Experiences of providing abortion care and contraceptive counselling to immigrant women in Sweden

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The 11th FIAPAC Conference, Ljubljana, 3-4 October 2014
Background

- About 15% of the Swedish population are foreign-born

- Universal access to health care services is a public health goal
  → one cornerstone, promote universal access to safe and secure sexuality and good reproductive health

- Immigrants from outside Europe report poor or very poor health in general, as compared to Swedish-born

- Increased risk of unintended pregnancy, induced abortion, and HIV/STDs among immigrants as compared to native-born women in the Netherlands

- Immigrant women in high-income countries in Europe have higher risk of abortion as compared to native-born women
Aim of this ongoing study

To explore health care providers experiences of abortion care and contraceptive counselling to immigrant women in Sweden.
Method

- Individual interviews with midwives and doctors in one clinic
- Audio-recorded and transcribed
- Thematic analysis
- Presenting preliminary findings
Theoretical framework

Patient-centered care, three dimensions:

1. **Holistic care**
   - Encompasses all domains of health (i.e. bio-physical, cognitive, emotional, social and spiritual) and consider all different needs.
   - Involves the assessment of patients’ conditions and the provision of interventions and services that target patients’ conditions

2. **Responsive care**
   - the individualization of care, goal to maintain consistency between the intervention or services to be delivered, and patients’ needs, values and preferences

3. **Collaborative care**
   - a partnership between the healthcare professional and the patient that should facilitate patients’ participation in making care-related decisions

(Sidani and Fox, 2014)
Preliminary findings

- Holistic
- Responsive
- Collaborative

- In general older
- Have a family
- Have had the children that they want
- Accompanying partner
- Asylum seekers
- Roma persons
- Young women hide contraceptives from parents
- Honour-based violence if sexually active/in a relationship
Preliminary findings

- Communication- interpreter
- Have poor general knowledge on bodily functions
- Less experience/knowledge about contraception
  - Withdrawal- common method
- Misconceptions about contraceptives
- Attitudes to abortion and contraception is affected by cultural values and norms and laws and regulations in home country
Preliminary findings

- Women not always decide themselves
- Partner crucial in decision-making regarding contraceptives
Major findings

- Knowledge on life situations and access to health care services
- Time for contraceptive counselling
- Deeper understanding of motivators for contraception acceptance
- Women with poor knowledge about contraceptives
- How are decisions made?
Conclusion

- Health care providers need to be aware of foreign-born women’s specific needs when providing contraceptive counselling.

- If male partners are more involved and informed about contraception, acceptance might increase among foreign-born women.

- More time for contraceptive counselling and repeated counselling sessions might increase the use of and adherence to contraceptives.

- More efforts on post-partum contraception might prevent unintended pregnancies, especially among foreign-born women.

- Interviews with foreign-born women planned.
Thank you

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