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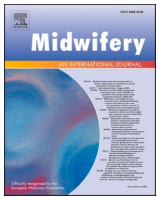

The dynamics of intercultural clinical encounters in times of pandemic crisis. Swedish healthcare providers' reflections on social norms in relation to sexual and reproductive healthcare

Mia Appelbäck [a,*], Aje Carlbom [b], Lise Eriksson [a], Birgitta Essén [a]

[a] Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden
[b] Faculty of Health and Society, Department of Social Work, Malmö University, Malmö, Sweden

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ABSTRACT

Background: Experiences from the COVID-19 pandemic may help to better understand resilience, competences and skills for healthcare providers and the healthcare system. Within sexual and reproductive health inequalities for migrants exist and it is an area where promoting both cultural competency and healthcare equity in the clinical encounter is expected of healthcare providers yet can create tension. The aim is to explore healthcare providers experiences of encounters with migrants in the context of the pandemic and the subsequent changes in routines and norms.

Methods: A qualitative study based on semi-structured interviews with 31 healthcare providers working in sexual and reproductive healthcare in southern Sweden. Interviews were conducted during the COVID-19 pandemic influencing how healthcare providers reflected on their experiences. Analysis was done using reflexive thematic data analysis.

Findings: Healthcare providers reflected on how changes in routines increased the understanding of challenges and enablers in the intercultural encounter including the impact on communication and role of relatives and male partners. They emphasized the dynamics of culture in the clinical encounter and healthcare system through highlighting the importance of structural awareness, self-reflection and the flexibility of conducts and norms, often given a cultural connotation.

Conclusion: The COVID-19 pandemic resulted in changes of previously established routines directly affecting clinical encounters, which provided a unique opportunity for healthcare providers to reflect, with communication and self-reflection being discussed as central in complex encounters. It highlighted the dynamics of presumed deeply rooted cultural norms and the interplay with social factors affecting healthcare providers and patients alike.

Introduction

This article aims to explore the COVID-19 pandemic's perceived impact and understanding of intercultural encounters in the provision of sexual and reproductive healthcare, a field where many misconceptions and inequalities exist. Migrants appear to be at greater risk of adverse sexual and reproductive health outcomes (Almeida et al., 2013; Casillas et al., 2015; Emtell Iwarsson et al., 2019; Esscher et al., 2013; Essen et al., 2000; Fernbrant et al., 2016; Sebo et al., 2011; Socialstyrelsen, 2016; Vangen et al., 2008; Wahlberg et al., 2013; Wendland et al., 2016; WHO, 2018). In the Nordic countries there is a lower contraceptive-use and protection against sexually transmitted infections, a higher prevalence of hepatitis B during pregnancy, a greater risk of mortality due to interpersonal violence and of unintended and termination of pregnancy among migrants (Emtell Iwarsson et al., 2019; Fernbrant et al., 2016; Vangen et al., 2008; Wendland et al., 2016). Adverse obstetric outcomes in the Nordic countries, apply largely to migrants from low- and middle-income countries (Esscher et al., 2013; Essen et al., 2000; Socialstyrelsen, 2016; Wahlberg et al., 2013). Suboptimal care in relation to maternal mortality is higher in foreign-born compared to Sweden-born women due to miscommunication, language barriers, lack of professional interpreters and limited knowledge about rare diseases

Abbreviations: PPE, Personal protective equipment

* Corresponding author at: Skåne University hospital, 205 02 Malmö, Sweden.
E-mail address: mia.appelback@skane.se (M. Appelbäck).

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and pregnancy complications among healthcare providers (Esscher et al., 2014; Essen et al., 2000).

It has been argued that these inequalities should be addressed through 'culturally sensitive' initiatives. This can seem reductionistic considering substandard care, higher burden of disease and being disproportionally affected by social determinants of health (political, social, and economic factors which ultimately impact health) explain some of the negative obstetric outcomes and increased risk of maternal near-miss events among migrants from low-income countries (Castaneda et al., 2015; Esscher et al., 2013; Essen et al., 2011; Serour, 2015; Wahlberg et al., 2013). This is exemplified by Somali women's avoidance of caesarean sections in high-resource settings due to fear attributable to their pre-migration experience, which may be understood by obstetric care providers as an informed decision (Essen et al., 2011). Complexity is added to sexual and reproductive healthcare, with many migrants coming from countries where traditional and collectivist values may dominate in contrast to predominant liberal and egalitarian values in Sweden. (Inglehart et al., 2014). This can potentially lead to tension in clinical encounters as healthcare providers are expected to practice cultural competency while simultaneously promoting gender equality (Bernhardsson, 2015; Borevi, 2014). It has been shown that healthcare providers try to act more culturally sensitive and fear not doing or saying the right thing (Arousell et al., 2019). This can paradoxically lead to stereotyping, with healthcare providers diverging from standard protocol and offering tailored care founded on assumptions assigned to the woman based on her ethnicity or religion, potentially resulting in subquality care (Arousell, 2019; Arousell et al., 2019). Studies have indicated that women's financial situation can influence contraceptive-use more than religious beliefs illustrating how factors such as socioeconomics affect reproductive decision-making (Arousell, 2019). This highlights the complexity and intersectionality of presumed cultural influences in the encounter, raising the question of the relevance of culturally-adapted counselling (Arousell, 2019). Swedish public health policies encourage 'culturally sensitive' consultations with the intention of improving clinical encounters between healthcare providers and patients of migrant background (Hjelm, 2018). Cultural competency is complicated by cultural norms being dynamic for migrant and non-migrant populations alike, requiring healthcare providers to instead focus on the needs of the individual (Kleinman and Benson, 2006). Neglecting that culture is intricately related to social determinants and not acknowledging their intersectionality can impact health outcomes (Napier et al., 2014).

The COVID-19 pandemic, which will be interchangeably referred to as "the pandemic" in this article, affected all levels of society, both macro and micro, including but not limited to the healthcare system (Sturmberg and Martin, 2020). Healthcare systems are shaped by and shape social norms with good quality healthcare systems being dynamic and able to adapt to changes in society (Kleinman, 1980; Kruk et al., 2018). With clinical encounters reflecting society, this article explores how these were influenced by the pandemic in the context of migrant sexual and reproductive healthcare in Sweden.

Good communication is key in intercultural clinical encounters (Villadsen et al., 2019). The pandemic resulted in poorer communication due to personal protective equipment (PPE) and the non-availability of informal interpreters yet also weakened prejudices and led to a greater closeness between migrants and healthcare providers (Berenguel Chacon et al., 2023; Nielsen and Dieperink, 2020). During a pandemic, healthcare providers are required to continually adjust to new routines. To adapt to the new context both individual and organizational resilience is necessary and interrelated (Groschke et al., 2022). The unusual context of the pandemic may shed light on resilience and the development of competences and skills for healthcare providers to better understand and improve clinical encounters. (Groschke et al., 2022; Nielsen and Dieperink, 2020). It provides an opportunity to explore the potential impact of the pandemic on intercultural clinical encounters with migrants in the provision of sexual and reproductive healthcare, a field where inequalities and divergencies exist and more understanding is needed to address these.

Methods

Aim

The aim was to investigate how healthcare providers working with the provision of sexual and reproductive healthcare experienced and reflected on encounters with migrants in the context of the COVID-19 pandemic and the resulting changes in routines and norms.

Research design

This is a qualitative study based on 31 thematically analysed semi-structured interviews with healthcare providers working in the provision of sexual and reproductive healthcare in Sweden. Kleinman's approach to understanding healthcare systems as a social reality was used as a conceptual framework (Kleinman, 1980). Kleinman views healthcare as a system both social and cultural in nature, encompassing all health-related components of society including patients and healthcare providers (Kleinman, 1980). Ethical approval was received by the Swedish Ethical Review Authority (Dnr 2020–01,043).

Setting, sampling and recruitment

Participants were recruited from women's healthcare clinics and youth clinics providing sexual and reproductive healthcare, in southern Sweden. Interviews were conducted with ten medical doctors, 15 registered nurses/midwives, three nursing assistants and three social workers or sexologists. The respondents were aged 25–65, and 27 were women while four were men. Two thirds were born in Sweden, while one third were foreign-born. Healthcare providers were primarily recruited with convenience sampling by the first author at her workplace with the conceivable advantage of a shared context with participants. The risk of bias, e.g., by participants at the author's workplace censoring themselves, was reduced by having two interviewers. Participants were also recruited with snowball sampling and finally targeted sampling to recruit more male participants, participants working at youth clinics and participants working in other locations in southern Sweden.

Data collection

Interviews were conducted individually face-to-face or via Zoom by one of two interviewers: the first author, resident doctor in obstetrics and gynaecology, or another interviewer, a PhD candidate with a public health background. Informed consent was obtained from all participants. Nearly half were conducted in Zoom, and no significant differences were found in the quality or content of the interviews conducted online or face-to-face. The interviews lasted approximately one hour and were conducted between August 2020 and February 2021, during the COVID-19 pandemic. The interview guide included questions aimed to explore participants' experiences of encounters with migrants in their workplace; dilemmas, what worked well, factors affecting encounters, and how participants addressed these issues. The influence of prevailing COVID-19 pandemic arose spontaneous and independently in multiple interviews during data collection and was further consolidated through the last two interviews where a direct question concerning the pandemic and its effect on the clinical encounter was included. Interviews were conducted until saturation was obtained, i.e., we found that new interviews did not add new perspectives. All interviews were audio-recorded and transcribed verbatim.

Data analysis

The interviews were read through multiple times for the authors to become familiarized with the data and start identifying recurrent patterns or themes. This reaffirmed the initial observation that many participants contextualized their thoughts in the context of the pandemic and subsequent changes in routines, recognized as a serendipitous, unplanned yet opportune, event. Data mentioning the COVID-19 pandemic was then coded inductively based on reflexive thematic data analysis (Braun and Clarke, 2006). Thus, at this stage we did not use any predefined codes about COVID-19 and novel codes were generated directly from the data. We then coded the whole data set deductively based on research questions about difficulties and solutions in the clinical encounter and COVID-19. These codes were then synthesized into themes, reviewed and defined (Braun and Clarke, 2006). An example being "no difference between migrants/Swedish-born" produced as a code after the inductive coding of the COVID-19 material. When the whole data set was analysed deductively, this code was applied and finally synthesized into the theme of "universality". The program, OpenCode 4.03, was used to facilitate the coding and synthesizing of themes. The data was throughout the process discussed, reviewed and analysed by a multidisciplinary team of obstetricians, sociologists and social anthropologists.

Results

Theme 1: routine changes leading to a greater understanding of challenges and enablers in intercultural clinical encounters

During the pandemic many changes in routines in the clinic, relating to hygiene, the use of PPE and visitor restrictions, were implemented on short notice. Healthcare providers used the pandemic to frame their reflections and highlighted core components of intercultural clinical encounters. Both communication and relative's role were discussed in this context. These components could be both challenges and enablers in the encounter.

Subtheme 1: all forms of communication are paramount

Communication, both verbal and non-verbal, was discussed in the context of the pandemic. Participants described challenges such as wearing facemasks and visors whilst trying to read body language, and other forms of non-verbal communication.

> *"…we are talking in another language than my mother tongue, which makes it even more difficult, and that person has as mask on as well. It mists up so much on the visor that we do not see each other […]…so it has a very big effect. As a large part of my work is for 45 min to sit and feel and interpret the other person's body language and facial expressions, detect anxiety, which is often possible to read, somewhere it is seen or felt in the room in some way…" (Respondent 14)*

The newly enforced PPE routines due to COVID-19 were often experienced as negative with many feeling that contact and non-verbal communication with patients was compromised. Another healthcare provider reiterates the effect of PPE on the clinical encounter:

> *"I am rather good at, for example, putting a hand on an arm or a hand on a knee, leaning forward, etc. Is it a bit more difficult now in Corona-times. But one can get a rather good connection just through body position, by not leaning backwards but rather forwards, even if one has a facemask and such…" (Respondent 16)*

In this example, the participant acknowledges that routine changes caused by the pandemic makes non-verbal communication more difficult yet compensated by adjusting these non-verbal cues. Other participants could see more positive effects of the implementation of PPE.

> *"I think that it has been affected in a positive way as everyone has a facemask now and maybe niqabs are a little more accepted." (Respondent 15)*

The healthcare provider deliberated over whether the use of PPE, where healthcare professionals are more covered up, could in turn lead to religious garments, that cover the body, being more accepted. These are examples of how healthcare providers reflected differently on the changes in routines, in this instance, the use of PPE. Although both negative and positive consequences were observed, the importance of communication in the clinical encounter was highlighted.

A tool vital for verbal communication is the use of interpreters. Due to visitor restrictions, telephone interpreters were mostly used instead of interpreters being present at the clinic to reduce the spread of infection.

> *"Before the pandemic, my colleagues and I nearly always had the strategy of having an interpreter physically present […], [as]we experienced that it results in a better dialogue […]. But during the pandemic we have of course only telephone interpreters…there can be advantages with only using telephone interpreters, like, if it is a good interpreter, you do not have to take into consideration the third person, as sometimes it can be of course sensitive for the woman, that another person from the same country is present. It has made me think a little differently, that there must not naturally be an interpreter present in the room." (Respondent 12)*

The change from physical to telephone interpreters made the participant reflect that an interpreter present in the room is not always necessary; an observation accentuated by the pandemics' subsequent changes in routines. As with the implementation of PPE, there were varied reactions over the now predominant use of telephone interpreters.

> *"I think that it is better with a… physical interpreter than a telephone interpreter. Yes, but right now it is obvious that we must adjust because it is COVID-times…" (Respondent 10)*

Despite being clear that a physical interpreter is better, this healthcare provider adjusted to the change pragmatically. Although some healthcare providers saw the benefit of using telephone interpreters while others were less in agreement, there was a general acceptance of these changes in routines. It was also observed that the subsequent change in routines, elicited by the pandemic, not only affected clinical encounters with migrants.

> *"I think it is difficult for everyone, not just migrants but for everyone, it has been much more difficult with patient contact [due to the pandemic]" (Respondent 15)*

Some perceived that the challenges in the patient-clinician relationship caused by the pandemic were applicable to all clinical encounters. This was also the case with communication, which participants discussed as central to overcoming barriers arising in any clinical encounter.

Subtheme 2: the role of relatives and male partners in clinical encounters

Another change in routine was the implementation of visitor restrictions. This resulted in the majority of consultations being between the healthcare provider and the patient alone, allowing healthcare providers to reflect on clinical encounters without relatives and male partners present. Many healthcare providers expressed that it was easier to talk to the woman without her partner or relatives.

> *"And now we have, the visitor restrictions came, so it is a lot easier… to talk." (Respondent 2)*

Participants believed verbal communication, due to the visitor restrictions, had improved, and that patients could make their voice heard and take a more central role in the encounter. Listening to the patient and exploring their thoughts and desires were communication strategies

in general mentioned by participants to overcome challenges in the consultation. Another issue brought up by healthcare providers was relatives acting as interpreters. The visitor restrictions resulted in fewer consultations being translated by relatives.

> "It has of course also changed, in relation to COVID and visitor restrictions, we can avoid that even more. It is easier to say no to it [relatives translating]." (Respondent 4)

The change in routine resulted in healthcare providers finding it easier to refuse relatives wanting to translate. Healthcare providers expressed challenges with male partners or relatives, believing they discourage examinations by male doctors, or that they talk on behalf of the woman and can be perceived to be too involved.

> *"At the moment, now with COVID and women coming alone, it is a completely different situation…It is possible to persuade them and explain and give advice and say it is important and far, far less women refuse examinations, it is an interesting observation now with COVID." (Respondent 10)*

When the woman is alone in the consultation without the presence of a male partner, it was easier to explain the importance of doing the examination, which resulted in fewer women refusing examinations, according to some informants. When reflecting on the refusal of gynaecological examinations, healthcare providers identified that language concordance can take president over gender preference and that it is not only connected to migration, but also influenced by other factors such as previous life experiences and age. The perception of improved communication was another issue thought to pertain to all individuals and not solely migrants.

> *"So you can just actually communicate with them…a little easier. But for me it is fantastic. But it is not just those from […] outside the country, it is for everyone." (Respondent 9)*

Although the issue of relative involvement was discussed in the context of encounters with migrants, some felt the visitor restrictions' unforeseen consequence of improved communication was universal, applying to all clinical consultations. Many healthcare providers expressed that visitor restrictions solved various challenges concerning relatives and male partners in intercultural clinical consultations. However, one healthcare provider voiced that not all women were used to being without the presence of relatives or her partner in the consultation.

> *"Now with COVID for example when they do not have their relatives… they are not allowed to have their husbands but are there by themselves and get all the information, and I do not know if it is so in certain cultures that maybe one is not accustomed with that the woman is responsible in such a situation by herself…and that one gets disconcerted maybe and a little nervous that one shall remember all of this and then pass it on, for example, to her husband." (Respondent 19)*

The participant expressed that being alone in the consultation and receiving and reconveying information given to other parties, otherwise accustomed to be involved such circumstances, may not be a scenario all women are used to. This idea was supported by the general discussion on partners or relatives' impact on the encounter, with many participants expressing that they can provide a feeling of safety and be of support to the patient when it comes to making important decisions and help when women are hesitant of gynaecological examinations. Many felt that relatives facilitated the consultation.

> "Before it was a little easier at times as they could bring maybe a relative and, now I know relatives should not interpret, but sometimes one experiences that they interpret very well as they are also well-informed on the situation, so they know which questions are asked etc." (Respondent 20)

Relatives can also be of assistance in the encounter and help with interpretation. This differs from what other healthcare providers expressed on relatives serving as informal translators, who found this to be a challenge in the clinical encounter with migrants. Thus, healthcare providers spontaneously discussed the impact of visitor restrictions on clinical encounters yet came to different conclusions.

Theme 2: the dynamics of culture in the clinical encounter and the healthcare system

The flexibility of assumed cultural conducts and the understanding that structural factors like socioeconomic status and other determinants of health, not only culture influences the encounter were discussed. Participants also described how self-reflection can be used as a tool to provide person-centred care.

Subtheme 1: the flexibility of assumed cultural conducts

Due to the acute awareness of the pandemic in society, there was a general acceptance of the subsequent changes in routines. Actions, previously controversial due to being coined as cultural, were also accepted. Handshaking for example is often a customary greeting in Sweden but this can differ between cultures and religions with some Muslims not feeling comfortable to shake hands with the opposite sex (Princeton University's Muslim Life Program in the Office of Religious Life, 2017). The refusal to shake hands because of religious believes has been debated. One healthcare provider reflected on the issue of handshaking in the light of the new practices and routines occurring during the COVID-19 pandemic.

> "Now we do not have any problem with it as we do not shake hands due to corona – which is also interesting that this suddenly is not a problem." (Respondent 7)

It was observed that healthcare providers had greater acceptance and themselves did not want to shake hands due to the pandemic, a custom previously considered having a religious or cultural connotation which could create tension. This highlights the flexibility of assumed cultural conducts of which healthcare providers also bear with them.

Subtheme 2: from cultural to structural awareness

COVID-19 strengthened the understanding of the health care workers of how the clinical encounter is influenced by and reflects greater societal factors, and that these structural components are dynamic, as is culture. The healthcare system is influenced by societal factors and thus structural determinants other than culture also influence the encounter.

> "….cultural differences can of course exist […] the clinical encounter…[…] is influenced by so many factors…like class, socioeconomic group" (respondent 5)

In line with the clinical encounter being influenced by societal factors, healthcare providers framed culture as one of many structural determinants that shape the encounter. Healthcare providers believed that many social determinants of health, such as class, education and social network, intersect with culture and acknowledged the complexity of this.

Subtheme 3: using self-reflection as a tool

Many participants expressed the importance of practicing self-reflection in the clinical encounter to address and acknowledge the intersection of culture with other social determinants of health.

> *"I must of course put myself on the level that I believe that the woman can take in, in what I say and that what I explain or want to convey. As with Swedish-born, that one must adjust based on who I have here in the room. Where she is.. […] in life but also…concretely in everyday life. Yes, level*

of education and knowledge that can of course also be different for Swedish-born. So that you must always in some way be aware of it." (Respondent 12)

Self-reflection was proposed as a solution to challenges that could arise in encounters and was seen as a continual process. Self-reflection as a tool is applicable to all clinical encounters, not only with migrants. Healthcare providers recognised that they work in a system being shaped and reflecting the greater society and that they themselves have their own culture which they bring into the clinical encounter (Table 1). Participants described the importance of continually working with oneself and being aware of one's own prejudices (Table 1). This also included being aware of the power imbalance between patients and healthcare providers in clinical consultations.

"…I have a position of power, while those who come there, if there is now someone who does not want to shake hands, why I can never forget that I sit on power with my knowledge, with my uniform…that I in addition should go in and 'no but you must do like we do it here, we shake hands here'…for me it is an exercise of power that is not defensible." (Respondent 7)

The issue of handshaking contextualised in the pandemics' subsequent changes in routines evoked further thoughts on healthcare providers' role in clinical encounters and the power imbalance present. The reflection of the flexibility of culture in the context of the pandemic illustrates how the pandemic catalysed self-reflection highlighting an understanding of societal influences in the encounter.

Discussion

Our findings demonstrate that the new context created by the COVID-19 pandemic served as a catalyst for reflection with healthcare providers contextualizing their experiences in the implementation of new routines and explored differences before and after these changes. Changes in routines led to a perceived increased acceptance, e.g., of not shaking hands, and the implementation of visitor restrictions accentuated the role of relatives and male partners in the encounter and the subsequent importance of communication. Other reflections included universality in clinical encounters with findings applying to migrants and non-migrants alike, especially in relation to societal factors, and use of communication as a strategy to overcome barriers. The general adaption to the pandemic highlights plasticity within the healthcare system and healthcare providers.

Changes in routines led to an increased understanding of challenges and enablers in clinical encounters, such as communication and relative involvement. Communication was used as a tool to address challenges with good communication being perceived as paramount in clinical encounters with migrants, described within and outside the context of the pandemic (Berenguel Chacon et al., 2023; Villadsen et al., 2019). Concerning relatives' involvement, many believed the visitor restrictions improved communication, with the woman's wishes, and desires being clearer. This has previously been described in the context of the pandemic and attributed to facilitating patients and healthcare providers coming closer to each other leading to fewer prejudices (Berenguel Chacon et al., 2023). Participants also stressed the importance of exploring patients' wishes to involve relatives. A patients' desire to include family could reflect a more collectivistic background. It has previously been observed that the pandemic resulted in greater collectivism in society with public good being prioritised over individual needs (Nielsen and Dieperink, 2020). Although aspects of such collectivism appeared to influence the encounter, such as acceptance of wearing garments that cover the body or not shaking hands in order to reduce the spread of infection, our findings illustrate how the pandemic highlighted the need of the individual and person-centred care in clinical encounters.

Healthcare providers brought up presumed fixed cultural conducts that had now changed or become accepted in the new context, thus being dynamic. Healthcare is a social reality, shaped by and shaping meanings, social structures and behaviours indorsed by society resulting in these structures and behaviours being either legitimized or not (Kleinman, 1980). Before the pandemic, it could be deemed culturally inappropriate to refuse to shake hands due to religious or cultural reasons. During the pandemic it was, on the contrary, improper to shake hands, thus the behaviour of not shaking hands was legitimized. It can be debated whether this greater acceptance is influenced by that there is now a more rational, biomedical, argument to reduce the spread of infection, rather than a moral one where gender dictates and a feeling of unfairness is involved. This is supported by that change in moral positioning on a group level is more likely to occur by the moral arguments of fairness and harm over more conservative ones, in this instance, solidarity in together reducing the spread of the infection being a more acceptable argument than traditional and conservative ones (Strimling et al., 2019). How permanent these norm changes are can only be speculated upon and would require further investigation in a post-pandemic setting.

When discussing the refusal of gynaecological examinations, participants identified other factors, such as age and previous life experiences, in addition to presumed cultural norms. Participants reflected on culture's complexity and interaction with structural factors. This is of particular importance considering the influence of such determinants on negative obstetric outcomes among migrants from low incomes countries in the Nordic setting (Esscher et al., 2013; Essen et al., 2011; Wahlberg et al., 2013). The healthcare system and healthcare providers are influenced by norms and values, and as individuals in the clinical encounter they also reflect the culture of the society they live in (Fioretos et al., 2013; Kleinman, 1980, 2011). Power, prejudices and one's own culture were acknowledged by healthcare providers, embodying an intersectional approach which allows healthcare providers to gain insight into the power dynamics and identities being brought into individual encounters (Fioretos et al., 2013). It has previously been observed how the pandemic highlighted healthcare providers' own dynamic culture, reflecting the context they work in (Nielsen and Dieperink, 2020). It has also been hypothesized that the potential success of group prenatal care on addressing racial inequities is due to their effect on healthcare providers rather than patients, through facilitating greater mutual understanding, awareness of upstream determinants of health

Table 1
Examples of healthcare providers expressing the need of self-reflection in the clinical encounter.

Condensed meaning	*Quotation*
Being aware of prejudices	"So that, we should not rely on but instead we should overcome all these prejudices, that one has before oneself, it can be something completely different when the question is asked. So prejudices, one must grind down ones prejudices the whole time. Above all, acknowledge that one has [prejudices]." (Respondent 3)
Continually work with oneself	"…healthcare providers can have rather high thoughts about themselves, that we are so nice and good and respectful in our encounters, but we need, the whole time, to work with ourselves." (Respondent 6)
Healthcare providers have their own culture	"Then I believe that we are always, when we speak about culture look at others, then forget that we have our own culture." (Respondent 7)
Healthcare providers as a part of a larger cultural system	"…that what permeates care is still some sort of Swedish cultural approach and it is that context I work in and relate to." (Respondent 12)

and clinicians overcoming their own biases (Carter et al., 2021). The American College of Obstetricians and Gynecologists recommends clinicians to recognise the role of upstream and social determinants and warn of cultural stereotyping to improve patient-centred care and address reproductive health disparities (Ades et al., 2018). This is reflected in our results, with healthcare providers appearing to acknowledge the importance social determinants of health in the encounter, representing a shift from cultural to structural awareness. This is of interest in the Swedish context where the attainment of gender equality and cultural competency simultaneously seem difficult to align (Bernhardsson, 2015; Borevi, 2014). Healthcare providers in our study seem to practice core components of structural competency in clinical encounters with migrants, addressing structural influences within medicine, which could be seen as a way forward, beyond these apparently incompatible ideologies (Metzl and Hansen, 2014). Healthcare providers having learnt good communication and self-reflection through clinical experience has previously been described and could explain these observations (Johnsen et al., 2021). Many concepts presented here such as critical self-reflection and structural awareness in the clinic are often discussed theoretically yet our results illustrate the application of these in encounters and could provide further research opportunities.

Our results further support that dynamics within health systems were highlighted by the pandemic (Sturmberg and Martin, 2020). It has been proposed that increased awareness due to shared experiences in overcoming challenges presented by the pandemic, resulted in structural adaptions of the health system with the potential of improving quality of care (Berenguel Chacon et al., 2023). Structural adaptions were illustrated in this study. To what extent these changes and increased understanding, illuminated by the pandemic, can address inequalities in migrant health outcomes in sexual and reproductive health remains unanswered. However, high-quality healthcare systems with the ability to adapt to social changes are needed to address health inequities and futures challenges (Kruk et al., 2018). This study offers an example of a dynamic healthcare system reflected in the clinical encounter with migrants who have an increased risk of adverse outcomes.

The findings reflect the perceptions of healthcare providers working in the provision of sexual and reproductive healthcare in southern Sweden and pertain to the context in which they were studied. The original aim was to explore perceived challenges and solutions in the clinical encounter with migrants. The interviews were conducted during the COVID-19 pandemic which arose as a concept with participants often contextualizing their experiences in the pandemic, as did the first author, due to working clinically during this time at both a women's healthcare clinic and in a COVID-19 ward. This serendipitous event resulted in changing the aim of the study, which is a potential limitation. Findings are not exclusive to, but strengthened by the pandemic which shed light onto the described phenomena thus no baseline of the clinical encounter before the pandemic is discussed.

Many participants seemed to practice self-reflection and expressed a holistic understanding of the issues discussed. With many participants being recruited from a city with a long history of migration with a large proportion of inhabitants having a migrant background, it is possible that exposure can have contributed to these findings. Further research to explore this theory and the transferability of these finding could be of relevance.

Conclusion

The COVID-19 pandemic contributed to changes in routines, providing healthcare providers an opportunity to reflect and contextualize their experiences of and changes in clinical encounters with migrants. The changes in routines highlighted challenges and enablers in intercultural encounters such as the roles of relatives and partners and the importance of communication. The findings demonstrate the dynamics of culture in the clinical encounter and healthcare system reflecting how healthcare systems are socially and culturally formed affecting clinical encounters. Healthcare providers expressed an awareness of structural factors intersecting with culture influencing the clinical encounter, with self-reflection being discussed as a tool to better understand the complexity of culture. Clinical approaches that promote self-reflection, awareness of the impact of structural factors and of healthcare providers own subjectivity are of relevance in all clinical encounters, not only with migrants.

Ethical approval and consent to participate

Ethical approval was received by the Swedish Ethical Review Authority (Dnr 2020–01043). Informed consent was obtained from all participants. All methods were performed in accordance with the ethical principles of the Declaration of Helsinki.

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CRediT authorship contribution statement

Mia Appelbäck: Writing – review & editing, Writing – original draft, Investigation, Formal analysis. **Aje Carlbom:** Writing – review & editing, Methodology, Formal analysis, Conceptualization. **Lise Eriksson:** Writing – review & editing, Formal analysis. **Birgitta Essén:** Writing – review & editing, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no conflict of interests.

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