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Meeting families in various social situations: reflections from healthcare staff working with an extended home-visiting program in Sweden

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Abstract

Objectives Health inequalities exist among children in Sweden, and one effort that the Swedish government has focused on to promote health among small children and their parents is an extended home-visiting program during the child's first 15 months. This study aimed to illuminate healthcare professionals' experiences of meeting parents in different social situations during the home visits within Grow safely.

Methods The chosen method was qualitative, and 13 interviews were carried out with healthcare, social, and dental professionals working with the extended home-visiting program within the child healthcare in the south of Sweden.

Results The results revealed that the parents raised differing needs in the meetings with the healthcare professionals in the program. The needs included advice on children with special needs, support with problematic breastfeeding, and more psychosocial support. The professionals met different groups of parents, such as young parents or newly arrived migrant parents, that in different ways needed the team to reach out to them. The professionals also met families who came from better-off areas and who were not initially considered to really need the program. As the program progressed, these parents could see that diverse, unpredictable needs could be met by the intervention. For example, the program provided access to and advice from social workers, which in turn created contacts that lasted longer than the program itself.

Conclusions The professionals encountered various family situations and needs within the extended home-visiting program. This highlights the need for a close collaboration between child healthcare nurses and social workers, in order to be able to support the families and work towards the aim of reaching equal health among all children in Sweden.

1 Introduction

The goal of the Swedish child healthcare system is to reach and promote health and well-being among all children aged 0–6 years and to support parents [1]. Specialist nurses working within child healthcare regularly meet families, closely follow children's growth and development, and give them vaccinations (through the national vaccination program); in addition, parental support groups are offered to all parents [1]. However, despite a well-functioning health program, health among children in Sweden is not equal, and several challenges within families (such as social isolation, housing issues, economic issues, and migration processes) could negatively affect the children and their parents [1]. According to the Public Health Agency of Sweden, early risk factors around small children need to be identified in order for the

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parents to make preventive efforts to protect their children against ill-health [2]. The health program that is given within the Swedish child healthcare consists of two home visits, one when the infant is newborn and one when the infant is 8 months old [1]. Home visits have been shown to benefit families in several ways. Research from both the US and Finland shows that home visits are beneficial both in the long and short run and could affect the child positively health-wise, physically and mentally, and they have also been shown to decrease excessive emotional sensitivity and to give fewer cases of speech delay [3–6]. A Swedish study demonstrated that home visits were well received and appreciated by migrants residing in Sweden [7].

To promote health among small children and their parents, the Swedish government has provided economic resources for starting extended home-visiting programs focusing on first-time parents during their child's first 15 months. An example of such programs is the Rinkeby project. The Rinkeby project consisted of six home visits by both nurses and social workers and took place in the vulnerable residential area of Rinkeby, outside Stockholm [8]. Inspired by the Rinkeby project, a similar extended home-visiting program was started within the county of Scania in 2019. The project was called Grow Safely, and it covered the whole county, both urban and rural areas [9]. Similar to the Rinkeby project, the Scanian home-visiting program offered first-time parents six home visits, but in addition to nurses and social workers, the professional team included midwives and dental assistants [9]. The midwife joined the nurse for the first visit (when the baby was 1–2 weeks), the social worker joined the nurse for four of the six visits (when the baby was 2–3 weeks, 4 months, 10 months, and 15 months), and the dental assistant took part in one home visit (when the baby was 8 months) [9]. So far, the results from Grow safely shows that healthcare professionals were satisfied working within the program and appreciated the collaboration among different professionals working together [10]. The healthcare professionals could learn from each other in the conversations with the families and also increase the support for the families through collaboration [10]. The families that received the program, appreciated it as well and felt that the professionals complemented each other through the knowledge and information that they received from different professionals [11]. Since the nurses and other professionals working with Grow Safely encountered a variety of parents within different social situations, and in both rural and urban areas, it is important to learn more about their experiences of meeting these parents during the home visits. This may be particularly important in the south of Sweden, since this part of Sweden has received a high influx of migrants during the last years [12], entailing different social, ethnic, cultural, religious, and parental needs. Therefore, this study aimed to illuminate healthcare professionals' experiences of meeting parents in different social situations during the home visits within Grow Safely.

2 Method

The current research note presents a qualitative study that derives from a larger research project called Grow Safely, which involves research on an extended home-visiting program in Scania, Sweden [9]. The whole research project has been running since 2019 and up until 2023 and has covered both qualitative and quantitative research regarding the experiences of not only the professionals involved but also the parents receiving the program. In the county of Scania, there are 150 child healthcare centers, of which 40 are family centers. In the Grow Safely project, a total of 26 child healthcare centers were enrolled, and 15 out of these were family centers. In all the included each child health care center within Grow safely, approximately 180 healthcare professionals were engaged. In total, around 600 children were enrolled in the Grow Safely.

2.1 Data collection

This study has been conducted through interviews with health, social, and dental care professionals who have worked within the program. The first author reached out to all health, social, and dental professionals working in all the included child healthcare centers within Grow Safely and requested them to participate in the interviews. Six pediatric nurses, one midwife, one dental assistant, and five social workers responded to the request and participated in the interviews. The informants came from eight different child healthcare centers (four of which were family centers). All interviews were conducted during 2021. They focused on how the healthcare professionals had experienced the home visits and their work within the program, and included probing questions. This data collection has already resulted in another publication, centered on the collaboration of the professionals within the program [10]. As the material obtained from the interviews was rich and several research questions were covered, it also included a focus on the professionals' experiences of meeting parents in different social situations during the home visits within Grow Safely. Illuminating the latter

aspects is the aim of the current paper. The interviews lasted between 25 and 76 min, and they were recorded on Zoom and transcribed shortly afterwards by both authors.

2.2 Data analysis

First, the data was read through, reread, and coded by the first author. The material that answered the aim of the current study was coded, and the codes that were similar were grouped into categories. Then the coded material was read by the second author, who provided feedback on it. The data was analyzed with content analysis following Burnard [13].

2.3 Ethical considerations

The interviews were carried out according to the ethical code and guidelines of the Declaration of Helsinki [14]. Informed consent was obtained from all subjects and they were ensured that the interviews were voluntary and could be finished at any time at the informants' request. According to Swedish Law, ethical approval is not necessary for studies that do not explore sensitive issues (e.g., political, sexual, or religious) [15]. However, the present study is a sub-study in the larger Grow Safely project with ethical approvals (Reg.no. FO 4.3-2018 and Reg.no. 2019-03266) granted by the Ethics Boards in Lund and Uppsala, Sweden.

3 Results

Totally, 13 health, social, and dental professionals were interviewed, and they had a working experience within their field of, on average, 16 years (ranging from 4 to 26 years). The results of the analysis were divided into three categories: *Being able to respond to different needs*, *Meeting families with challenging backgrounds*, and *Even families in a better-off situation have a need of the program*.

3.1 Being able to respond to different needs

Through the Grow Safely home-visiting program, the informants encountered families with a variety of needs. The analysis of the results revealed meetings with, for instance, families with children with special needs and families where the mothers were only teenagers, circumstances which made these families more needing of support. The healthcare professionals experienced that Grow Safely needed to cater to the needs of the involved families. This was especially important when encountering needs for professional support in overcoming certain challenges, such as problematic breastfeeding, dealt with by the midwife and the nurse, and parents with mental ill-health a concern for both nurses and social workers. An extensive need for psychosocial support was demonstrated during the Grow Safely home-visiting program. Although this need could to a certain degree be met by the Grow Safely team, extended support after the program was also needed. This was expressed as follows by one of the informants:

> *We would need more help with psychosocial support around when the children are 2.5 years and when the parents are back working and, at the same time, they must manage the development of the child as well as the needs that the child has. (A10)*

According to the professionals, it is not uncommon for parents to suffer from mental ill-health, especially today when first-time parents face high demands in society. As it can be difficult for parents to manage these demands, they need support from the child healthcare team. The informants expressed that they tried to normalize what it is like to be a parent and explain that all parents can face problems. Both nurses and social workers found that the Grow Safely home-visiting program facilitated such conversations, where parents seemed to feel free to express themselves about their challenges.

3.2 Meeting families with challenging backgrounds

The professionals met different groups of parents during the program. For example, they met newly arrived migrant families, single-parent families, and families dependent on social welfare for economic support. One of the professionals described a meeting with a newly arrived family like this:

Some of these people have problems with the Swedish language and need help to, for example, apply for their daycare school placement. (A6)

Some of the parents in the program were from vulnerable areas and were unemployed or on sick leave and could therefore be considered a group of parents with particular challenges. One of the professionals talked about meeting these families in the following terms:

We are used to meeting families in socially and economically vulnerable situations, which makes us prepared for these situations when meeting them during the current project. (A12)

Another aspect of meeting newly arrived migrant families within this program was that the healthcare team had to be able to help these families become familiar with how to raise children in a Swedish context and understand the prevailing expectations for parenthood in this context.

3.3 Even families in a better-off situation have a need of the program

The professionals talked about the fact that they mostly met families who were better off and who were usually second or third generation immigrants with a higher level of education. Generally during these home visits, the dialogues flowed effortlessly and the parents hardly had any questions. At the same time, the professionals realized that these parents would really need information and support at some point, so they continued the conversation. In such a situation, they found joy in helping these families build up knowledge for the future. One professional described encountering one of the better-off families as follows:

We have one family that we probably wouldn't have thought would have needed this program, based on where they live and what they work with, but they have got really good help and now have a good contact with the social worker. (A5)

Further, there was a concern among the professionals about who should be in the program and who should not, especially with regard to the ones that were better off. However, it was concluded by one of the professionals that those families who were in a better-off situation also deserved to be in the program and that they too might be in need of it.

4 Discussion

The results revealed that, through the home-visiting program, the healthcare team could meet different groups of people (such as young parents, newly arrived migrant parents, parents on sick leave, or parents with mental ill-health) who in different ways needed the team to reach out to them, and this included parents from better-off situations. The fact that different groups of parents in society may have different needs, due to both internal and external factors, is important to consider. The Swedish child healthcare strives for equal health among all children that they encounter and aims to give special support and attention to families in need [1]. Furthermore, as the parents and their children have different needs, a close collaboration between the child healthcare center and the social workers is essential. Such collaboration has been shown to be positive, in earlier studies in Sweden, demonstrating how the nurse and the social worker complemented each other and could offer different perspectives for helping and supporting the families, both in practical work and through dialogues [16, 17]. This was also confirmed in an earlier study within Grow safely, where the professionals expressed that they learned from each other and that the conversations with the families were deepened through the close collaboration between for example the child healthcare nurses and social workers [10]. For example, the social workers were more confident and skilled in talking about domestic violence and could help and support the nurses in these discussions. The satisfaction with different professionals working together in Grow safely, was also expressed among the

families receiving the program [11]. This underlines the importance of collaboration between healthcare professionals for the possibility to meet the needs of families in different social situations. This is particularly important today in Sweden, where some of the marginalized groups of society have doubts regarding the intentions of social workers and fear being in contact with them, as they are afraid their children will be taken away from them [18, 19]. This emphasizes the need for building trust with the social workers at an early stage and also for a close collaboration between child healthcare nurses and social workers in the future, in order to meet the needs of the families that they are in charge of within each health service. Based on the program's more collectivist approach through the mutual support between the professions, this became something natural that the professionals brought with them in the work of supporting the parents in their parenting based on their respective needs [20]. Efforts in that direction could be facilitated through the family centers that several of the included child healthcare centers in the Grow Safely project are part of, since there the contact between the social workers and the child healthcare nurses is established from the start. Such a close collaboration could benefit the needs of each family enrolled in the health service, which could ultimately improve the overall health among the families in Sweden and support the aim of achieving equal health among all children in the country [1].

5 Conclusions

The health, social, and dental care professionals served various support functions in different family situations and regarding different needs, within the extended home-visiting program in the county of Scania. This shows that interprofessional teamwork is crucial to meet the various needs of each family that the team encounters during the home visits.

6 Limitations

The study would have been better had we been able to recruit informants from more than eight child healthcare centers. It would also have been beneficial to recruit more midwives and dental assistants for the interviews, but the 13 informants who participated were the best we could recruit. The sample could therefore be considered a convenience sampling, which could be viewed as a limitation for this study. It is a strength that both authors conducted and transcribed the interviews (EM eight interviews and MH five) and that they both have prior experience with qualitative research. The first author (EM) has a pre-understanding of child healthcare and the second author (MH) has experience in social work and therefore a pre-understanding of that field. The coding of the data material was done first by the first author and then independently by the second author, and subsequently discussed between both authors, in order to ensure credibility [21]. Transferability is up to the researcher or practitioner who aims to transfer the results into their own setting [21]. But the transferability of this study could be limited, since only 13 health, dental, and social professionals were included, representing only eight child healthcare centers.

Author contributions EM conducted eight interviews and transcribed these, and MH conducted five interviews and transcribed these. EM conducted the analysis and the writing of the current paper, and MH provided methodological considerations and approved and read the last version of the paper.

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Availability of data and materials The datasets presented in this article are not readily available because pursuant to national legislation, ethical review boards in Sweden do not allow release of sensitive raw data to the general public.

Declarations

Ethics approval and consent to participate Informed consent was obtained from all subjects, who were informed that they could withdraw from the study at any time. According to Swedish Law, ethical approval is not necessary for studies that do not explore sensitive issues (e.g., political, sexual, or religious). However, the present study is a sub-study in the larger Grow Safely project with ethical approvals (Reg.no. FO 4.3-2018 and Reg.no. 2019-03266) Granted by the Ethics Boards in Lund and Uppsala, Sweden.

Consent for publication Not applicable.

Competing interests The authors declare that they do not have any competing interests.

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