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Midwives' experiences of providing contraception counselling to immigrant women

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ABSTRACT

Objective: To describe midwives' experiences of providing contraception counselling to immigrant women.
Methods: The study was conducted with a qualitative design, based on interviews followed by inductive content analysis. Ten midwives were interviewed, working at midwife-led prenatal clinics in immigrant-dense areas in southern Sweden.
Results: Midwives require knowledge and understanding of cultures and religions in order to provide contraception counselling to immigrant women. It is important for the midwives to be aware that women have different values regarding sexual and reproductive health. The challenge for the midwives is to understand and to be curious about every woman's lifeworld perspective, culture and religion. The midwives knowledge and understanding of cultures and religions is acquired through experience and shared between them. Knowledge makes a midwife confident in her role as the contraception counselling provider to immigrant women.
Conclusion: Cultural and religious factors affect contraception counselling. According to the midwives, knowledge and awareness of these factors is crucial and leads to improved understanding of midwives providing contraception counselling, better compliance, fewer unwanted pregnancies and improved sexual and reproductive health among women.

Introduction

Sexual and reproductive health is a fundamental right and essential for all people's empowerment and ability to influence decisions such as when and with whom to have children [1]. It affects all people's everyday lives and is a matter of life and death and the right to be oneself. Sexual and reproductive health is enhanced by access to contraceptives, safe abortion and care after unsafe abortion. Access to sex education, contraception and trained midwives improves the lives of women and children worldwide [1]. According to the World Health Organization (WHO) and the United Nations (UN), contraception and family planning is important for women's health [2,3]. Nonetheless, approximately 300,000 women still die every year related to pregnancy and childbirth [3]. Being able to control the interval between pregnancies and the number of children each woman and family has entails major benefits for women's health and autonomy [2].

The United Nations' Millennium Development Goal (MDG) number 5 was to increase contraceptive use and promote women's sexual and reproductive health [3]. When addressing MDG 5, the Swedish government has chosen to focus on strategic areas such as contraception and contraception counselling, promoting sexual and reproductive health and rights (SRHR) [4]. The MDG's provided an important framework for development and significant progress has been made in a number of areas according to the United Nations (UN) [5,6]. But the progress has been uneven, and some of the MDGs remain off-track, in particular those related to maternal, newborn and child health and to reproductive health [5–7]. The work with improvement of sexual and reproductive health continues with new goals, UN's Sustainable Development Goals (SDG), which are built on the Millennium Development Goals and seeks to complete what these did not achieve [6].

The Swedish midwifery profession is strong; Swedish midwives are well-educated and successful in their clinical work and they also conduct extensive research in the field of SRHR [8]. In Sweden,

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contraception counselling is provided mostly by midwives in prenatal clinics or youth clinics and the counselling visits are free [9]. Many types of contraceptives are subsidized by the county health authorities for women younger than 26 years of age. Most contraceptives are prescribed by midwives or doctors, while emergency contraception is sold over the counter in pharmacies and condoms are sold in grocery stores [9–11]. This Swedish model, entailing easy access and free contraception counselling, is unique. Nonetheless, there are approximately 33,000–38,000 abortions annually in Sweden, the highest rate in Western Europe [11]. There are many, and often complex, reasons why contraception is not used despite access and knowledge [9,12].

Midwives in Sweden meet women from all over the world in their profession [10]. Today, about twenty percent of Sweden's population are immigrants or descendants of immigrants, i.e., they were either born outside of Sweden or have at least one parent who was born outside of Sweden [10,13]. It cannot be ignored, that the term 'immigrants' encompasses a very diverse group comprising people representing around 200 nationalities and with different socioeconomic backgrounds [10]. Being an immigrant woman is a risk factor for poor sexual and reproductive health [14,15,10,16,17]. The number of years in Sweden, educational level and language skills are factors influencing the woman's use of birth control, how many children she has, her sexual and reproductive health and her socioeconomic status [10,18,19]. For many immigrant women, the first encounter with Swedish health care is a consultation with a midwife [10]. Midwives provide safe and professional care, according to the Patient Act [20], that stipulates that care is to be provided with respect for the equal value and dignity of each person and must promote the patient's privacy, self-determination and participation in the caring process. Furthermore, the midwife contributes her professional competence to meeting each woman within her unique lifeworld perspective, culture and context [21,10,22,23].

Working transculturally entails applying one's knowledge and experience of different cultures [10]. Midwives develop their own contraception counselling models in order to handle clinical encounters optimally [9,21]. While there is a risk of generalization and stereotyping when knowledge is based mainly on experience [9,21], previous research shows that the caregiver's knowledge of intercultural communication and understanding of different cultures is a good platform for effective treatment [24]. Effective communication, "speaking the same language", between the care provider and the patient leads to better compliance [24,25]. One important question is whether there are other necessary factors that the midwife should know or understand in order to create positive contraception counselling situations, with good compliance as a result. Midwives' own experiences of providing contraception counselling to immigrant women with different cultures thus needs to be examined in order to obtain deeper knowledge about the factors they themselves perceive as affecting the counselling situation. To have knowledge about midwives' experiences of providing contraception counselling to immigrant women is important, in order to improve SRHR work in Sweden, both at the individual and societal levels. In the global perspective, well-educated midwives and successful contraception counselling are factors that could ultimately improve women's health. The aim of this study was to describe midwives' experiences of providing contraception counselling to immigrant women.

Methods

The study was conducted with a qualitative design, based on interviews followed by inductive content analysis according to Graneheim and Lundman [26]. The study followed ethical guidelines for informed consent, confidentiality, use, consequences and the role of the researcher, issued by the Swedish Research Council and according to the Declaration of Helsinki (WMA Declaration of Helsinki) [27,28]. Written informed consent was documented by the participants signing a consent form including information about study purpose, the voluntary nature of participation and the possibility to withdraw at any time, as well as a guarantee of confidentiality. Furthermore, the form stated that no information about the participants would be made public in a manner that identifies them and that the data material would only be accessible to researchers. Confidential code identification numbers were used for each participant during the analysis process and quotes were numbered accordingly, in order to disguise the participants' identities.

Data collection

Three midwife-led prenatal clinics situated in immigrant-dense areas in southern Sweden. Six midwives were interviewed from one clinic, three midwives from the second clinic and one midwife from the third clinic.

Inclusion criteria were: registered midwife with at least one year of professional experience of providing contraception counselling to immigrant women.

A total of ten midwives, all women, with professional experience ranging between two and thirty-nine years, were interviewed. A semi-structured interview guide was used so that both the researchers and participants could maintain their focus on the study aim and the research question, while the latter responded openheartedly to open-ended questions. The interview guide was structured according to the funnel model [29–31]. The informants started by answering general questions about their age, professional background and professional experience as midwives and were thus introduced to the topic. Subsequent questions were more specific: "What are your thoughts about providing contraception counselling and health care to women from different cultures?"; "What is your experience of immigrant women's contraception use and preferences?"; "Is there anything else you want to share in relation to providing contraception counselling to immigrant women?" Supporting follow-up questions ("Can you describe that in more detail?"; "What did you think or feel?") were asked, when necessary for clarification.

Most interviews were conducted in secluded and quiet areas at the participants' workplaces. One interview was conducted by phone. The interviews lasted 18–35 min (mean 28 min). They were digitally recorded and transcribed verbatim.

Data analysis

The data underwent inductive qualitative content analysis, according to Graneheim and Lundman [26]. The researchers read the transcribed material several times in order to obtain a whole sense of the content. The next step was selection of bearing meaning units. The units were all carefully identified, compared and thoroughly discussed by the researchers in order to achieve a similar idea and awareness in relation to the material and purpose of the study. To make the text shorter and more manageable, the researchers condensed it and then coded each meaning unit, ensuring that the code was closely related to the core of content, context and meaning of the unit. The codes were grouped into categories and subcategories, based on similarities and differences, making sure that no code was grouped more than once or left outside a category. This process was repeated several times and the codes were analyzed and moved back and forth according to the context and aim of the study. The final analysis process generated six subcategories, three categories and a theme.