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Midwives' experiences of providing care and contraceptive counseling to foreign-born women seeking abortion care in Stockholm

Master thesis in sexual, reproductive and perinatal health, 15 hp,
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Barnmorskors erfarenheter av vård och preventivmedelsrådgivning till utlandsfödda abortsökande kvinnor i Stockholm

Magisteruppsats i sexuell, reproduktiv och perinatal hälsa, 15 hp, (Avancerad nivå) 2014

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Abstract

Objective: To explore midwives' experiences of providing care and contraceptive counseling to foreign-born women seeking abortion care.

Methods: Qualitative interviews with eight midwives from three abortion clinics in the Stockholm area were analyzed using thematic analysis.

Results: Midwives were reluctant to generalize the needs of foreign-born women. Yet, data revealed specific needs of foreign-born patients as experienced by midwives. A main theme was identified; *Accommodating the specific needs related to pre- and post migration factors - a challenge in the encounter*. Three categories were identified: *Handling poor knowledge, The influence of life situations,* and *Perceptions and beliefs influencing contraception*. These can be interpreted as needs that appear when pre- and post migration factors co-exist or collide.

Conclusions and interpretations: In midwifery abortion care, it has to be acknowledged that foreign-born women often have special needs that have an impact the health care encounter due to migration factors. This is due to poor language knowledge, insufficient knowledge of sexual and reproductive health and cultural and religious influences. Midwives' understanding of the needs of foreign-born women is informal; the impact of culture and migration has not been officially acknowledged or incorporated into guidelines and protocols for abortion care. Visits at abortion clinics are standardized, even though the needs of women seeking abortion care may vary greatly.

Key words: Abortion care, midwifery, SRH, foreign-born women, immigrants, thematic analysis, qualitative method.

Abstrakt

Syfte: Att undersöka barnmorskors upplevelse av att ge abortvård och preventivmedelsrådgivning till utlandsfödda abortsökande kvinnor.

Metod: Kvalitativa intervjuer med åtta barnmorskor från tre abortkliniker i Stockholmsområdet analyserades med hjälp av tematisk analys.

Resultat: Barnmorskorna var ovilliga att generalisera utlandsfödda kvinnors behov. Dock framkom det att barnmorskorna upplevde specifika behov i vården av utlandsfödda patienter. Ett huvudtema identifierades; *Att tillgodose specifika behov relaterade till pre- och postmigrationsfaktorer – en utmaning i vårdmötet*. Tre kategorier identifierades: *Hantering av dålig kunskap, Inverkan av livssituation* samt *Tro och uppfattningar som influerar preventivmedelsanvändning.* Kategorierna kan tolkas som behov som uppstår när pre- och postmigrationsfaktorer samexisterar eller krockar.

Slutsats: Inom abortvården måste det uppmärksammas att utlandsfödda kvinnor ofta har specifika behov pga. sämre språkkunskaper, sämre kunskap om sexuell och reproduktiv hälsa samt kulturella och religiösa influenser. Barnmorskors förståelse för utlandsfödda kvinnors behov är informell; inverkan av kultur och migration har inte formaliserats eller införlivats i riktlinjer och protokoll för abortvården. Patientbesöken inom abortvården är standardiserade, trots att behoven hos abortsökande kvinnor inte är statiska.

Nyckelord: Abortvård, barnmorska, SRH, utlandsfödda, invandrare, tematisk analys, kvalitativ metod.

Background

The general objective for public health work in Sweden is to create social conditions for good and equal health. Sweden has adopted a national public health policy consisting of 11 objective domains. One is to *Promote Health-promoting Health Services*, and another one to *Promote Universal Access to Safe and Secure Sexual and Reproductive Health Care*. The Public Health Agency of Sweden also notes that people with different ethnical backgrounds to a higher extent are subjects to factors that might lead to a deteriorated sexual and reproductive health (SRH) (The Public Health Agency of Sweden 2014).

Immigration and Health

Sweden is a multicultural society where more than 15% of the population consists of immigrants from different regions of the world (Migrationsinfo 2015). Current crises globally have led to increased numbers of immigrants, and in 2014 more than 80 000 people sought asylum in Sweden (The Swedish Migration Board 2015). The largest groups of immigrants in Sweden were in 2013 from Finland, Iraq, former Yugoslavia, Poland, Somalia, Syria, Turkey and Thailand (Statistics Sweden 2013).

Good health is one of the main factors for successful integration and is closely linked to the possibility of finding an employment (UNHCR, 2013). Keygnaert et al (2014) have shown that immigrants, especially from outside of the European Union, have a higher degree of poor health compared to the general European population, and that they also might have different health care needs. There are large disparities both between and within immigrant groups; however, some factors have been reported to increase the risk of ill health. Immigrants who have arrived in the host country at higher ages (over 15) and/or have lived in the host country for a shorter period of time are more likely to suffer from poor self-rated health (Leão, Sundquist, Johansson & Sundquist 2009). Wiking, Johansson & Sundquist (2004) have suggested that socioeconomic status, discrimination and poor acculturation in the host country could be associated to ill health among immigrants. Acculturation is a process of social and cultural integration to the mainstream by adaptation of different domains such as attitudes, values, behaviors, and sense of cultural identity (Ryder, Alden & Paulhus 2000).

According to a report on social differences in Swedish health care, foreign-born persons initially refrain from seeking health care twice as often as Swedish-born persons (Swedish

Association of Local Authorities and Regions 2009). Among immigrants in Sweden born in countries outside of Europe, 17% reported poor or very poor health in 2009, as compared to 4% of native-born Swedes (The National Board of Health and Welfare 2009 a).

In a more globalized world, an increasingly amount of people settle in a country other than their ancestral homeland. Migrants bring both risk factors and protective factors for health to their new country (Hjern 2012). Social determinants of health, such as living- and working conditions and life style factors, are of relevance to all people's health (Wilkins & Marmot 2003). Hjern (2012) have presented a framework describing three additional factors that might influence health inequities between native-born and immigrants; pre-migration factors, during-migration factors and post-migration factors. Pre-migration factors are described as factors related to the society and the population from which a person have moved away. During-migration factors are factors related to the migration per se and how migration is handled in the country of immigration. Post migration-factors are factors relating to the experience of living in a new country.

Immigration and Sexual and Reproductive Health

SRH was recognized as a human right at the International Conference on Population and Development of 1994 in Cairo. The World Health Organization (WHO) defines sexual health as a state of physical, mental, emotional and social well-being in relation to sexuality; and not merely the absence of dysfunction, disease or infirmity. Further, WHO establishes that "sexual health requires a positive, respectful approach to sexuality and sexual relationships /…/ For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled" (WHO 2010).

Sub-optimal SRH care of foreign-born people have been reported in both international and Swedish research (Essen 2001,Saastad, Vangen & Froen 2007,). Increased prevalence of unwanted pregnancy and abortion, sexual violence, HIV and sexually transmittable diseases (STD) have been shown among immigrant groups in Western Europe, as compared to native-born people. Effective use of contraceptives is held back by knowledge deficits, uncertain living conditions, problems of access and ambivalence regarding the use of contraceptives (Rademakers, Mouthaan & de Neef 2005). A review from 2013 summarizes that women in immigrant populations have later first antenatal care attendance and higher rates of both maternal deaths and children with low birth weight. However; incidences vary widely among different population groups (Almeida, Caldas, Ayres-de-Campos, Salcedo-

Barrientos & Dias 2013). In Sweden, the risk of stillbirth among foreign-born women varies by both region of birth and time since immigration. These risks cannot be explained by socio-economic factors, pregnancy complications or maternal morbidity (Ekeus, Cnattingius, Essén & Hjern 2011). Complications among foreign-born mothers in obstetric treatment are often due to obstacles in health care services such as poor communication, waiting times, transportation or absence of qualified interpreters (Essén 2001, Saastad et al 2007, Small et al 2008, Ekéus et al 2011, Almeida et al 2013,). Results from both Denmark and the Netherlands indicate that immigrant women report lower contraceptive use and have higher abortion rates than native-born women (Loeber 2008, Rasch et al 2008). Similarly, a Norwegian study demonstrates significantly higher abortion rates among immigrant women, as compared to women born in Norway (Vangen, Eskild & Forsen 2008).

Interventions to improve the communication between recently settled immigrant mothers and health care may have a potential of lowering stillbirth rates among immigrants.

Language barriers, health care providers' own misconceptions about other cultures and misunderstandings of patients' needs have been suggested by Newbold & Willinsky (2009) to add to the complexity of health care provision to immigrants. Culturally marked norms and values have a profound impact on the area of SRH, including contraceptive counseling and abortion care. A culturally competent approach in health service provision has been shown to improve reproductive health care utilization among foreign-born women in Australia (Riggs et al 2009).

SRH and abortion care in Sweden

Sweden has the highest rates of induced abortions among the Nordic countries, and the highest abortion rates among adolescents in the EU (Gissler et al 2012). During 2012, a total of 37.366 abortions were performed in Sweden (The National Board of Health and Welfare 2015). Of all women giving birth in Sweden, 25% were foreign-born in 2013 (The National Board of Health and Welfare 2014). Yet, foreign-born women in Sweden use preventive care services, such as cervical screening and antenatal care, to a lesser extent than native-born women (Azerkan, Sparén, Sandin, Faxelid & Zendehdel 2012, Rassjo, Byrskog, Samir & Klingberg-Allvin 2013). According to a Swedish study conducted in 1999-2000 (the most recent Swedish study performed in the field), immigrant status is an independent risk factor for having an induced abortion in Sweden (Helström et al 2003). Moreover, foreign-born women have less experience of contraceptive use than Swedish-born women.

Helström et al (ibid) suggest socio-economic factors, such as low educational level, unemployment and weak social networks, to influence the higher rates of induced abortions among immigrant women.

Legislations affecting Swedish abortion care

Swedish law allows registration of patient data in association with medical treatments and procedures. The registers constitute basic data for statistics, assessment, evaluation, development and improvement of Swedish health care. However, abortion patients are excluded, and registration of country of birth, citizenship, abode and marital status of abortion patients is prohibited by Swedish law (SFS 2001:707). The law was established in 2001 to protect women, but as a result there are no indicators of the quality or equality of abortion care in Sweden.

In 2010, the Swedish Parliament and the government introduced a relatively deregulated market model for health care where compensation is linked to the patient. Swedish county councils have been at liberty to design their own principles for billing systems, using different combinations of fixed and variable remunerations. The fixed part of the compensation is based on each listed patient, and the variable part is activity-based. In addition, the county councils distribute a restricted amount of criterion-referenced compensations that are related to health care quality and outcome. The Stockholm county council differs from other county councils by having a relatively high share (60%) of flexible compensations (Dahlgren, Brorson, Sveréus, Goude & Rehnberg 2014). The reform means that the healthcare providers are now competing for patients. A report by the National Audit Office (2014), investigating how new model have affected primary healthcare, found that these reforms have had strong governing effect on primary care and made it harder for healthcare services to maintain their ethical principles. Furthermore, healthcare costs seem to be increasing, the consumption of healthcare services appears to be increasingly unequal, and patients of higher medical care need are being disadvantaged. The different Swedish county councils have not become as equal and similar to each other as the Parliament had anticipated. Instead there are significant differences between the county councils, both with regards to tasks and compensation requirements.

Patient centered care

Patient centered care (PCC) is defined by The National Board of Health and Welfare (2009 b) as care provided with respect and sensibility to each patient's individual needs, expectations and values. The National Board of Health and Welfare has declared PCC as a major challenge for the future of Swedish health care (ibid).

Sidani and Fox (2014) have identified three specific elements of PCC: holistic, collaborative and responsive care. Holistic care refers to comprehensive care that involves all domains of health, aiming to consider all of a patient's needs at the time of a particular health care encounter. Collaborative care consists of a partnership between the health care professional and the patient, in order to facilitate the patients' participation in care-related decisions. The process involves a discussion between healthcare professional and the patient to find a common understanding and to implement the treatment option agreed upon. Responsive care refers to the individualization of care, aiming to maintain consistency between the services or interventions delivered and the patients' needs, values and preferences. There is a difference between dissimilarities and inequalities in health care, as stated by The Swedish Agency for Health and Care Services Analysis (2014). However; the Swedish health care system fails to adjust the health care to each patient's different qualities and conditions, for instance in offering the same quality of care regardless of the patient's previous level of knowledge (ibid).

Problem formulation

To improve SRH among immigrants, there is a need of more research. From a public health perspective, and to reach the goal of equal and patient centered health care, it is important to gain a deeper understanding of how abortion care is provided to immigrant women, and possible differences between native and immigrant women in this respect.

Study aims and expected outcome

The overall aim was to explore midwives' experiences of providing care and contraceptive counseling to foreign-born women seeking abortion care.
Specifically, the study aimed to obtain a deeper understanding of the following issues:

- Do midwives deem that immigrant women seeking abortion care have different needs as compared to women born in Sweden?
- Do midwives experience any specific challenges in the care of immigrant women seeking abortion care?
- What are midwives' experiences of contraception among immigrant women seeking abortion care?

The results are expected to add to the body of knowledge and to provide evidence-based information that could be used to adjust and improve abortion care and contraceptive counseling to better meet the needs of immigrant women. This could possibly contribute to increased equality within abortion care.

The study results will be discussed based on the framework of pre-migration, during-migration -and post-migration factors described above (Hjern 2012).

Methods

Since the main aim of this interview study was to describe and understand midwives' experiences, a qualitative design was considered appropriate.

This interview study serves as a complement to gain a deeper understanding of the results of a parallel ongoing cross-sectional study aiming to establish whether there are differences in defined issues between foreign- and native-born women seeking abortion care in Sweden. Specifically, this concerns choice of abortion procedure, gestational age by the time, and contraceptive use before and after the abortion.

Participants and data collection

The thesis was based on qualitative semi-structured interviews with midwives from three different abortion clinics in the Stockholm area included in the quantitative survey mentioned above. The abortion clinics were selected since they are the largest abortion clinics in the area. Both private and public clinics were included. To collect study participants, the supervisor asked the contact person for the quantitative study at each clinic to suggest midwives with experience of abortion care to foreign-born women. A sample of eight midwives was asked to participate in the study, and all of them agreed. The collecting of data ended when saturation was reached and time did not allow for more interviews. The interviews were performed in March 2014 - February 2015 by either the author or the

supervisor. Each interview was performed individually, either on the working place of the interviewee or the researcher, and each interview lasted for about 40-50 minutes.

A semi-structured interview guide was prepared, containing background information along with open-ended questions, allowing the interviewee to respond freely and expand on issues of particular interest to her (Appendix 1). Initially, the background of the study was presented to the interviewees, including the previous data showing that immigrant women are at higher risk of having abortions than native-born women. They were asked to reflect on this, and consider whether this corresponded to their own experience. The following questions concerned experienced differences between foreign-born and native born women seeking abortion care regarding abortion decisions, choice of abortion method, contraceptive use and special needs. The interviews were audio-recorded after permission from the informants and transcribed verbatim by a research assistant.

Data analysis

A thematic data analysis was used in six steps as described by Braun & Clarke (2006). This method was chosen since it offers an inductive systematic, yet flexible technique, and a possibility to summarize key features of a large body of data and a 'thick description' of the data set. To obtain an overview of the data, the transcripts were read and re-read several times. Subsequently, text extracts were identified and grouped according to content in a matrix, and themes and patterns were identified. In the next step, temporary categories were constructed and crosschecked against groups, initial text extracts, and transcripts. Finally, the categories were arranged under a main theme. During the process of analysis, groups, categories and main theme were frequently discussed and revised by the author and the supervisor. Background characteristics were put into a separate table. Quotations used to illustrate the findings were translated from Swedish to English by the main author.

Ethical considerations

Ethical approval was obtained from the Ethical Review Board in Stockholm (dnr. 2014/376-31/5). Before giving their written consent to participate in the study, all study participants received comprehensive oral and written information on the study objectives and methods, and were informed that participation was voluntary. All participants were granted anonymity and the interviews were performed in privacy.

Definitions

We are aware that the terms *immigrant* and *foreign-born* are heterogeneous. Even though immigrants, as shown above, in general report poorer health than the majority population, there are large disparities both between and within immigrant groups. Immigrants have their origin in different regions and countries, and specific groups of people differ with respect to cultural background, legal status, religion, acculturation, educational level, migration history, present living conditions etc. Some have been in their new country for several years, while others are more recent and less integrated in society. Asylum-seekers and refugees have specific problems, living in uncertain conditions and sometimes traumatized by their experiences. All these factors of diversity must be taken into consideration when issues of "immigrants" or "foreign-born persons" are being discussed.

In this thesis, the terms immigrant or foreign-born person have been used interchangeably. The definition is intentionally broad and includes all people born outside of Sweden. Those terms have been used since it is currently difficult to decide what countries to include or exclude.

Results

In table 1, the background characteristics of the respondents are summarized.

Table 1: Background characteristics of respondents

	Years of clinical experience as a midwife	**Years within abortion care**	**Age**	**Education**	**Site**
Midwife 1	26	5	54	RN, Midwife	Clinic 1
Midwife 2	10		44	RN, Midwife	Clinic 1
Midwife 3	14	8	55	RN, Midwife, wellness consultant	Clinic 1
Midwife 4	27				Clinic 1
Midwife 5	20	20	65	RN, Midwife	Clinic 1
Midwife 6	11	7		RN, Midwife	Clinic 2
Midwife 7	20	6	55	RN, Midwife	Clinic 3
Midwife 8	8	6	45	RN, Midwife, sexologist, naprapath	Clinic 2

Main theme and categories

The participating midwives were reluctant to make general assumptions regarding the needs of foreign-born women. This was due to an articulated aim to perceive each patient as an individual person with individual needs, in order to provide equal and patient centered care. Furthermore, the aversion towards generalization was apparently related to fears of being perceived as a racists or as someone who is expressing racist ideas. However; even though respondents were unwilling to generalize, the data analysis revealed specific needs of the group of foreign-born patients as experienced by midwives, and a main theme appeared; A*ccommodating the specific needs related to pre- and post migration factors - a challenge in the encounter*. Three categories were identified sorting under this theme: *Handling poor knowledge, The influence of life situations,* and *Perceptions and beliefs influencing contraception*. For each category, a number of sub-categories were identified. A summary of the data analysis is presented in table 2.

The three categories can be interpreted as needs that appear when pre- and post migration factors co-exist or collide. It was observed that mainly pre- and post migration factors had an impact on health care encounters with foreign-born women, while during migration factors were less evident.

Table 2: Main theme, categories and sub-categories

Main theme	Accommodating the specific needs related to pre- and post migration factors - a challenge in the encounter.		
Categories	Handling poor knowledge	The influence of life situations	Perceptions and beliefs influencing contraception
Sub-categories	• Poor knowledge on contraceptives, body functions and anatomy • A demand of more time	• Partners more often involved in decisions • Cultural and religious believes • Honor-based violence • Poverty	• Different starting points for contraceptive use • Foreign-born women want monthly bleedings

1. Handling poor knowledge

Poor knowledge on contraceptives, body functions and anatomy

All participants seemed to agree that some foreign-born women appeared to have a lower level of knowledge on SRH issues than Sweden-born women. This regarded matters such as female genital anatomy, the menstrual cycle, reproduction and contraceptive use, function and supply, as well as SRH rights. In particular, this concerned foreign-born women who had not attended Swedish primary school:

> …We meet many women who have difficulties absorbing information on these issues. (…) To read, understand, and this thing with body, own body… What do I look like, what do my genitals look like, when do I get pregnant and why. I mean, body knowledge that not everyone has. (…) (Midwife 3)

> …I met a foreign-born woman, and she hadn't received any information on… contraceptives and this… sexual and reproductive health. (…) These issues had not been included in her schooling, for example. And that makes you think, that, maybe, if you've lived abroad during your school

> years and there were no access to it or you didn't get that, then you might not have that … natural… *experience* of it. (Midwife 6)

The insufficient knowledge could sometimes generate misunderstandings and miscommunication. One midwife gave an example of such a situation:

> It's not only once that it happened, but in particular I was thinking of one woman who asked me why I had prescribed such a large amount of pills "because I don't have sex that often", you're supposed to eat them for a whole year, "but, like, I don't have sex that much". And then it turned out that she took them only when she had sex. (Midwife 4)

Many respondents stressed that low levels of knowledge on contraceptives, body functions and anatomy was associated to educational level and social class rather than to culture or ethnicity:

> They might not have that much information on protection and how to, menstrual cycle and such things. (…) But on the other hand, I think it's about level of education, where you live… on your social relations. (Midwife 8)

A demand of more time

Respondents agreed that providing abortion care and contraceptive counseling to foreign-born women overall requires more time in comparison to other patients. This was generally seen as due to language barriers and the necessity of professional interpreters, and the fact that foreign-born patients often need more information and guidance:

> You have to do it (provide information) stepwise. You can't just meet for an hour, talk about abortions. You need a different plan. (…) They can come on return visits. (Midwife 2)

> It's got to be on the level where she is. And then you get to draw pictures, show brochures, models, yes we show pedagogically and inventive, and take them back again. That one appointment might not be enough. So the woman will have to come back for more visits. (…) And sometimes you can book a whole hour. You might not have those 30 minutes, you have to prolong it. Make sure that "now I need this time with this woman". Then you take that time. But there is a time pressure, absolutely. (Midwife 3)

Even though all respondents agreed that foreign-born patients in general demand more time, there were no routines or protocols in the clinics that allowed extended appointments for this purpose. However, the health care providers responding in the study had their own means to acquire the time needed by booking double appointments or by scheduling patients for

return visits. One midwife described how the compensation is disproportional to the amount of time and effort invested:

> But what's sad, in my opinion, is that working with these women requires extreme amounts of time, even though, we're allowed, we take the time, but to provide care for several foreign-born per day with professional interpreters, after that you're totally exhausted. So we would need more resources for these women. We should… yes, we should get more paid as well, so we could give them more time. I find this unacceptable. (…)And time is money. And if we don't get that… then I think we'll get a hard time providing for these women in an optimal way. Because, an optimal way is to take the double amount of time, because that's the time it takes when you're using a professional interpreter. (Midwife 8)

2. The influence of life situations

Partners more often involved in decisions

Many caregivers stressed that male partners of foreign-born women often are more involved in decision-making regarding both abortion and contraceptives, as compared to male partners of Sweden-born women. Foreign-born women also more often seemed to decide on contraceptive method in consultation with their partners. As an example, one midwife reported how a foreign-born patient wanted to wait for three months until her husband came home from a journey before deciding on contraceptive method. Foreign-born women did also more frequently visit the clinics accompanied by their male partners, as compared to native-born women:

> In Muslim families, I think, the decision not to have more children is mutual. And you get an abortion. When I think of Swedish women, I think it's more often their own decisions. (Midwife 1)

Male partner participation was seen by respondents as enabling contraceptive use, since many of the foreign-born women wanted to consult their partner before starting a contraceptive method. Some respondents pointed out, that men sometimes might be less informed than their spouses, and that the male partners had to be educated as well. This led to counseling sessions where the caregivers had to address both the man and the woman:

> … And then he said "If you get an IUD, I'll divorce you." So I had to take out the book and explain the whole process on why you get an IUD and what good it makes and everything. So at the end he

said, “It’s your decision, do as you like” to her. So he understood, he hadn’t had the knowledge about anything, didn’t get what I was talking about. (Midwife 5)

Cultural and religious believes

According to some respondents, women from other cultural or religious backgrounds did often have a lower acceptance of contraceptives, and because of this they were more likely to have repeated abortions:

> These women are absolutely not allowed to have sex before marriage. They stand with one foot in Sweden and one there. (…) And then they have their abortion and then they don’t want any contraceptives, even though they live with a boyfriend and have sex. Are at risk of getting pregnant once again. (Midwife 4)

It was also noted that culture and religion are present as contributing factors in women’s abortion decisions:

> It can be, “in my family you’re not allowed to make abortions” (…) or “according to how I was raised, abortions are not appropriate”. (…) I think that as a woman, regardless if you live in Norway, Saudi Arabia, or Sweden, you feel the same agony or no agony about the decision itself. I think we have the same… or very similar, that’s what I think. Then it might be aggravating that in some cultures abortions might be hard or aren’t allowed, that you´re like under pressure for different reasons. So cultures can overall be more difficult, yes. (Midwife 3)

Honor-based violence

The caregivers reported that they sometimes encountered abortion care-seeking women and girls from honor based societies. These women and girls lived in fear of their families getting to know about them being pregnant or having boyfriends:

> There was this young woman who lived with protected ID, and she did really say that “if my family gets to know this, then I’ll be dead tomorrow.” And she was having an abortion. (…) The last thing she said when she walked from here was “if you’re reading about a woman who’s been killed in the newspapers tomorrow, you know it’s me.” She was so afraid. She was wearing clothes to cover herself up when she… She was afraid to even be seen in this building. (Midwife 6)

According to respondents, these patients worry that their medical records will be read, that the clinic will try to approach them by mail or phone, or that their families will find their contraceptive pills:

> Many women have their contraceptive pills at school in their locker because they can't bring them home, are afraid that their mother might find them. (Midwife 4)

This fear might also be a determining factor in these women's choice of contraceptive method. The midwives stated that these patients tended to choose a method that can be hidden from others, such as an IUD or hormone implant:

> They often choose a hormone implant, and then they ask: "will it show on the outside (of the arm)?" (…) It stays there and no one else can tell that it's there. No one will know that you have it and that too is… You understand that it's a good option. (Midwife 4)

Poverty

One respondent shared an experience that had made a deep impact on her, of a Romanian immigrant woman who was homeless and lived outdoors, and had sought a second trimester abortion. The midwife expected that she and her colleagues would see an increased amount of poor immigrants from the EU to seek abortion care in Sweden in the near future:

> So it was a meeting that made a deep impact, and then we've had some other (patients) from out in the woods - I think it's a tip of the iceberg, that we'll see more of these women… (Midwife 3)

3. Perceptions and beliefs influencing contraception

Different starting points for contraceptive use

In some respondents' experience, foreign-born women tend to start using contraceptives at an older age. This is when they already are married and have the number of children that they wanted. In contrast, Swedish women often come for contraceptive counseling at earlier age:

> In some cultures, (women) don't want to start using contraceptives before they have children. While Swedish girls start taking pills when they are seventeen. (Midwife 3)

> It might be more common in some immigrant groups not to use any contraceptives at all. (…) I think that, during a period of life when they have children they don't use contraceptives, but then, after you've had your children, then you want contraceptives. (Midwife 1)

Foreign-born women want monthly bleedings

Several interviews revealed a perceived difference in attitudes between Swedish- and foreign born women towards monthly bleedings. The midwives had noticed that while Swedish-born women in general tended to opt for contraceptives that remove or reduce bleedings, foreign-born women seemed to attach great value to monthly bleedings:

> …There's a difference, Swedish women, when you introduce a Mirena (hormonal IUD), (…) a lot of them say "oh, I want that!" If you present that to a foreign-born woman, she will say "I want my periods." (…) They want their monthly period, and that is very common. (Midwife 1)

> They don't want their periods to go away, they don't want any gestagen methods. They want to bleed. That's a big difference, I think. I mean, Swedish, and especially young girls, think it's a great relief to get rid of their periods. (Midwife 6)

Reasons for this, as perceived by the respondents, was that foreign-born women often view menstruation as a purification process, and believe absence of bleeding to be harmful:

> They (foreign-born women) often tell me that they want to cleanse themselves, that you're supposed to bleed out. "Can't it be dangerous, where does the blood go if you don't bleed out?" (Midwife 6)

Some respondents did also point out that young women from honor-based societies might need a monthly bleeding to not arouse suspicions in their families:

> But some of them might say that "I can't, I have to bleed at home, I have to show them that I have my periods", like, I don't know, if the mother will go check her laundry basket… (Midwife 6)

> And that's a reason why you might not want to get a hormonal contraceptive, for example an IUD. (…) Often, you want regular periods, it's supposed to show that you're menstruating, or you think that the body needs to bleed out. (…) In many of those honor related, they want a contraceptive that gives you bleedings. For many are being under control. (Midwife 7)

Discussion

Midwifery can make specific contributions to both preventive and supportive care. These have been highlighted in a framework for quality maternal and newborn care, recently

published in the Lancet (Renfrew et al. 2014). Here, more than 50 outcomes that could be improved by care within the scope of midwifery have been identified. Among them are reduced maternal mortality and morbidity, a decreased number of unnecessary interventions, and improved psychosocial and public health outcomes. Midwifery was associated with more efficient use of resources and with a positive impact on both health outcomes and women's perceptions. Women requested "caring health care professionals who combine clinical knowledge and skills with interpersonal and cultural competence." This framework identifies components of importance that mirror findings in our study.

The hesitation among the responding midwives to acknowledge that foreign-born patients often have specific needs might sometimes be counterproductive, and might pose a barrier to PCC. According to Sidani & Fox (2014), PCC involves an individualization of care, aiming to maintain consistency between the services or interventions delivered and the patients' needs, values and preferences. The statement that generalization of needs on a group level could lead to a more patient centered care may sound like a contradiction. However, as pointed out by The Swedish Agency for Health and Care Services Analysis in a recent report analyzing inequalities in Swedish health care (2014), there is a difference between dissimilarities and inequalities in health care. This report states that the Swedish health care system fails to adjust the health care to each patient's different individual qualities and conditions, for example in offering the same quality of care regardless of the patient's previous knowledge level. This corresponds with the findings of our study. To acknowledge and discuss the special needs of foreign-born women seeking abortion care is a first step towards giving this patient group the resources needed to achieve equal health care.

The difficulties in the provision of PCC shown in our study also correspond with results from another report from The Swedish Agency for Health and Care Services Analysis (2013). This report stated that the Swedish health care system "often fails to anticipate and respond to patients as individuals with particular needs, values and preferences. Failure to meet patient expectations can have demonstrable costs to patients, the health system and the public purse."

Our findings show that health care professionals often need more time in the provision of abortion care and contraceptive counseling to foreign-born women in comparison to other patients, due to language barriers, the necessity of professional interpreters and a higher demand for information and guidance. The notion that patient encounters with foreign-born

women require more time is corroborated by previous studies Fatahi, Mattsson, Lundgren & Hellström (2010) Newbold & Willinsky (2009) and Wiking, Saleh-Stattin, Johansson & Sundquist (2009).

The lack of routines and protocols allowing prolonged appointments and extra financial compensation for patients with communication barriers might contribute to inequalities in healthcare. This has previously been shown by Akhavan (2012). The results of this thesis raise questions on whether the Swedish health care system will be able to reach the goal of equal care when conditions differ between county councils and when the billing systems promote quick visits, rather than allowing extra costs for health care providers to allocate extra time required for provision of equal care (Swedish National Audit Office 2014).

All of our respondents agreed that foreign-born women more often have a low level of knowledge on contraceptives, body functions and anatomy. According to our respondents, the insufficient knowledge could be due to both educational and cultural matters. This involves both a lack of schooling and lack of a cultural background where women discuss these issues. Similarly, Canadian family planning healthcare professionals have experienced that immigrants often have different ideas regarding sexuality and a lack of knowledge about the body and reproduction, in comparison with native-born clients. This leads to misconceptions associated with the body and birth control (Newbold & Willinsky 2009). Furthermore, immigrant women appeared to be less likely to state that they had sufficient knowledge about contraception when compared to Danish-born women (Rasch et al. 2007). The latter study concludes that it seems more difficult for immigrant women to protect themselves against unwanted pregnancies, possibly because these women experience more barriers in accessing contraception as well as in using the methods correctly (ibid).

SRH education is part of the Swedish school curriculum. However, previous research indicates that the knowledge of SRH might be insufficient among young people in general, and among foreign-born youth in particular. These results correspond with our findings, indicating a lower level of knowledge on anatomy and contraceptives among foreign-born women seeking abortion care. In a survey on youth and sexuality in Sweden performed in 2009, half of the respondents considered themselves to have recieved sufficient SRH education in school, while one third stated that they had gained inadequate knowledge (Tikkanen, Abelsson & Forsberg 2011). Helström, Zetterström & Odlind (2006) demonstrated a difference in contraceptive practices and knowledge between Sweden-born

and foreign-born teenage women seeking abortion care. Thus 15 % of the immigrant women had no experience of contraceptive counseling, as compared to 6 % of the Sweden-born women. Participants born in Sweden also had wider experience of contraceptive use, as witnessed by the fact that 95% of the Sweden-born women had experience of contraceptives, as compared to 86% of the foreign-born.

According to our results, midwives working with abortion care face women and girls living in fear of honor-related violence and oppression. The Government offices of Sweden (2015) have stated that about 70 000 people between the ages of 16 and 25 belive that their parents views, culture or religion restrict who they can marry. Of these, an estimated 8 500 are concerned about not being allowed to decide who they will marry. There are indications that the phenomenon of honor-related violence and oppression may be more widespread in certain urban areas.

A major concern for patients living under honor-based oppression, as perceived by our respondents, was to hide the secret of being pregnant and/or having boyfriends from their families. This concern was also affecting the work of the health care professionals, who tried to protect their patients and create a safe environment for them at the clinics. Similar results have been obtained previously, showing how midwives and counselors at Swedish youth health clinics try to create a refuge for such girls where their secrets can be safely disclosed, without any risk of it being revealed to their social network (Alizadeh, Hylander, Kocturk & Törnkvist 2010). A recent study concluded that Swedish antenatal care midwives perceived that Somali immigrant women often have low knowledge about women's rights and possible support systems in their new society. Patience, trustful relationships and networking were key aspects in the work with violence among Somali-born women, and midwives took on positions as 'bridge-functions' between the Somali woman and the community (Byrskog, Olsson, Essén & Allvin 2015). The need for midwives working in non-institutional care to guide and inform foreign-born women on Swedish lawful rights or what kind of official support she has access to in her new society can be identified as an additional specific need in the midwifery care of foreign-born women.

Another finding was that our respondents perceived male partners of foreign-born women to be more involved in decision-making regarding both abortion and contraceptives, as compared to partners of native-born women. The male partner participation was seen by respondents as enabling contraceptive use. Many of the foreign-born women wanted to

consult their partner before starting a contraceptive method, and it was thus more convenient to have him present in the discussion. A few respondents pointed out that male partners could sometimes oppose contraceptive use because of ignorance or misconceptions. Newbold & Willinsky (2009) have evaluated Canadian health care providers' experiences in the provision of family planning and reproductive healthcare to immigrants. Their analysis showed that men of some cultural groups tended to get more involved in contraceptive decision-making, but that health care providers felt that women often had little say in the decisions. Similarly, it was found that in the experience of Spanish midwives providing SRH services to immigrants, the men often decided whether or not to use contraceptives, and they often held negative attitudes regarding family planning (Otero-Garcia, Goicolea, Gea-Sánchez & Sanz-Barbero 2013). These results highlight that the outcome of male involvement can sometimes be that decisions are being made mainly by the male partner instead of by the couple in agreement. According to a report from Järva Men's Clinic, a SRH clinic located in an immigrant-dense area of Stockholm, men with foreign background are particularly difficult to reach with health promotion information (Warenius, 2010). Our results show that the contraceptive counseling encounter post abortion can provide a good opportunity to inform couples about SRH and family planning. In particular, it can provide a unique opportunity to approach men who otherwise may lack venues to discuss these issues.

Some of our respondents perceived that women from other cultural or religious backgrounds were more likely to have repeated abortions, due to a lower acceptance of contraceptives. It was also noted that culture and religion seem to be contributing factors in women's abortion decisions, especially for women with backgrounds in societies with a low acceptance of abortions. Results from a study made among African-Americans and Caucasians in the southeastern USA have shown that views about God, nature and the human body can intertwine to create a concept about God's natural order for the world. In this, women are seen as physical vessels for bearing children. People of such faith had distrust in the health care system, including practitioners, pharmaceutical companies and the government. These results illustrate the significant impact that culture and religion may have on contraceptive decision-making (Woodsong, Shedlin & Koo 2004). Helström et al (2006) reported that immigrant girls in Sweden were over-represented among adolescents who seek termination of pregnancy. However, the study concluded that cultural disparities was an unlikely explanation. The variation in abortion rate could instead be explained by differences in socio-economical factors and other difficulties associated with immigrant status per se. A

qualitative systematic literature review aiming to synthesize data on immigrant women's experiences of maternity services in Canada highlighted the fact that while immigrant women expected maternity health care to take into account their cultural needs, health care professionals put most emphasis on biomedical needs. The study concluded that cultural knowledge and beliefs, as well as religious and traditional preferences were highly relevant in maternity services, but often overlooked (Higginbottom, Hadziabdic, Yohani & Paton 2014).

Our results indicate that midwife perceive foreign-born women to tend to start using contraceptives at an older age, often when they already are married and have had children, whereas Swedish women generally come for contraceptive counseling at earlier age. An association between socio-economic status and use of contraceptives is well established (Dehlendorf, Rodriguez, Levy, Borrero & Steinauer 2010, UNFPA 2012, Poncet et al 2013). Our findings also correspond with the results of a Danish study, showing that foreign-born women had both greater lack of contraceptive knowledge and experience of contraceptive failure, as compared to Danish-born women (Rasch et al 2007). Furthermore, a recent Norwegian registry-based study concluded fewer immigrants than native women used hormonal contraceptives (Omland, Ruths & Diaz 2014). This study also showed that while marriage and birth giving were associated with lower contraceptive use among native women, the opposite was the case in immigrant groups with otherwise relatively low use. It was suggested that this increase in contraceptive use among foreign-born women after childbirth could be due to a free control visit 6 weeks after delivery, where contraceptives is one of the issues that should be discussed according to protocols. There is a possibility that immigrant women, who usually have infrequent contacts with the health system, may use this opportunity to get contraceptives (ibid).

Free control visits postpartum are offered within the Swedish health care system as well, and our results underpin the importance of time and resources for family planning within post natal care. Yet, the results also raise questions on whether lower use of contraceptives among foreign-born women is due to a lower demand for contraceptives or to lower access. Access is a concept often referred to. Levesque, Harris & Russell (2013) have introduced access to healthcare as a concept and five determinants of access have been defined: approachability, acceptability, availability and accommodation, affordability and appropriateness. Considering these determinants, several possible barriers for foreign-born women to get access to contraceptives can be identified. Without basic knowledge on SRH it

is more difficult to identify healthcare needs. Furthermore, without knowledge on the Swedish health care system and with lower language skills it is more difficult to reach and use healthcare services and to actually benefit from the services provided.

This thesis reveals that midwives perceive differences between Swedish-born and foreign-born women in their attitudes towards monthly bleedings and amenorrhea induced by contraceptives. Both cultural and regional differences in attitudes have previously been well established (Glasier et al 2003, Snow, Hardy, Kneuper, Hebling & Hall 2007, Szarewski von Stenglin & Rybowski 2012). A reason for foreign-born women's aversion towards absence of bleeding, as perceived by our respondents, was that menstruation was viewed as a purification process, and amenorrhea believed to be harmful. Similar results have previously been presented in a Turkish study by Ay, Hidiroglu, Topuzoglu, Ucar, Kose & Save (2007), describing women to believe that the uterus is being filled with 'dirty blood', which has to be released during menstruation. Similarly, an American study revealed how both Afro-Americans and Caucasians perceived that a woman's body has a natural order and rhythm, and contraceptives were viewed as potentially dangerous since they disrupted this natural flow and interfered with God's plan for the body. Monthly bleeding was viewed as an indication of health and fertility and menstruation was seen as cleansing the body (Woosong et al 2004).

When the results of this thesis are interpreted based on the theory of pre- during- and post migration factors (Hjern 2012), it is primarily the pre- and post migration factors that seem to have an impact on the patient group of foreign-born women. During migration factors are less evident. However, the homeless Romanian immigrant woman seeking abortion care (see above) is an example of a health care encounter deeply influenced by during migration factors. This group of patients will probably be more frequently seen within the Swedish health care system, since the group of EU immigrants is currently increasing in Sweden. The midwives' experiences of providing abortion care to these women also illustrate the importance of taking pre- during and post migration factors into account in the health care encounter, as well as acknowledging them on a structural level.

Many of the special needs identified in this thesis in the provision of abortion care and contraceptive counseling to foreign-born women can be seen as due to pre- during- and post migration factors that interact, and sometimes collide. Barriers to equal care can be found in the interaction between what a person carry with her/him and what she/he faces in a new

environment. This is for instance when the Swedish health care system anticipate patients to have a certain level of knowledge that was neither expected nor accessible in the home country. It may also occur when the Swedish society does not share a person's definition of honor and morality. This has been illustrated by the Swedish philosopher Torbjörn Tännsjö, who has described honor-based values as "the right morality system in the wrong environment" (Tännsjö 2011).

Methodological considerations and limitations

Since this thesis is based on interviews with a small sample of eight midwives, the results cannot be generalized. All of our respondents were midwives working in the Stockholm area. If midwives from less urban areas would have been included, the results may have been different. However; the findings do not seem to differ much between participants and clinics. Midwives' experiences of provision of abortion care and contraceptive counseling to immigrant women seem rather similar across settings, which strengthens the results.

In this thesis, the needs of foreign-born women seeking abortion care are only described as experienced by midwives. A suggestion for further research is qualitative interview studies with foreign-born women to define their experiences of and views on abortion care and contraceptive counseling.

Conclusions and interpretations

The group of foreign-born women is heterogeneous. However, within midwifery abortion care, it has to be acknowledged that foreign-born women often have special needs due to migration factors that affect the health care encounter. Examples of such factors are as poor language knowledge, insufficient knowledge of SRH and cultural and religious influences.

The midwives working in abortion care recognize the special needs among foreign-born women, but the understanding is informal. The impact of culture and migration on the health care encounter has not been officially acknowledged or incorporated into guidelines and protocols for abortion care. Instead, visits at abortion clinics are standardized, for instance in terms of time allotted for each patient, even though the needs of women seeking abortion care are not fixed.

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Appendix 1: Interview guide

Intervjuguide. Vårdpersonal verksamma inom abortvård

Den här studien syftar till att öka förståelsen om abort bland kvinnor med utländsk bakgrund. Bakgrunden till studien är att man i tidigare forskning i Sverige, och även i Norge och Danmark har sett att kvinnor födda i andra länder är överrepresenterade i abortstatistiken.

<u>Allmänna probes:</u> Vad tror du att det kan det bero på? HUR? Kan du berätta mer om det? Vad tänker du om det?

Jag tänkte börja lite allmänt.

1. Kan du berätta om lite om din professionella bakgrund, din erfarenhet av att arbeta inom abortvård och preventivmedelsrådgivning?
    a. *Hur länge?*
    b. *Var?*

2. Mot bakgrund av att man sett att kvinnor med utländsk bakgrund är överrepresenterade i abortstatistiken så tänkte jag fråga dig vad du tänker om det? Är det nåt du tänkt på?
   Varför tror du att det är så? Vad skulle det kunna bero på?

3. Upplever du att det är finns det skillnader mellan utrikesfödda kvinnor och svenskfödda kvinnor som söker abort?
   Hur? Vad? Livssituation? Hur har situationen sett ut innan besöket?
   Ålder? Orsak till abort?

4. Finns det fall där du sett att kvinnor med utländsk bakgrund har behov av extra mycket omvårdnad eller stöd jämfört med svenskfödda?
    a. *Kan du berätta om det? Varför?*
    b. *Hur har du hanterat det?*

5. Hur upplever du att det är att använda tolk när du pratar med abortsökande kvinnor?

6. Hur kan beslutet angående aborten se ut bland kvinnor födda utanför Sverige?
    a. *Upplevelsen?*
    b. *Pre /post migration effekt?*

7. Hur ser valet av abortmetod ut bland utrikesfödda kvinnor?
    a. *föredrar de någon särskild abortmetod? Varför?*

b. *Finns det några svårigheter ser vad gäller information i relation till abortbeslut och val av abortmetod?*

8. Kan du beskriva ett särskilt lyckat möte med en utlandsfödd kvinna? *Varför blev mötet bra? Vad var det som gjorde att mötet blev bra?*

9. Skulle du kunna berätta om ett svårt eller klurigt möte med en abortsökandekvinna som inte är född i Sverige. Ett möte som fick dig tänka till eller som väckte frågor?
    a. *språk?*
    b. *kultur?*
    c. *religion?*
    d. *Tid i Sverige?*
    e. *Utbildning?*

10. Vilken är din upplevelse av preventivmedelsanvändning bland utrikesfödda kvinnor som söker abort?
    a. *Tidigare erfarenheter?*
    b. *Några särskilda metoder innan? efter?*
    c. *Vilka resurser behövs för en bra rådgivningssituation?*
    d. *Hur kan rådgivningssituationen se ut? (Varför, hur?)*
    e. *Hur ser beslutet av preventivmetod ut?*
    f. *Vad anser du är påverkar hur en kvinna väljer preventivmedel?*

11. Bland dem ni träffar på återbesök, vad är deras upplevelse efter aborten?
    a. *Skillnader mellan utlandsfödda och svenskfödda kvinnor? Valt preventivmedel?*

12. Är det ngt annat i relation till abort och eller preventivmedelsrådgivning till utlandsfödda kvinnor som du tänkt på och som du vill dela med dig av?

Socio-demografisk data:

A. Ålder
B. Kön
C. Utbildning
D. Antal år kliniskt verksam
E. Antal år kliniskt verksam abortvård

Tack!