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Equitable abortion care – A challenge for health care providers. Experiences from abortion care encounters with immigrant women in Stockholm, Sweden

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ABSTRACT

Objective: To explore health care providers' experiences of providing care to immigrant women seeking abortion care.
Methods: A qualitative study including interviews with ten midwives and three medical doctors at four abortion clinics in the Stockholm area. Interviews were analysed using thematic analysis.
Results: Initially, health care providers were reluctant to make statements concerning the specific needs among immigrant women. Yet, the health care providers sometimes found it challenging to deal with the specific needs among immigrant, mostly non-European, women. Three themes were identified: (1) Reluctance to acknowledge specific needs among immigrant women; (2) Striving to provide contraceptive counselling to immigrant women; (3) Organizational barriers hindering patient-centred abortion care to immigrant women
Conclusions: Health care providers' experiences of the specific needs among non-European, immigrant women are not openly discussed, although they are acknowledged. To achieve equitable access to sexual and reproductive health (SRH), health care providers need to be better equipped when encountering immigrant women in abortion care, especially regarding contraceptive counselling. The potential impact of patients' knowledge, norms and values is not adequately dealt with in the clinical encounter. Moreover, to provide patient-centred care, it is crucial to understand how to develop and implement SRH care that ensures equal access to high-quality care.

Introduction

Sweden is a multicultural society. Its population includes a large number of immigrants from different regions of the world (16% of the total population) [1]. Due to current global crises, the number of asylum seekers in Sweden is increasing, and more than 160,000 people applied for asylum in 2015 [2].

Immigration results in greater demands on the national health systems in many European countries. Recent evidence indicates that immigrants often have different access to sexual and reproductive health (SRH) care compared to non-immigrants due to socioeconomic, cultural, and political issues [3]. International and Swedish research reveals sub-optimal reproductive health care [4,5] and adverse SRH outcomes among non-European immigrant groups living in Western settings [6–10]. In addition, increased maternal mortality and morbidity among women with an immigrant background living in Western countries are indicated [7,11]. Previous experiences of sexual and reproductive care events as well as prior encounters with the health care system are all factors that may influence health care seeking behaviour after migration [12]. Moreover, culturally marked norms and values have a profound impact on SRH, including family planning, family size, contraception and abortion [12–14]. In addition, misconceptions of culture and misunderstanding of clients' needs among health care providers (HCPs) have been described as adding to the complexity in health care provision to immigrants [15].

Research from a Nordic setting indicates that socioeconomic factors such as being single, being younger than 19, having a low educational level and being unemployed are associated with higher levels of unintended pregnancies and induced abortions [16]. Immigrant women in Denmark requesting induced abortions report lower contraceptive use and have higher abortion rates as compared to Danish-born women seeking abortion care [16]. A population-based study in Norway shows a significantly higher rate of induced abortions among immigrant women compared to non-immigrant women [13]. Swedish studies show that being foreign-born is an independent risk factor

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for induced abortion [17,18]. Immigrant women requesting termination of pregnancy in Sweden had lower use of contraceptive methods compared to Swedish-born women [18]. What is more, Sweden has the highest abortion rate within the Nordic countries and the highest rate of abortions among young women in the EU, reflecting low use of effective contraceptive methods [19].

The concept of patient-centred care (PCC) defines an approach where the HCP is guided by the knowledge, experiences, needs and preferences of the patient, and recognizes each person's individual meaning of an illness/condition [20,21]. The Swedish National Board of Health and Welfare has defined PCC as care provided with respect and sensitivity to each patient's individual needs, expectations and values.

Although studies have found a higher prevalence of abortions among immigrant women than among non-immigrant women, immigrant women is a heterogeneous group and there is a lack of knowledge regarding health care providers' experiences of providing abortion care to non-European immigrant women. The aim of this study was to explore health care providers' experiences of providing care and contraceptive counselling to immigrant women seeking abortion care.

Methods

This is a qualitative study including individual interviews with midwives (n = 10) and doctors (n = 3), all women, in four abortion clinics in Stockholm County. In Sweden, both midwives and doctors can provide abortion care, but most of the care is carried out by midwives [22]. The clinics were selected since they are among the largest abortion clinics in the area, and both private and public clinics were included. To identify study participants, a contact person from each clinic was asked to suggest HCPs with experience of abortion care. The interviews were held at the provider's workplace or at the researcher's office depending on what was convenient for the interviewee. The first (ECL) or second (SF) author carried out the interviews. An interview guide was used that contained open-ended questions, allowing the interviewee to respond freely and to expand on issues of particular interest to her. Initially, the background of the study was presented to the interviewees, and they were asked to reflect on the hypothesis that immigrant women (as shown previously in Sweden, and elsewhere) are at higher risk of having abortions as compared to Swedish-born women. The interviewees were then asked about their thoughts and reflections regarding this and about their own experiences of providing abortion care to immigrant women. The interviews were audio-recorded upon permission from the informants and transcribed verbatim by a research assistant.

Thematic data analysis was applied [23]. 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, provisional categories were constructed and cross-checked against groups, initial text extracts, and transcripts. Finally, the categories were arranged under three themes. This method was chosen since it offers an inductive, systematic, yet flexible approach, and allows for a summary of key features in the data. During the process of analysis, groups, categories and main themes were frequently discussed and revised by the authors. Quotations used to illustrate the findings were translated from Swedish to English by the authors.

Ethics

Ethical approval was obtained from the Ethical Review Board in Stockholm (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's objectives and methods, and were informed that participation was voluntary. All participants were granted anonymity and the interviews were performed in privacy. All informants agreed to have the interviews audio-recorded.

Results

Three themes were identified during data analysis: *Reluctance to acknowledge specific needs among immigrant women; Striving to provide contraceptive counselling to immigrant women;* and *Organizational barriers hindering patient-centred abortion care to immigrant women*. Below, each theme is presented and illustrated with quotes from the interviews.

Reluctance to acknowledge specific needs among immigrant women

Initially, the informants were unwilling to acknowledge any specific needs among immigrant women at a group level. The health care providers were in general hesitant to make any general statements regarding specific needs among immigrant women. The HCPs' unwillingness to generalize when talking about immigrant women's needs seems to relate to a fear of stereotyping and expressing ideas that could be perceived as racist. However, as the interviews proceeded, respondents did (reluctantly) acknowledge specific needs among immigrant patients.

> Sure, I would say that, yes, they are less informed (…), if I'm allowed to generalize, I think it sounds awful when I generalize, actually… (Midwife 8)

All informants agreed that there are groups of immigrant women that have a lower level of knowledge regarding female genital anatomy, the menstrual cycle, reproduction, and contraceptive use and function, as compared to non-immigrant women seeking abortion care. The informants interpreted this as being due to the women not having attended primary school in Sweden as children, where they would have had access to sexuality education. According to the interviewees, the immigrant patients' sometimes limited knowledge of sexual and reproductive health issues might cause misunderstandings and miscommunication in the health care encounter. One midwife gave an example of such a situation:

> It's not only once that it happened, but also 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 take them for a whole year, "but, like, I don't have sex that much". And then it turned out that she only took them when she had sex. (Midwife 4)

Furthermore, the interviewees stressed that cultural background and religious beliefs sometimes seemed to have an impact on decisions related to contraceptive counselling and contraception use. According to the providers, some women with a cultural/religious background that was very different from a Swedish background had a lower acceptance of contraceptives, which instead could result in unplanned pregnancies and repeated abortions:

> Then there are patients (…) where there have been religious barriers to the use of any contraceptive at all, and where they were yet to be married and instead they have ended up having had several second trimester abortions. (Doctor 1)

The informants also stated that in their experience, women born in Sweden to parents who have immigrated also sometimes have a lower level of knowledge regarding sexual health, even though they have been brought up in Sweden:

> It's a little surprising that they're not (informed)… They should have been taught in school how the body works and how babies