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EMPIRICAL STUDIES

Midwives' experiences of encountering immigrant women during labour and birth who do not master the host country's language. A lifeworld hermeneutic study

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Abstract

Background: Immigrant women are in a vulnerable position during labour and birth due to language barriers. Communication with women who do not master the host country's language is difficult for midwives, but there are few studies about midwives' experiences.

Aim: To explore Norwegian midwives' experiences of encountering immigrant women during labour and birth who do not master the native language.

Method: A hermeneutic lifeworld approach. Interviews with eight midwives working at specialist clinics and hospital maternity wards in Norway.

Results: The findings were interpreted based on four concepts in the theory "Birth territory: A theory for midwifery practice" by Fahy and Parrat presented in five themes: *language barriers can cause disharmony and prevent participation*, *language barriers can lead to midwifery domination and poorer care*, *midwives strive for harmony and to be a guardian*, *medicalisd birth due to language barriers*, and *disharmony can lead to crossing boundaries*. The main interpretation shows that it is *midwifery domination* and *disintegrative power* that are prominent. However, the midwives strived to use their *integrative power* and be guardians, but in doing so they encountered challenges.

Conclusion: Midwives need strategies for better communication with immigrant women involving the women and for avoiding a medicalised birth. To be able to meet immigrant women's needs and to establish a good relationship with them, challenges in maternity care need to be addressed. There are needs of care that focus on cultural aspects, leadership teams that support midwives, and both theoretical and organisational care models that support immigrant women.

KEYWORDS

birth, hermeneutics, immigrant women, maternity care, midwifery

The first authorship is shared between Amran Ahmed Abdulle and Natalia Borrego.

INTRODUCTION

Central to midwifery is to "develop a partnership with each individual woman" [1, p.1]. In the context of respectful relationships, cultural competence is important for strengthening women's capability during childbearing [2]. A safe and caring relationship with the midwives contributes to increased self-esteem for the immigrant women, who can thus manage more on their own, are calmer, have additional strength, and are better able to prepare for birth [3–6]. However, migrants and ethnic minority women are more likely to lack adequate information, report suboptimal communication with care staff caused by language barriers, be offered fewer opportunities to express preferences, and be less involved in decisions about their care compared to ethnic women according a review based on 22 studies from various countries [7]. Further, immigrant women with non-Western backgrounds have a greater risk of premature birth, episiotomy, operative vaginal birth, acute caesarean section, postpartum haemorrhage, low Apgar score, and low birth weight in the newborn compared to ethnic women [8–12].

A study from Switzerland about women, health professionals and cultural interpreters' experiences about communication barriers in maternity care shows that intercultural interpreting services and health care professionals' reflections on their transcultural communication are of importance for overcoming barriers [13]. Midwives' knowledge and self-perceived cultural competence were improved by a cultural competence training project carried out in three European countries (Greece, the Netherlands, and the UK) with differing contexts and workforce provision [14]. Studies from Norway and Sweden from 2012 show that midwives working in maternity care have difficulties, since the care is not organised to meet the needs of immigrant women, contributing to health care inequalities according to the midwives [15, 16]. A recent study from Sweden shows that most midwives rated that caring and communicating with non-speaking Swedish women during birth was difficult or very difficult, and that the most common resource was an adult relative [17].

The study presented here was conducted in Norway. According to Statics Norway, 38,600 people immigrated to Norway in 2021 [18] in a country with 5.4 million inhabitants. Everyone with legal residency in Norway has the right to equal health care services [19]. In Norway, midwives have an independent professional role during normal pregnancy, birth and postpartum [20]. However, equal access and deliver good health care services can be challenging when there are language barriers between the women and the midwives [21].

In summary, studies show that immigrant women are in a vulnerable position during labour and birth. Communication with women who do not master the host country's language is difficult for midwives, but few studies exist about midwives' experiences in meeting immigrant women during labour and birth. Therefore, the aim of this study was to explore Norwegian midwives' experiences of encountering immigrant women during labour and birth who do not master the native language.

METHODS

In this study, a lifeworld hermeneutic approach was used [22]. Lifeworld hermeneutics is based on the work of Husserl [23] and Gadamer [24] and provides a phenomenological foundation for the understanding of hermeneutics [22]. Lifeworld research attempts to describe everyday experiences in a systematic and methodical way [22]. Both phenomenology and lifeworld hermeneutics emphasise openness, and that conclusions are derived from the data rather than external structures. The scientific attitude of interpretation is concretised in the circular process of understanding, a process where people try to understand a phenomenon and being open and responsive to be able to see "otherness." This means having an open mind when interviewing and analysing data for research [22]. In lifeworld research, the focus is on the meaning implicit in the data, and it is important that the researcher is aware of the pitfalls in the process of interpretation to avoid merely seeing what is already understood [22, 24].

Setting and participants

In Norway, there are three levels in maternity care, namely specialist clinics, hospital maternity wards, and midwifery-led units. Two different levels, specialist clinics and hospital maternity wards, were chosen to cover a broader range of experiences. The midwives were recruited after information about the study was distributed by the head of the delivery ward at two hospitals where two of the authors (AAA and NB) practiced as midwifery students. Interested midwives also informed other midwives in line with Snowball sampling. The inclusion criteria were midwives who mastered Norwegian and had a minimum of 5 years of clinical practice as a midwife. The midwives received written information about the study, and if they were interested, they contacted the researcher for more information. If they wanted to participate, they signed informed consent forms. The midwives' ages ranged from 34 to 60 years, and they had 5–35 years of experience as midwives, as shown in Table 1.

TABLE 1 Participants.

Pseudonym	Work experience (years)
Sandra	5
Bente	8
Kine	25
Greta	35
Stine	8
Sol	5
Frida	10
Gry	10

TABLE 2 Interview guide.

What is your experience as a midwife in encounters with immigrant women?
Can you elaborate on your experiences from labour and birth with women who do not master the Norwegian language?
From your experience, what is the most challenging when encountering immigrant women who do not master the Norwegian language?
From your experience, which tools and knowledge are important to have as a midwife when encountering immigrant women who do not master the Norwegian language?

Data collection

The midwives were interviewed on one occasion, during September 2021–January 2022, and were asked four questions, as shown in Table 2. Each question was openly followed up by asking "Can you describe more about ...?" The length of the interviews varied from 23 to 40 min, average 30 min.

Data analysis

The data analysis was based on a lifeworld hermeneutics approach [22]. First, all interviews were transcribed and read several times to get a sense of the whole. The next step was to mark and identify "meaning units," which are descriptions that correspond to the aim of the study. In the next step, "meaning units" were clustered and named. Clusters are several "meaning units" that have similar meanings. Based on these clusters, a text was formulated describing the meaning of each cluster. This text is used as a document for the next step in the analysis but is not presented in the findings. In lifeworld hermeneutics, a theory, a concept, or a metaphor can be used for further analysis [22]. The use of a theory should not be chosen until the data suggest the need for it. When a theory is used, it is important to still be close to the original experience. The themes are then formulated and described in line with the theory used [22]. Throughout the process, the researcher goes from whole to part and back to whole in line with the hermeneutic circle [22]. In the analysis, this means going back to the interviews, "meaning units," and clusters, and themes several times before the results are presented. Finally, a main interpretation, that is a form of structure on a higher level than the earlier analysis, was presented [22].

In this study, "Birth territory: A theory for midwifery practice" by Fahy and Parrat was used for interpreting the findings [25]. The theory focuses on the birth room, called the "terrain," and the use of power within the birth room, which is referred to as "jurisdiction." Four concepts from "jurisdiction" have been used in the interpretation of the findings in this study: *integrative power*, *disintegrative power*, *midwifery guardianship* and *midwifery domination*. [25]

FINDINGS

The findings are presented with five themes and a main interpretation. The themes are as follows: *language barriers can cause disharmony and prevent participation*, *language barriers can lead to midwifery domination and poorer care*, *midwives strive for harmony and to be a guardian*, *medicalised birth due to language barriers*, and *disharmony can lead to crossing boundaries*.

Language barriers can cause disharmony and prevent participation

The language barrier affected midwives' communication and the ability to convey information to the women. Challenges related to language barriers could reduce the opportunities the women had to participate and to contribute to their own birth and what offerings the women could receive. Communicating without the opportunity to speak was particularly challenging for the midwives, and they often used body language without success.

> You can't convey the information in the best viable way; you can't help them in the best possible way.
>
> (Kine)

The language barrier created disharmony because it deprived immigrant women of their rights to participate, according to the midwives. The midwives were not able to

give the information the way they wanted, which from the midwives' experiences resulted in the immigrant women not being given the treatment to which they were entitled. The midwives said that all women giving birth have equal rights in labour and birth but described how the immigrant women were at risk of receiving different treatments.

> There is a risk that they will not get what they should have, even though everyone has equal rights and access to health care regardless of language barriers.
>
> (Bente)

The midwives described that some of the younger midwives were more prepared to meet immigrant women than the older generation of midwives. Births led by the older generation of midwives were described as more controlled and that the immigrant women were given few or no options due to language barriers.

> The woman is a bit at the mercy of who they meet inside the birth room. They will simply receive different maternity care.
>
> (Sandra)

Although an interpreter was a useful tool in many situations for better participation, it could also create disharmony during labour and birth. The use of interpreters varied among the midwives, and some of the midwives had never used interpreters during active labour. The use of an interpreter by phone was described as disruptive because the women would not be receptive to information. Acute situations were described as especially challenging because there was no opportunity to inform the women. Interpreters could, when appropriate, be an aid for the women's participation and choices. The midwives expressed that it is the midwife's job to inform the women sufficiently for participation. However, it was challenging in practice to reach harmony in the birth room.

> It is important to contact the interpreter if you have time and there is room for it. If the woman enters the hospital when in the latent phase, we have sufficient time to find an interpreter and explain what will happen.
>
> (Greta)

One important aspect that hindered harmony and participation was when the women became frightened. The midwives experienced that communication was challenging when trying to help the women with fear because the midwives were unable to convey information in such a way that the women felt safe.

> It is challenging when you realize they are scared. Then it is exceedingly difficult. During labour you are so inside yourself and you are in so much pain and if you also are scared then it can be difficult because you cannot have calm communication and talk about things. This is the biggest challenge, but it is important to stay calm.
>
> (Frida)

Language barriers can lead to midwifery domination and poorer care

Midwifery *domination* and poorer care meant that the view of labour and birth depends on the attitude of the midwife the women meet, which is not always good according to the midwives. The midwives described insecurity among their colleagues and sometimes they chose to take over the care of the immigrant women themselves because they considered the women to be safer in their hands than with other colleagues. There were situations that the younger midwives described where they felt they had to justify their actions so that the immigrant women did not feel they were receiving poorer care.

> You hear in the lunchroom that people are different. Also, in how we meet people... Some have a lot of understanding while others have little, and sometimes I think, 'Let me take these women because they will get the best care with me'. Because some people can, and others cannot. That is just how it is.
>
> (Sandra)

Midwifery domination could lead to the immigrant women being at the mercy of who they meet in the birth room because there are different attitudes and practices among the midwives. Midwifery domination was also about negative attitudes towards immigrant women due to language barriers and negative attitudes among their colleagues. These aspects were described as slightly racist by one midwife.

> I do not take part in the ideology of the elder generation of midwives who seem to have a slightly racist and different view of immigrant women.
>
> (Gry)

The midwives said that cooperation between the midwife and the woman was especially important for good care. They described challenges when the women have

expressed that they have understood something, but their actions show that they have not. This could, according to the midwives, lead to poorer care and dangerous situations.

Midwives strive for harmony and to be a guardian

The midwives described how they strived for harmony by working differently and in a better way to meet immigrant women, their cultures, and their different beliefs. Being a midwife was described as more than just a job by the midwives because for the women and their partners it was important for the rest of their lives. There was an aspiration to work as a guardian by meeting each woman individually, but many challenges hindered the midwives from being a guardian.

> You feel like you have a very important job. Even though it is challenging, you do the job for both the mother and the child.
>
> (Sol)

The midwives wished that the immigrant women had a safe support person with them when giving birth so that harmony could be created in the birth room. However, these women did not always have their partner or other supporters presents. According to the midwives, the women often sought the confirmation and security that they could find in the midwife. The midwives then became the guardian for the woman, which according to the midwives could give increased self-esteem.

> The immigrant women may find security and support in the midwife. As a midwife, I find it nice and natural. I get a good feeling.
>
> (Greta)

The midwives described an enormous respect in meeting immigrant women. Being a guardian for these women was about being able to respect different choices despite one's own values and attitudes. The midwives described it as challenging to meet the individual woman's needs and choices when they do not have a common language. Because it is fundamental in midwifery practice to meet each individual woman, it was frustrating to not be able to do that. Creating harmony requires the midwives to adapt to the individual woman's culture.

> One must create space for them to be allowed to do what feels natural and important to them.
>
> (Bente)

Medicalised birth due to language barriers

Regarding the risk of complications, the midwives described an increased risk when there were language barriers. Midwives described situations where healthy multipara ended up with interventions. Midwives concluded that dangerous outcomes, unnecessary interventions, and misunderstandings were caused by language barriers.

> The women express that they have understood without having really understood. That can potentially create dangerous situations. It is difficult and uncomfortable when they do not understand. It is challenging for the partnership.
>
> (Stine)

When women are considered at risk, midwives experienced that it could lead to more medicalised births with interventions. This creates a challenge for the partnership between the midwife and the woman during birth. The midwives expressed that they had to take over the births to a greater extent and they experienced this as a negative development in the birthing process because it could cause unnecessary stress for the women.

> Midwives take over the birth to a greater extent, which can create an adrenaline rush in the women. It can create fear and a feeling of not feeling safe, which can result in too little oxytocin. They can get bad contractions that can result in a prolonged process that requires instrumental births.
>
> (Gry)

The midwives described it as a challenge when no plan had been made in advance for these women, and it was necessary to clarify what expectations there were for the woman and the midwife. The midwives described the importance of having patience and that it was important to make time so that the women could feel comfortable and be present. Without patience, the midwife was not able to take care of the women, which could contribute to unnecessary interventions and a medicalised birth.

Disharmony can lead to crossing boundaries

Although the midwives felt it was rewarding meeting these women, it was described as a psychological strain for the midwives and could lead them to crossing

boundaries. The midwives described feelings of despair, mental exhaustion, powerlessness, and helplessness, and these were factors that could contribute to disharmony during the birth and could lead to midwives crossing boundaries.

> You are afraid of crossing boundaries because the women have no control. You must take over the steering wheel, and at the same time you must not 'push' too hard. It is a difficult balance. It does something to you as a person when you feel it.
>
> (Frida)

Disharmony and crossing boundaries affected midwives' work because they were not able to work as they wanted to. The midwives felt unsuccessful in providing security for the women. The midwives described situations where they felt they were crossing boundaries because both the woman and the midwife had lost control. There were two situations where the midwives in particular risked crossing boundaries, namely immigrant women who had undergone female genital mutilation and women who were alone during the birth. It was especially difficult in encounters with women who were exposed to genital mutilation because most of them wanted to be re-infibulated after birth. The midwives described a feeling of abuse against this group of women and felt it weighed heavily on their conscience when they had to tell the women it is illegal to re-infibulate. The midwives agreed that strength is required to be able to stand in these births.

> It is a shock for them when we start opening without talking about it... without talking tools...it feels like an abuse. Because they do not want to be opened but it must be done. At least when we cannot re-infibulate again either, it feels like we are crossing all boundaries... That is a lot to handle.
>
> (Stine)

The midwives described that due to the language barrier, their communication skills were affected, and a lot of energy was spent on explaining things, which created disharmony. What usually happens according to the midwives is that they find themselves in a situation where they act without the woman's consent. These situations felt desperate, but it helped their conscience when the woman was grateful afterwards. The midwives wished this topic were more talked about so they would not have to carry the mental strain alone and would not cross the women's or their own boundaries.

Main interpretation

The main interpretation from this study shows that *midwifery domination* and *disintegrative power* were prominent. The language barrier prevented immigrant women from being involved in the birth room, and the balance of power could be disturbed by interpreters, midwives, and the women themselves. Lack of trust could lead to disharmony and fear, which could negatively affect the birth process through further complications. When disharmony occurred in the birth room, the births were taken over and controlled. This caused the immigrant women to receive few or no options. The use of *disintegrative* power could lead to a medicalised birth with unnecessary interventions. The use of *disintegrative* power and *midwifery domination* in the birth room could also lead to border crossing and disharmony. On the other hand, if the midwife should be a guardian and use *integrative power*, changes were necessary. This could be achieved by the midwife being able to see the individual and not focusing on language barriers, cultural differences, and different beliefs primarily without considering the individual women's thoughts, values, and attitudes. The midwife could then use *integrative* power and take *guardianship* so that the woman could have an undisturbed birth. Women also need to prepare for and use their power during birth.

DISCUSSION AND CLINICAL IMPLICATIONS

The findings from this study reveal that language barriers cause *midwifery domination* and *disintegrative power,* which hindered the midwives from using their integrative power and being guardians for the women. Thereby, a supportive relationship that is central for both midwives [1] and women [3–6] is hindered.

To prevent *disintegrative power* and create harmony a professional interpreter can be a solution according to our study. However, the use of an interpreter varied among the midwives, where some of them had never used an interpreter during labour. The importance of using an interpreter during labour is confirmed by the Swedish study about language barriers during birth. This study shows that the quality of the professional interpreters' work was reported as good or very good by most of the midwives, but also that "increased availability" was the most common suggestion for improving the interpreter service [17]. The interpreters' important role is also confirmed by the study from Switzerland showing that a primary step in dismantling language barriers is to guarantee intercultural interpreting services [13]. However, using interpreters too late or in acute situations can lead to disharmony in the

birth room according to our study. By using "Birth territory" when interpreting the findings of our study, a deeper understanding of the complex relationship between the midwife, the woman, and other persons involved in the birth room, such as interpreters, can be described. The importance of using an interpreter is also confirmed by Wikberg's theory on "intercultural caring in maternity care" [26], which proposes that women who have a professional interpreter during labour feel that the midwives have an interest in their culture and values. Wikberg's theory focusing on the caring relationship between the midwife and the woman that involves four dimensions, universal, cultural, contextual, and unique caring, can be used for understanding communication with immigrant woman who do not master the native language holistically.

According to our study, if the midwife could use *integrative* power and take *guardianship*, a mutual understanding between the immigrant women and the midwives is developed that creates safety and harmony in the birthing room. These findings are supported by studies showing that when women feel safe and cared for they become calmer and their self-esteem increases, which leads to the women being able to manage more on their own, gain strength, and be able to prepare for the birth [4–6, 27]. According to Wikberg's theory, childbearing refers to pregnancy, birth, and the postnatal period. However, in most settings, midwives encounter women for the first time during the birth. Could one solution related to language barriers be to adopt a theory such as Wikberg's [26] for the whole childbearing period. Another solution is to offer continuity of care for these women. A care model that is related to both improved birth experiences and birth outcomes for women [28] and improved work situations for midwives [29].

The findings from our study show that when language barriers were present it was difficult for midwives to meet each woman's needs individually. This is supported by Wikberg's theory [26] that emphasises that even though the women receive information, they may not understand everything. Our theme *Midwives strive for harmony and to be a guardian* shows that even if the midwives desired this there were still challenges that often led to disharmony in the birth room. Disharmony led the midwives to take over control, and by doing so the midwives were aware that the immigrant women were left with no opportunities to impact their births. Johnsen et al. [30] showed that institutional structures affected the relationship between midwives and immigrant women. Therefore, striving for harmony must be related to organisational factors in the birth institutions, which have been asked for in previous research [15, 16].

One aspect of *midwifery domination* according to our study is negative attitudes among midwives, which were even described as slightly racist by one midwife. However, midwives in our study described these attitudes among colleagues and not among themselves. Negative attitudes are confirmed by Wikberg's theory [26] explaining that these attitudes toward immigrant women creates vulnerability because the women experienced racism or discrimination. This findings is confirmed by a study from Sweden [12] reported that when immigrant women felt treated as strangers, ignored, or rejected in maternity care the women felt devalued and discriminated against. However, when the women felt "taken seriously" they gained a confident and caring relationship with the midwife. By focusing on cultural communication, as in the project from three European countries, communication can be improved [14]. However, more research is needed about strategies for improved communication.

One way of handling poorer care and *midwifery domination* according to our study was to keep the immigrant women safe from the negative environment by the midwives taking over the care for the immigrant women themselves because they considered the women safer in their hands than with some of the colleagues. Previous research from Norway and Sweden confirms that midwives working in maternity care have difficulties since the care is not organised to meet the needs of immigrant women, which contributes to health care inequalities according to the midwives [15, 16]. The Norwegian study concludes that it is necessary to organise leadership and adopt flexible models that support migrant women's health [15]. The Swedish study suggests that more research is needed about the potential of educating health care staff on the provision of transcultural health care [16]. These studies are from 2012, but the problem seems to still exist according to our study. Further, there is a need for midwives' to reflect on their transcultural communication as described in the study from Switzerland [13].

According to our findings, the theme *medicalised birth due to language barriers* shows that immigrant women are at risk of receiving a medicalised birth with poorer birth outcomes. The language barrier challenges the midwife's role, and the lack of *integrative power* and *midwifery guardianship* results in immigrant women often receiving a medicalised birth with unnecessary interventions according to our study. This is supported by studies [8–12] that found that immigrant women have a higher risk for premature pregnancy, episiotomy, operative vaginal delivery, acute caesarean section, postpartum haemorrhage, low Apgar score, and low birth weight in the newborn compared to ethnic women. Our findings also revealed that when the births become more medicalised, the midwives experience suffering and powerlessness that lead them to take over control of the birth room. By taking over the birth, *disintegrative power* and *midwifery domination*

are present, and the midwives cannot create a partnership with the immigrant woman [1].

The findings show that striving to create harmony also helps the midwives to have a greater understanding of each woman's individual needs and to assess them so that the women can experience an undisturbed birth by using the power in the birth room. Robertson [27] found that when immigrant women's capabilities and strengths are not acknowledged, this leads to immigrant women feeling disappointed and discriminated against. Midwives have an immense role in supporting women during labour and birth and should strive to work in a way that leads to good birth outcomes for the immigrant women [1, 25, 26]. Therefore, strategies for supporting these women need to be developed. However, when language barriers exist a multicultural doula [17, 31] who speaks the immigrant woman's language could be one solution. Lundgren [31] found that by having a multicultural doula during birth, the women could experience a stronger capacity to give birth. More research is needed on how to support women with language barriers as well as midwives working in these situations.

Methodological considerations

This study involved qualitative research with a lifeworld hermeneutic approach, which attempts to describe everyday experiences in a systematic and methodical way [22]. In this study, a lifeworld hermeneutic approach was considered a suitable method. A limitation as well as a strength in this study could be that the midwives were recruited from a private network. The strength is that the midwives had an interest in the theme and willingly decided to take part. However, a limitation might be that this fact could affect the variations related to the research question. Generalisability in qualitative research is linked to the results being contextual. This means that the results must be understood in the context in which it was conducted, which in this case is a high-income country, and the midwives primarily worked at specialist clinics and maternity hospitals wards. When the results are to be transferred to other contexts, they must be interpreted in relation to the new context [22].

CONCLUSION

The findings from this study show that when midwives encounter immigrant women during labour and birth who do not master the Norwegian language, *disintegrative power* and *midwifery domination* are prominent. Language barriers affect midwives' ability to communicate and convey information, which leads to disharmony in the birth room. *Disintegrative power* and *midwifery domination* could lead to a more medicalised birth with unnecessary interventions. However, when the midwives were able to use *integrative power* and *midwifery guardianship*, harmony could be established, and the midwives could fulfil their role as a *guardian*. By being a *guardian*, the midwives could help the immigrant women use their own power in the birth room and be strengthened to have an undisturbed birth. To be able to meet immigrant women's needs and to establish a good relationship with them, numerous challenges in maternity care need to be addressed. There are needs of care that focus on cultural aspects, leadership teams that support midwives, and both theoretical and organisational care models that support immigrant women. Research is needed that explore strategies and guidelines on how to support these women. Also, further studies exploring the women's experiences and their role and how to use their own power during birth are needed.

AUTHOR CONTRIBUTIONS

AAA conducted the interviews, data-analysis, and writing the original draft. NB conducted the interviews, data-analysis, and writing the original draft. IL contributed to supervising the data-analysis, reviewing, and editing the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Ethical approval was obtained, and permission to undertake the study was granted by the Norwegian Centre for Research Data (NSD).

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