obtain their often different experiences [14]. Therefore the purpose of this study was to describe Middle Eastern mothers' experiences of the maternal health care services in Sweden and the involvement of the father.

Methods

Setting

In Sweden antenatal care is offered free of charge. Seven to nine visits are offered in accordance with the National recommendations and a further visit 8-12 weeks postpartum. [4] Those women whom the midwife considers to be at risk are refereed to a Specialist antenatal clinic. One ultrasound scan is offered in gestational week 16-18, this is performed by midwives with the purpose of determining the delivery date as well as detecting eventual foetus malformation. The present programme was introduced in 1996, when a reduced number of visits (earlier 13-14) were recommended as well as the deletion of the earlier obligatory visit to a physician.

This study took place in a multiethnic city of Malmö in Southern of Sweden (n=270 000) inhabitants of which 45% were born, abroad [15]. Focus groups and individual interviews were conducted. Focus group A met at an antenatal clinic, group B at a university and group C at a school for immigrants. The first two individual interviews were conducted in the women's homes, then two at a school for immigrants, and the remainder at an antenatal clinic.

Participants

A total of 25 women were asked to participate and 13 agreed. Eight women accepted to participate in three different focus group discussions using Arabic, and five other women accepted to be individually interviewed (one using an Arabic interpreter) in Swedish after being asked by the interpreter, 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 were asked by the midwife at the antenatal clinic, after conducting the postpartum check-up, if she was interested in participating in this study. The researcher, using a female interpreter, explained the purpose of the study and asked again if the woman was interested in participating. If the woman understood Swedish she was then asked to participate in the individual interview. One week later the woman received a letter of invitation written either in Swedish or Arabic explaining the purpose of the study, the practical arrangements regarding time and place for the interview and their right to decline participation at any time. None of the participants was in any way dependent on personal care from the researcher. Two of the women chose to be interviewed in their homes. In the case of the women who were asked to participate by their teacher, the whole class was first introduced to one of the researchers who explained the purpose of the study. Thereafter a specific time schedule was offered and those interested then met the researcher.

The inclusion criteria was immigrant women born in the Middle East [16] 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 (both Lebanese and Palestinians). The reasons for their immigration where not investigated, however most of the women had come to Sweden as refuges due to wars and conflict. 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 time lapse since participating in the Swedish MHC was between 3 months 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 also in Sweden. The rest had participated in the Swedish MHC and given birth here. 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 to 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 groups (A) and (B) was 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 having babies were represented in all three groups and all the women had participated in the Swedish MHC.

Data collection

Triangulation [17] with focus group discussions, individual interviews, interviews in the participants' native language and in Swedish were used in this exploratory research since the participant's knowledge of Swedish differed among them. There was no

requirement that the participants should be able to read or write either in Swedish or Arabic.

Conducting cross-cultural research adds layers of complexity and therefore the interpreter should translate as verbatim as possible [17], which requires time. All interviews were recorded and 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. The semi-structured interviews were used as a guide that explored areas regarding the women's experience of the MHC and the participation of their husband in the MHC. All participants filled in a short questionnaire regarding their socio-demographic data before participating in the interviews and they all gave their consent to participate in the study.

The questions were developed by the research team who had experience of constructing questions for immigrants regarding antenatal care [3] and formed into an interview guide. Using an interpreter, the guide was tested in one focus group interview with women born in Lebanon and now living in Sweden. The guide was found to be acceptable and relevant; as no negative comments came up regarding the questions the interview was included in the analysis.

Each focus group discussion took two to 2.5 hours, and was always conducted by the same moderator and interpreter. The individual interviews took between 45 min and 1h 20 min and were conducted in Swedish all except one individual interview that was conducted in Arabic. The interviews were done during the spring of 2005 and 2006.

Cross cultural research that crosses both cultural and language barriers needs special consideration and this study was performed in close contact to with the interpreter from the Middle East in order to minimise both linguistic and cultural misunderstandings.

The study was carried out with written informed consent from the respondents and according to the ethical principles of Biomedical Ethics. The study was conducted and approved in accordance with the Swedish legislation governing non invasive studies and the Helsinki declaration of 1996 [18].

Data analysis

Content analysis is a suitable method for cross linguistic studies [19] and is used to determine what is significant [17]. The text was analysed according to the content analysis method by Burnard [20] 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, during the analysis, into the same codes and into subcategories. The result of the content analysis was discussed with the interpreter with the purpose of excluding misinterpretations of the content due to the cross-cultural and cross-linguistic context. Finally the authors agreed on the four main categories of the texts. In order to ensure consistency in the translation, parts of the audiotape were translated from Arabic into Swedish by an independent female

translator from the Middle East with Arabic as her native language but who herself was not involved in the study.

Findings

The following four main categories were developed in the analysis, presented with respective subcategories:

Access to the professional midwife

- To be respected and met with kindness
- The trustworthy midwife who has the required knowledge
- The need for frequent visits

Useful counselling

- Counselling from the MHC
- Parental group meetings, to receive correct information from a proper source
- Information can also be frightening

Stable motherhood in transition

- The mother is the best person for her child
- Integration into Swedish society

Being a family in a different culture

- The presence of the husband
- The female network

- Experiences of the man as father and partner

Each main category will be presented with its own sub-category/ies. Quotes have been used in reporting some of the findings to illustrate both individuals and dialogues in the focus groups. A to C represents the three different focus groups and 1 to 5 represents the five different individual interviews.

Access to the professional midwife

To be respected and met with kindness

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.

"I got more help during the first pregnancy (from the MHC) than now since I have more experience. When I need to I ask them and they answer me in a very nice way. Here (in Sweden) they take care of the woman and care for the little things.(3)

Some of the women also had bad experiences of the care they received in Sweden, one woman expressed a feeling of neglect, her midwife did not listen to her and did not take her worries seriously. Other women stated they had met midwives from their own country who were now working in Sweden and that they had been dissatisfied with their encounter. Even though the communication was simplified regarding language they wished that the attitude of these midwives, towards them, had been better.

” That the staff knows our language is not enough, she has to be like you, helpful. To be kind is important. ” (C)

”I had a midwife originating from my home country, but she was not nice or helpful.” (3)

None of the women expressed a wish for Arabic speaking staff, but several of them described the immense importance of being able to handle Swedish in their encounter with the midwife. Otherwise it was difficult to express ones self and an interpreter is only a poor substitute since that person can never fully understand one’s exact meaning, not even if they are a husband or a female friend.

”It is so important to know the language so that the mother can tell herself, because the husband might not say exactly what she means.” (4)

Having to talk via an interpreter regarding personal matters such as obstetric and gynaecological matters was not satisfactory.

The trustworthy midwife who has the required knowledge

The midwife was considered trustworthy by the women on the basis of her knowledge and education. The same was expressed regarding the different physicians that the women had met. The difference in getting advice from your mother or a friend compared with the midwife is that your mother has only experience, but the midwife has both experience and education.

”I listen to the midwives advice; my mother is not a midwife or a physician. The midwife is educated so she knows more.” (5)

The midwife knows what she is doing because she has studied and has experience so I have to listen to her. If I have a question I ask her. I do trust the midwives and the physicians. " (1)

Some of the women also stated that they felt safe because the MHC takes care of both their health and the baby's. You don't have to worry about bad hygiene or sickness. *"You feel safe when you go to the MHC, they think about everything and they take care of you and your child. You don't have to be afraid of unhygienic conditions or to get infected by diseases." (2)*

The need for frequent visits

Several of the women stated that there was a long time lapse from their first visit to the MHC in early pregnancy to the second. 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 emotionally for both the woman and her partner, therefore there is a need for communication with the midwife. If this need is not satisfied some women might feel the need to seek care elsewhere, they said.

One of the groups noted in their discussions:

"-I wonder if there is a possibility to have an extra visit between the first and the second? During this time there are so many changes in the woman's body. It is important for both body and mind that a pregnant woman gets support and information from a knowledgeable person.

- A woman needs a lot of information during this first period, not later when all has calmed down.

- Otherwise you have to seek care at the emergency clinic and there it is difficult to get through and get help.

- An appointment to a midwife can give a feeling of security and help women not to get anxiety or depressed. During this time a pregnant woman needs someone to talk to who is patient and keen." (A)

Useful counselling

Counselling from the MHC

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 common during pregnancy such as constipation, sickness, tiredness and backache and advice on 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.

"The midwife tried to comfort me and she gave advice. But I didn't need to follow her advice, even though she listened she did not force me to do anything, they just give you information I mean."(A)

The MHC seemed important to the women and one woman said (C) *" Nothing can stop the woman from going to MCH, nothing is more important. The child can die otherwise!"*

Parental groups, to receive correct information from a proper source

To be informed in a group was considered positive among all of the women, but not all women said they 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, as for example, in this dialogue:

"-I went there because I got information at the right time. They were sort of one step ahead, so one knew what to expect.

-I did not feel a need, but I was invited. I have family and also friends that have children already, so they know a lot.

-I went there with my husband, but he only came twice since he got bored. He does not understand Swedish that well. It was hard to go by your self because every one else was there as a couple." (B)

Information can also be frightening

In some societies talking about risks may be unacceptable due to the risk of making them happen. Some believe that talking about death and ill health may cause these things to take place. Some cultures also believe that the outcome of the pregnancy is not for them to decide, it is either in Gods hands or in the hand of the fate. Several of the women stated they wanted information but at the same time it could also be frightening, as for example in this dialogue:

"-I think it is good with information so that you can be prepared if something happens.

-Yes, but they should only say things they are certain about otherwise you get really worried.

-Yes, because if it then turns out that there wasn't anything wrong you can't trust the person again. How could she have been so wrong?" (B)

When the women were asked if they thought it was worth getting information even though it could be frightening they all stated that it was worth it as the advantages predominated.

Stable motherhood in transition

The mother is the best person for her child

Nearly all women stated that the mother is 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 a 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: *"-Yes women are born with it, it comes natural for her."(B)* and it is stable. In the move to a new country the external conditions could be different, such as division of labour within the family as well as different housing conditions:

"In Iraq the men work fulltime and the women part time so women would have had more time there for her children there. We would also have lived in a big house. The society affects the conditions! " (B)

Integrating into Swedish society

Three of the mothers expressed their wish to obtain work as for them it felt unsatisfactory to be supported by the social welfare. Due to the situation in their country of origin some women had not been able to go to school regularly which affected their ability to learn Swedish and to find a job here.

”-Due to war in the homeland I could not study since the school was closed. I don’t have an education so it is hard to get a job here.”(4)

”If the woman has a job and feel well she can raise her children in a better way. If the mother is not well the children does not feel well either.”(4)

Most of the woman did not have any close friends among their fellow countrymen either.

Being a family in a different culture

The presence of the husband

All the women except one described the presence of their husbands both at the MHC and during the delivery in a positive way. 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 also actively stated that they were there as support only because it concerned the woman’s body. Being able to utilize the MHC services by herself made the woman feel less dependent on her husband. Also according to the women the men expressed a need for the woman to be independent.

”No, the midwife only talked to me. He wanted it that way since this is my thing and it is important that I know what is happening. If I need help I know he will help me.”(1)

”He said you have to be independent to be strong.”(5)

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.

"The presence of the man is needed to share the woman's suffering. Sometimes you just have to get him in the picture. "(A)

The female network

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' mothers living outside Sweden were allowed to visit their daughters during the perinatal period. The mother has both experience of pregnancy and childbirth and would normally be a support during her daughter's confinement.

"It is only ones mother that can help. You can not expect that much from the husband. He soon gets bored and gives up the new responsibility."(A)

"If I could make a wish I would like to have my mother present at the delivery."(5)

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.

"It is a heavy responsibility in Sweden because in the home country there is always someone that helps, such as a mother in law, an aunt or sister. Everyone plays their part in the care and upbringing of the child."(A)

"I had no one to ask when I was pregnant for the phone calls to my mother were really expensive and you cannot handle the cost when you live on subsidies from the government. Sometimes I asked my friends, but I don't know that many so life was difficult."(3)

Experiences of the man as a father and partner

Life in Sweden was most often quite different compared to life in the native country. Below is a dialogue concerning men within a family living in Sweden:

"Difficult experiences due to war is the reason for the lethargy among our men. Those fathers living in Sweden who mostly stay in the home could be disturbing for the women.

-The life, the system and the culture is very different in Sweden compared to that of our home countries.

-Here in Sweden women's development runs parallel to that of the men. She goes to school, learns the language and receives just as many hours at school as the man. This creates a problem for the men who have the traditions and praxis that the woman should take care of the household by herself. This, the man does not want to loose."(A)

Some women also expressed a wish to be able to continue taking the main responsibility for their household.

"When the mother cooks and cleans at home and the father goes to work the children feel that they have a family." (2)

Among those women who did not work, all of them expressed concern as to how they should be able to take care of the 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.

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.
”Here in Sweden the mother is strong and she can decide. In our home-country you have to listen to the rest of the family. It is better for me here. Life with my husband is also different. We both decide what is best for our children so our life is better.”(1)

In focus group (A) the women discussed how the different circumstance in the country one is living affects you:
“-In the home country the husband works more and the woman less so she has time for her children. In Sweden I always have a bad conscience since I am working so much, but that depends on me not having been raised there. If I had been raised in Sweden I would not have thought about it. Now since my husband has time he mostly takes care of our child. That is good, because now he is a real father, not just a father on paper.
-Yes it is the society you live in that forms you. In Sweden there are other conditions.”(A)

Discussion

Trustworthiness is important for qualitative research and includes concepts such as stability and credibility. The authors have analysed the data separately in order to

secure that the descriptive categories are in accordance with the interview material. The text was read through many times in order to achieve stability [21]. The discussions among the authors reduced the risk of researcher bias and enhanced validity; the risk of the latter was also minimised by using triangulation - a combination of methods [17]. To maximize the quality of the data it is of importance to make interviews in the first language of the participants [22] and use the same interpreter throughout each of the interviews [19].

Depending on the explorative and cross-cultural character of the study and the use of interpreters, two to four participants per group was found to be suitable. This is also the experience of Twinn [22] who conducted a content analysis of transcripts in English translated from Chinese. By having small groups we eliminated the risk of any frustration caused to the participants by not having enough time or the possibility to fully express themselves. We followed the concept of 'higher involvement' where the participants were seen as being the experts [23].

One limitation was the non response by 12 women 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, in finding women who were willing and had the time to participate. Similar difficulties are mentioned by Small & Liamputton [24] when doing research among immigrant groups in Australia. This is a dilemma connected to the transferability of the result [25] and must be considered when interpreting the result.

The credibility of the result increased due to the fact that several focus group discussions were conducted, also mentioned in Sim [26]. This was combined with individual interviews, as stressed in Bhugra et al [25]. The reason for not using the same informants in focus groups and individual interviews was the desire for variety as proposed by Twinn [19], since finding common patterns in a heterogeneous group of people are of particular interest [17].

Conducting interviews in the participants native language seems to be important. Even though the participants in the individual interviews had lived in Sweden for several years their ability to talk about private matters in Swedish was limited. This in turn might have limited the outcome of these interviews and might have made it impossible for the participants to fully express their true meaning, which has to be taken in consideration when interpreting the results [27].

Women taking part in this study have experienced seeing other women suffer during pregnancy and birth, in their home countries, often due to war and economical restraints and through being treated by 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 recourses and is free of charge. Therefore it is not surprising that women who participated in this study are grateful for the maternity health care offered to them and the way it is given. This was also recognised in a study of immigrant women from the Middle East living in Australia [28].

Trust in the MHC

In this study, in contrast to others [29, 30, 31, 32] none of the women expressed a need for a midwife who was knowledgeable of their culture or able to speak their native language. An approach by a professional (by professional the authors imply knowledgeable as well as empathetic] midwife was experienced as trust promoting. Deveugele et al [33] mean that good communication requires both knowledge and empathy where the interaction between patient and care provider is most important [34]. Furthermore being met with kindness and a feeling of acceptance was vital to the health of immigrant families in Sweden [35]. Also "*culturally competent care*" entails several properties which stress the importance of recognising differences as well as creating trusting relationships [36, p. 12] In that respect it is important for care givers to see beyond the context of religion, cultural and ethnic background and focus on the individual woman, which was also expressed by Tsianakas [28]. This could be seen as an empowering gesture.

The time lapse between the first and second visit (gestational week 12 to 25) in the antenatal care programme was experienced as being too long as it could induce the woman to seek spontaneous care, often at the emergency clinic, which is unsatisfactory. The National recommendations in Sweden [4] are in the process of change, both in content and in regard to the number of visits. The first trimester is the time when great changes affect the woman's body, both physically as well as psychologically. This could be a period where continuous contact with knowledgeable personnel at the municipal clinic is a necessity for the women.

According to the women in this study, information and communication are central issues, but as shown in Nigenda et al [37] this can differ according to cultural background. The women in our study noted that midwives give both advice and recommendations, but they leave it to the individual woman to make her own decision; a quite different experience than the feeling of being pressured into action, as was stated in an Australian study [28] or a feeling of being ignorant as in the UK study [31]. The Swedish National Board of Health and Welfare [4] gives recommendations regarding antenatal care, but it is the responsibility of the midwife to implement the care individually and in communication with the pregnant woman.

Parenthood in transition

By transition the authors imply the effects of migration and how immigration can influence parenthood which is not identical to transition due to modernity [38]. Women saw their male partners as supporters, someone to pave the way before them during pregnancy and delivery. Several of the women also expressed being supported by their partners as essential to their effort to manage themselves in this new society, both in their contacts with health staff and in daily life. The women were positive to this idea which was quite similar to the findings of Wiklund et al [39] regarding Somali men and their participation. The Middle Eastern societies most often have a patriarchal structure and moving to Sweden can create conflicts due to different ways of looking at gender both in society in general and also within family life. The way women and men respectively view their new possibilities can be quite different. [40, 41, 42]

The women in this study had immigrated for different reasons, they had moved from a traditional family/group oriented society to a Western individualised society [41]; one

thing that remained stable for them was the feeling for motherhood, which was expressed by the women. Life with their partners was in transition, life as a woman was in transition, but the feeling for motherhood was stable. This is totally opposite to the experiences of immigrant men from the Middle East in Sweden [3]. The men experienced an altered balance of power within the family when living in Sweden and thereby a change in their position as a father. They still saw themselves as the providers, but since most of the men were unemployed they could not manage to support their family economically by themselves. Often the immigrant father's role as a leader and decision maker was threatened [3, 40]. Fatherhood seems to be more dependent on outer factors such as, being more easily affected by external dynamics than motherhood. In this study some of the men involved had shouldered their new situation well according to the women, but some of the men were not regarded by the women as being particularly supportive since they quickly became less enthusiastic about their new fathering ways. Meadows et al [43] found that many immigrant women in Western societies feel isolated in an alien system devoid of their female relatives. One of the focus groups, among the women, discussed what involvement of the men could actually offer them as fathers, and it was concluded that by being more involved in daily activities around their children the fathers would not only become more emotionally close to their children, but would also gain a better understanding of the work that the women do in the home The women in our study had experienced that a changed situation had effects on their family life and some of the women said that their men were not interested in changing from the old system, even though they did not manage to achieve the old. Some of the women even had a total opposite view of partnership and fatherhood than the immigrant men when living in Sweden. A father taking practical care of his children was a real father, *"not a father only on paper"* (B).

The women spoke about how a couple should help and support one another both in family matters as well as in more practical matters related to society. This was also referred to by some men who meant that since the Swedish society is different "*I as a man I have to change otherwise the family will not last* ". [3] Often the men who had come to terms with their situation had employment and they expressed that they had finally found their place as full citizens since they now contributed to society and paid taxes. That gave them the confidence to also view family life and gender differently.

Conclusion

According to the participants in this study the requirement, of the midwife, to know the woman's native language or her culture was not vital, Instead the immigrant woman could develop trust in the midwife working within the maternity health care services, based on the midwife's knowledge and empathy and her way of imparting it. This interesting finding requires further research.

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 emergency clinic. 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 husband in the perinatal period, such as caring for older children and with household chores since the mother's earlier female network was often lost. According to the women, not all men managed to give this support which often placed the woman in a stressful situation at the time after the birth.

Clinical implications

There is a need to involve immigrant parents in parental education in order to prepare them for the reality of parenthood in their new country as well as for exploring their changed family situation. Collecting immigrant women and their partner's experiences of the MHC, offers a possibility to improve the existing care, both in content, access and availability, where also the timing of visits and content require further evaluation.

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