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**ORIGINAL ARTICLE**

# Immigrant women's experiences of childbirth in Swedish maternity care: a systematic review of the qualitative and quantitative literature

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## ABSTRACT

**Aim** To investigate immigrant women's experiences of childbirth in Swedish maternity care.
**Methods** A systematic search was conducted in PubMed, Embase, CINAHL, and Web of Science for qualitative and quantitative literature on immigrant women's experiences with Swedish maternity care. An inductive thematic analysis generated themes and subthemes.
**Results** Sixteen studies were included in this research. The three main themes were access to healthcare, professional treatment, and feeling significant in care. Key findings revealed that immigrant women struggled with trauma, difficult interactions with midwives, communication issues, interpreter problems, lack of detailed information, the role of doulas, and future concerns.
**Conclusion** Immigrant women's experiences of Swedish maternity care were marked by information gaps, ignorance, and disrespect, leading to mistrust and delayed help-seeking. Language barriers with midwives caused misunderstandings. A sense of belonging to Swedish society was crucial for a positive experience. More qualitative research, education in transcultural care, and training in interpreter use are needed to improve maternity care for foreign women.

**Keywords:** experience, immigrant, maternity care, review, women

## INTRODUCTION

In Sweden today there are approximately a hundred different ethnicities. According to the Central Statistics Office, about 1.8 million of Sweden's 10,600,709 inhabitants were born abroad and immigrated to Sweden by 2023 (1). The Swedish healthcare system aims to continuously improve care and expedite the process of securing and streamlining healthcare services (2). According to the law, healthcare workers are required to provide care on equal terms to the entire population of Sweden, regardless of ethnic, cultural, religious, or other affiliations (3). However, significant communication challenges may arise with increasing immigration, as a growing proportion of Sweden's residents do not speak Swedish as their mother tongue. Women's clinics and various maternity wards often serve individuals who do not speak Swedish and come from diverse cultural backgrounds. Despite progress in improving patient safety in hospitals, recent studies indicate that patients from minority, cultural, and linguistic backgrounds often face a higher risk of experiencing adverse effects compared to Swedish-born patients (4,5). One possible explanation for this could be insufficient training of healthcare professionals in transcultural care and nursing, policies that do not prioritize staff training in these areas, and patient safety programs that overlook the critical relationship between culture, language, and the safety and quality of care for patients from minority groups (5,6). Previous studies in Sweden have shown that immigrants generally experience worse health outcomes compared to native Swedes. Socio-economic factors, gender disparities, unemployment, language barriers, and feelings of insecurity may contribute to this discrepancy (4–7). Further research in Sweden has indicated a correlation between worse health outcomes for mothers and children with two foreign-born parents, while having at least one domestic-born parent act as a protective factor (8–10). Additionally, there is ample evidence linking inequalities among foreign-born women to higher maternal mortality and morbidity rates, as well as an increased incidence of low birth weight and preterm births (10,11). A report from the National Board of Health and Welfare (12) highlights that woman born abroad, particularly those from outside the Nordic countries, are more prone to severe birth injuries compared to Swedish-born women. Around half of the midwives surveyed regarding their experience with foreign-born women's access to quality care

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during childbirth expressed concerns, citing shortcomings in care provision and a declining access to care for foreign-born women, which could heighten the risk of complications and severe birth injuries (13). These findings, along with statistics from the National Board of Health and Welfare, suggest that foreign-born women's access to quality care may be compromised in several ways (12,13). Childbirth in Swedish maternity care is managed from a risk analysis perspective at the group level, which may create uncertainty and doubt regarding the care received. The negative health outcomes experienced by foreign-born women in Sweden highlight the existence of unequal care. Midwives have the skills to treat everyone with equal value by tailoring care through an intersectional perspective. Foreign-born women encounter daily challenges with midwifery and maternity care in Sweden (7,9,12).

The aim of this study was to investigate the childbirth experiences of foreign-born women in Swedish maternity care.

## PATIENTS AND METHODS

### Patients and study design

This systematic review was conducted in accordance with PRISMA (Figure 1) guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) (14). General recommendations for the production of systematic reviews have been followed (14). An initial selection of studies was made with an expert at the University Library in Gothenburg. The authors searched in different databases: PubMed, Medline, CHINAL, Embase and Cochrane Library to find the articles. The search for articles was conducted between January and July 2023, and the included articles were published from 2000 to 2022.

### Methods

**Study selection.** A Population, Intervention, Comparison, Outcome (PICO) model was used to guide the article selection process (Table 1) (15). Inclusion criteria were: English language, qualitative and quantitative approaches, original studies, and peer-reviewed articles. Exclusion criteria were articles written in languages other than English, mixed method studies and control groups studies. The articles were assessed by two authors of our study.

**Table 1. PICO Framework**

| PICO Framework | |
|---|---|
| **P** - Population | Immigrant women in the Swedish maternity care |
| **I** - Intervention | The women's experience in maternity care |
| **C** - Comparison | Experiences during the visiting on Hospitals |
| **O** - Outcome | Different kinds of category and subcategory regarding women's experiences in the maternity care in Sweden. |

**Literature search strategy.** Qualitative studies were selected to align the study's purpose of highlighting women's experiences with maternity care in Sweden. The authors agreed that a qualitative approach was most suitable for capturing these personal experiences. By using words suggested in Swedish MeSH, the results of searched studies became much more specific. The keywords used to find relevant studies were foreign, women, maternity, care, experiences, difficulties, culture, language, quantitative, qualitative, research. The search terms were separated using the search operator AND, to produce search results. MeSH terms and text words for community were combined with terms relating to foreign, maternity care and experiences. The searches were carried out in PubMed, Medline, CHINAL, Embase and Cochrane Library. Systematic reviews and meta-analyses published on this topic were screened for additional reports. The authors initially reviewed the titles of all the studies and then read the abstracts. Studies whose abstracts appeared to align with the study's purpose were further selected for a complete reading. In total, 339 studies were reviewed, and 16 were included in the study (Table 2).

**Table 2. Search terms and search results of databases**

| Database | Hits |
|---|---|
| PubMed | 255 |
| Medline | 25 |
| CHINAL | 34 |
| Embase | 28 |
| Cochrane Library | 97 |
| Total | 339 |

Search terms used: Foreign AND Women AND Maternity AND Care AND Experiences AND Difficulties AND Culture AND Language AND Quantitative AND Qualitative AND Research.

**Study selection.** All the authors of the present study separately screened abstracts for inclusion/exclusion. All scientific studies that were found to be suitable in presenting results were analysed according to the five-step model analysis process. A written model means that selected articles were divided from their entirety to be further "collected" as selected parts of a completely new study. First, all the authors read the selected studies with special emphasis on their results. Then they identified the main findings in these studies, and, in the next step, the similarities and differences of the key findings were compiled, followed by comparing the similarities and differences to identify new themes and sub-themes. In the final step, a new whole was formulated from the identified themes and subthemes, which were then used as headings in the results section of the new study. No automated approaches were used. The selected data were sent to two senior researchers (FK and LS) for any adjustment. The first two authors (SS and MK) extracted data to a Microsoft Excel file. In case of any ambiguities and in need of consultation, the senior researcher (FK) was contacted.

**Risk of bias assessment.** The risk of bias (16) for included studies was assessed with the Risk of Bias Assessment tool for Non-Randomized Studies (RoBANS). The document includes six domains – selection of participants, confounding variables, measurement of intervention, blinding assessment of outcome, incomplete data outcome and selective outcome reporting (17). For every included domain, the risk of bias was valued as high, low or unclear. The reports were independently graded by two authors (SS and MK), and if disagreement occurred a senior researcher (FK) was consulted.

**Certainty assessment.** The certainty of evidence was assessed using the GRADE working group methodology. The quality of evidence for the outcomes was evaluated by two authors (SS and MK). The certainty of evidence was categorized as high, moderate, low, or very low. In the GRADE model, it is possible to evaluate factors such as risk of bias, indirectness, imprecision, inconsistency, and publication bias (18). However, since most of the studies included in our research were qualitative, the latter assessments were not conducted.

## RESULTS

### Literature search and study descriptions

The literature search shown in the PRISMA flow diagram (Figure 1) identified 339 articles, of which 39 were selected for full-text review. Ultimately, 17 articles (19–35) were included, involving 190 informants (89 male, 101 female). Data were gathered through semi-structured interviews, focus groups, and unstructured interviews. The articles, published between 2000 and 2022 highlighted three main themes: access to healthcare, professional treatment, and feeling significant in care.

### Access to health care

Women identified several factors affecting their access to maternity care: lack of knowledge about the system, feeling dismissed, long wait times, constant questioning, language barriers, and communication through male interpreters, which contributed to feelings of discrimination. As a result, some women chose not to seek care at all.

### Communication problems

Many women reported that their primary communication challenge arose when trying to contact healthcare, as their Swedish proficiency was inadequate. Attempts to book hospital appointments often involved making phone calls (22), raising concerns about the quality of care due to inadequate support for individuals unfamiliar with the system (29). Studies revealed that not being understood during midwife interactions fostered mistrust and uncertainty among foreign-born women (22,29,31). While most women recognized the importance of language in communication, they felt their proficiency was lacking, which deterred them from seeking care (26). This created uncertainty for midwives as well (29). Despite having some knowledge of Swedish, many foreign-born women were denied access to interpreting services, as midwives often underestimated their language difficulties. Information was more easily understood in their native languages (22). Communication barriers resulted in confusion, anxiety, and feelings of helplessness (22,31), impacting their independence and decision-making abilities (27). Ultimately, not understanding the language sometimes led women to avoid or be unable to seek care in Sweden.

### Access to interpreter

Communication difficulties often required interpreters, but some women felt this support was inadequate. When healthcare professionals used complex medical terms, understanding the information became difficult (23,28). Many women were uncomfortable discussing intimate matters through interpreters, fearing that important details might be lost (20,22,27,31,34). In some instances, women chose to withhold sensitive information when a male interpreter was present, limiting discussions and leading to delayed or urgent care-seeking (19,22). This contributed to a sense of losing control over their health and heightened feelings of mistrust and uncertainty regarding care (24). Some women emphasized the value of non-verbal communication, noting that a friendly attitude, eye contact, and positive body language from midwives were reassuring (27,30). Many preferred non-verbal cues over depending on interpreters during healthcare interactions (27).

### Insufficient information

Women emphasized the need for comprehensive information about their health, their child's condition, birth processes, and postnatal care (20–23,26–28). When information was lacking, it negatively impacted their maternity care experience (20–23,26–28). Many sought clarities on physical symptoms during pregnancy and childbirth but felt insecure due to limited opportunities for follow-up questions (23,28). Cultural factors, including fears related to religious beliefs, made some hesitant to discuss pregnancy risks with healthcare staff (21). Nonetheless, foreign-born women wanted information, even if it was potentially negative (21). Inadequate midwife consultations led to anxiety and fear, sometimes discouraging them from seeking care (22). Feeling uninformed about childbirth left women feeling abandoned (34) and providing information in Swedish or their native language often did not address concerns due to low literacy levels among some participants (31).

### Having professional treatment

In examining immigrant women's experiences with treatment in Swedish maternity care, most women indicated that their perceptions were largely shaped by the behaviour of midwives. Their experiences were influenced by interactions in their home countries, which varied from respectful to disrespectful.

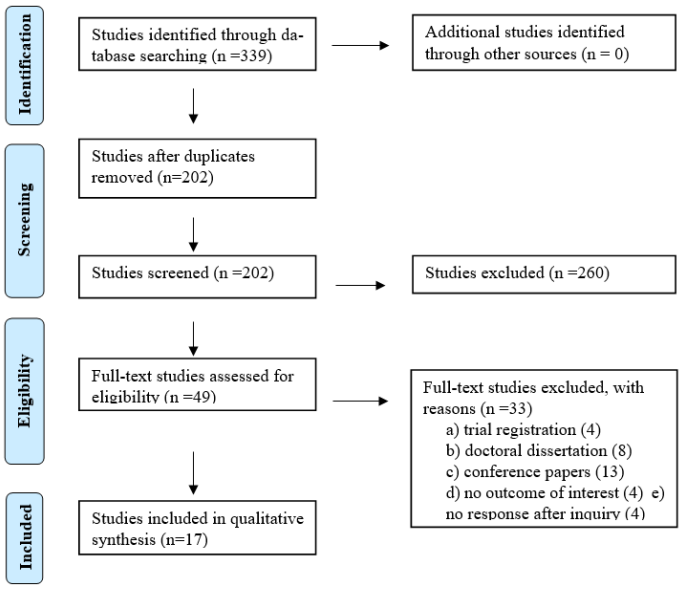


**Figure 1. Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines**

### To be met with respect

In most studies, women's experiences in Swedish maternity care were heavily influenced by their treatment from midwives. Positive interactions fostered feelings of security and well-being, encouraging women to seek care again (20–23). Being seen and listened to was perceived as very respectful (23). Many women appreciated physical support, such as a midwife holding their hand during childbirth, which made the midwife feel like family (23). Studies showed that midwives that listened, expressed concern, and shared their own childbirth experiences were particularly well-liked, enhancing the relationship and encouraging women to share their own experiences (20,24). Professional treatment not only created a sense of security but also expanded the social networks of foreign women with few acquaintances in a new country (22,24,25). Overall, women reported positive experiences in maternity care, noting that a friendly midwife helped them feel welcomed and safe (20,26–28)). However, many still grappled with trauma from their home countries. For example, Somali women appreciated being allowed to express emotions in Sweden, as this was often seen as a weakness back home (23,26). In contrast to the often-harsh treatment in their home countries, Swedish midwives were seen as friendly and kind (24). Being treated with respect and equality in maternity care greatly improved their sense of security (20).

### Treatment with knowledge and respect

The attitude of midwives had a profound impact on women's maternity care experiences. Many women reported instances of disrespect, condescension, and denial of care, which led to negative feelings (20–22,26,28). Some believed their care was compromised due to their background, resulting in mistrust and anxiety (22,23,26). Language barriers and cultural insensitivity further exacerbated these issues, with women feeling ignored or misunderstood (20,22,26–28). Programs that prepared women for consultations with midwives helped facilitate discussions and reduce anxiety (31). Continuous support during childbirth was essential for fostering connection and security, especially for those feeling disconnected from the Swedish culture (29). Cultural interpreter doulas helped bridge communication gaps, providing vital support and enhancing women's sense of belonging and understanding of the healthcare system (20,24,29,32).

### Increased security

Acknowledging the vulnerability of foreign-born women by midwives fosters recognition and validation (20). Providing clear information reduced anxiety and fear regarding childbirth (31). Continuous support during childbirth was crucial for connecting women to the experience and to Swedish culture, helping them seek community and support among other foreign-born mothers (29). Immigrant women advocated for universally tailored programs that promote dignity and rights (29).

### Feeling more significant in care

Many immigrant women sought a sense of belonging and community during pregnancy and childbirth in Sweden (22,26,31). Feelings of loneliness and exclusion heightened anxiety and negatively affected care experiences (20,25). Solidarity with other women and support from midwives and doulas were considered invaluable (22). Integration into Swedish society was viewed as essential for improving the pregnancy and childbirth experience (20). Cultural interpreter doulas were particularly effective in providing ongoing support and fostering a sense of belonging (26,29,32).

### To feel more belonging

Feelings of not belonging to Swedish society and difficulties adapting to maternity care impacted women differently. Some reflected on their relatives, while others worried about coping with their circumstances (25,29,34). Loneliness, exclusion, and a lack of belonging led to poorer maternity care experiences and heightened anxiety for many women (23,28). Connecting with other women facing similar challenges, using social media, and receiving encouragement from midwives enhanced their sense of belonging in both care and society (25). Identifying with others in similar situations proved beneficial (24,33,34). Meeting new women, learning about their rights, and fostering a sense of independence also contributed to foreign-born women's connections during pregnancy and childbirth (23,24). This sense of belonging was found to improve as women integrated more into Swedish society (23).

### Cultural interpreter doula in care

Cultural interpreter doulas were introduced in Sweden to address communication challenges and reduce reliance on male interpreters. Women highlighted the significance of having a doula who shared their culture, religion, and language, which greatly enhanced their experience (20,24,29,32). The continuous presence of a doula during childbirth led to increased satisfaction among women (24,29,32,35). Studies showed that women with a doula found it easier to express pain and request relief, comparable to native women (20,22). However, positive experiences were contingent on the relationship between the woman and the doula, with occasional compatibility issues (24,29). Despite these challenges, foreign-born women emphasized the value of having a cultural interpreter doula during maternity and childbirth (20,24,29). The presence of a doula fostered a sense of belonging and complemented the support from partners and midwives (29,32,35).

### Suggestions for improvement

To improve maternity care for immigrant women, continuous support during childbirth, tailored programs, and cultural competence training for healthcare professionals were recommended (25,29). Key steps included addressing language barriers, providing culturally sensitive care, and utilizing cultural interpreter doulas (20,29). Increasing education in transcultural care and interpreter use could further address these challenges and improve the overall maternity care experience forimmigrant women.

## DISCUSSION

This study aimed to synthesize qualitative and quantitative research on women's experiences in Swedish maternity care. A literature review of both qualitative and quantitative articles was chosen as the method to provide a comprehensive understanding of the topic (19,25). The systematic review highlighted several challenges faced by immigrant women in Swedish maternity care, including trauma from their journey to Sweden, difficulties with midwives, communication issues, and lack of information. International research has indicated that stress

factors among foreign-born women, especially refugees, can lead to negative health consequences during childbirth (36). There is a clear need for specialized and individualized care to address these issues, as immigrant women often face barriers such as discrimination, language barriers, and structural obstacles (37). Immigrant women had experience of poorer access to good care due to perceived discrimination, language barriers and other unforeseen obstacles. These obstacles speak for individual and structural discrimination, where the structural care system is built based on Swedish standards, and for Swedes, which limits accessibility for those who do not belong to these standards (37). In a literature review study from three high - income countries, authors investigated the results of various studies for foreign women who sought childbirth care before and 12 months after birth. They concluded that there was heterogeneity in the methods to determine the efficiency of improving access, mothers and affecting health results and acceptability for women and service providers and service providers (38). Most models of care resulted in increased satisfaction in women who sought care. There is a critical need for better documentation of culturally tailored models of care and rigorous evaluation with the help of several quantitative and qualitative performance measures to show efficiency, acceptability from women's perspectives and experiences, their partners, family members, and service providers. The question is only whether this can be introduced in Swedish healthcare and whether healthcare is willing to invest in foreign women who seek maternity care.

One way to prevent this is also for students on the nursing program to read about other ethnicities and for transcultural care to become a core subject. Today, unfortunately, these students do this, but once a year and the allowed time for this subject is 45 minutes. The midwife's ignorance and lack of respect increased the risk of a negative experience during the woman's pregnancy and delivery. The immigrant women described how the midwife showed a lack of interest and treated them as strangers. The majority of those women, however, describe that they were not treated badly in the meeting with the midwife in Sweden. The meeting with a midwife who showed willingness to listen and understand contributed to a positive experience. Problems in the use of interpreters in the Swedish healthcare system have generally been known for a long time. Not arriving at the appointed time, being late, not being able to interpret the medical terms, not knowing the patient's language, interpreting incorrectly or guessing certain words, were just a few things, which the reader could read in previous journals. In a system review study from America, the authors showed that, a pregnant woman with limited English proficiency is at risk of receiving suboptimal care and experiencing negative outcomes during the antepartum, intrapartum, and postpartum periods. They suggested even that the use of medically trained interpreters and the provision of language concordant care, through workforce diversification and the creation of forms and educational materials in diverse languages, can improve patient safety, outcomes, and quality of care (39).

In an Australian study (40), more flexibility is requested from midwives who have the task of providing adequate information to women, that women are offered options, to give them confidence and support throughout the birth journey. By communicating this with the woman, trust is strengthened between the two parties. The continuous support has been shown to lead to fewer medical interventions and provide a more positive experience (41,42). Then cultural doulas were introduced into maternity care. Continuous support from a cultural interpreter doula leads to fewer medical interventions and less need for pain relief and increases the chance for a more positive birth experience (42). Most women expressed a feeling of not belonging and missing a female community. According to the authors, this shows that there is a need for maternity care to adapt interventions as maternity care has the task of supporting the pregnant woman. This is based on the psychological and social changes that occur during pregnancy (36–38,42). Cultural competence and a transcultural perspective are essential to counter structural discrimination and meet the unique needs of immigrant women. Additionally, education on transcultural care and interpreter use is crucial for healthcare personnel to provide effective support. Accordingly, the main goal for Swedish healthcare and the world's healthcare is to provide this kind of health protection.

Our study has some limitations. First, most selected studies in the results of our study are of qualitative nature. This can cause the writing and results of the upcoming study to be based on the informant's experiences and not so much on the objective picture of the issue and based on questions and answers at different kinds of widowhood. The second is that all the selected studies were written in English and none of the study's authors is a native English speaker. This can cause problems when interpreting the data and can also cause biased results.

In conclusion, despite advancements in Swedish maternity care, immigrant women remain a vulnerable group. Immigrant women's experiences of Swedish maternity care were marked by information gaps, ignorance, and disrespect, leading to mistrust and delayed help-seeking. Language barriers with midwives caused misunderstandings. A sense of belonging to Swedish society was crucial for a positive experience. The attitude of midwives significantly influences the care experience, with friendly treatment fostering trust, while poor treatment leads to mistrust and potential avoidance of seeking help. Further qualitative research, along with increased education in transcultural care and interpreter use, is necessary to improve maternity care for foreign women. Addressing these issues will help ensure that all women receive the support and understanding they need during pregnancy and childbirth.

## AUTHOR CONTRIBUTIONS

Conceptualization, S.S., M.K., L.S. and F.K.; Supervision, S.S., M.K. and F.K.; Validation, S.S., M.K., L.S. and F.K.; Formal Analysis, M.K., L.S. and F.K.; Software, M.K., L.S. and F.K.; Visualization, M.K., L.S. and F.K.; Data curation, L.S. and F.K.; Methodology, L.S.; Investigation, F.K. All authors have read and agreed to the published version of the manuscript.

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## TRANSPARENCY DECLARATION

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