Migrant women’s experiences of an individual language-assisted information and support visit to the labor ward before giving birth – A qualitative study from Sweden

Elin Ternström a,b, Rhonda Small a,c, Helena Lindgren a,d,*

a Department of Women’s and Children’s Health, Karolinska Institutet, Stockholm, Sweden
b School of Health and Welfare, Dalarna University, Falun, Sweden
c Judith Lumley Centre, La Trobe University, Melbourne, Victoria, Australia
d Sophiahemmet University, Stockholm, Sweden

ABSTRACT

Background: Migrant women are less likely to receive an individualized maternal care where they feel safe, informed and supported but few measures have been undertaken to meet their needs. In Södertälje municipality in Sweden, community-based antenatal care midwives identify migrant women and offer them and their partners language-assisted information and support through an individual two-hour-visit to the labor ward. The aim of the present study was to explore migrant women’s experiences of antenatal care including receiving language-assisted information and support during pregnancy through a two-hour INFOR-visit to the labor ward. Methods: Semi-structured interviews were conducted with 10 non-Swedish speaking migrant women, using an interpreter. Interview analysis was conducted using reflexive thematic analysis.

Results: The individualized support, including thorough information given with language support available, sufficient time for questions and discussion, and a caring approach – did appear to inform and reassure the women. Overall, they felt that they were seen and treated as individuals during both pregnancy and birth and that their specific needs were listened to and met by the health care providers. Having professional interpreters was seen as essential for receiving the right information, something achieved at the individual visit.

Conclusions: The findings from this study provide evidence that a two-hour-visit to the labor ward during pregnancy has potential to empower migrant women during pregnancy and birth and to improve their experiences of maternity care. The two-hour-visit is a relatively simple intervention with the potential of not only improving migrant women’s experiences of pregnancy and birth, but also their medical outcomes.

Background

Forced displacement has now reached the record high number of 70.8 million people [1]. In Sweden, 20 % of the population is born abroad [2] and at least 28 % of women giving birth in Sweden are foreign born [3].

There is strong evidence that pregnancy and birth outcomes differ between foreign born women and women born in the host country. Looking at suboptimal outcomes for migrant populations in Canada and Western Europe, the disproportionately high maternal mortality rate and risk of serious maternal morbidity, especially among refugees and migrants from Sub-Saharan Africa, are central [4–7].

According to a systematic review comparing migrant women with non-migrant women, migrant women are less likely to receive individualized maternal care where they feel safe, informed and supported. They also feel less positive about the care they receive [8]. Thus, pregnant women who find it hard to read and speak the national language may not be fully benefiting from mainstream health care services. The reasons behind this likely include lack of familiarity with the health care system, communication difficulties or inadequacies in care provision [7–11].

Yet, despite the higher risk of adverse pregnancy outcomes and known inequities in health care, few measures have been undertaken to better meet migrant women’s specific needs in relation to maternal health care [8,11]. A systematic scoping review from 2020 found only 17 studies from the last ten years focusing on models of care in
pregnancy or postpartum for migrant women living in high-income countries [12]. In Sweden, community-based bilingual doulas as well as group-antenatal care have been tested for groups of migrant women [13,14], but no intervention has employed an individualised approach to specifically address the needs of all migrant women in relation to pregnancy and childbirth. Factors to be targeted to improve individual experiences of care and pregnancy outcomes include: breaking down language barriers and bridging cultural gaps, increasing familiarity with and enhancing understanding of how maternity care is provided, and empowering women’s sense of safety and confidence in giving birth [15,16].

This study is part of a research project evaluating the INFOR-visits for non-Swedish speaking women. The aim of the present study was to explore migrant women’s experiences of antenatal care including receiving language-assisted information and support during pregnancy through a two-hour INFOR-visit to the labor ward.

Methods

Design

This was a qualitative study based on interviews with 10 non-Swedish speaking migrant women. Semi-structured interviews were conducted using an interpreter. Reflexive thematic analysis (reflexive TA) was used to make sense of the findings [17,18]. Reflexive TA was chosen as it is a flexible and appropriate method when seeking to understand and interpret participant experiences, while requiring us to reflect upon our own assumptions and values as researchers wishing to improve care for migrant women [19].

Collecting and presenting migrant women’s perspectives in a meaningful way can be challenging, the list of strategies proposed by Merry et al [20] “Strategies to improve qualitative research interviews with migrant women” was used in preparing and undertaking the interviews described here.

Setting

In standard Swedish antenatal care, pregnant women are taken care of by community-based midwives, and women who do not speak Swedish have a legal right to interpretation during these visits, most often delivered by telephone. All expectant parents should be offered parental education, however, noone is invited to the labor ward before birth. Continuity of midwifery care is not provided routinely, given that antenatal care takes place in the community and labor and birth care occurs with different midwives in hospitals; nor is homebirth offered as a standard option for care. In Södertälje municipality, nearly half of the inhabitants are foreign born [21], and community-based bilingual doulas are accessible to some migrant women, similar to certain areas in Sweden.

Intervention

The INFOR-project commenced in 2016 in at Södertäljehospital in Sweden with the aim of addressing some of the shortcomings in maternity care provision for migrant women. The design of the intervention was developed in collaboration between the researchers, midwives in antenatal care and at the hospital, migrant women in the community and social workers. INFOR only exists at Södertälje hospital and offers a two-hour language-assisted, individual birth preparation visit to the labor ward for non-Swedish speaking pregnant women unfamiliar with the maternity care system in Sweden. INFOR is a Swedish word for “before” or “ahead of”, here used to signify “before the birth”.

Community-based antenatal care midwives, providing standard care for all women, specifically identify migrant women and offer them and their partners (or other relative) extra support through an individual visit to the labor ward. At the hospital they have an individual consultation with a labor ward midwife or nurse assistant (their INFOR-guide) and a guided tour through the labor and postpartum ward. A professional interpreter (by phone or face-to-face) is used and the visit usually lasts for about two hours. A follow-up consultation can be provided if there are special needs identified during the consultation. The INFOR-guides experiences of INFOR have been published elsewhere [22].

Recruitment and data collection

The participants in this study were selected by purposive sampling. The inclusion criteria were having participated in INFOR and subsequently giving birth. From mid-November 2018 until February 2019 all women attending INFOR were informed about the study, had the chance to ask questions and were asked about participation by the allocated guide. The guide responsible for the visit was also responsible for informing them about the study through an interpreter. In total, 13 out of 15 women gave their consent to participate. The written informed consent documents were collected by the first author (ET), who then phoned the women two to three months postpartum. All thirteen women were telephoned, two of them did not answer and one withdrew her consent to participate, which left 10 women in the final sample. Ethical approval for the study was granted from the Research Ethics committee in Stockholm, Sweden (Dnr: 2017/1312-31/5).

Before conducting the interviews an interview guide was developed [20] by ET and then edited by HL and RS, who both have extensive experience in both qualitative methods and research with migrant women. The questions in the interview guide were piloted once, which resulted in shortening the guide, specifically by reducing less salient questions about postpartum care. All participants were informed that the focus of the interview was experiences of care during pregnancy and childbirth and that all information would be treated confidentially.

The interviews were conducted by ET between February and August 2019, ET has a background in midwifery with experience in interviewing women postpartum. The women themselves chose the time for the interviews. The interviews were mostly conducted by phone in Swedish and interpreted for the woman by the interpreter; with the exception of the interviews with two English-speaking women which were conducted by phone with the first author only. The study used the same interpreter service as the antenatal care service, making it possible for the participants to request an interpreter they had met before. The interviews conducted with an interpreter were carried out in a three-way phone call between the interviewer, the informant and the interpreter. When possible, the interview guide was sent to the interpreter before the interview took place, and this occurred in half of the interviews.

All interviews started with an open-ended question about how the participant was doing right now and continued with a few sociodemographic questions. Thereafter the participants were asked about their experiences of care during pregnancy and childbirth using open ended questions, and with specific questions about the labor ward visit. The interviews were audio-recorded and each interview lasted between 40 and 80 min. After each interview, the interpreter was asked for feedback: “What did you think of the interview questions and how the woman answered them?” and “Were there specific factors of language or culture that may have affected the answers to questions asked?” [20]. Their answers were used as an extra check on the acceptability and relevance of the questions for women and the general flow of the interviews to ascertain that the participants had the chance to share what they wanted to share. Depending on whether the interviews were conducted in Swedish with an interpreter or in English, the interpreted Swedish or English responses were transcribed verbatim from the recordings by the first author. Translation from Swedish to English in quotations for this paper was undertaken by ET.
Data analysis

Reflexive thematic analysis, as described by Braun and Clark was used to analyze the data [17,18]. For the first author, familiarization with the data began already during the interviews and continued with transcription while reading them through several times. During this phase, particularly interesting findings and quotes were written down. Thereafter, initial codes, with surrounding data to stay close to the context, were generated manually and written down in connection to each transcript. Most of the coding was semantic, trying to capture the participants’ interpretation of their experiences. This was then done through the entire data set. The first author performed the initial coding, which was then read through by the last author. The codes were thereafter pasted to a Word document and organised into potential themes. Potential sub-themes were created by grouping codes that had commonalities. Relationships between the codes and themes and the different levels of themes were discussed by the first and last author, which led to refinements and a potential overarching theme. The codes in each theme were then reviewed again to see that they did fit in each theme, and during this phase some codes were discarded and some sub-themes were combined or moved to a different theme. The themes’ relation to the entire data set was then discussed by the authors and themes were named.

Results

The women participating in this study were non-Swedish speaking and had limited familiarity with the Swedish healthcare system when they became pregnant. All had participated in the INFOR-visit during pregnancy. As seen in Table 1, the participants originated from nine different countries, were 19–34 years old and had lived in Sweden between 18 months and 5 years. Though two of the participants had given birth before, none had given birth in Sweden before taking part in the INFOR-visit.

Four main themes, with sub-themes were constructed: “Facing the unknown, but with help available”, “Achieving communication on everyone’s terms”, “Building relationships with the health care staff” and “The way forward - feeling safe for the future”. These main themes formed the overarching theme “Being seen and cared for as an individual in pregnancy and birth”, see Fig. 1.

Facing the unknown, but with help available

Facing the unknown was a prevalent theme in the interviews. It ranged from the first encounter with Sweden and the Swedish health care system after becoming pregnant, to arriving at the labor ward. Navigating the Swedish health care system after finding out about the pregnancy was not straightforward, even for highly educated women. Usually, the participants or their partners knew about community health care centers and first sought care there.

“It was really surprising for us because I thought that any health care center would be ok (...), I went to the health care center and I wanted to do my pregnancy test, maybe I’m pregnant. Then they said that “Oh so you have to go to the ANC [antenatal care clinic], there is no ANC here”, I was a bit surprised that I had to go there. Then I went to the ANC and found out that they have fixed times and I can’t just go there, I have to get an appointment. And then I went another day to get an appointment and that day I got an appointment for next week.” (Participant no 4, from Bangladesh)

During pregnancy, the participants recognized that there were differences regarding giving birth in Sweden compared to their home country. The differences were challenging on the one hand; a lot was unknown which made them feel worried. At the same time, they had received some information, mostly from relatives, reassuring them that maternity care in Sweden was good, that one would feel safe and be well taken care of. This, together with support from health care staff, was very helpful and made the participants feel calm and positive about giving birth in Sweden.

“All my friends told me that there is a huge difference between Romania and Sweden and giving birth in Sweden is something like “WOW”, and therefore I felt very safe.” (Participant no 7, from Romania)

Both the participants and their relatives found the INFOR-visit valuable in preparing for birth. It was described as interesting, comforting and useful, especially as the participants and their relatives received detailed information about giving birth and had the chance to see the hospital and labor ward with their own eyes. As antenatal care occurs mostly in community-based clinics in Sweden, women mostly do not visit the hospital where they will give birth before they are in labor. After the visit, the women felt less stressed and worried about giving birth and more confident that they were actually able to give birth.

“I had a lot of worries that I got rid of after I met them, because everything was unknown for me. But after all these explanations my worries went down. I was very scared that I cannot give birth to the baby. I was obsessed with that, but after I met them, it became clear.” (Participant no 5, from Iraq)

Arriving at the labor ward was in general described as a time when women felt nervous and in pain. However, when the participants saw and sensed that the staff were there for them, they felt that they would get the help they needed and so felt more relaxed.

“I was in a lot of pain, I thought I was going to die. I have seen many people who died in Somalia due to pregnancy so I was a little scared. It became much easier when I saw the doctors, midwives and everyone who was there, so I was relieved... I felt I would receive help from them.” (Participant no 9, from Somalia)

Achieving communication on everyone’s terms

Communicating on the patients’, care givers’, relatives’ and

<table>
<thead>
<tr>
<th>Informant</th>
<th>Country of birth</th>
<th>Years in Sweden</th>
<th>Previous births</th>
<th>Highest level of education</th>
<th>Occupation before giving birth</th>
<th>Migration status</th>
</tr>
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<tr>
<td>1</td>
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<td>1.5 years</td>
<td>0</td>
<td>University</td>
<td>Studying Swedish</td>
<td>Asylum-seeker</td>
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<tr>
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<td>Pakistan</td>
<td>1 year</td>
<td>3</td>
<td>Primary school</td>
<td>Home duties</td>
<td>Permanent resident</td>
</tr>
<tr>
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<td>3 years</td>
<td>0</td>
<td>University</td>
<td>Preschool teacher</td>
<td>Permanent resident</td>
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<tr>
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<td>1 year</td>
<td>0</td>
<td>University</td>
<td>Home duties</td>
<td>Foreign student</td>
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<tr>
<td>5</td>
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<td>1.5 years</td>
<td>0</td>
<td>University</td>
<td>Studying Swedish</td>
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<td>6</td>
<td>Syria</td>
<td>1 year</td>
<td>0</td>
<td>University</td>
<td>Studying Swedish</td>
<td>Temporary resident</td>
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<tr>
<td>7</td>
<td>Romania</td>
<td>5 years</td>
<td>0</td>
<td>High school</td>
<td>Home duties</td>
<td>Permanent resident</td>
</tr>
<tr>
<td>8</td>
<td>Syria</td>
<td>5 years</td>
<td>2</td>
<td>Primary school</td>
<td>Studying Swedish</td>
<td>Permanent resident</td>
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<tr>
<td>9</td>
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<td>3 years</td>
<td>0</td>
<td>High school</td>
<td>Studying Swedish</td>
<td>Permanent resident</td>
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<tr>
<td>10</td>
<td>Georgia</td>
<td>2.5 years</td>
<td>0</td>
<td>High school</td>
<td>Studying Swedish</td>
<td>Temporary resident</td>
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interpreters’ terms was considered important, but at the same time difficult. Most participants had access to and had positive experiences with a professional interpreter during their antenatal care visits and the INFOR-visit. “It [the interpretation] worked well, I’m very happy about that. I’ve almost always had the same interpreter.” (Participant no 10, from Georgia)

However, some participants chose not to involve an interpreter as they wanted to manage the communication themselves. None of the participants had access to a professional interpreter during birth, which was considered as challenging and an area for improvement. “It would have been better to have an interpreter (...) hopefully the interpreter would interpret everything that is said, interpret correctly and exactly as we speak…” (Participant no 1, from Macedonia)

The participants had all had relatives interpreting for them at some point during pregnancy or birth. Some felt that it worked out fine, while others found it unsatisfactory. Those who were positive felt that it was easier as they already knew each other, so the interpreting relative provided a safety net for the women. Those who were less positive felt that accuracy was the most important thing, which could not always be achieved when a relative interpreted for them. Participants also mentioned that they had communicated with health care staff without using any words. Attentive staff in combination with the use of gestures and non-verbal communication was considered at times to work well.

**Building relationships with the health care staff**

Despite the participants’ different backgrounds, the importance of feeling cared for by the staff was a recurrent theme in the interviews. To be treated individually, on one’s own terms, led to trust in the staff, not only the ones they actually met, but also the rest of the staff in the same health care facilities. This description was also characteristic for the ANC-midwives, who were greatly appreciated by the participants. They described the ANC-midwife as someone who cared more for them than themselves, was available, encouraging, helpful and considerate and took the time needed to inform and explain things carefully. This made the participants feel understood as individuals with their own needs and challenges.

“When I met the midwife, from day one, I felt calmer. She said I could come by and call at any time and I got recommendations on what to do. For example, (...) if I needed advice or anything, then I could always call and get help from her, always.” (Participant no 10, from Georgia)

Similar to the descriptions of the ANC-midwives, the INFOR-guides were viewed as helping women in an individual way and took the time to explain things in detail about care for the birth. The participants learned a lot from the guides and it made them feel seen and cared for. Furthermore, the participants explained that getting to know staff who actually work in the labor ward where one intends to give birth, reassured them that they would be well cared for also during birth. “I really liked that she took into account what I wanted, like that she understood that I was really stressed so she explained to me that I could have help with acupuncture, that I could have like a bath and that if someone was speaking French on the day I gave birth, they would be with me. A lot of stuff like that, that everything would be here to help me.” (Participant no 3, from France).

The participants were also very positive about the support given by staff during labor and birth. They described the staff asking questions, listening to their answers and giving advice. Some felt that they had behaved in a bad way during birth (e.g. screaming at the staff, crying, using bad language). Despite that, they were treated with respect and...
got support from caregivers which was a surprising and positive experience. Most participants felt they had all the information they needed while giving birth, though some did express a desire for even more support and information.

**The way forward - feeling safe for the future**

All participants said that they would recommend the INFOR-visit to their peers, as they were very pleased with the outcome of the visit.

“…these meetings mentally and psychologically they, anyone can become stronger by having this meeting, because everyone, when it’s your first baby, everyone fears what will happen. And if they [pregnant women] are actually alone here, everyone is alone (…) when they move from their country, I would definitely recommend this meeting if possible.” (Participant no 4, from Bangladesh)

The births were described as natural, positive and as a good experience, the only exception was the memory of the pain during birth. Some of the participants had also met their INFOR-guide during birth or postpartum. This was very much appreciated and other participants stressed that a follow-up meeting after birth would have been valuable.

Women were happy about the thought of giving birth again, preferably at the same hospital; and this was true even among those not planning further children. To give birth again was also explained as an opportunity to develop even more confidence in their capacity to give birth.

“I can only say that everything felt good from the beginning to the end. I have told my mother and sister that it is great to give birth here in this country.” (Participant no 2, from Pakistan)

The overarching theme, “Being seen and cared for as an individual in pregnancy and birth”, is reflected from different angles in the main themes. The women’s experiences highlight the importance of feeling acknowledged and understood by healthcare staff. This includes being treated on their own terms, receiving individualized care, and having their needs and challenges recognized. The presence of attentive and supportive ANC-midwives and INFOR-guides, who took the time to provide detailed information and explanations made the women feel seen and cared for. The support received during labor and birth, along with respectful treatment despite moments of distress, further emphasized the theme of individualized care. The positive experiences and desire to recommend the INFOR-visit to others indicate a sense of being valued and supported throughout the pregnancy and childbirth. Overall, the participants’ accounts convey the significance of personalized care and attention in fostering a positive birth experience and building confidence in their own abilities.

**Discussion**

The individualized support provided by the INFOR-guides – including thorough information given with language support available, sufficient time for questions and discussion, and a caring approach – did appear to empower the participants. Overall, the participants felt that they were seen and treated as individuals during both pregnancy and birth and that their specific needs were listened to and met by the healthcare providers. Having professional interpreters was seen as essential for receiving the right information, something achieved at the INFOR-visit. Lack of access to interpreting support, especially during birth itself, was common however, identifying a remaining area for improvement.

Receiving good information and being treated as an individual is a finding consistent with a systematic review of studies by Balaam et al [23] which found that individualized high quality information and knowledge made migrant women feel confident and in control. Appointments with enough time, having the opportunity to ask questions and obtain advice and information when needed was highly valued by the participants in the present study, which probably contributed to their positive experiences of care. These findings are also consistent with other studies of migrant women’s experiences of their maternity care [24–26]. These desires are not exclusive to migrant women [27], but they appear more for difficult for maternity services to fulfil for this group [15,27].

The participants had mostly positive experiences of care during both pregnancy and birth, and it appears from women’s descriptions that the INFOR-visit had a clear impact on these experiences. A systematic meta-ethnographic review of Canadian qualitative studies of immigrant women’s experiences of maternity care, identified seven key concepts as important for positive experiences [28]. Among these: support from staff, the organization of maternity care (allowing more time for consultations), increasing knowledge about maternity care and understanding different expectations between staff and women are all areas that INFOR has been developed to address to improve care for migrant women. In line with this, Small et al [29] reported that caregivers who experienced as kind and respectful, and involvement in decision making were related to more positive experiences of care during birth. To meet staff who work in the labor ward before women arrive in labor and to receive detailed information about giving birth on site, made the participants in the present study feel reassured that they would be well taken care of during birth and seems to have made them more likely to feel involved during the birth itself.

It is well-known that continuity of care during pregnancy and birth increases satisfaction with care [30] and such care would be beneficial for all pregnant women in Sweden and for migrant women in particular. Even though meeting a midwife or an assistant nurse once in the hospital where one intends to give birth is not the same as continuity of care, the trust built up with one member of the staff may be transferred to others in the same team [31].

Participants in this study wanted professional interpreters during pregnancy and birth, yet this was in fact uncommon during birth. Earlier research has demonstrated that a shared language is central in interactions in multietnic obstetric care settings [32] and use of professional interpreters has been associated with higher satisfaction, better communication and improved clinical care [33]. The absence of shared language, inadequate interpreting services and using relatives as interpreters continue to be common issues in maternity care [22], leading to miscommunication, decisions being made without the prospective parents’ full understanding and using relatives as interpreters [22,34].

**Strengths and limitations**

This study has a number of strengths, but also some limitations. As the INFOR-visits only exist at one hospital in Sweden, the study sample was necessarily limited to that hospital. However, the thorough descriptions of the research context, data collection and data analysis should facilitate transferability and increase trustworthiness [18]. The participants came from a range of different countries and spoke a range of languages, varied in age and also had quite diverse educational backgrounds, all of which should have captured potential variations in the women’s experiences. Using an interpreter to assist with the conduct of the interviews was unavoidable. To enhance interview quality and rapport, the participants were asked if they had an interpreter they preferred. If so, that interpreter was contacted to interpret the interview. Furthermore, when possible, the interview guide was sent to the interpreters beforehand. Telephone interviews were chosen to provide flexibility for women about the time and place for the interviews. Though telephone interviews result in the loss of nonverbal data, they may also allow participants to feel more relaxed in revealing sensitive information [35], which is probably beneficial when sharing the personal experiences like those in this study. To enhance credibility, the interpreters, following the guidance of Merry et al. [20], were specifically asked to, for example, assess the participants’ understanding of the interview questions. While most interpreters had no additional comments, a few emphasized their confidence in the participants feeling...
The findings from this study provide evidence that a two-hour INFOR-visit to the labor ward during pregnancy has the potential to inform and reassure migrant women during pregnancy and birth and to improve their experiences of maternity care. Despite the relatively short time spent at the ward, women judged the visit important for their sense of familiarity with the care they would receive at birth and for the chance it offered to meet, get to know and trust a staff member working in the labor ward. The visit also added positively to women’s experience of being treated as individuals and on their own terms. The positive potential of this relatively simple intervention for migrant women warrants replication in more maternity settings so that it can be robustly evaluated. The importance of greater access to professional interpreters was emphasized by the participants, and this should be seen as an additional area for improvement, especially during labor and birth.

Ethics approval and consent to participate

Ethical approval for the study was granted from the Research Ethics committee in Stockholm, Sweden (Dnr: 2017/1312-31/5). The study was performed in accordance with the Declaration of Helsinki and all methods were carried out in accordance with relevant guidelines and regulations. Informed consent for participation in the study was obtained from all participants in the study after they had been informed in their chosen language on the purpose of the study, risk and benefits, anonymity, confidentiality and the right to discontinue participation at any moment.

Consent for publication

The participants gave verbal consent for the findings of the study to be published.

Availability of data and materials

The data supporting the findings presented in this paper are kept in an anonymous file, at the archives of Karolinska Institutet, entrusted according to regulations stated by the Regional Committee for Medical Research Ethics. Transcripts can be made available by the first author upon reasonable request.

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References


Authors’ contributions

HL, RS and ET conceived and designed the study. ET collected the data. ET, HL and RS analysed the data. ET drafted the manuscript and HL and RS reviewed the manuscript. All authors read and approved the final manuscript.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

E. Ternström et al.  

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