Contextualising a South African social innovation for maternal and child health to mothers with experiences of migration in Sweden

PER KÂKS
Abstract

Despite a universally accessible and high-quality welfare system, disparities in health and wellbeing persist between families who have migrated to Sweden and the native population. The South African Mentor Mother programme, a social innovation for maternal and child health among socially disadvantaged communities, was transferred and adapted to benefit mothers and pregnant women with experiences of migrating to Sweden.

This thesis aims to explore the adaptation, implementation and further development of the South African Mentor Mother programme in two locations in Sweden, based on professional and lived experience among various groups of stakeholders.

In Study I, three workshops and eleven interviews were held with stakeholders to explore central aspects of the adaptation process. These aspects entailed prioritising social determinants of health over health behaviour change, using indirect mechanisms and social ripples to achieve change, prioritising referring clients over intervening directly, recruiting peer supporters with competencies responding to a heterogeneous socio-cultural context, and allowing flexibility in programme content and methods.

In Study II, nineteen interviews with different stakeholders and digital field logs of peer support meetings (n=1,294) were used to evaluate the implementations of the programme. Contextual factors of importance included institutional mistrust, gender norms, unpredictable funding, and the organisation's third sector affiliation. Peer supporters prioritised linking clients to welfare services over educational intervention components, and sometimes experienced blurring between professional and personal roles. Practical support and trustful relationships emerged as important entry points to support more sensitive issues.

In Study III, the photovoice method was used to conduct a focus group discussion and six interviews with Mentor Mothers and their coordinator in Gothenburg, exploring how they developed empowerment strategies perceived to be relevant, feasible and effective. These strategies consisted of various aspects of using both informative, practical, psychosocial and motivational support to meet community health and social needs.

In Study IV, twenty-one interviews with Mentor Mothers, client mothers and other stakeholders were conducted to explore the emergence and management of mistrust in welfare services in Gothenburg. Mistrust was described to arise through rumours, unclear interactions with services, and lack of familiarity with the welfare system. Mentor Mothers used various strategies to build trusting relations with clients, which enabled them to promote institutional trust through information and humanisation of service providers.

This thesis illustrates how innovative community-based solutions to complex societal problems can be transferred between contexts, implemented and further developed to ensure their relevance to the target group.

Keywords: Social innovation, peer support, migration, parenting, parents, children, health promotion, trust, mistrust, implementation, empowerment

Per Kåks, SWEDESD - Sustainability Learning and Research Centre, Akademiska sjukhuset, Uppsala University, SE-751 85 Uppsala, Sweden.

© Per Kåks 2024

ISSN 1651-6206
ISBN 978-91-513-2069-4
URN urn:nbn:se:uu:diva-524965 (http://urn.kb.se/resolve?urn=urn:nbn:se:uu:diva-524965)
List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.


* These authors contributed equally to this work and share first authorship.

Reprints were made with permission from the respective publishers.
Contents

Preface ........................................................................................................................9

Overall introduction to the project ................................................................. 11

Background ............................................................................................................ 12
  Conceptual framing .................................................................................. 12
  Migration, health and parenthood in Sweden ......................................... 13
  Trust and its relation to public health ....................................................... 14
  Social innovation in health ........................................................................ 16
  Peer support ............................................................................................... 20
  Empowerment in health promotion ......................................................... 22
  The Mentor Mother programme ............................................................... 23
  Summary of programmes ........................................................................... 23
  Philani in Western and Eastern Cape, South Africa .................................. 25
  Yallatrappan in Malmö, Sweden ............................................................... 27
  Tidigt föräldrastöd in Gothenburg, Sweden .......................................... 31

Rationale ........................................................................................................... 35

Aims and objectives .......................................................................................... 38

Methods ............................................................................................................. 39
  Study design .............................................................................................. 39
  Study contexts ............................................................................................ 41
  Samples ....................................................................................................... 41
  Data collection ........................................................................................... 42
  Analysis ....................................................................................................... 45
  Ethical considerations ................................................................................. 48

Results ............................................................................................................. 50
  Study I ...................................................................................................... 50
    Focus on the social determinants of health ............................................ 50
    An organic systemic approach ............................................................... 52
    Linking to existing services ................................................................... 52
    Matching peer supporters with the community .................................... 53
    An intervention governed by flexibility ................................................ 53
# Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTL</td>
<td>Det tidiga livet</td>
</tr>
<tr>
<td>GDPR</td>
<td>General Data Protection Regulation</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>SIHI</td>
<td>Social Innovation in Health Initiative</td>
</tr>
<tr>
<td>TF</td>
<td>Tidigt föräldrastöd</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>YT</td>
<td>Yallatrappan</td>
</tr>
</tbody>
</table>
I have always been interested in cultures – both my own and others. Perhaps I can trace it back to my grandmother, who has invested a lot of time and engagement in matters related to international development cooperation and migration throughout her life. During my undergraduate years, I studied cultural anthropology in parallel with medicine. Early on, I had the idea that I wanted to do something more with my professional future than focusing solely on clinical medicine. Both my anthropology studies and experiences such as travels gave me insight into how social and cultural beliefs about ourselves and our place in the world affect how we interact with other people and society. Naturally, this was applicable to public health in many ways. My medical training sometimes touched upon issues such as social disparities in health and healthcare consumption, but the explanatory models were often limited to socio-economic factors. Perhaps it was that less tangible factors such as trust and a sense of belonging did not quite fit into the ontology and epistemology in which we were trained.

The biomedical perspective I had gained through medical studies and practice was increasingly complemented by a broader understanding of health and wellbeing. At one point during my undergraduate studies, my mother gave me a copy of Aaron Antonovsky's book *Unravelling the Mystery of Health*, in which the author outlines the salutogenic model of health and wellbeing and the concept of sense of coherence. Something inside me clicked at that point. Somehow it was only then that I fully understood the value of health promotion and realised how interesting I found the link between health and factors such as social capital.

I have thoroughly appreciated the opportunity to explore such topics further during this PhD project. My doctoral studies have also given me the opportunity to reflect on Swedish culture at large and how public health ties to overall social and political developments. This project has therefore not only given me knowledge that I will have use of throughout my career, but also new perspectives on the culture and society I live in.

The studies I have conducted have largely focused on communities that are socially disadvantaged in various ways. An important insight I take with me is, however, the strengths and opportunities that can also be found within these communities. Sometimes the solutions to complex societal problems are
closer than what we might think. It is my hope that the studies I have conducted can be useful in some way for others who are interested in the development and implementation of community-based initiatives aiming to channel these strengths.
Overall introduction to the project

The link between migration and health is complex. For families with young children, migration can in many ways be positive as it can often offer an opportunity to start a new life in a context where the social determinants of health in the best case are favourable. However, parenting in a new socio-cultural context can also be challenging in many ways. New norms, expectations and practices can take time to navigate. For first-time parents, this can be particularly difficult as all aspects of pregnancy, birth and new life take time to fully comprehend and render manageable.

This process of becoming a parent in a new sociocultural context can be facilitated through innovative means. One such innovation is the Mentor Mother programme developed in South Africa. The programme is based on the idea that peer support through the parenting process can benefit both maternal and child health and social outcomes. The Mentor Mother programme was adapted to two sites in Sweden, aiming to provide peer support to socially disadvantaged mothers of young children and pregnant women with experiences of migration. Social disadvantage in this context includes both socio-economic factors such as income and education, but also factors such as the ability to participate in society and utilise its resources, which can be limited by a variety of social barriers such as challenges related to communication and access to information.

The process of transferring an innovation developed in a low-income context to a high-income context is somewhat innovative in itself and can be seen as representative of a new dynamic between different countries in global public health. This thesis aims to explore different aspects of this process, including how the programme was adapted, implemented and further developed to meet community needs.
Background

Conceptual framing

The studies in this thesis draw on concepts and theories from several areas of research that cover various public health challenges and ways to respond to such challenges. More specifically, these research areas cover the links between migration and health, including challenges in the form of stressors related to migration among parents and barriers to utilisation of health and welfare services among those with migration experience, the latter including low accessibility and institutional mistrust. Responses to such challenges can take the form of peer support, which can be described as a type of social innovation in health, which can be used to promote trust in welfare services and empowerment through various mechanisms.

Understanding the nuances of these research areas and their concepts – i.e. migration and health, trust and mistrust, social innovation in health, peer support and empowerment – enables a deeper understanding of how the programmes studied in this thesis were adapted, implemented and further developed. The relationships between the central concepts in this thesis are presented in Figure 1.

Figure 1: Relationships between central concepts
Migration, health and parenthood in Sweden

Sweden has a long history of immigration that has taken different forms in different time periods. Extensive labour immigration in the early 20th century peaked in the 1950s and 1960s, after which asylum immigration became more dominant in the 1970s. The later 20th century was marked by the arrival of political refugees from Iran in the 1980s and victims of the Balkan civil war in the 1990s. In the 21st century, those arriving as refugees have often migrated from parts of sub-Saharan Africa and the Middle East. The peak in arrival of refugees took place during 2015, among other things as a consequence of the civil war in Syria.

In 2023, around 100 000 immigrants were granted residence permits in Sweden. Some of these were granted asylum (16%), while others were granted permits on the grounds of family ties to current residents (25%), labour migration (36%), studies (15%), relocation within the European Union (7%), or that a rejection of the asylum application could not be enforced, e.g. because the country of origin refuses to receive the person (1%). Among those seeking asylum, some of the most common countries of origin over the past ten years have been Afghanistan, Iraq, Syria, Iran, Somalia, and Eritrea.

Migration is linked to public health in various ways. A well-researched link is the phenomenon called the ‘healthy migrant effect’, a term that refers to the fact that many newly arrived immigrants have better health than the general population in the new country, especially during the first 5-10 years. This is explained by a selection effect where those in good health are more likely to have the capacity and resources to undertake migration.

However, migration is often a stressful process. In line with this, research in Sweden has indicated that the health of parents who have migrated and their children varies depending on the context they have migrated from and the outcomes measured. For example, a study by Juárez and Revuelta-Eugercios showed a higher risk of premature birth among mothers who have migrated from Central America, Eastern Europe, the Middle East and Africa, and a higher risk of low birth weight among children born to mothers who have migrated from Eastern Europe, Africa and Southeast Asia. This shows how the healthy migrant effect might not be applicable to all groups and health outcomes. Social and environmental challenges can occur before, during and after migration, and these can negatively affect health and wellbeing of those who migrate if the necessary resources are not available to respond to them. The post-migration settlement process can involve stressors such as uncertainty about livelihoods, housing and residence permits. It can also entail challenging adjustments to a new social life as well as new norms and social expectations surrounding issues such as parenthood. Social challenges related to migration thus have implications for the services that the welfare system should provide and accommodate for those migrating to Sweden.
Ensuring stable life conditions and opportunities for parents and their chil-
dren is vital to ensure good health and wellbeing through the life course. In
line with this, Sweden has a highly universalist welfare system and the condi-
tions of early life is a public health priority. However, in order for the wel-
fare system to be used effectively, it is important that it is not only highly
available but also highly accessible. This includes, for example, clear commu-
ication to mitigate language barriers and easily accessible information on
where to turn for help in different situations. In Europe as a whole, the un-
derutilisation of welfare services among marginalised groups is linked to a
variety of factors. These include language difficulties, discrimination, chal-
 lenges in grasping the organisation of the welfare system and the range of
services available, and institutional mistrust. A consequence of such bar-
riers is lower use of preventative health services and higher use of emergency
services. The trend towards lower use of preventive services, combined with
a general socio-economic disadvantage among families who have migrated to
Sweden from countries outside of Europe, has tangible health consequences.
A striking example of this is that the infant mortality rate among children of
parents who have immigrated from outside of Europe is about twice as high
as among children of parents born in Sweden.

In a systematic review on challenges in health care delivery to immigrants
in high-income countries, Brandenberger et al. have described these barriers
as suboptimal continuity, communication and confidence. Communication
includes factors such as the language skills of the service provider and the
availability of interpreters, which in turn facilitate continuity and confidence.
Continuity with service providers is affected by factors such as beneficiaries'
knowledge of the welfare system, service accessibility and collaboration be-
tween different services. Confidence refers to both a sense of control amongst
service users and to trust in services. With this in mind, it is important to con-
tinue exploring ways to promote such dimensions of the welfare system to
ensure good life conditions for both parents and children, which can lay the
foundation for health and wellbeing throughout the life course.

Trust and its relation to public health

The concept of trust, as it relates to public health, has dimensions that need to
be clarified in order for it to be operationalised. Trust has been defined as
having two components: firstly, a willingness to be vulnerable in contacts with
another party, and secondly, positive expectations of the behaviour and inten-
tions of the other party that enable this vulnerability.

Institutional trust, i.e. a general trust in authorities or societal functions, has
been linked to subjective wellbeing on an individual level. The concept is
also relevant for public health because of the link between institutional mis-
trust and underutilisation of health and welfare services. This is a fact that
has had tangible consequences in terms of vaccine hesitancy, not least during the COVID-19 pandemic.\textsuperscript{27–29} Institutional trust has also been linked to health behaviours, self-reported health and a range of health outcomes.\textsuperscript{30–32}

Some studies indicate a positive impact of institutional trust on interpersonal trust, i.e. a perception that other people can generally be trusted, a relationship that may be mediated by feelings of security.\textsuperscript{33–35} Interpersonal trust is linked to wellbeing,\textsuperscript{25,36} better mental health and lower psychosomatic symptoms,\textsuperscript{37,38} higher self-rated health\textsuperscript{36} and lower all-cause mortality.\textsuperscript{36,39} It is also crucial for a functioning society, as higher interpersonal trust is linked to higher civic engagement and an economically and politically viable state.\textsuperscript{30,41}

Trust can be understood as a scale ranging from high trust to low trust. However, the concept of mistrust refers to something that is distinct from low trust, as it also involves feelings of unease or suspicion.\textsuperscript{42} This sentiment is often directed towards whole systems, dominant cultures or populations with power. A similar but separate term is distrust, which has been conceptualised as an unease or suspicion directed towards a specified object, i.e. an individual or a specific service, sometimes due to them being seen as representatives of a discriminating system.\textsuperscript{42}

Distrust and mistrust can be rooted in personal experience, but does not always have to be. Both concepts may rather be driven by distant causes such as the negative experiences of others with prejudiced institutions or discrimination at the societal level. These distal causes can then be mediated by proximal drivers such as negative narratives or discourses within groups.\textsuperscript{31} In other words, mistrust and distrust can be reactions to very real phenomena, such as marginalisation, even in cases when these sentiments are not directed at the right object or based on accurate explanatory models.

The unusually high generalised trust in the Nordic countries has been described as ‘the Nordic exceptionalism’.\textsuperscript{43,44} This trust has contributed over time to political stability and a well-functioning public sector. As in other parts of the world, both interpersonal and institutional trust are lower among groups with lower income, education and self-reported social status in Sweden.\textsuperscript{44–47} On average, those who have migrated to Sweden also have lower trust in the healthcare system than the general population.\textsuperscript{46} In recent years, mistrust of social services among various socially disadvantaged immigrant groups has received particular attention in Sweden.\textsuperscript{12,48,49} This mistrust is connected to the spread of rumours that the social services take custody of children on social grounds without justifiable and transparent processes. Some qualitative research has indicated that this can lead to parents who have immigrated to Sweden avoiding contact with welfare services for fear of being seen as inadequate parents and thus being reported.\textsuperscript{12}

Few interventions have focused specifically on building institutional trust. In relation to vaccines, trust-building initiatives have largely focused on providing information and promoting awareness through strategies such as use
of mass media, communication tools for health care workers, and the use of trusted messengers to provide this information. In the context of research, initiatives to promote trust and participation among marginalised groups have involved long-term engagement, participant-centred approaches and building personal connections. These strategies can be described as the promotion and communication of a set of distinct values underpinning institutional trust. A widely referenced framework for building trust by Mayer et al. highlights three crucial values that must be displayed to gain trust:

- **Ability**, which is the perceived group of skills and competencies that are relevant for being able to have influence within a relevant area,
- **Benevolence**, referring to a perception of the trustee as having motives aligning with those of the trustor, and
- **Integrity**, meaning a perception that the trustee adheres to principles that the trustor finds acceptable.

In an official report of the Swedish government on institutional trust, these three dimensions has been framed by Bringselius as *being able to help, wanting to help, and daring to help.* Regarding the dimension of ability, Bringselius underlines that this is not limited to individual or organisational competencies, but also includes legal frameworks or organisational structures that determine the possibilities for action.

Mayer et al.’s framework has been used to guide the development of and research on various public health initiatives in contexts where trust is crucial. These include initiatives in Sweden, ranging from postnatal home visiting programs to elderly care. Similarly, the framework has also been used, for example, to explain trust in different health information providers in the United States and child welfare services in Norway.

The studies in this thesis focus on how maternal and child health can be promoted in a social context characterised by a lack of trust in institutions. Working on health promotion in such a context requires innovative methods and a commitment to also promote interpersonal trust between those delivering and receiving support.

**Social innovation in health**

Over the last century, medical advances have led to major opportunities to improve public health. In parallel with these developments, a high level of ambition for good and equitable health has emerged as a central part of the Swedish political agenda. However, this ambition can only be realised if all parts of the population take part in the range of welfare services available, both in terms of health care and the social aspects of welfare. In addition to
institutional mistrust, barriers to service use can include geographical, cultural, social and linguistic aspects of the services. In other words, effective service provision requires a focus not only on what is provided within health and welfare systems, but also how it is provided. Innovative solutions for providing health and welfare services thus not only involve the development of new services per se, but may also include new ways of making already existing services more accessible.

Social innovation has emerged as an overarching framework to conceptualise a wide range of innovative solutions to complex societal challenges. The concept of social innovation has received a variety of definitions, a common one being formulated by Mulgan and Pulford, stating that:

Social innovations are innovations that are social both in their ends and in their means. Specifically, we define social innovations as new ideas (products, services and models) that simultaneously meet social needs (more effectively than alternatives) and create new social relationships or collaborations.

This definition highlights how social innovation can be contrasted both with commercial innovation in terms of ends, i.e. with a priority for social rather than economic gains, and with innovation in merely physical products in terms of means, i.e. by bringing about change through new forms of social organisation. It also highlights the interactive and collaborative aspects of developing and implementing social innovations, which can include interpersonal, inter-organizational and inter-sectoral cooperation. Entities that create hybrid (economic and social) value, such as social enterprises, also show that different motivations for innovation do not necessarily have to collide. One common feature of social innovations is that they are often formed by the combination of already existing resources in new ways to harness latent value.

Interest in the concept and terminology of social innovation has increased in academia in recent decades. Innovative solutions to complex societal challenges always existed, but have often been described using different terminology in fields such as service design, public health, social work and business management. The benefit of adopting a new shared terminology can be that it creates a common framework that facilitates interdisciplinary and inter-sectoral engagement in issues that previously might have been approached within individual disciplines and sectors.

Social innovations can involve more than one sector and different types of stakeholders in multi-sectoral collaborations can play complementary roles. The public sector can promote innovation and fund innovations in other sectors, but it is often reluctant to invest in solutions that have not been proven effective for fear of wasting taxpayers' money. On the other hand, the non-profit sector is highly flexible in developing innovative intervention models and adapting them to perceived needs and conditions. However, this flexibility can sometimes be hampered by conditional public funding. The non-profit
sector can fulfil a function both as a provider of new services and by compensating for existing but rigid public services. The private sector can develop and implement social innovations both through social enterprises and through corporate social responsibility programs. Academia can contribute both with innovative intervention development and by evaluating and shedding light on new aspects of existing innovations.

Social innovation has been proposed to represent a new paradigm in public health innovation, embracing complexity thinking and consideration of social values. Complexity thinking involves an interdisciplinary and comprehensive approach to understanding problems and their solutions, avoiding reducing and simplifying complex problems and instead looking at the interaction between individual parts and the larger whole. This can be done by seeking system-wide approaches to complex challenges. A concrete example is to understand mental ill-health not only as a consequence of individual factors but as a feedback loop between collective social processes (as understood e.g. through sociology) and individual neurobiological processes (as understood e.g. through psychiatry). As such, the complexity thinking that underpins social innovation allows for a systemic and holistic approach to health promotion.

However, the term social innovation in health is often used specifically for innovative ways of delivering healthcare. The multilaterally funded stakeholder network Social Innovation in Health Initiative (SIHI) defines social innovations in health as ‘inclusive solutions to address the healthcare delivery gap that meet the needs of end users through a multi-stakeholder, community-engaged process’. This focus on healthcare delivery implies a focus on prevention or curative services rather than health promotion. However, the results of such innovations often extend beyond clinical outcomes to include changes in social relationships, social inclusion, empowerment of individuals and communities, and greater health system resilience. Thus, the clinical focus that is implied in this definition of social innovations in health does not capture all aspects of these innovations, but may rather reflect traditions within the discipline. In comparison to other disciplines, health researchers tend to more often use the term social innovation in a technocratic and instrumental sense, aiming to promote patient participation in health programmes. In contrast, a broader definition of social innovation in health can also include community-based health promotion that takes place outside a clinical context. This can entail initiatives to tackle inequities in social determinants of health by, for example, promoting physical activity in public housing communities or promoting mental health among elderly through reducing social isolation.

Globally, social innovations in health are often developed and implemented within the non-profit sector. Mulgan et al. has suggested that cutting across sectors and disciplines is one of the defining features of social innovations. This, together with acknowledgement of the intricate interplay between the causes of health inequalities, leads social innovations for health promotion
to often include new organisational forms or collaborations. While the non-profit sector is seldom described as a central part of the welfare system in Sweden, there are many examples of actors within the sector that compensate for or complement the health and social care systems in various ways.

Social innovations in health can entail both new processes and services (e.g. new types of health services or care pathways), products (e.g. phone applications), new roles and behaviours (e.g. task-shifting approaches), market mechanisms (e.g. social impact bonds), and paradigms or policies (e.g. decriminalisation of drug use). Ideally, social innovations in health have an active involvement of the target group in design and implementation in order to ensure the relevance and anchoring in the context where the innovation is implemented. Thus, beneficiaries are often involved as active co-creators rather than passive recipients, reflecting a bottom-up approach to innovation. Another way in which this bottom-up approach can manifest itself is through continuous adaptation to the needs of the beneficiaries. This can be done either through systematic mapping of these needs and subsequent planned adaptations, or through flexibility and adjustability in the implementation of the innovation.

Social innovations that have proven to be effective on a small scale can be scaled in several ways to increase their impact. This scaling process does not always entail organisational growth, but can be undertaken to increase impact through other means. Moore et al. have described this in terms of three typologies:

- **Scaling out:** Increase reach by increasing the operational capacity or by replicating the intervention model to a new context.
- **Scaling up:** Increasing reach and viability through institutionalisation and formalisation, by integrating civil society-driven solutions into the public sector or by influencing policies, regulations and laws.
- **Scaling deep:** Consolidating the fundamental ideas of the innovation by influencing deeper values such as cultural beliefs, practices or norms.

Using Moore et al.’s typology, scaling out can be done by transferring the innovation from one social or cultural context to another. Optimally, this is done with careful consideration of the various enabling and hindering factors within both external and internal (i.e. organisational) contexts to which the innovation will be transferred. Four groups of factors affecting the success of such transfers of social innovations have been described by Mulgan and Pulford:

- **‘Push’ factors**, in the form of effective supply. This refers to innovative solutions that have been shown to be effective and feasible, and that are effectively communicated and disseminated.
• ‘Pull’ factors, in the form of effective demand. This is constituted both by an acknowledged need that the innovation can address, and recognition from stakeholders with financial capacity to address it.
• Strategies to connect ‘push’ and ‘pull’. These include organisational forms with capacities and strategies for implementation.
• Continuous adaptation and learning. This can include user involvement in adaptation and implementation, responsiveness to emerging needs, evaluation of the implementation, and a readiness to adapt to changing circumstances.

Research can fulfil functions in relation to all these points, and thus provide different types of value during various stages of the process of transferring and contextualising the innovation. Firstly, trials can demonstrate the effectiveness of social innovations in terms of health or social outcomes. Secondly, needs assessments can show what unmet needs exist in the new context and the factors that affect how these can be met. Thirdly, research on the implementation and adaptation processes can be used to examine dimensions such as feasibility and acceptability in both the original and the new context, the capacity for implementation, how implementation is carried out, how the innovation is adapted and used in practice, and the contextual factors that influence this.

Peer support
One way to conduct socially innovative health promotion is through peer support. The concept of peer support is based on the idea that problems can best be understood by individuals who share certain characteristics or experiences with the person receiving support. This shared background both allows for building credibility through an understanding of the problems the recipient faces and promotes personal and emotional connection. The peer support can have both emotional and instrumental aspects, where the instrumental aspects can build on a logic of both providing direct intervention (e.g. breastfeeding support) or linking to other services (e.g. by connecting supported individuals with relevant health services). The underpinning idea of peer support is not to compete with traditional health and welfare services, but rather to complement them by offering components that are difficult for professional services to provide. This can include building deep emotional ties or acting as a role model. Being a role model can include a mentoring component that involves expressing a belief in the individual and their capacity, agency and development. In line with a notion of emotional connection being a central component, peer support programs have been shown to be more successful when they report having strategies building on trust and respect.
An underpinning mechanism is the liminal position occupied by peer supporters. Liminality is defined as being between two identities with the possibility of adopting both at the same time. In the case of peer support, this liminal position exists between professional and private roles. Balancing these two roles allows the peer supporter to build strong personal relationships while also engaging in professional tasks, such as facilitating the interaction between formal services and the individual being supported.

Peer support programs exist in a variety of organisational contexts, both clinical and non-clinical. The concept has been extensively employed to promote health, wellbeing and psychological resilience in mental health services, where the peer supporters are individuals who themselves have overcome or learnt to manage mental ill-health. Peer support has also been used extensively to promote health and wellbeing for non-communicable diseases and maternal health.

There are also many examples of peer support being used to complement health care, or the wider welfare system, through community-based initiatives implemented outside formal health and welfare service settings. This can for example be through home-visiting programmes. In some cases, this support is specifically aimed to address social determinants of health, social connectedness and social integration among marginalised groups, rather than focusing on specific health outcomes. When the support is focused on such social factors, the concept of liminality is applied to the peer supporters’ experience of belonging to both those who are marginalised and those who are within society.

Peer supporters have a position where they are expected to be positive role models and provide guidance for others. Some research has focused on how this leads to a reciprocal exchange that also has positive effects for the peer supporters themselves. This can entail a reframing of peer supporters’ past adverse experiences to give them meaning in the present. Peer support interventions can thus be seen as having a bidirectional intervention logic, with expected positive outcomes for both parties.

In low- and middle-income countries, community-based peer support sometimes takes the form of community health workers, who act as an extension of primary care services provided by paraprofessionals who usually share characteristics with their target group. In high-income countries with high access to primary care, peer support is more likely to be seen as a parallel and complementary process to health and welfare services rather than an extension of them. Regardless of setting and relation to formal services, these programs have in common that support is provided in settings that are close to target groups. This can be in the form of home visits, online, through telephone, or in locations that are perceived to be neutral, sometimes being flexible in regards to location or mode of contact.
Empowerment in health promotion

As defined by Brodsky and Cattaneo, the concept of **empowerment** refers to the strengthening of self-efficacy and agency through changing attitudes, skills and knowledge.\(^{105}\) This can take place either at the individual or the community level. Empowerment differs from the closely related concept of **resilience.**\(^{105}\) Empowerment and resilience are described as related in that both concepts refer to the management of adversity. However, the concepts differ in the sense that empowerment refers to a capacity for transformative reaction that is acted out socially and aims at external change, while resilience refers to an adaptive response that takes place internally and aims at coping with a situation as it is. While both empowerment and resilience have been linked to positive change on an individual level,\(^{106–108}\) empowerment may be more closely linked to social integration in the context of immigration as it is more aligned with a notion of assertiveness.\(^{109–111}\)

Empowerment can be both a process and an outcome in itself. As a process, empowerment refers to how people can gain power to define and express their needs and to control decisions concerning individual, social and political factors that affect their health.\(^{112,113}\) A commonly highlighted aspect of this is that people can not be empowered by others directly, but can only empower themselves by gaining more of various forms of power.\(^{114,115}\) Others can, however, contribute to the process by promoting the conditions that enable empowerment to take place, which links empowerment to the concept of peer support. A World Health Organization (WHO) report on empowerment in health promotion emphasised that the most effective empowerment strategies are those that promote autonomy in decision-making, a sense of connectedness and community, and psychological empowerment of community members.\(^{116}\)

In research, empowerment has been measured in a variety of ways, using qualitative, quantitative and mixed-methods measures.\(^{117,118}\) This wide array of available measures reflect a heterogeneity in how empowerment is conceptualised. Using various measures, empowerment interventions have been shown to contribute to self-esteem and wellbeing.\(^{115,116}\) The concept has also been linked to tangible health outcomes such as higher life expectancy, lower child mortality and lower rates of depression.\(^{108,119}\)

Interventions aimed at facilitating community empowerment reflect an approach to health promotion that builds on bottom-up development of problem formulation and intervention development, aiming to let communities define their own problems and support their capacity to overcome these.\(^{120}\) This approach acknowledges the complexity and contextual variation in addressing health and its determinants, mirroring a view of public health interventions as ‘events within complex social systems’ rather than as sets of decontextualized components.\(^{121,122}\)

The bottom-up approach contrasts with a more top-down approach to health promotion, where the focus lies on the management of lifestyles or
health literacy through strategies specified by an external party.\textsuperscript{120} When empowerment is incorporated into a top-down approach, it is generally viewed instrumentally as a tool for behaviour change. While the two approaches each have their use and are not necessarily mutually exclusive,\textsuperscript{123} the benefits of community involvement in service design and research have become increasingly highlighted in the public health discourse.\textsuperscript{121,124,125}

As community empowerment interventions produce change in complex systems, comprehensive evaluations of such interventions need to account for non-linear changes that do not happen directly.\textsuperscript{126,127} It has been argued that this, in turn, requires a paradigm that emphasises exploration of how interventions can evolve through continuous community involvement and contextual adaptation, how change can happen in unpredictable ways, and how communities are impacted over longer periods of time.\textsuperscript{126–129}

The Mentor Mother programme

Summary of programmes

This thesis explores how a Mentor Mother programme developed by the South African organisation \textit{Philani} has been adapted, implemented and further developed in two locations in Sweden. The formats of the three programmes are summarised in Table 1. The studies included in this thesis focus on the programmes implemented by the organisations \textit{Yallatrappan} (YT) and \textit{Tidigt föräldrastöd} (TF) in Sweden.

Table 1: Summary of programmes

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Philani</th>
<th>YT</th>
<th>TF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location</strong></td>
<td>Western and Eastern Cape, South Africa</td>
<td>Rosengård, Malmö, Sweden</td>
<td>Bergsjön, Gothenburg, Sweden</td>
</tr>
<tr>
<td><strong>Year of foundation</strong></td>
<td>2002</td>
<td>2021</td>
<td>2021</td>
</tr>
<tr>
<td><strong>Peer supporter titles</strong></td>
<td>Mentor Mothers</td>
<td>Peer supporters (\textit{Yallalotsar})</td>
<td>Mentor Mothers (\textit{mentormammor})</td>
</tr>
<tr>
<td><strong>Number of employed peer supporters</strong></td>
<td>(~230)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>Initially six weeks, then training component in monthly meetings</td>
<td>Initially two weeks, then training component in weekly meetings</td>
<td>About four weeks as Mentor Mothers, four days as community doulas, and four days as cultural interpreters</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Supervision</strong></td>
<td>Weekly group meetings, and coordinator providing in-the-field supervision</td>
<td>Weekly group meetings, and coordinator continuously available for in-person or phone consultation</td>
<td>Weekly group meetings, and coordinator continuously available for in-person or phone consultation</td>
</tr>
<tr>
<td><strong>Target group</strong></td>
<td>Pregnant women and mothers of children up to age five, living in socially disadvantaged areas</td>
<td>Pregnant women and mothers of children up to age five, who are socially disadvantaged and have migrated to Sweden</td>
<td>Mothers of children up to age five, who are socially disadvantaged and have migrated to Sweden</td>
</tr>
<tr>
<td><strong>Strategy for recruitment of new clients</strong></td>
<td>Going door-to-door</td>
<td>Using own social networks, client’s networks, through open preschools, public places, ethnic associations</td>
<td>Using own social networks, client’s networks, referrals from maternal and child health services</td>
</tr>
<tr>
<td><strong>Intervention activities</strong></td>
<td>Individual meetings</td>
<td>Individual meetings</td>
<td>Individual meetings and group courses</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td>Clients’ homes</td>
<td>Peer supporters’ premises, open preschools, public places, clients’ homes</td>
<td>Mentor Mothers’ premises, clients’ homes</td>
</tr>
<tr>
<td><strong>Frequency of contact with individual clients</strong></td>
<td>Weekly to monthly</td>
<td>Tailored to individual needs</td>
<td>Weekly group courses, individual meetings tailored to individual needs</td>
</tr>
<tr>
<td><strong>Studies in this thesis</strong></td>
<td>-</td>
<td>Studies I and II</td>
<td>Studies III and IV</td>
</tr>
</tbody>
</table>
Philani in Western and Eastern Cape, South Africa

In 1978, the South African non-governmental organisation *Philani Maternal, Child Health and Nutrition Trust* (subsequently referred to as *Philani*) was established to prevent and treat malnutrition and infectious diseases among mothers and children in socially disadvantaged areas in Cape Town, Western Cape. These areas are referred to as townships, a term denoting underdeveloped and racially segregated urban areas that emerged in the late 19th century and were later upheld by the apartheid regime. During the 1980s and 1990s, South Africa was hit hard by the spread of human immunodeficiency virus (HIV), which became another focus of Philani’s work. The organisation also gradually realised that it was difficult to reach the most vulnerable families, who often did not have the resources or health to travel to the clinics. This motivated the development of an innovative community-based approach.

In 2002, Philani established the Mentor Mother programme. The Mentor Mother programme developed from the idea of *positive peer deviance*, an approach to community engagement that emerged from nutrition research in the 1970s. The concept refers to the notion that within any population there are individuals who use exceptional strategies to solve problems better than others, even if everyone in the group has access to the same resources. Building on these strategies, the individuals that are successful can support others with similar life situations in the community where they live. Applied to Philani's target group, this meant identifying women who manage to raise healthy children despite difficult social circumstances. These women have been employed as *Mentor Mothers*, providing peer support through home visits to other pregnant women and mothers of young children in their community. The programme has also drawn inspiration from nurse-led home visiting programs in the United States, which have demonstrated the value of using the home as an arena for community outreach.

The Mentor Mother programme was expanded to rural Eastern Cape in 2010. At the time of writing the programme employs around 180 Mentor Mothers in the Western Cape and around 50 in the Eastern Cape. The Mentor Mothers all work in the areas where they live. They draw their caseload from this neighbourhood, recruiting new client mothers by going door-to-door. By offering their services to all mothers in the area and not only those who are most at risk, they prevent their clients from being stigmatised by their contacts. The Mentor Mother programme is summarised by Philani in five principles that describe its prioritised activities:

1. *A careful recruitment process*. When recruiting Mentor Mothers, Philani aims to identify women who can act as role models for the
women they support. Continuous assessments are carried out during the initial training, and only those who can adequately fulfil the professional role can be permanently employed as Mentor Mothers.

2. **Appropriate training.** The Mentor Mothers receive training in the form of a six-week course. This training covers both theoretical components such as on health and development, and practical strategies such as motivational interviewing and behaviour change techniques. After the course, continuous training is also provided on a monthly basis.

3. **Home-based, action-oriented health intervention.** Meetings between Mentor Mothers and their clients are held in the clients’ homes. The support consists of monitoring child growth and discussing themes such as child development, maternal and child health, nutrition, infectious diseases such as HIV and tuberculosis, mental health, and adverse effects of alcohol. The Mentor Mothers also link families to clinic-based services if needed, and can sometimes assist with social matters such as applying for child grants. Home visits are made weekly to monthly, with higher frequency during late pregnancy and early childhood.

4. **In-the-field supervision and support.** Each Mentor Mother receives intermittent support and supervision in the field from programme coordinators. During weekly meetings with these coordinators, they also have the chance to discuss difficult cases.

5. **Monitoring and performance feedback.** Through field notes recording the activities of the Mentor Mothers and the health outcomes of their clients, data is collected on performance and effectiveness. This information makes it possible to identify particularly vulnerable clients and provide feedback to the Mentor Mothers.

The Mentor Mother programme in South Africa has been extensively evaluated. A series of trials have shown that it has contributed to improved health behaviours to prevent vertical (i.e. mother to child) HIV transmission, higher rates of exclusive breastfeeding, lower rates of depression, lower rates of symptoms of infections among children, higher antenatal care attendance, better vocabularies among children, and lower rates of hospitalisation among children. Several studies have demonstrated better child growth in client families receiving support from Mentor Mothers, with one study showing no effect on growth. The effects of the programme have been less pronounced among those receiving support in a rural setting, which might present unique challenges to implementation. These rural studies were also conducted later than the urban ones, and the less pronounced effects may also be due to improved health among
the population in general. A cost-benefit analysis conducted in the urban setting in Cape Town indicated that the outcomes of the Mentor Mother programme could be achieved at a relatively low cost.\textsuperscript{144}

Philani’s Mentor Mother programme has been contextualised to Eswatini, Egypt and Ethiopia. Qualitative studies on the programme in Eswatini have centred on causes of unplanned pregnancy\textsuperscript{145} and the implementation of tools to discuss reproductive health.\textsuperscript{146,147} A quantitative cohort study showed that the programme in Eswatini improved rates of exclusive breastfeeding among client mothers.\textsuperscript{148}

In 2018, an initiative was taken to contextualise the Mentor Mother programme to Sweden. This initiative was led by the Church of Sweden, which had long worked with socially disadvantaged groups in Sweden and supported Philani’s work in South Africa. During 2018 and 2019 the Church of Sweden conducted an inventory of organisations with a capacity for and interest in implementing a Mentor Mother programme in Sweden. This inventory led to the identification of two suitable organisations: the social enterprise \textit{Yallatrappan} (YT) and the non-governmental organisation \textit{Tidigt föräldrastöd} (‘Early parental support’, TF). These organisations initiated two community outreach programmes based on the South African Mentor Mother programme in 2021.

\textbf{Yallatrappan in Malmö, Sweden}

The Mentor Mother programme was contextualised to the setting in Malmö city in Sweden in 2021. The programme was implemented by the social enterprise \textit{Yallatrappan} (YT).

YT was founded in the socially disadvantaged district Rosengård in Malmö city in 2010, operating as a work-integrating women's cooperative. The enterprise's main focus is to provide work experience opportunities for women who have migrated to Sweden and who are far from the labour market. In January 2019, YT initiated a project named \textit{Det tidiga livet} (‘The early life’, DTL) in cooperation with the local municipality’s preschool department. The project aimed to increase preschool enrolment among children in families who had recently migrated to Sweden, through the use of outreach workers sharing their language and culture. The project was active until December 2020 and was replaced in January 2021 by a peer support programme with the ambition to provide more comprehensive support to meet the different types of social and health needs of the families constituting the target group. The target group is defined as pregnant women and mothers of children up to five years old who have migrated to Sweden. The programme has a steering group with representatives from YT, the Church of Sweden, Uppsala University and a local housing company. The latter finances parts of the programme and has an interest in improving livelihoods and knowledge of social rights and obligations.
among tenants. Until the end of 2022, the steering group also included representatives from the local preschool department, with whom they had a formal partnership agreement.

The peer supporters are five women living in the area where they work who have themselves migrated to Sweden and successfully integrated into Swedish society. They all have previous experience of working with women and children in different ways, ranging from childcare and healthcare to female entrepreneurship. In addition to speaking Swedish fluently, the peer supporters also have different language competencies covering the other main languages spoken in the area: English, Arabic, Somali, Dari, Urdu, Pashto, Russian, Hindi, and Bengali. They all have their own group of client mothers that they follow over time. The peer supporters do not use the title Mentor Mother but have instead chosen to keep the designation Yallalots which was established during the DTL project. Yallalots has no immediate English translation and for clarity they will be referred to as peer supporters throughout this thesis, as they have been in the included studies. YT describes that the aim of the peer supporters' work is:  

[T]o contribute to empowerment and opportunities to create a good life by reducing social isolation, exclusion, low trust in authorities and society, increasing the number of children enrolled in preschool and increasing knowledge about the health, learning and development of young children. The main objectives are to strengthen the role of parents and make social functions accessible to the project’s target group: asylum seekers, newly arrived and foreign-born women.

The peer supporters find and recruit new clients through the use of several platforms. These include their own social networks, their clients’ networks, public places such as libraries or playgrounds, and ethnic associations in the city. After establishing contact with a new client, they map their needs to identify how they can best support them with matters related to welfare service use, health and wellbeing, parenting, and social integration. All support is provided through individual meetings that can take place at the peer supporters’ office, in public places, at open preschools, in the clients’ homes, or over phone. The support is provided through both linking parents to relevant welfare services, authorities and civil society organisations, and through educating clients on topics such as how Swedish society is organised, health and children’s development, children’s rights, and rights and obligations of parents. The frequency and number of contacts between peer supporters and their clients are not specified in advance.

During the start of the peer support project in 2021, a logic model for the programme was created through three workshops involving YT, the Church of Sweden, the local preschool department and Uppsala University. Logic models are descriptions of envisaged pathways from actions to results, outlin-
ing relationships between a programme’s resources, planned activities and intended effects. This process of adapting the Mentor Mother programme to the Swedish environment by creating a logic model, along with the considerations that emerged, is described in Study I. The logic model is described in Figure 2.
Figure 2: Logic model of the peer support programme in Malmö
The logic model specified inputs, activities, outputs, outcomes and overall impact of the peer support programme, as well as underpinning causal assumptions. In the logic model, the inputs included five salaried peer supporters and a coordinator, a partnership agreement with the preschool department, training and supervision for peer supporters, and quality monitoring through the use of digital activity logs. Activities were defined to include identifying socially vulnerable pregnant women and mothers of children up to age five, mapping their needs, building trustful relationships, and providing individualised information and linking to other services. Outputs corresponded to these and consisted of information received and being linked to other services. Outcomes for the programme were defined to include improved utilisation of health and welfare services, improved capacity to navigate Swedish society, improved parenting capacity and improved health of both mothers and children. These outcomes corresponded to an overarching intended impact of empowering clients to lead a good life on their own terms. The causal assumption underpinning this intervention logic was that peer support is an effective means for empowerment, that improved service use will correspond to improved ability to navigate Swedish society, that improved knowledge of health and parenting practices will translate to improvements in actual health and parenting practices, and these intended improvements will facilitate the empowerment of the target group. The fidelity (i.e. adherence) to the activities specified in this logic model, and the factors that affected this fidelity, was evaluated in Study II.

The training that peer supporters receive consists of two initial weeks when starting and subsequently continuous training in connection to weekly supervision sessions. The training covers topics such as psychosocial support techniques, maternal and child health, child development, early childhood education, children’s rights, parenting techniques, the organisation of Swedish society and the welfare system, and housing rights. Supervision is provided in the form of weekly group meetings between all peer supporters and their project coordinator, during which they can discuss difficult cases. They also have the option to discuss cases individually with their coordinator when needed, often over phone.

Tidigt föräldrastöd in Gothenburg, Sweden

The Mentor Mother programme was also contextualised to the setting in Gothenburg city in 2021, where it was implemented by the non-governmental organisation Tidigt föräldrastöd (TF).

TF was founded in 2013 and has since been running a community doula project in socially disadvantaged areas in north-eastern Gothenburg city in Sweden. The community doulas provide peer support for pregnant client women in the area, all of whom have experiences of migrating to Sweden from non-European countries. These clients receive individual support focusing on
information about pregnancy, childbirth, breastfeeding, sexual health and rights, and family planning. This support is provided continuously during pregnancy. The community doulas attend the birth if possible and continue to provide support for two weeks afterwards. TF also runs a cultural interpreter programme, where both women and men who have recently migrated to Sweden can receive help in their own language in contacts with authorities and public services. Many of the employed women work as both community doulas and cultural interpreters.

In July 2021, TF established a Mentor Mother programme in Bergsjön, one of the districts where the organisation operates. The Mentor Mother programme extends the previous community doula programme up to five years after birth. It aims to address both the social and health needs of families who have migrated to Sweden and who need support in the process of integrating and establishing themselves in Swedish society. Five Mentor Mothers are employed within the project, all of which also work or have worked part-time as community doulas and cultural interpreters. They are all women who live in the area, and all have experience of motherhood and migration. They are all fluent in Swedish and collectively they also cover several other language groups: English, Arabic, Somali, Pashto, Dari and Urdu. Each Mentor Mother is responsible for a set of clients corresponding to her language and cultural competencies. These clients are recruited through their own social networks, the networks of their current clients, and through referrals from the local maternal health services and child health services.

The peer support provided through the programme aims to be a comprehensive response to the needs of both the client mothers and their children. Occasionally, the Mentor Mothers also support fathers. The needs addressed within the programme include social isolation, contacts with welfare services and authorities, knowledge about parenting and maternal and child health, and civic participation. The Mentor Mother programme does not have an explicit logic model or theory of change, but the core ideas of the programme have been summarised as follow: 151

The Mentor Mothers are trained in the project and will provide individual support to newly arrived and particularly vulnerable mothers. They follow the families during the first five years of their children's lives. The objectives are that, through the support, the mothers will increasingly turn to, trust and use society's health and care system (family centre, dental care, etc.) and preschool activities. An expected result is that the target group feels included in society, which has a positive impact on their children. It also increases the women's chances of entering the workforce in the long term.

The support is provided in two different ways:

- **Individual support** is provided during meetings between the Mentor Mothers and their clients. The Mentor Mother makes an initial mapping of the client's needs, which allows for an individualization of
the support they provide. The support can be, for example, in the form of explaining matters relating to health or processes within services to the client, supporting them in contacts with authorities and welfare services or being available for emotional support. Meetings can take place at the Mentor Mother's office or at clients’ homes. Individual contacts can also take place digitally or by phone, but the first meeting is always in person to promote the development of a personal and trusting relationship.

- **Group courses** are given to groups of clients who speak the same language. They cover topics related to child development, maternal and child health, breastfeeding, mental health, dental care, parents' rights and responsibilities, parenting strategies, and the organisation and functions of Swedish society and welfare authorities. The courses are sometimes held by the Mentor Mothers themselves, if the topic falls within their expertise. They can also be given by external actors such as staff from child health care or social services. In cases where the courses are given by external actors, the Mentor Mothers are present as interpreters. The courses are held at the Mentor Mothers' premises.

The support provided by the Mentor Mothers has developed gradually over time based on what they themselves have experienced as effective, appropriate and relevant to facilitate the empowerment process. In this process of developing individual support, the Mentor Mothers draw on their own lived experience and deep knowledge of the social and cultural context, empirical insights into what works, and their professional expertise. The result of this is a programme that has grown organically and is developed continuously by the Mentor Mothers and their coordinator. The perceptions of which peer support strategies are effective, appropriate and relevant for promoting the empowerment of their clients are further described in Study III. Furthermore, the programme activities that have been developed specifically to promote trust in institutions are described in Study IV.

The Mentor Mothers receive intermittent training in their role as Mentor Mothers, in addition to the previous training they also have as community doulas and cultural interpreters. The doula training consists of sessions on prenatal care, breastfeeding, sexual health and rights, and family planning, and includes study visits at the local maternity ward. The cultural interpreter training covers topics such as counselling techniques, public health and health equity, migration and integration, managing culture clashes and challenges to integration, and Swedish history and values. The Mentor Mother training is provided sporadically and amounts to about four weeks of sessions on topics such as sexual and reproductive health, mental health, parenting practices, and children’s rights. They also continuously develop their knowledge on various relevant topics by attending group courses held by external actors. Supervision
of the Mentor Mothers takes place in the form of weekly group meetings. They can also contact their coordinator over phone or in person if they need help with difficult cases.
Rationale

In summary, this thesis explores how the community outreach methods within a South African peer support programme for mothers in socially vulnerable areas – the Mentor Mother programme – has been contextualised and implemented in two different locations in Sweden. This has resulted in two new programmes that involve slightly different interpretations of the original community outreach approach. Both the Swedish programmes are implemented by non-profit organisations that have made their own choices regarding how to contextualise and implement them. Three implications of this are important for understanding the choice of topics of the studies included in the thesis and how these studies have been conducted.

Firstly, separate roles for researchers and implementers have influenced the choice of research focus. The implementing organisations have had the freedom to choose how they adapt their programmes to the local contexts. This means that much of the literature on adaptation of innovative solutions is not fully applicable, as it assumes that those who study a phenomenon (e.g. the needs of the target group) also have the power to adapt the intervention accordingly. As an outside observer of the peer support and Mentor Mother programmes in Sweden, it has not been possible to delay the design and implementation of the programmes until after a needs assessment has been undertaken. Instead, the programmes have developed continuously over time based on perceived needs.

Secondly, the flexible design of the programmes has also influenced the choice of study focus. The two peer support programmes in Sweden have been implemented with a very high degree of freedom for the peer supporters themselves to continuously adapt their work and strategies according to their lived experience, empirical insights into what is meaningful and valuable to do, and an understanding of what works in practice and not. The studies exploring these continuous developments of the programmes represent an ambition to harness this expertise.

Thirdly, the vast differences in context have meant that the studies focus on the transfer and implementation of a method rather than an intervention. The evidence that exists for the Mentor Mother programme in South Africa, in relation to e.g. HIV and malnutrition, is not applicable in Sweden. The transfer of the Mentor Mother programme from the South African context to the Swedish should thus not be seen as a replication of a specific evidence-
based practice, but rather as a transfer of an innovative approach to community outreach that could be used to deliver a variety of specific programmes. I describe the development of two such new programmes in this thesis. Future causal research may evaluate the effects of the programmes in the Swedish context after the continuous development of these has arrived at established programme plans.

With this in mind, the following gaps in the literature were identified, motivating the choice of studies on the two Swedish programmes:

I. Previous literature on social innovations has called for studies that provide an understanding of different levels of the scaling process and analyse how various aspects of the local context set the boundaries for scaling. Using the typology to describe scaling and transferring social innovations in health by Niang et al., this includes both functional aspects (what the innovation is doing, i.e. what the innovation can achieve in a new context and why) and ontological and ‘genetic’ aspects (what the innovation is and what it becomes, i.e. what form the innovation takes in different contexts, scales and time periods during adaptation and implementation). Understanding the logic behind the adaptation of a social innovation to a new context enables a deeper understanding of the system into which it is placed, factors that are perceived to underpin change processes, and various aspects of the implementation process.

II. When transferring a social innovation in health to a new context, an understanding of the implementation process can be valuable to shed light on how the innovation and its implementation can be further improved, adapted, and scaled. This includes exploring what is actually delivered and how this is done, the factors affecting the implementation, and the mechanisms through which change is accomplished. Understanding the implementation process of the Mentor Mother programme in a new context can facilitate the further adaptation and scaling of this and similar social innovations in health.

III. There are many examples of peer support services for people with experiences of migration in Sweden, but it is rare that the insights and expertise of these peer supporters are explored systematically through research. This expertise involves both a deep understanding of the communities in which they work and a professional understanding of what strategies work in practice to meet the needs of these communities. Harnessing this expertise through research can contribute to the development of hypotheses about change processes, which can be formalised and evaluated through future studies.
IV. Although mistrust of welfare services and authorities has received much media attention in Sweden, including but not limited to mistrust in the social services, there is a lack of research on the subject. This is particularly the case for research on what is perceived to work to address this mistrust.

Scaling, adapting and implementing social innovations in health can be non-linear processes with multiple uncertainties and emerging causality, meaning that change might be produced in ways that was not initially envisaged.\textsuperscript{70,84,155} In line with this, the studies in this thesis focus on the insights gained during the process of adapting, implementing and further developing the programmes.
Aims and objectives

The overall aim of this thesis is to understand the process of contextualising the South African Mentor Mother programme to two sites in Sweden aiming to benefit socially disadvantaged mothers and pregnant women with experiences of migration, based on the expertise and lived experiences of Mentor Mothers, peer supporters and other stakeholders. The specific objectives of the respective studies are:

I. To document and analyse the process of adapting the Mentor Mother programme to a socially disadvantaged area in Malmö, Sweden.

II. To assess how the peer support programme was implemented in Malmö, Sweden, what the contextual barriers and facilitators were, and how the implementation was perceived by those who delivered and received it.

III. To investigate which empowerment facilitation strategies that Mentor Mothers perceived to be relevant, feasible and effective in Gothenburg, Sweden.

IV. To explore perceptions of how mistrust towards welfare services and authorities arises and perceptions of how this could be met through the Mentor Mother programme in Gothenburg, Sweden.
Methods

Study design

All four studies in this thesis were mainly based on qualitative methods but had variations in design, sampling, data collection methods, and analysis (see Table 2). Study I was a qualitative study that followed an intrinsic case study design, meaning that it aimed to provide insight into a unique and context-specific phenomenon. Study II was a process evaluation, aiming to determine whether the programme activities had been implemented as intended and resulted in the planned outputs. It used mixed methods with a convergent parallel design, in which qualitative and quantitative data was collected simultaneously and merged at the point of analysis. The process evaluation followed the guidance developed by the United Kingdom Medical Research Council (MRC). Study III and IV were both qualitative instrumental case studies, meaning that they aimed to contribute to a broader understanding of studied issues or phenomena through the use of particular cases.
<table>
<thead>
<tr>
<th>Study</th>
<th>Design and sample</th>
<th>Data collection</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Adapting a South African social innovation for maternal peer support to migrant communities in Sweden: a qualitative study</td>
<td>Intrinsic case study, qualitative</td>
<td>Semi-structured interviews, stakeholder workshops</td>
</tr>
<tr>
<td>II</td>
<td>Implementing a social innovation for community-based peer support for immigrant mothers in Sweden: a mixed-methods process evaluation</td>
<td>Process evaluation, mixed methods with convergent parallel design</td>
<td>Semi-structured interviews, digital field reports specifying peer support activities</td>
</tr>
<tr>
<td>III</td>
<td>Empowerment strategies of the Mentor Mother peer support programme among immigrant mothers in Sweden: a photovoice study</td>
<td>Instrumental case study, qualitative</td>
<td>Photovoice, focus group discussion, semi-structured interviews</td>
</tr>
<tr>
<td>IV</td>
<td>Mentor Mothers as trust brokers between immigrant communities and the Swedish welfare system: A qualitative study</td>
<td>Instrumental case study, qualitative</td>
<td>Semi-structured interviews</td>
</tr>
</tbody>
</table>
Study contexts

The studies included in this thesis were conducted in socially disadvantaged areas in two of Sweden’s largest cities. Study I and II took place in Malmö city, and Study III and IV took place in Gothenburg city (Figure 3).

The city of Malmö is Sweden’s third largest city, located in the far south, with a population of 357,000. Thirty-six percent of the population is born abroad. The city has a median income of 334,000 SEK per year. The city is segregated, with neighbourhoods in the central parts of the municipality having a lower average income than those on the periphery. Rosengård is one such district in Malmö. It has a population of 23,300, 63% of which are born in another country. The mean income is 188,000 SEK per year. YT's peer support programme is based in Rosengård, but also offers support for clients in surrounding neighbourhoods.

The city of Gothenburg is located on the west coast. It has a population of 604,000, making it the second largest city in Sweden. The mean yearly income in the city is 347,200 SEK per year. The city is socio-economically segregated, with higher average incomes in the centre and the south-west than in the north-east. Twenty-nine percent of the population is born outside of Sweden. The city district Bergsjön is located in the north-eastern part of Gothenburg and has a population of 18,000. The average income is 216,000 SEK per year. Among the residents in Bergsjön, 61% are born in another country. TF's Mentor Mother programme offers support only to clients residing in Bergsjön.

Samples

This thesis builds on data in the form of 48 individual semi-structured interviews, three workshops, one focus group discussion and 1,294 digital activity
logs. Studies I and III used total population samples, which included all persons involved in the implementation of the respective programmes. Similarly, Studies II and IV used total population samples for those implementing the programmes and purposive samples for client mothers, representing the major language and cultural groups.

In Study I, the sample consisted of stakeholders involved in the implementation of the programme in Malmö. Specifically, these included members of the project's steering committee (n=5) and peer supporters (n=3).

In Study II, the sample consisted of steering group members (n=6), peer supporters (n=5) and client mothers who had received support (n=8) for the collection of qualitative data. The interviewed client mothers were Arabic and Somali speakers. For quantitative implementation data, the sample consisted of client mothers who the peer supporters had been in contact with during one year of data collection in January to December 2022 (in total 1,294 registered meetings).

In Study III, the sample consisted of all those working operatively with the Mentor Mother programme (n=6), more specifically Mentor Mothers (n=5) and the project coordinator (n=1).

In Study IV, the sample consisted of Mentor Mothers (n=5), client mothers (n=12), and other stakeholders in the form of the programme coordinator (n=1) and health and social care professionals cooperating with the Mentor Mother programme (n=3). The client mothers came from Arabic, Somali, Dari and Urdu speaking communities. The interviews with Mentor Mother and the programme coordinator were the same as in Study III.

Data collection

Data for Study I were collected in the form of semi-structured interviews and workshop sessions. Interviews were conducted from June to July 2020 focusing on challenges and opportunities of providing individual peer support in the local context. Interview questions focused on how hard-to-reach families were contacted and engaged, as well as on barriers and enablers to promoting preschool attendance and social inclusion more broadly. The interviews were conducted online and lasted 23-79 minutes.

From February to March 2021, three online workshop sessions were held focusing on the contextualisation of the Mentor Mother programme. The workshops were set up to formulate a logic model for the peer support programme in Malmö. This was done by workshop participants specifying intended inputs, activities and outputs, direct outcomes and a long-term impact for the programme. The participants had previous knowledge of the Mentor Mother programme, which was further enhanced through an online educational meeting with representatives from Philani, which was held between the first and second workshop session. Observer notes on preliminary ideas and
themes were taken during the sessions, which were later used to inform the analysis. The use of workshops as a research method was chosen as it provided a dual opportunity to generate consensus on the components and objectives of the peer support programme while allowing for qualitative data collection. The workshops lasted 108-212 minutes each. All interviews and workshop sessions were audio recorded and transcribed verbatim.

In Study II, the data consisted of both field reports from peer supporters and semi-structured interviews. The field reports (n=1,294) were digital forms collected via the software Kobo Toolbox which were filled in on electronic tablets by peer supporters after each meeting with a client mother. They were collected over 12 months, from January to December 2022, with data collection starting when the programme had been running for one year. The forms were created in consultation with the peer supporters and their coordinator to ensure they were relevant to their work and feasible to use in practice. The forms included questions on the date and location of the meeting, what information about service and authorities and support in accessing these that the mother had received, whether the meeting was held in person or by phone, and how many times they had previously met with the client. To ensure ease of use, the forms did not include data on specific topics of discussion between peer supporters and clients, as this was perceived to be too complicated and time-consuming to record. No personal data for the client mothers were registered. This decision was taken by YT to ensure compliance with the European Union's General Data Protection Regulation (GDPR), as well as avoid challenging the trusting relationship the peer supporters built with their clients.

The semi-structured interviews were conducted from June to August 2022. The interviews with members of the project’s steering group were conducted digitally, covering organisational aspects of the implementation process. Interviews with peer supporters were conducted in-person with all peer supporters, centring on their experience of delivering the programme. Interviews with client mothers had a focus on how they perceived the programme and how the support they had received corresponded to their needs and expectations. Interviews with peer supporters and steering group members were conducted in Swedish by me, while interviews with client mothers were conducted in Arabic and Somali by two female public health students. Before conducting their interviews, these students received training by me on conducting interviews, including the use of probing techniques, as well as a general orientation on the peer support programme and process evaluations. The interview guides had been developed to cover the domains and subdomains of the MRC guidance. The interviews lasted 18-75 minutes. All interviews were audio recorded and transcribed verbatim. Transcripts in Arabic and Somali were translated by the interviewing students to Swedish and English.
Data for Study III was collected during a photovoice workshop and individual semi-structured interviews. Photovoice is a participatory data collection method building on the idea that visual imagery can be used to enable critical reflection and discussion on the factors that shape people’s lives.\textsuperscript{163} It also involves research participants in deciding how to represent their own community to a greater extent than might be usual in structured or semi-structured interviews. From the researcher’s point of view, it provides an opportunity to use the participants’ own views of what is important in relation to a particular topic as starting points for the co-creation of knowledge. The five Mentor Mothers employed by TF were given instructions during an in-person meeting to take photographs of their daily work, focusing on perceptions of community needs and their strategies to empower the clients by addressing those needs. During the meeting, the Mentor Mothers were given the chance to ask questions about the study and the photovoice method. The Mentor Mothers took photos of relevant situations in their work during the course of six weeks, using their own phones, and were asked to select a few photos per person that they felt were the most significant. A workshop was organised with the Mentor Mothers and the project coordinator at TF, during which all participants (n=6) discussed the photos. These discussions were structured according to the technique ‘SHOWeD’, consisting of five questions that participants are asked in relation to each photo:\textsuperscript{164}

1. What do you see here?
2. What is really happening here?
3. How does this relate to our lives?
4. Why does this situation, concern, or strength exist?
5. What can we do about it?

The workshop lasted 153 minutes and involved discussions on 13 photos. Two of these photos were screenshots of digital meetings included on the Mentor Mothers’ own initiative, as they saw the digital environment as an important part of their work. Individual semi-structured interviews were also conducted with all participants. The interviews first continued the discussions about the photos, and then followed the interview guides. These interviews provided an opportunity to discuss implementation aspects including the feasibility of employing different empowerment strategies and the contextual factors that influenced this. These included factors in the internal (organisational) context, which could be difficult to discuss in a group setting. The interviews lasted 38-61 minutes. The photovoice workshop and interviews were conducted by me and a postdoctoral researcher. Both the workshop and interviews were audio recorded and transcribed verbatim.

In Study IV, data was collected through semi-structured interviews. The interviews with Mentor Mothers and their coordinator were the same as in Study III, and were conducted at their premises. The interviews with external
stakeholders were conducted by a postdoctoral researcher at the local child health centre. Interviews with Arabic and Urdu speaking client mothers were conducted by two female public health masters students. Before the interview they received training by me on interview techniques and information about the Mentor Mother programme. They also had debriefing sessions between the interviews with me and the postdoctoral researcher. Due to difficulties in finding interviewers who spoke Somali and Urdu within the time frame of the study, interviews with client mothers belonging to these language groups were conducted by me and the postdoctoral researcher. As institutional and interpersonal trust had previously been described as interacting with other focus areas of the Mentor Mother programme, the interview guides were developed to explore several different aspects of the programme. The interviews lasted 20-65 minutes. The interviews were audio recorded and transcribed verbatim, and the transcripts in Arabic and Urdu were translated to English by the interviewing students.

Analysis

In Study I, III and IV, the data were analysed using reflexive thematic analysis, as described by Braun and Clarke. In Study II, the qualitative data were analysed using content analysis as described by Elo and Kyngäs. These methods for analysis were chosen as they offer flexible approaches to coding and generation of themes. This was considered appropriate as the data to be analysed was often heterogeneous, unstructured and contained much material that fell outside the scope of the research question. During and immediately after workshop sessions, the focus groups discussion, and interviews, I wrote memos outlining preliminary themes and ideas. Similarly, I also took notes during the transcription of audio records. These notes were later used to inform the analysis.

In Studies I, III and IV, the transcripts were coded inductively. In Study I, the material was coded by me using Microsoft Word. A subset of the coded material was discussed between the authors to ensure that the coding was relevant. The codes were condensed into themes and sub-themes which were revised during several meetings with the authors.

In Study III and IV, the transcripts were coded inductively by me and a postdoctoral researcher, using ATLAS.ti 23.0 software. All transcripts were read through before coding. One and two transcripts were respectively selected in the studies to be coded jointly to agree on coding structures. The coding structures were then used to code the remaining transcripts individually, and the final coding was checked against the transcripts by us both to ensure that it was credible. Condensation and grouping of codes was done jointly, and themes and categories were discussed and revised in meetings with all authors.
In Study II, all transcripts were coded deductively by me for manifest content using predetermined themes. These themes were borrowed from the MRC guidance on process evaluation of complex interventions (Figure 4). The MRC guidance constitutes a framework specifying key domains affecting the possibility of accomplishing effective implementation of complex interventions. The domains in this guidance include:

- **Context**: Barriers and facilitating factors in the internal or external environment that affects the intervention or its implementation.
- **Implementation**: Fidelity to the planned activities, the dose and reach of the intervention, adaptations and strategies employed during the implementation process.
- **Mechanisms of impact**: Mediation pathways, provider and recipient interactions with the intervention and unintended pathways and consequences.
Figure 4: The MRC guidance on process evaluations of complex interventions
The MRC guidance describes a method for systematically exploring the implementation of complex interventions, which can be useful for assessing what was delivered within the intervention, how it was delivered, the various factors that shaped this process and the intervention itself, and the ways in which the intervention produced change. Understanding these factors can provide insights relevant for future adaptation, improvement, scaling and replication.

After deductive coding, the data within each MRC guidance sub-domain was re-coded inductively by me and a postdoctoral researcher. These codes were subsequently condensed into categories. During this process, the material was read repeatedly, the generated codes were compared and discrepancies were discussed continuously. Before the analysis was finalised, the categories were discussed between all authors. The quantitative data were compiled and presented descriptively under the sub-domains relating to implementation, to illustrate what was done within the programme and the extent to which different groups of recipients were reached. The qualitative and quantitative data were integrated at the point of analysis to allow for triangulation, corresponding to a convergent parallel study design. This design was chosen as it allowed for capturing a changing process with both methods simultaneously. It was also seen as a feasible design to ensure that the study was finished within the planned time period.

In Studies III and IV, the results were presented during two member checking sessions, to be discussed with a subset of study participants. This made it possible to collect feedback on how the studies' findings were framed and reported and to highlight any potential misunderstandings. This feedback was used to refine the findings and their presentation.

Ethical considerations

Ethical approval was granted for all studies by the Swedish Ethical Review Authority (registration number 2020-04288 for Study I, 2022-01975-01 for Study II, and 2023-00915-01 for Studies III and IV). All studies were conducted in accordance with the Declaration of Helsinki.

Before participation in interviews, workshops and the focus group discussion, all participants received written and verbal information about the studies and what participation would entail. All participants also had the opportunity to ask questions to the researchers. The participants gave written consent to participate before data collection started. For client mothers, information about the studies was provided in their native languages by peer support and Mentor Mothers, which was repeated by the interviewing students. For the Somali-speaking client mothers in Study IV, information was given in Somali by Mentor Mothers. Interviewed client mothers in Studies II and IV also had the opportunity to ask questions to peer supporters or Mentor Mothers speak-
ing their languages, an opportunity which many of them used to clarify concerns. For peer supporters, Mentor Mothers, and other stakeholders, information was provided in Swedish. All participants were also informed that they could withdraw their participation at any time without consequence. No financial compensation was provided for participation. The data was stored on secure university servers accessible only to the involved researchers.

The interviews with client mothers touched on issues relating to integration into Swedish society which in turn had implications for their possibilities of providing the best possible start in life for their children. During the interviews with peer supporters and Mentor Mothers, issues related to their job performance were raised, especially during Study II when assessments of fidelity to the logic model addressed how the individual peer supporters’ used their time. As these types of discussions are of a sensitive nature, it was particularly important to explain the purpose of the studies, how the data would be handled in a confidential manner, how the results would be published, and their right to skip questions or withdraw their participation if desired. Careful consideration was taken to ensure that data collection was carried out in a respectful and sensitive manner. Some of the participants asked to read through the transcripts after the interviews, which was promptly arranged.
Results

Study I

In this qualitative article, we studied the process of adapting a social innovation to the context in Gothenburg city by analysing how stakeholders reason about the relevance of the Philani Mentor Mother programme, developed in a low-income context, being implemented in a high-income context.

The thematic analysis generated five main themes and fifteen sub-themes (Figure 5). These themes described different aspects of how the Mentor Mother approach to community outreach was adapted to fit the local context.

Focus on the social determinants of health

One tendency in the discussions was to highlight how the Mentor Mother approach was primarily seen as a method for promoting social integration and efficient use of welfare services among the recipients. This led to a focus on the social determinants of health rather than on improving maternal and child health directly. This was motivated by the fact that the predominantly perceived barriers to quality of life in the local context were seen to be marginalisation and social isolation, social barriers to accessing health and other welfare services, and lack of integration on the labour market. A related conclusion was that the natural target group for the peer support programme was mothers of young children and pregnant women with experiences of migrating to Sweden from countries outside of Europe, as these were described to be the most disadvantaged in terms of social factors relevant to maternal and child health. Social disadvantage among vulnerable groups was also discussed as being increased during the Covid-19 pandemic.
Figure 5: Themes and sub-themes in Study I
An organic systemic approach
Participants described the feasibility of using an organic systemic approach to both target support to parents of young children and prioritise support that focused on social drivers of health. By outlining an intervention logic based on ripple effects, the potential impact of the peer support programme was expected to extend beyond the areas directly targeted by the peer supporters. Building on their extensive experiences of working with social integration among vulnerable groups, the participants described an interrelation between social integration and health that extended both ways. By improving social conditions in early life and beyond, they sought to achieve indirect effects on the physical and mental health of those receiving the programme, and vice versa. Participants described it as natural to target the programme towards mothers, given the existing norms in the context. Supporting mothers to access welfare services was also thought to benefit the health and wellbeing of their children.

So, the goals are for the parents, but the parents are also a means to an end. They are the means for the children to be empowered. (Workshop #3, participant #8)

Linking to existing services
The high quality and accessible welfare system in Sweden was highlighted as an important factor to consider in that a new peer support service should not have the ambition to compete with existing services. Participants’ discussions on how to approach this led to the conclusion that although peer supporters could have an educational function, one of the main focuses should be on linking to existing services and facilitating contacts with the welfare system and authorities. Participants also pointed out that there were several barriers to the use of existing services that the peer supporters could help to overcome, including mistrust of authorities, language barriers, and lack of knowledge about how the welfare system is organised. Participants described that a prerequisite for linking to other services was an understanding among clients of why social participation, active involvement in child development and the use of, for example, preventive services and early childhood education were important. This connected educational aspects of the peer support to linking to services. The thresholds for using welfare services were also discussed to be reduced by the peer supporters accompanying clients physically to these services, which was highlighted as more important than merely providing information about their existence.

To dare to take the step towards what you don't know, to be confident in that, and that the peer supporter can be a support in that effort. And perhaps apply
for Swedish for Immigrants [language course], find out what support is available from the employment agency and get in touch with various support services such as women's shelters. [...] Being a support all the way. (Workshop #3, participant #2)

Matching peer supporters with the community

The great cultural and linguistic heterogeneity of the relevant target group meant that there was a need for corresponding diversity among the peer supporters. Matching peer supporters with clients allowed them to share not only their past experiences, but also language and culture. This recruitment of peer supporters from multiple linguistic and cultural groups was deemed to be crucial for the development of trusting relationships, which in turn would enable clients' long-term engagement.

An intervention governed by flexibility

Linguistic and cultural heterogeneity within the target group was described as corresponding to heterogeneous needs. This justified a flexible approach to several programme components and implementation strategies. As the target group was defined by social exclusion, this also necessitated a flexible approach to client recruitment, where the peer supporters were required to use a variety of physical and social arenas. This included open preschools, informal networks and ethnic associations, which allowed the peer supporters to use their own knowledge of the social context.

One mother knows the function of the peer supporters and yes, but my friend, she needs [support] too. So, it's within these unofficial networks that the most things are happening, I would probably say. It’s like there you actually get direct contact. (Workshop #3, participant #9)

This shifted control over parts of the implementation process to the peer supporters themselves. A broad and flexible approach was also described in relation to how the stakeholders involved in the steering group defined the overall objectives of the programme, despite their own delimited individual areas of interest.

Study II

In this mixed-methods study we investigated how the adapted peer support programme in Malmö had been implemented. This was done by assessing what was delivered in the programme, what adaptations were made during the implementation process, how the peer supporters working in the project enacted their roles, what barriers and facilitators were identified, and how the
implementation was perceived by those who delivered and received the programme.

Seventeen categories were identified in the qualitative analysis (Figure 6). These categories represented various aspects of the MRC domains of context, implementation and mechanisms of impact. The categories under *Implementation* that related to activities in the programme were illustrated by quantitative data.

**Context**

Several contextual factors that acted as barriers and enablers during implementation were identified. These factors existed in both the internal organisational context and the external context.

Peer supporters and steering group members described how a widespread mistrust of the social services was a barrier to providing peer support. This mistrust was due to misconceptions that social services can separate children from their parents on social grounds without proper prior investigation of the case and involvement of parents in this process. Peer supporters expressed that this mistrust could lead to client families avoiding contact with social services. In some cases, it led families to avoid contact with other health and welfare services, such as mental health services, for fear of being observed and reported. It could also lead to families avoiding contact with peer supporters, as they shared certain characteristics with social workers. However, during the interviews, none of the interviewed client mothers described any aversive attitude towards social services.

> In the beginning, when I talked to someone about that I work as a peer supporter at Yallatrappan and help those in need, they thought I worked with the social services, and they didn't dare talk about anything. They said no, no, no, in case a second mother wanted to say something, the first mother said [hushing sound]. Why, I said. No, no, we have everything, my husband is doing great, my children are doing great. I said wait, you misunderstand. I don't work with the social services. (Peer supporter #2)

Obstructive norms and expectations around women's autonomy and responsibility for the home were described as factors impacting the possibility of implementing the programme. These led some men to be sceptical of the programme's goal of empowering client mothers. Similarly, norms around parenting were highlighted as a challenge to increasing client mothers' participation in society, as young children were expected to stay at home instead of attending pre-school, leading the mothers to be bound to the home as well.
Figure 6: Categories in Study II sorted by MRC guidance domains

Context
- Mistrust of the social services
- Obstructive norms and expectations
- An enabling organisational form
- Lack of funds

Implementation

Implementation process
- Building trust through flexibility, credibility, competence and care
- Internal support structures
- Multiple arenas for outreach
- Practical assistance as an entry point to comprehensive support

Reach and dose
- Wide reach within specified groups
- Needs-based dose

Fidelity and adaptations
- Linking rather than educating clients
- Doing more than originally intended
- Local adaptation of Philani’s methods

Mechanisms of impact

Mediators
- Relationship-building enables difficult conversations

Participant responses to and interactions with the intervention
- Clients appreciating the intervention but seeing its limits
- Clients value the close personal bond

Unexpected pathways and consequences
- Blurred lines between work and personal identity
The implementation of the programme was facilitated by an enabling organisational form. This consisted partly of the organisation's good reputation in the target community. Combined with their experience in running large projects and their established network of other actors, this reputation made it possible to build trust. The facilitating organisational form was reinforced by the organisation's role as a non-governmental entity, belonging to the third sector, which provided freedom to shape the programme as they saw fit and allowed them to act as a neutral party between client mothers and the welfare services and authorities they linked them to.

Participants expressed that a persistent barrier to implementing and scaling up the peer support programme was a lack of funds, most notably in the form of unpredictable funding. One factor for this was the organisation's joint ventures with public actors in other projects. This was described as leading to hesitation about new collaborations with the organisation due to demands to distribute public funding for social projects across multiple third sector partners.

Implementation

Reach and dose

A total of 1,294 contacts between peer supporters and client mothers were recorded in the activity logs. These contacts consisted of 1,081 (83.5%) face-to-face meetings and 213 (16.5%) telephone contacts. Five hundred and ninety-seven contacts (46.1%) were held by two Somali speaking peer supporters, 275 (21.3%) by a peer supporter who spoke Dari, Pashto and Russian, 237 (18.3%) by a peer supporter who spoke Urdu, Bengali and Hindi, and 185 (14.3%) by an Arabic speaking peer supporter (Figure 7).

![Figure 7: Language groups reached and meeting locations in Study II](image)

In the interviews, the peer supporters and steering group members stated that they felt they had a wide reach within specified groups, but were limited to the specific language groups covered by the peer supporters. The heterogeneity of the target group meant that not all potential client mothers could be reached. One major cultural and language group that fell outside of this were
the Romani. Another group that was perceived difficult to reach was the most socially isolated women. This was partly explained by the lack of ways to identify and establish contact with them.

The peer supporters work a lot in their local area where they live, because they have a pretty good idea of who lives around them and so on. But those who are the most isolated, we don't reach them. You probably have to reach them through the social services, and maybe not even then. (Steering group member #6)

The peer supporters implemented the intervention with a needs-based dose, meaning that both the frequency and number of contacts were adapted to the individual client mothers’ wishes and expressed needs. In the activity log data, this was reflected by the fact that there were about half as many second contacts (n=281, 55.4%) as first contacts (n=507) This suggested that many client mothers had only a single contact with a peer supporter during the data collection period. Peer supporters and client mothers were more likely to talk on the phone the longer they had been in contact. In the interviews, client mothers voiced that the need for practical support decreased over time, as client mothers became more comfortable with solving matters on their own.

Fidelity and adaptations
Overall, peer supporters and stakeholders described that the peer supporters tended to focus on linking rather than educating clients. This meant that their work largely adhered to the part of the logic model that involved facilitating client mothers’ connections with health and welfare services and civil society organisations. The educational elements of the logic model, which for example involved teaching parenting techniques and maternal and child health topics, were not prioritised by all peer supporters. This was described as a consequence of peer supporters not feeling comfortable enough to take on specialised topics, preferring to link clients to experts working in other services.

I think some peer supporters [educate mothers] a lot and some peer supporters don't do it at all. I know that [one peer supporter] is very good at doing it, and I've heard her do it too. And she often talks about it, like this, the importance of education. This is very important, this is for the sake of your children. And if your children get a good education, they will be strengthened in life. Very much like that. A lot about gender equality and women's rights and so on. A lot about old cultural structures from [the country of origin] that she talks about in a very nuanced way. While I know that some peer supporters are very practically oriented. (Steering group member #6)

Where they took on an educating role, peer supporters described that they were careful to clarify the limits of their own knowledge. In their efforts to link client mothers to other services, they tended to focus on linking to early childhood education and parenting classes during initial meetings, and then
used discussions on these topics as entry points for building relationships with their clients. Support on issues related to health care was more common in later contacts.

Figure 8: Peer supporters’ activities in Study II. The upper two charts use a scale of 0-300 and the lower two use a scale of 0-100.

The design of the peer support programme allowed a certain flexibility in what the peer supporters focused on. In the interviews, steering group members described that this was further accentuated by the fact that the logic model was not used as a manual for their daily work, but rather had the function of giving the project an overall direction at the organisational level. The peer supporters
expressed that they did not always stay within the stated framework of the project, often doing more than originally intended when supporting the mothers of the clients. In practice, this could mean helping them with housing issues or helping them buy things for the home. Peer supporters also expressed that they sometimes found it difficult to limit themselves to the target group. Both doing more than planned and not sticking to the defined target group were motivated by the fact that they did not feel comfortable denying support to clients in need, to mothers of older children or women without children. This was justified as a way to potentially spread the word about the peer support programme in the wider community.

Some of Philani's core strategies were adapted to local conditions and needs. Training materials on conversation and counselling techniques, which had been translated from the Philani manual, were described to not be widely used in practice. Instead, other training materials on counselling techniques were used as they were perceived to be more relevant in the local context.

The interviews also highlighted that home visits were not seen as an appropriate strategy. In the log data, only 9 (0.83%) of 1,081 recorded in-person meetings were home visits. This was explained by four factors. One factor was that implementation had started during the COVID-19 pandemic, which affected working practices. In addition, the peer supporters felt that it was too private to make home visits, and that they wanted to keep their meetings with the clients personal but at the same time professional. From a work environment perspective, home visits were also described as problematic as it was difficult to know what to expect during such a visit. It was also highlighted that it was not possible to assume that the client mothers themselves experienced their homes as a safe environment for meetings.

**Implementation process**

Trust building between peer supporters and client mothers was described as a key implementation strategy. The trust of other actors in the peer supporters was also highlighted as central. This included, for example, maternal and child health services. To promote trust among the clients, the peer supporters aimed to act as generalists by providing a range of knowledge about the structure of the welfare system and society, parenting, and health issues. At the same time, they were careful to be clear about the limits of their knowledge. Through this, they strived to communicate both competence and credibility. Their competence was reinforced at the organisational level through continuous training that was adapted to the needs that the peer supporters experienced with their clients. The interviews revealed a need for further training in sexual and reproductive health, domestic violence, mental health, social insurance, the organisation of the legal system, and conflict management and de-escalation techniques in contacts with other people. Peer supporters described a flexible approach to being available and accessible, and they adapted meeting places
according to what clients felt was safe and appropriate. They also described how they actively sought to nurture their relationships with clients to promote trust.

Supervision was highlighted as another key strategy in implementation. This supervision was provided with a high degree of accessibility, where the peer supporters could directly contact the project coordinator when needed, allowing for difficult cases to be resolved promptly. The peer supporters also highlighted the value of supporting each other and referring clients with various native languages between each other for support.

The use of multiple venues was seen as necessary to reach socially isolated individuals. In the course of implementation, the peer supporters themselves had identified a number of such venues. These included language courses for immigrants, social media groups targeting specific ethnicities and languages, and recruitment via library staff who gave out their contact information. Several of the peer supporters also described recruiting new clients through random meetings with mothers in public settings such as parks and public transport, sometimes outside working hours.

The parts of the peer supporters' work that were perceived as sensitive or emotionally burdensome, such as support with health care or discussions about domestic violence, were described as being made possible by first providing support with more practical things that were perceived as less sensitive. This practical support could include, for example, filling in forms or translating letters from authorities.

It starts with like, can you help me with this paper? There are often very practical concerns to begin with. And then it builds up along the way. [...] So often it's those needs first, and then it's like this... Yes, but knowledge and information. How do you do this? How do you do that? And are you entitled to it and how much does it cost and how do you register, and so on. And one thing often leads to another. (Steering group member #6)

It also included discussions about preschool, which was emphasised as an easy way to establish contacts with new clients. This was also reflected in the log data, which showed that support with pre-school was common during the first visits (Figure 8).

Mechanisms of impact

Mediators

Trusting relationships were described as central to the work and enabled difficult conversations. In the log data, support with health care was more common in subsequent contacts than in the first contact (Figure 8). Peer supporters
also highlighted relationship building as important in convincing client mothers of the confidentiality of their conversations, which enabled discussions on sensitive topics.

**Participant responses to and interactions with the intervention**

The client mothers highlighted how they valued the close relationships with peer supporters. In some cases they described the relation to peer supporters in terms of ‘friendship’ and ‘sisterhood’. The informal feeling was described as enabling them to discuss anything. These close relationships were made possible by cultural proximity and shared language. The support they received was described as contributing to less worry and anxiety. Some of them described how the programme had made them feel more independent and empowered.

> When I needed help communicating with the children's schools and I couldn't do it myself, they helped. When I wanted to contact the health service, they taught me how to do it and also helped me with the language. When I had problems with financial assistance, they supported me and talked to the social services officer and explained the situation. As a mother, I could sleep well and my mind calmed down and my worries disappeared. My mind, my soul and my body have become calm. This led me to become more motivated and start thinking about how to develop myself. (Mother #3)

The client mothers also described seeing the limitations of the programme, such as not being able to support them in obtaining asylum or employment.

**Unexpected pathways and consequences**

Several peer supporters described how their professional role had become an important part of their identity. Peer supporters expressed that the boundary between the personal and professional in the relationship with client mothers was often blurred, and that this was reflected in a blurred boundary between working hours and free time. This could be expressed by performing tasks outside working hours, such as answering phone calls from clients during evenings and weekends. It could also take the form of accompanying clients to, for example, emergency medical services outside working hours. In meetings during working hours, they could also discuss topics that fell outside their job description and were more of a private nature. Factors contributing to blurred lines between work and private life were the fact that the client mothers had peer supporters’ private phone numbers, a high demand for their services which justified working outside working hours, and that the peer supporters enjoyed their work.
Study III

In this study we investigated which strategies Mentor Mothers in Gothenburg perceived as relevant, feasible and effective in facilitating empowerment among their clients. This was done by exploring what needs Mentor Mothers saw among their clients, how these needs were met through different strategies and how the value of these strategies was discussed.

In the analysis, nine sub-themes were identified, constituting four distinctive overarching themes: informative support to meet a need for making sense of the external context, practical support to meet a need for managing challenges in daily life, psychosocial support to meet a need for improved mental wellbeing, and motivational support to meet a need for finding fulfilling purpose (Table 3). The findings are illustrated with selected photos from the photovoice focus group discussion, which are cropped to preserve confidentiality.

Informative support to meet a need for making sense of the external context

Discussions about photos of educational situations in the context of Mentor Mothers' work highlighted how they perceived clients' need to understand the structure of Swedish society, in terms of the organisation of both the health and welfare system and the political system. This was described as being met through increased knowledge of the range, functions and value of different services, authorities and institutions. By promoting this knowledge, they felt that the clients had a greater capacity to interpret events in their social context. A concrete example of this was bookings of appointments for preventive health care, such as dental care or child health care, whose purpose became easier to understand after training sessions explaining them.
Table 3: Themes, sub-themes and examples of codes in Study III

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Examples of codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informative support to meet a need for making sense of the external context</td>
<td>Providing a roadmap to navigating society</td>
<td>Increasing understanding of benefits of health services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need for understanding the purpose of social services</td>
</tr>
<tr>
<td></td>
<td>Clarifying the expected process of becoming a parent</td>
<td>Informing on what can be expected during delivery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need for knowledge of child health</td>
</tr>
<tr>
<td></td>
<td>Explaining cultural norms and expectations on parents</td>
<td>Providing information on rights and obligations as parents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need for understanding parenting norms</td>
</tr>
<tr>
<td>Practical support to meet a need for managing challenges in daily life</td>
<td>Facilitating contacts with the welfare system and authorities</td>
<td>Booking appointments for healthcare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cultural misunderstandings in contact with authorities</td>
</tr>
<tr>
<td></td>
<td>Strengthening the parenting role through practical strategies</td>
<td>Providing strategies for boundary setting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Parents losing their parent role</td>
</tr>
<tr>
<td>Psychosocial support to meet a need for improved mental wellbeing</td>
<td>Providing a sense of safety through togetherness</td>
<td>Providing psychosocial support during divorces</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor maternal mental health</td>
</tr>
<tr>
<td>Motivational support to meet a need for finding fulfilling purpose</td>
<td>Fostering a sense of purpose through increased social interactions</td>
<td>Breaking isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Need for a sense of belonging</td>
</tr>
<tr>
<td></td>
<td>Promoting civic engagement</td>
<td>Encouraging mothers to vote</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of trust in the political system</td>
</tr>
<tr>
<td></td>
<td>Inspiring hope and motivation by sharing the life stories of others</td>
<td>Finding inspiration in others’ journeys</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sense of missing a role in life</td>
</tr>
</tbody>
</table>
Informative support was also described as valuable in addressing a need to understand what it means to become a parent in Sweden. This included providing information on both physiological and psychological processes during and after pregnancy, what to expect during childbirth, and things to consider in relation to breastfeeding. Understanding the process of becoming a parent was described as facilitating empowerment through an improved ability to prepare for challenges during various phases of parenthood. Educational sessions were also held to shed light on expectations of parents, meeting a need for understanding what rights and obligations parents have in Sweden in relation to both their children and to authorities. The Mentor Mothers described how clarifying such expectations enabled clients to feel more secure and comfortable in their parenting. Due to a widespread mistrust in authorities, including the social services, this was presented as helping parents with feeling comfortable with setting boundaries for their children, without a fear of being reported to the social services.

Practical support to meet a need for managing challenges in daily life

The Mentor Mothers described how many clients struggle with contacts with authorities and welfare services such as schools, health and social services. Challenges may include language barriers, cultural differences that contributed to misunderstandings, power asymmetries, and practical difficulties in
making appointments or finding the way to services. To meet these needs effectively, interpretation was provided, often with an element of cultural interpretation where Mentor Mothers explained ideas and beliefs underpinning what was said. It also involved explaining letters from authorities, booking appointments, and accompanying client mothers to meetings. The Mentor Mothers described how the support to facilitate these contacts not only helped the client mothers temporarily but also improved their ability to independently manage these problems themselves in the long term.

Practical support was also provided in the form of concrete strategies for parent-child interaction. The Mentor Mothers described how many of their clients had expressed that they felt they were losing their parental role. This was closely linked to uncertainty about parental rights and obligations in Sweden, and a fear of overstepping the boundaries of how parents could act towards their children. Practical strategies for boundary setting and everyday routines in the home were provided in the form of courses in cooperation with the local social services. This was described by the Mentor Mothers as contributing to a sense of control in the daily lives of the client mothers.

Figure 10: Group course on boundary setting within the family. Reprinted with permission from TF.

[This photo] touches us very much, this particular course because one of the mothers in the picture, she came to us after the course ended and told us how her situation had changed at home. [W]hen she met this amazing preventive social worker, she got methods that she could use, that strengthened her paren-
tal role. And she also got methods for reducing stress, giving the children responsibility, participation, sitting and talking beforehand in preparation. And she also received information about what the law says and what your rights are as a parent. So when she took the method and used it at home, she came back and told her story about how it has changed. (Study participant #4)

Psychosocial support to meet a need for improved mental wellbeing
A perceived need for a sense of security and calm was met by the Mentor Mothers striving to create a sense of belonging. This could mean giving space for the client mothers to talk about psychosocial burdens without discussing them in terms of solutions. It could also mean that they were present during difficult meetings with the authorities and thus created a sense of security. This was also described as making it easier for client mothers to assert their rights in such situations. Another important aspect was to provide psychosocial support to clients who had difficult close relationships or were going through divorce. This could also include discussing self-esteem, autonomy and gender norms to facilitate empowerment.

Motivational support to meet a need for finding fulfilling purpose
Mentor Mothers also described a need for many clients to be motivated to want to invest time and energy in themselves, their families, and their community. This could mean overcoming social isolation, promoting participation in local communities, civil society and society at large, and supporting social integration. Social isolation was addressed by motivating clients to actively seek out and interact with other people. It also involved creating platforms where this could happen by organising group courses where there was time and space for social interaction, and motivating participation in these.

Motivational support was also provided to promote community engagement and social inclusion. This was done through discussions on the importance of participating in and trying to influence society, for example by voting in elections. They also organised meetings with politicians to instil a sense of proximity to public officials. Through this, the Mentor Mothers felt that they could promote a notion among their clients that they could influence not only themselves but also structural issues in society.

A concrete strategy to foster clients' motivation to invest time and energy in themselves and their families was to create platforms where both clients and Mentor Mothers themselves could share their life journeys. In practice, this often meant that during group courses they would discuss their own challenges and how they overcame them. By sharing this, clients could realise that they
were not alone in their problems and that there were solutions to them, thereby both normalising adversity and inspiring hope.

We all sit together. When she sits and talks, you can see that she has problems. Others, you know, women open up and she sees that it's not just me who is [isolated] at home, it's not just me who has problems. There are others too. You feel a bit, how can you say, you feel that it's not just me. And that makes you feel that it's less stressful. (Study participant #2)

The challenges discussed in such forums could include difficulties in social integration, mistrust of authorities, pregnancy and breastfeeding concerns, and social isolation. The Mentor Mothers described how the sense of shared experiences was perceived to contribute to strengthening the client mothers' belief in their own abilities.

Study IV

This article investigated perceptions of how mistrust of welfare services and authorities arises and perceptions of how this could be overcome through the Mentor Mother programme in Gothenburg.

The analysis identified five overarching themes: Reasons for mistrust in welfare services and authorities, consequences of mistrust, strategies for building trust in Mentor Mothers, strategies for building trust in welfare services and authorities, and consequences of trust-building. These themes consisted of 19 categories covering specific elements of the processes of mistrust and trust building. Based on the findings of the study and the participants' descriptions of how the various factors within the trust-building process were related, a conceptual model was created (Figure 11). This conceptual model outlines a perceived topic-specific intervention logic in the programme, encompassing both perceived problem, intervention, and perceived outcome.
Figure 11: Conceptual model for the trust-building process in Study IV
Reasons for mistrust in welfare services and authorities

A widespread mistrust of authorities and welfare services was described by study participants. This mistrust was often directed towards social services, but could also be directed towards schools, preschools, health services, authorities, or the police. This was described as having multiple causes. One cause was described to be exaggerated rumours and misinformation. The study participants voiced that these rumours related to the right of social services to take children into care, and consisted of perceptions that this was done in the absence of proper processes and that it could be done arbitrarily. This misinformation was spread from person to person, sometimes via social media. Other welfare services, such as preschool, school and child health care, were also described as being perceived to have a controlling function, where parents feel scrutinised and evaluated if they are good parents or not. This led to a fear of being reported to social services.

Another reason for mistrust highlighted was lack of clarity in interactions with service providers. This could consist of cultural clashes in encounters between parents and staff in, for example, schools and health services, resulting in misunderstandings or parents not feeling respected. Examples also included discussing sexual and reproductive health in ways that parents were not comfortable with, or service providers asking detailed questions without explaining why. It could also consist of information being given without service providers ensuring that the receiving parents understood it well.

For example, when I go to [an agency], they talk to me, not just with language, but with body language as well. They explain the information and show me the form, and sometimes they say, when it's finished, put it here. Sometimes they say to put the form here, they think that I will understand and do everything, but still I don't really understand. (Mentor Mother #5)

A further factor that participants voiced during the interviews was a lack of familiarity with the parts of the welfare system and their functions. This meant that it could be difficult to distinguish between different authorities and services. It also led to speculation about the motivation behind different services, such as why the child health care centre booked appointments or home visits. Experience of poorly functioning authorities and welfare systems in other countries was also described as contributing to this.

Consequences of mistrust

In the interviews, mistrust was described both as a problem in itself and as having wider consequences. Study participants described how mistrust could sometimes lead to parents living in a state of fear. This thus affected their wellbeing and could be a factor in many types of decisions in their lives. Such decisions included how they utilised and interacted with welfare services and
authorities. In some cases, this meant avoiding answering the phone when unknown numbers called for fear that it could be, for example, the social services.

I used to be very stressed, I had a lot of stress. If the phone rang, a number I hadn't saved, what would happen? What would they say? I was like that. I got it from other parents, this fear I got from other mothers. Before I became a mom, I've seen moms who were scared all the time. Who has called me? Is it the school? Is it social services? (Client mother #2)

It could also mean avoiding enrolling children in preschool. In extreme cases, parents were described as having chosen to leave Sweden because of the fear. Participants voiced that another consequence of mistrust and fear of authorities was that parents lost their authority and parental role as they did not dare to set boundaries for their children. This was also influenced by an uncertainty about what rights and obligations parents had in Sweden. In several cases, the study participants described how this led to children threatening their parents with reporting them to social services if they did not get what they wanted.

**Strategies for building trust in Mentor Mothers**

To enable the Mentor Mothers to work effectively with their target group, they prioritised building trusting relationships. Several strategies were described to achieve this. One such strategy was to use and communicate the neutral position of being employed by a third sector organisation. This neutrality, combined with perceived benevolence, was described as enabling the building of strong and trusting relationships with their clients. The perceived neutrality was reinforced by communicating the confidentiality of meetings and avoiding asking questions related to topics that the clients themselves have not raised.

Another strategy was to use and clearly communicate social proximity. In practice, this meant that the Mentor Mothers emphasised that they shared experiences of migration and parenting with the clients. It also meant that they discussed that they had gone through the same process of integration as the clients, and that they themselves had in many cases had similar experiences of institutional mistrust. Client mothers described how this enabled them to more readily accept new information.

It gives you comfort because it comes from [someone with] the same culture and same background. (Client mother #10)

To promote trusting relationships, Mentor Mothers also described using individual mapping of needs and individual tailoring of their support to clients. In addition, they also described using continuity over time to promote good rela-
The support they provided often started when the clients were pregnant and the Mentor Mothers met them in their capacity as community doulas, then followed them until after the birth. This continuity was important as it often took some time for client mothers to open up to discussions on sensitive topics.

Strategies for building trust in welfare services and authorities

To promote institutional trust, Mentor Mothers and stakeholders described using a variety of strategies. The Mentor Mothers’ neutral position was used to facilitate interactions with welfare services and authorities. This was described as happening in two ways. Firstly, it could be done by providing individual support to client mothers, discussing the functioning of different services and authorities and supporting them in their contacts with them. An example of individual facilitation of contacts was participating during appointments at authorities or health care centres, where they took on a mediating role. It could also be done through group courses in cooperation with social services or healthcare providers, where the Mentor Mothers acted as interpreters and contributed a sense of security in the situation.

To counteract misconceptions and ignorance about services and authorities that could form the basis for mistrust, the study participants highlighted how the informative components of the Mentor Mother programme were valuable. Understanding the organisation of the public sector, the political system, and the logic behind decisions in e.g. the social services was considered to promote institutional trust.

It's mostly with social services or schools and preschools. Yes, it is. But it's all connected, you know, all the needs and all the authorities and so on. They usually inform us about how it works and what we are entitled to and what we are not entitled to and you know, things like that. (Client mother #1)

Trust in services and authorities was also perceived to be promoted by client mothers developing personal relationships with individuals representing them. This humanised the otherwise impersonal institutions. In practice, this meant cooperation with social workers and health professionals through joint group courses on the Mentor Mothers' premises. Study participants also voiced that there was value in gradually increasing interactions and initially allowing clients to be anonymous. This could mean attending sessions without participating in discussions or attending online courses with cameras turned off. This initial anonymity allowed for later active participation when the client mothers had become more comfortable with the situation.
Consequences of trust-building

Both Mentor Mothers and client mothers described the Mentor Mother programme as contributing to increased institutional trust. This trust was described as being enabled by improved understanding of processes within welfare services and authorities, and by improved awareness of parental rights and obligations. The latter helped boost confidence among parents, and several client mothers described how they were now more comfortable establishing boundaries with their children. Improved trust in welfare services and authorities was described as leading to an increased willingness of clients to independently contact authorities and service providers. A sense of control arising from an understanding of rights and procedures, particularly in social services, was also described. This resulted in feelings of calm and a sense of safety.

We used to be afraid, but now we are not afraid. [...] We thought they would take our children, just take the children without asking. But now we are calm. Like me, I'm very calm and I'm not afraid of the social services. (Client mother #1)
Discussion

Main findings
The studies in this thesis focus on various aspects of how a Mentor Mother peer support programme was adapted to benefit socially disadvantaged mothers with experiences of migrating to Sweden, how the implementation took place, and how the expertise and experiences of implementers and clients guided its further development, including how institutional trust was promoted. The findings in these studies entail aspects of responses to perceived needs, enabling factors and barriers in the peer supporters’ and Mentor Mothers’ work, implementation outcomes and strategies, and mechanisms of impact. These findings both reflect and contrast with previous research.

Needs and programme developments for health, integration, trust, and empowerment
The perceived needs and corresponding programme developments were primarily described in Studies I, III and IV. The peer support programme in Malmö and the Mentor Mother programme in Gothenburg were both adapted, developed and implemented with high flexibility and consideration of the needs of the community. As described in Study I, the programme was adapted based on perceived needs including social exclusion, institutional mistrust, and challenges in navigating the range of available public services. This motivated a focus on social determinants of health and linking to other services, while keeping some aspects of the South African programme’s focus on educating clients. In Study III, the Mentor Mothers described responding to perceived needs for support with social isolation, parenting practices, maternal and child health literacy, civic engagement, understanding rights and obligations of parents, understanding the organisation and purpose of various public services and authorities, and a need for practical assistance in interactions with these services and authorities. Study IV examined different aspects of the need to address institutional mistrust, including how this need arose from misinformation and rumours, lack of clarity in interactions with service providers, and lack of familiarity with the system. In summary, community needs in the two study sites were described to largely relate to social isolation, lack of civic participation, low use of public services due to institutional mistrust and lack of knowledge about the welfare system, and difficulties in navigating the
parent role due to limited understanding of expectations on parents, low maternal and child health literacy, and institutional mistrust.

Such community needs have also been highlighted in previous research. A review of peer support programmes for immigrants in high-income countries showed that many tended to prioritise social determinants of health, as this was in line with perceived needs. Social isolation has been described as a burden for parents who have recently migrated to Sweden, which can be exacerbated by having left a cultural context where raising children is a more collective process than it is in the new context. Some studies have also highlighted the challenges of navigating new expectations on parents and new dynamics between parents and their children after arriving in Sweden. Studies on barriers to effective use of health and welfare services among persons who have migrated to Sweden have described factors such as communication issues, cultural differences in interacting with service providers, practical obstacles, shame of being ill, and cultural insensitivity among services. In a qualitative study on peer support for cancer prevention in Sweden, the role of peer supporters as a bridge between services and services users was highlighted as central, which was in line with prioritising a linking function as described in Study I.

Institutional mistrust has also emerged as a challenge in previous studies among immigrant groups in Sweden, both in relation to providing parental support and in relation to vaccine programmes. A quantitative study on trust in the social workers in Sweden showed a positive correlation to income level and education, but the study did not explore variables related to migration or social exclusion. Mistrust in the social services in Sweden, which was the most widely referred institution to mistrust in the studies in this thesis, is however still underexplored in research. Study IV, which specifically explored perceptions of how institutional trust can be promoted through peer support, appears to be the first study to explore mechanisms of overcoming institutional mistrust in Sweden.

Qualitative studies in other countries provide examples of using community leaders, social mobilisation, and using trusted messengers such as parent advocates to promote trust in vaccines. Common for these strategies are that they rely on interpersonal trust to promote institutional trust. In Study IV, the categories describing how institutional trust was promoted consisted of using Mentor Mothers’ perceived neutrality to facilitate interaction with representatives from public services, explaining processes within service and authorities, personalising and humanising services and authorities, and letting interactions between clients and services increase gradually. These strategies can be interpreted through Mayer’s conceptualisation where trust is described as being based on positive expectations of the other party’s ability, benevolence and integrity. Especially the latter two were applicable to the findings in Study IV. Specifically, perceptions of benevolence were promoted by facilitating relationships with the people representing support services, and by
providing insight into the wide range of social support and health services that are available for parents. Perceptions of integrity, on the other hand, was promoted by increasing insight into how and why certain decisions were taken, which principles that the public sector adheres to, and what rights and obligations that parents have towards their children and towards authorities. Perceptions of ability as a factor for trust did not emerge as a strong finding in Study IV.

In Study III, the Mentor Mothers described strategies that they saw as relevant, feasible and effective for responding to community needs by promoting empowerment among their clients. This was described as being accomplished through providing information, practical support, psychosocial support, and motivating clients. Psychological empowerment has been described by Wallerstein as being constituted by three components.175 The first of these is perceived competence and control, which aligns with the Mentor Mothers’ notion of expanding the knowledge base amongst their clients. The second component is skill development and resource mobilisation, which corresponds to promoting client mothers’ abilities to assert their rights in society, as well as managing both their role as parents and difficult interaction with authorities and public services. The third component is community involvement and participation, which can be interpreted as corresponding to Mentor Mothers promoting social interactions, institutional trust, and civic participation. In a report to the WHO, Wallerstein has also concluded that the most effective strategies to promote empowerment for health are those that reinforce psychological empowerment, a sense of community and local bonding, and autonomy in decision making.116 These strategies align well with the strategies that were perceived as relevant, feasible and effective by the Mentor Mothers in Study IV.

Enablers and barriers

The enabling factors and barriers to delivering peer support were described in Studies II and IV. In Study II, study participants described barriers such as unpredictable funding, gender norms that made it difficult for client mothers to participate in activities outside the home, and mistrust of social services that impacted the target group's attitude towards peer supporters. Uncertain funding is an ever-present barrier for many third sector actors implementing social and health services.176 Gender norms related to parenting have also been explored in previous studies. A qualitative study on Somali-born parents' parenting support needs indicated that mothers experience restrictive gender norms in terms of childcare responsibilities, which may conflict with social integration ideals such as being employed.12 Such factors can represent both needs of the target group and barriers to providing support for the same needs, pointing to the multi-levelled challenges of responding to these needs through parental peer support. Similarly, in Study II and Study IV, institutional mistrust was
highlighted as both a need of the target group and a barrier to support, the latter because mistrust of social services caused potential clients to be sceptical toward peer supporters.

In Study II, factors that enabled the peer supporters’ work were the implementing organisation’s third sector affiliation, reputation, network and experience. The third sector affiliation provided both freedom in the management and further development of the programme, and contributed to them being seen as a neutral part when peer supporters linked client mothers to other services. The perceived neutrality was also highlighted in Study IV, where the Mentor Mothers communicated this neutral position to promote interpersonal trust, which later enabled them to work on promoting institutional trust. Previous research has pointed towards the value of services being delivered by third sector organisations, as these can be better at connecting with vulnerable groups, driving altruistic values and being seen as approachable.176 A systematic review of barriers and enablers of lay health worker programmes highlighted that they are often seen as more accessible and friendly than professional services, indicating a value in providing support in less formal formats than those offered through for example the healthcare sector.177 In the literature on peer support in mental health services, concerns have been raised that peer supporters lose their perceived neutrality if they are employed within these services rather than by an external party.178 This is also in line with the notion that peer support can be delivered effectively through the third sector, and that the same can be difficult to do in the public sector.

Implementation

The value of flexibility in how peer supporters worked was emphasised in both studies I and II. This included freedom for peer supporters to decide how to recruit clients, the possibility to adapt their support to clients' individual needs, and flexibility in terms of how and where interactions took place. In Study IV, Mentor Mothers and their clients described how individualisation of programme content could promote the development of trusting relationships, which also reflects a type of flexible approach being seen as valuable.

Study I highlighted some underpinning philosophies and priorities of the peer support programme in Malmö that are central to fully understand the implementation process explored in Study II. One such priority was to match the linguistic and ethnic diversity of the relevant target group with a similar diversity among the peer supporters. This diversity has implications for the supervision of the peer supporters, as their coordinators cannot undertake in-the-field supervision in the same way as the coordinators of the Mentor Mothers in the linguistically relatively homogenous communities in South Africa. Less in-field supervision is likely to result in more decisions about how to interact with clients being made by the peer supporters themselves rather than by their
coordinators. The result of this is that programme components and implementation strategies are developed and adapted with flexibility and in a bottom-up manner by the peer supporters themselves. This was reflected in Study II, where peer supporters enacted their roles in different ways and independently devised new strategies to reach new potential clients.

A previous narrative review of strategies used in peer support home visiting interventions that I have written highlighted that flexibility is common, both in terms of content (what is delivered) and form (how it is delivered).87 This is also in line with previous research on engaging vulnerable groups through peer support. A review by Sokol and Fisher on peer support for hard-to-reach groups indicated that a majority (70%) of included peer support programmes described some type of strategy of flexibility.90

In the literature on community health workers, who are often peers with the end-users, flexibility has been highlighted as a crucial aspect in ensuring their relevance in meeting complex needs.179 However, flexible content or form of an intervention also poses challenges as it can make it difficult to define what the intervention in question actually entails and what it does not,179 a challenge that is inherent for many complex interventions.180 This uncertainty of the boundaries of the role of the peer supporter was mirrored in Study II, where peer supporters did not strictly adhere to defined roles. This entailed giving lower priority to the educational elements of the programme than intended, helping clients with things not specified in the logic model of the programme, and working outside of office hours. The result was thus a low fidelity to parts of the logic model of the programme outlining that peer supporters’ work should include an educational component.

If addressing institutional mistrust is a priority, and providing information in an accessible way is a means of achieving this as highlighted in Study IV, then being uncomfortable with delivering the educational components of the programme can be an obstacle. In previous research, the implementation of interventions in the third sector has been highlighted to be negatively affected by factors such as lack of expertise and experience.176 It is possible that the expertise required to feel comfortable implementing an educational intervention requires not only short-term training but also experience in working with these issues, such as with Mentor Mothers in Gothenburg who all had professional experience as doulas and cultural interpreters.

A central component of the South African Mentor Mother programme is home visits. Study II found that peer supporters did not conduct home visits to a large extent, constituting only 0.8% of contacts with client mothers. This was explained by the fact that they saw the home as too private a place, that it was suboptimal from a working environment point of view, that the home could be an unsafe place for client mothers, and that the routines of the peer support programme had been established during the Covid-19 pandemic. A wide range of research on home visiting programmes has indicated that the
home can be a feasible setting for delivering interventions from both professionals and peer supporters. A qualitative study on a Mentor Mother programme for intimate partner violence in the Netherlands indicated that the home was seen as a valuable platform for meetings by the Mentor Mothers as it provided a more complete picture of the clients’ social situation. Studies on an extended home visiting programme implemented by the child health services in Sweden have also indicated that it is feasible to use the home as an arena for interventions. Other research has indicated that worries about confidentiality can be a barrier to conducting home visits, as recipients fear that home visitors will observe and share personal information with each other or with others. One way of interpreting the challenges of conducting home visits in Study II is that the liminal relationship between peer supporters and clients already balances between personal and professional, and that meetings in the home cause the relationship to go from being personal to being private in an undesirable way.

Mechanisms of impact

A strategy described in Study II was the use of practical support as a gateway to more comprehensive peer support, which was considered feasible as support with practical matters was described as undramatic and easily accepted during early meetings with client mothers. This strategy had emerged spontaneously through peer supporters’ insights into what worked in practice. Participants also described that a mediating mechanism of the programme was close relationships that enabled addressing sensitive topics. In Study IV, participants described the value of having a gradual approach when promoting trust in welfare services and authorities, where clients were allowed to be anonymous during early meetings, which reflects the strategy in Study II.

These strategies and mediating mechanisms are all based on the idea of sequentiality, where programme components follow each other, e.g. practical support being an entry point to providing other types of support. Such a sequential approach was described as a type of intervention logic by the peer supporters, even if this was not an outspoken strategy in the logic model of the programme. This sequentiality of intervention components was also described as being enabled by gradually building interpersonal trust, which in turn enabled the peer supporters to gradually engage the clients in utilising other aspects of the peer support more actively. Using this as a deliberate strategy has been described sparingly in previous research. One example can be drawn from a qualitative study on peer support for migrant women by Gower et al., that described how initial hesitation among clients was gradually overcome by building trust, with peer supporters being careful not to proceed too quickly in this process. Peer supporters for cancer prevention in Sweden have also been described to use a strategy of approaching sensitive topics
slowly and with care, by initially having discussions on less sensitive matters such as healthy lifestyles in general.\textsuperscript{172}

The value of trustful relationships to reach programme goals was highlighted by both peer supporters and stakeholders on an organisational level in Study I. In Study II, this was mirrored by the development of trustful relationships being put forth as both a central implementation strategy and as a mediating factor that enabled approaching sensitive topics. In Studies IV interpersonal trust between Mentor Mother and clients was described as enabling the efforts to build institutional trust. Trustful relationships have also been highlighted as critical in research on the implementation of the Mentor Mother programme adapted to Eswatini.\textsuperscript{146}

The close relationship to clients is also tied to the blurring of professional and personal roles, as highlighted in Study II. Qualitative studies on the Mentor Mother programme in South Africa have indicated that the blurring of professional and personal roles can be experienced as positive, as it enables one to become a respected member of the own community.\textsuperscript{186,187} It can however also be negative, as it brings expectations of availability and selflessness.\textsuperscript{186} In Study II, these negative effects could manifest themselves as clients expecting peer supporters to provide assistance with issues outside of working hours. A study by Mourra et al. found that peer supporters tended to blame themselves for bad outcomes among those they supported, increasing the personal psychosocial risk of the peer supporter role as compared to traditional professional roles.\textsuperscript{188} Mancini and Lawson have suggested that such self-blaming could relate to difficulties in upholding distance to the experience of others in the peer supporter-client relationship.\textsuperscript{93} This highlights the importance of organisational support in managing side effects of the blurred role that peer supporters may experience, which is further discussed below.

**Implications**

The findings of this thesis have implications for the programmes implemented by YT and TF in Sweden, as well as for similar programmes based on peer support for vulnerable groups. They also have implications for research conducted on such programmes.

In a context of complex and heterogeneous needs, flexibility in content and form can be a critical component of peer support. During implementation it can however seem to contrast with an ambition to follow a manualised programme plan with high fidelity. Very flexible interventions can also be difficult to evaluate rigorously.\textsuperscript{180} The process evaluation in Malmö, described in Study II, found that peer supporters’ sometimes struggled with the educational components of the programme, suggesting flexibility in terms of role enactment and inconsistent fidelity to these parts of the logic model.
Previous research has also highlighted how it can be challenging to communicate what the broad role of peer supporter entails and how it relates to those of other professions. Ensuring that what is planned is also delivered is valuable as a standardised programme enables both rigorous evaluation of programme outcomes and a clear communication of what the programme entails. In the case of the peer support programme in Malmö, the fidelity to the educational parts of the logic model varied between peer supporters, as described in Study II. In Study I, stakeholders highlighted the value of a flexible programme, which contrasts with the idea of strictly following a plan in the form of a logic model. The Mentor Mothers in Gothenburg also developed both content and form of their programme according to perceived needs and relevance of strategies, as described in Studies III and IV, allowing for flexibility in roles and role enactment across the whole programme.

This tension between fidelity and flexibility has been at the centre for an ongoing debate in implementation science. Fidelity to a programme plan means ensuring that what was planned was also delivered. However, it is important to keep in mind that lack of fidelity need not be seen as a failure of implementation. Rather, allowing for adaptation to emerging circumstances can ensure the relevance of the programme in a context of complex and heterogeneous needs. With this in mind, flexibility can be a core component of complex interventions. A concrete example of this can be drawn from a qualitative study aiming to identify core components of an extended home visiting intervention provided by the child health services in Sweden, which highlighted flexible content as such a core component. It is however important that flexibility in the way a programme is implemented does not compromise its intervention logic.

An intervention logic can be maintained intact while allowing for flexible approaches by standardising programme processes and functions rather than programme content. In practice, this translates to consistency in terms of what role peer supporters see themselves having rather than standardising the topics that are discussed during meetings. This approach to standardisation has for example been described for Peers for Progress, a peer support programme focused on diabetes that has been implemented in a wide range of contexts. For the peer support programme in Malmö, this approach would translate to ensuring consistency in regards to how the peer supporters focus on educating client mothers versus focusing on facilitating interactions with other services and authorities. For the Mentor Mothers in Gothenburg this approach would mean formalising a logic model based on the strategies and mechanisms perceived as relevant and effective, to ensure uniform perceptions of what the role of Mentor Mother entails and how it is enacted, while allowing Mentor Mothers to tailor discussions with clients to individual needs. Such standardisation of roles rather than content can allow peer supporters and Mentor Mothers to be flexible in responding to the complex needs of their
clients, while ensuring that the programme is consistent enough to be evaluated for effectiveness and communicated clearly.

With the liminal position of balancing the personal and professional being an underpinning mechanism of peer support, the blurring of roles must be seen as both a resource and as a potential risk. Previous research has highlighted how lack of organisational support in managing this blurring of roles can place a large emotional burden on peer supporters. A qualitative study on the Mentor Mother programme in South Africa has indicated that Mentor Mothers can experience difficulties in upholding personal boundaries, with potential negative consequences in the form of emotional exhaustion. Other studies on community-based health workers conducted in South Africa, Brazil and India reflect these findings.

To ensure the sustainability of the programmes and prevent burnout among peer supporters and Mentor Mothers, such difficulties in upholding boundaries can be managed on an organisational level. Previous examples exist of how this has been done through active supervision, training on mental health and the use of strategies such as structured debriefing. Self-care strategies have also been described as important for other professional categories with such as social workers. For the peer support programme in Malmö and the Mentor Mother programme in Gothenburg, promoting healthy boundary-setting would mean continuing to provide active supervision and being sensitive and responsive to the self-care needs that arise, e.g. by providing training on these topics.

Trust and mistrust in institutions in Sweden has been extensively researched in various fields. There is still a lack of studies on how institutional mistrust affects the willingness to use welfare services in general. There is also a lack of research on how institutional mistrust can be overcome in the Swedish context. Study IV outlines the perceived mechanisms of how institutional mistrust arises and how it is managed through the work of the Mentor Mothers. Future studies could evaluate the impact of participation in the Mentor Mother programme on institutional trust using any of the existing quantitative measures, preferably after validating those for this specific purpose and in this context.

Future causal studies could also examine the effectiveness of the Mentor Mothers’ empowerment strategies by using any of the many measures and study designs described in earlier intervention studies on empowerment in health promotion. This could for example be done by assessing how exposure to programme activities aligning with individual empowerment strategies correlate to such measures. The empowerment strategies described in Study III could also inform the choice of more specific and concrete measures, such as the impact of informational support provided by Mentor Mothers on health literacy. In line with how complex interventions are often evaluated, multidimensional measures might be appropriate. Optimally, the choice of outcome measures would be preceded by the creation of a logic model for the
Mentor Mother programme in Gothenburg to clarify how change is intended to be achieved and an evaluation of how this is followed in practice. Formalising these informal strategies would also make the Mentor Mother programme easier to communicate.

Similarly, the peer support programme in Malmö could be standardised by updating the logic model to reflect what peer supporters do in practice, including the sequence of different programme components, the functions of peer supporters and the flexibility of content, and whether more tasks should be included than previously specified. This would bring further clarity to the intervention logic and theorised change processes, thus enabling the choice of outcome measures matching this theory of change.

Methodological considerations

Trustworthiness and quality

This thesis describes several aspects of health-focused peer support for socially disadvantaged mothers and pregnant women with experiences of migration. The studies included in the thesis are based on different methods of data collection and analysis, with a predominant focus on qualitative methods. As Study II also included a quantitative component that was presented descriptively to illustrate aspects of implementation, methodological considerations regarding both qualitative and quantitative methods will be discussed below.

The qualitative methods used in this thesis will be reviewed and discussed using Lincoln and Guba’s trustworthiness criteria. These criteria consist of credibility, transferability, reliability and confirmability. According to Lincoln and Guba, these criteria broadly correspond to four quantitative quality criteria, which are internal validity, external validity, reliability and objectivity. Each of the criteria has been promoted through a set of research techniques.

Credibility refers to the confidence in the ‘truth value’ of the findings. In other words, credibility concerns whether the researcher has been able to understand and reflect the participants’ subjective reality. This can be accomplished by using techniques such as prolonged engagement, triangulation and member checking. For all studies, parts of the research team participated in the steering groups for the two programmes that were being studied, and some of the researchers had long engagement with Mentor Mother programmes in South Africa and Eswatini through research and operative work. Researchers working on all included studies had also followed the development of the two programmes in Sweden over several years and had come to know both peer supporters, Mentor Mothers and other study participants well. This long-term commitment probably contributed both to the credibility of the results, the willingness of study participants to take part in the research, and willingness
to discuss matters openly during interviews, workshops, and the focus group. Triangulation was undertaken both in terms of assessing perspectives from different categories of research participants, using several data collection methods, using multiple sources of data, and multiple analysts. Studies I, II and IV combined perspectives from several groups, i.e. client mothers, peer supporters and Mentor Mothers, project coordinators, and other stakeholders. Study I and III relied on data from both group discussions (recorded workshops and a focus group) and individual interviews, aiming to enable discussions on sensitive topics during interviews that might have been difficult to raise in a collegial setting. Study II used both semi-structured interviews and quantitative log data from peer supporters to assess various aspects of implementation. Studies II, III and IV had two researchers involved in the coding process, and a subset of interviews were double coded to assess discrepancies and agree on a common coding structure. Member-checking was done for Studies III and IV through two group sessions, where the findings and their presentation were discussed with all Mentor Mothers and external stakeholders, and a subset of client mothers. This provided an opportunity to gather valuable insights into how they viewed the research findings and the wording used to articulate them. With regard to the quantitative log data collected for Study II, internal validity was promoted by training peer supporters on how to complete activity log forms correctly and by providing ongoing supervision in this regard through the programme coordinator at YT. Peer supporters were also continuously encouraged to record activity logs immediately after meeting with client mothers, to ensure that the data on activities represented what had happened during these meetings.

Transferability refers to whether the findings have applicability in other contexts or circumstances. The concept of transferability has to be interpreted through the choices of qualitative study designs. The four studies in this thesis follow research designs that aim to gain an understanding of local phenomena in specific contexts. In the terminology proposed by Crowe, Study I was an intrinsic case studies, meaning that it aims to shed light on a unique phenomenon that is distinguished from other phenomena of the same category. Study II was a process evaluation where the aim was to produce findings that can add value to the specific programme being evaluated. Studies III and IV were instrumental case studies, meaning that they aimed to investigate specific cases but also to generate findings that can contribute to a broader understanding of the studies topics. These study designs thus have different aims in regards to transferability. Despite this, the findings of all included studies may be relevant for and transferable to other contexts or interventions to some degree. Transferability can be promoted through the use of techniques such as purposive sampling and developing a ‘thick description’. Purposive sampling refers to the recruitment of a diverse range of participants to capture a range of perspectives and experiences. This was applied in Studies I, II and IV, but most notably the two latter, where the recruitment of study participants aimed
to include client mothers from several different linguistic and cultural groups. Thick description is a term used to denote detailed and rich descriptions of the context in which the research is conducted, including both the outer sociocultural context and the inner organisational context. Such a detailed description allows the reader to contextualise and more fully comprehend the phenomena being studied, thus facilitating the assessment of the applicability and relevance of the study's findings in other contexts. This was sought to be done in all of the studies. In Study II, external validity was not an outspoken goal, as the quantitative log data reflected activities of specific individuals within a specific programme.

*Dependability* refers to the reliability, stability and consistency of research findings. In other words, a study with high dependability produces findings that can be replicated and verified. This is accomplished through transparency in terms of clearly described research design, purpose, and methods for data collection and analysis. It also involves rigour in terms of systematic and consistent application of data collection and analysis methods throughout the study. In order to promote dependability, the studies in this thesis have had a careful application and description of the methods. The research team also had continuous discussions on the interpretation of the data to ensure that the findings were well grounded in the data and that the methods were applied rigorously to reduce any potential bias. This was also the case for the quantitative log data. However, *dependability* and *reliability* are less central concepts when studying transient phenomena, as in the case of the process evaluation in Study II.

*Confirmability* means whether the study is conducted according to principles of neutrality. For a study to have high confirmability, the findings should be shaped by the study participants and not the researcher’s bias or interests. Techniques to achieve this include triangulation, describing the process in detail, and reflexivity. Triangulation and carefully describing the research process are both outlined above. Reflexivity is the acknowledgement and systematic examination of the effects of the researcher on the research process. This includes the researcher's background, perspectives, assumptions and values, which may introduce potential biases influencing the research process or findings. The research team sought to achieve this in all studies through continuous reflection and reporting of the researchers’ own backgrounds and experiences, and how this could influence the research process. Continuous dialogues were also held between researchers of different backgrounds to identify any potential bias in how methods were applied or conclusions drawn. In the quantitative data collection in Study II, the log forms were designed together with the project coordinator and peer supporters at YT. This aimed to reduce researcher bias in the choice and phrasing of form questions, thus promoting *objectivity* in the quantitative data collection.
Limitations

Studying mistrust with data collection methods based on face-to-face interaction is a methodological challenge. Being a researcher means being a representative of a type of authority, which in a context of institutional mistrust brings a risk of bias in the recruitment of client mothers as study participants. This is difficult, if not impossible, to compensate for fully, but the bias can be mitigated. In both Study II and IV, most of the interviews with client mothers were conducted by public health and global health master students in the client mothers’ own languages. An exception to this was made for Somali-speaking client mothers in Study II as the research team was unable to find a Somali-speaking research assistant in time for data collection, despite extensive efforts. These lenient mothers were instead interviewed in Swedish or English. This may have influenced the selection of participants towards client mothers who had spent enough time in Sweden to feel comfortable with these languages. All interviewed client mothers also had the opportunity to go through the information for study participants in detail with a peer supporter or Mentor Mother. Interviews were conducted at the peer supporters and Mentor Mothers venues, to provide a venue that interviewees were familiar and comfortable with. Confidentiality and the possibility of discontinuing participation were also repeatedly emphasised.

Studies I, II and IV triangulated data from several categories of interviewees. This allowed for a more complete picture of the processes being studied. However, multiple categories of interviewees combined with multiple research questions make it difficult to delve into individual phenomena. A more thorough understanding of the views of each category of interviewees could probably have been achieved if the data collection had been limited to individual processes or categories of interviewees. This could have meant, for example, studying only the emergence of mistrust of authorities through interviews only with client mothers.

The sample size in Study III limited the amount and variety of data that could be collected. In traditional photovoice studies, a sample size of 7-10 participants is recommended, to promote breadth in the data while also allowing for in-depth discussions. In our case, we used a total population sample consisting of all those working within the Mentor Mother programme, so a larger sample size was not an alternative. We did, however, use both a focus group discussion and individual interviews with an aim of promoting depth in the data. With this limited sample size in mind, the study should be read as an example of how a programme for empowerment promotion can be developed from the bottom up based on the perceived needs of individuals with a deep understanding of the context, albeit specific individuals in a specific context. Such smaller studies can be valuable in that they contribute to the generation of hypotheses or research questions that can be investigated through further research.
In Study II, not all aspects of implementation were explored through triangulation of different methods. The data on fidelity to the logic model contained quantitative data on the practical support provided by peer supporters, i.e. which services and authorities they linked their clients to. However, it did not contain data on aspects such as the topics of discussion that peer supporters raised with their clients, nor personal information that could be used to identify individuals. Therefore, it was not possible to rely on the quantitative data to assess how the peer supporters adhered to the planned education components of the logic model, or to trace individual client mothers over time in the data. This was a conscious choice made in the design of the activity log forms to ensure ease of use of the forms, YT's compliance with the European Union's General Data Protection Regulation (GDPR), and to not compromise the trusting relationships with the client mothers.

Finally, the very objects of study – the peer support and Mentor Mother programmes – have an approach to empowerment that imposes limitations on the studies. The challenges faced by client mothers are in many ways structural issues such as discrimination and political under-prioritisation of social determinants of health among vulnerable groups. Addressing such factors requires action at the structural level as well as at the individual level. The programmes' focus on individual agency only reflects the latter, meaning that the scopes of the studies are only limited to certain aspects of how inequities in health and wellbeing can be addressed. As the studied programmes focused on peer support for women, the interviewees were also all women. This is a limitation that must be taken into account when assessing the transferability of the results to groups with a different gender composition.

**Reflexivity**

Reflexivity entails clarifying and continuously considering how personal characteristics and preconceptions of the researcher affects the research process. My background is as a white male medical doctor from rural Sweden, which means that I was born and raised in a context that is very different from those described in this thesis in several ways. The context of my upbringing was secular, very egalitarian and has in many ways provided a very privileged existence. This has shaped my perceptions, assumptions and values, both in ways that I can grasp and in ways that might exist at a subconscious level. These biases affect how research questions are chosen and formulated, how methods are used, and how findings are interpreted and presented.

Throughout the research processes, it has been a great value to be able to discuss the setup for the research with other researchers, with the peer supporters and Mentor Mothers, and with other people involved in the studies. This has been done for example by discussing interview guides with representatives from YT, discussing the planned research process with Mentor Mothers at TF, and discussing findings with Mentor Mothers, client mothers
and other stakeholders through member checking sessions. I have gained valuable insights from these discussions regarding matters such as how to formulate interview questions and how to describe findings.

Nevertheless, I have had an outside perspective throughout the research process. To reduce this outside perspective, methods such as photovoice can help by allowing study participants to choose which perspectives constitute the starting points for data collection. I hope that I can continue to explore such participatory research methods in the future.
Conclusions

The studies in this thesis explore the adaptation, implementation, and further development of a Mentor Mother peer support programme for socially disadvantaged mothers and pregnant women who have migrated to Sweden, implemented in the cities of Malmö and Gothenburg. The findings highlight how a social innovation in health developed in low-income contexts can be transferred and contextualised to high-income contexts, how the implementation of this innovation took place and the factors that influenced the implementation. The studies also highlight how the innovation was developed based on the lived experience and empirical insights of Mentor Mothers and other stakeholders in their efforts to both facilitate empowerment of the target group and build trust in welfare services and authorities. The ambition of this thesis is to increase the understanding of how innovative community-based responses to complex societal problems can be transferred between contexts, implemented and further developed to ensure their relevance to the target group. Specifically, the individual studies conclude that:

I. In contextualising a South African Mentor Mother peer support programme to socially disadvantaged mothers and pregnant women with experiences of migration in Malmö, contextual factors warranted a number of adaptations. Tangible social needs motivated a broad focus on social determinants of health rather than on direct medical issues, as well as a systemic approach to meeting community needs. The wide range of available welfare services warranted a priority on linking clients to these. The diversity of the relevant target communities and their needs required the employment of peer supporters with different languages and cultural competences, and motivated flexible content and working methods.

II. When implementing the peer support programme in Malmö, peer supporters had a perceived high adherence to components of the programme plan focusing on linking clients to welfare services and authorities, but inconsistent adherence to components focusing on educating clients. Peer supporters experienced blurred lines between personal and private roles, often providing support with matters outside of the programme plan. Initial focus on prac-
tical support enabled later provision of more comprehensive sup-
port, a mechanism that was enabled by developing trusting rela-
thionships.

III. The Mentor Mothers in Gothenburg identified empowerment
strategies that they perceived as relevant, feasible and effective
in addressing community social and health needs. Informative
support met a need for improved ability to navigate society and
the welfare system, understand the process of becoming a parent,
and understand cultural norms and expectations on parents. Prac-
tical support responded to a need for help in dealing with welfare
services and authorities, and obtaining concrete parenting strate-
gies. Psychosocial support addressed the need for a sense of
safety and belonging. Motivational support responded to the need
to find a sense of meaning, increase civic engagement, and find
inspiration and hope in the life stories of others.

IV. Mentor Mothers, mothers they supported and other stakeholders
in Gothenburg described that mistrust of welfare services and au-
thorities arose from a combination of lack of clarity in interac-
tions with service providers, unfamiliarity with the welfare sys-
tem and misinformation leading to rumours. This caused fear,
avoidance of services and authorities, and loss of parental author-
ity over children. By building interpersonal trust with the sup-
ported mothers, the Mentor Mothers enabled the application of a
range of strategies to promote trust in welfare services and au-
thorities. This process was described as leading to increased un-
derstanding of institutional procedures and functions, regained
parental self-confidence, institutional trust, willingness to engage
with welfare services and authorities, and a sense of calm.
Populärvetenskaplig sammanfattning


I studie I undersöks själva processen att anpassa mentormammaprogrammet till den sociala kontexten i Malmö. Detta åstadkoms genom att de som arbetade med programmet på organisatorisk nivå genom en serie workshops (n=3) skapade en logisk modell som beskrev programmets tänkta aktiviteter och effektmekanismer. Intervjuer hölls med samtliga personer som arbetade med projektet (n=11) i syfte att undersöka hur olika kontextuella faktorer motiverade olika aspekter av programmets upplägg. Påtagliga sociala behov motiverade ett brett fokus på sociala bestämningsfaktorer för hälsa snarare än på medicinsk direktintervention, liksom ett systemiskt förhållningssätt för att tillgodose målgruppens behov. Utbudet av välfärdstjänster motiverade en prioritering av att länka klienter till dessa tjänster. Mångfalden i de relevanta målgrupperna och deras behov motiverade att Yallalotsar med olika språklig och kulturell kompetens anställdes. Denna mångfald motiverade även flexibelt innehåll och flexibla arbetsmetoder. Dessa insikter bidrog till att bättre förstå logiken i Yallalotsprogrammets upplägg i Malmö samt olika faktorer med betydelse för hur programmet kunde implementeras i praktiken.
I studie II utvärderades implementeringen av Yallalotsprogrammet i Malmö. Detta gjordes genom att undersöka vad som hade gjorts i praktiken, hur väl detta stämde överens med vad som var planerat, vilka faktorer som påverkat vad som var möjligt att göra, hur programmet bidrog till förändring, samt hur programmet uppfattades av de som implementerade det och mottog det. Digitala loggbooksanteckningar (n=1294) registrerades efter varje möte enskilt mellan Yallalotsar och kvinnor de stöttade. Dessa loggbooksanteckningar beskrev vad som hade gjorts under respektive möte. Intervjuer (n=19) hölls med Yallalotsar, kvinnor som fått stöd av Yallalotsarna samt personer som arbetade med programmet på organisatorisk nivå. Studien belyste hur implementeringen underlättades av organisationens goda anseende, nätverk, erfarenhet och det faktum att de tillhörde den tredje sektorn. Hinder för implementeringen var bland annat misstro mot socialtjänsten, normer kring könsroller och föräldraskap som gjorde det svårt för kvinnor att lämna hemmet, samt svårigheter att planera långsiktigt på grund av oförutsägbar financiering. Yallalotsarna tenderade att prioritera att länka de stöttade kvinnorna till andra tjänster snarare än att prioritera utbildningskomponenterna i programmet. Ofta ägnade de sig åt andra uppgifter än de som ursprungligen planerats. För att främja implementeringen prioriterade Yallalotsarna att bygga förtroendefulla relationer med de kvinnor som fick stöd, använda flera olika kontakttytor, och använda interna stödstrukturer som handledning. De använde också praktiskt stöd som en ingång till att kunna ge stöd i mer känsliga områden, som våld i nära relationer eller sjukvårdsfrågor, efter att en förtroendefull relation byggs upp. Den personliga kontakten till Yallalotsar värderades högt av de kvinnor som fick stöd. Yallalotsarna upplevde att gränsen mellan yrkesrollen och privatlivet ibland blev otydlig. Genom dessa resultat så bidrog studien till en tydligare förståelse för hur Yallalotsprogrammet kan vidareutvecklas och vilka faktorer som man måste ta hänsyn till i denna process.

I studie III intervjuades mentormammorna och deras projektkoordinator i Göteborg (n=6) om vilka strategier som uppfattades som relevanta, lämpliga och effektiva för att främja målgruppens egenmakt avseende både sociala och hälsomässiga utmaningar. Mentormammorna hade en hög grad av frihet att utveckla programmet utifrån sin egna djupa förståelse för det kontext de arbetar i samt sin professionella förståelse för vilka strategier som fungerar i praktiken. Studiedeltagarna beskrev hur informativt stöd kunde tillgodose ett behov av förbättrade förmåga att navigera i samhället, förstå processen att bli förälder samt förstå kulturella normer och förväntningar på föräldrar. Praktiskt stöd svarade mot ett behov av bättre interaktioner med vällärdstjänster och myndigheter samt att konkreta strategier för föräldraskap. Psykosocialt stöd beskrevs tillgodose behovet av en känsla av trygghet och tillhörighet. Motivationsstöd svarade mot behovet av att finna en känsla av mening, öka samhällsengagemang och att få hopp och inspiration genom andras livserättelser. Dessa resultat belyser både upplevda behov hos målgruppen, olika aspekter
av att främja egenmakt som framtida interventioner kan använda i sin utformning, samt upplevda förändringsprocesser som kan utforskas vidare och utvärderas genom framtida studier.


Sammanfattningsvis bidrar denna avhandling till att öka förståelsen för hur innovativa och lokalt baserade lösningar på komplexa samhällsproblem kan överföras mellan kontexter, implementeras och vidareutvecklas för att säkerställa deras relevans för målgruppen. Resultaten belyser hur en social innovation för hälsa som utvecklats i en låginkomstkontext kunde överföras till en höginkomstkontext, hur anpassningen och implementeringen av denna innovation gick till och vilka faktorer som påverkade denna implementering. Studierna belyser också aspekter av hur innovationen vidareutvecklades för att stärka målgruppens egenmakt och bygga förtroende för välfärdstjänster och myndigheter, baserat på den levda erfarenheten och empiriska insikter både från de som arbetat med den i fält, de kvinnorna som utgjort målgruppen och andra berörda aktörer.
Acknowledgements

I once read a tweet about the social environment in academia concluding that ‘we are all smart here – distinguish yourself by being kind’. Perhaps this reflects the idea that good leaders are those who can guide and inspire others through both competence and warmth. I am glad that I have had supervisors who personify both these values.

Mats, Sibylle and Anna – thank you for your support and for always being there. You have complemented each other and it has been a privilege to have access to such expertise in my supervisory team. Mats, thank you for helping me discover new dimensions of global public health, for always being available, and for believing in me when I have needed it. I have learnt so much from you. Thank you Sibylle for your wise advice and guidance. You are a methodological pillar and role model to me and many others. Thank you Anna for helping me develop in so many ways. You are an academic powerhouse and a source of constant inspiration.

To all my colleagues at Swedesd – thank you for your support, for all the interesting discussions, and for creating a sense of community. I have thoroughly enjoyed being part of the social environment we have built together, especially after the pandemic that shaped the first years of my PhD project. This is especially true for my roommates and fellow students Luong, Kalkidan, Johanna, and Rejina, with whom I have enjoyed discussing daily, and Carin, with whom I had so much fun organising the global medicine course.

A special thanks also to Linnea – it has been so valuable and developing to have a companion through the research process in several of the studies. Conducting research together has been great fun and I hope we can continue doing that in the future.

Thank you also to everyone at YT and TF, especially all of you project coordinators, peer supporters and Mentor Mothers who engaged in the process of recruiting study participants and helping us with the practicalities. You are so excellent at what you do and you are all sources of inspiration.
Thanks to my family – I took on this PhD project in the first place largely because I grew up in a setting where I was encouraged to reflect on and take an interest in society in different ways. Thank you for your support and for taking such an interest in what I do.

And last but not least – thank you Amanda, for your unwavering support and love. I could not have done this without you.
References


59. Terrefe TA. Immigrant parents’ experiences of child welfare assessment processes in child maltreatment cases: Implications for trust. *Barn*. Published online 16 August 2023. doi:10.23865/barn.v41.5479


Acta Universitatis Upsaliensis

Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine 2033

Editor: The Dean of the Faculty of Medicine

A doctoral dissertation from the Faculty of Medicine, Uppsala University, is usually a summary of a number of papers. A few copies of the complete dissertation are kept at major Swedish research libraries, while the summary alone is distributed internationally through the series Digital Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine. (Prior to January, 2005, the series was published under the title “Comprehensive Summaries of Uppsala Dissertations from the Faculty of Medicine”.)