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Fostering empowerment through communication: The needs, expectations, and experience of maternity care among polish migrant women in Iceland

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ABSTRACT

Objective: Over recent decades, Iceland has evolved into a more diverse society, revealing disparities in perinatal outcomes for migrant women. This study explored the needs, expectations, and experiences of Polish migrant women regarding midwifery care during childbirth in Iceland.
Methods: This longitudinal qualitative study involved semi-structured interviews conducted from December 2021 to May 2022. Eight Polish women participated in two interviews: one during their third trimester pregnancy (T1) and another within 12 weeks postpartum (T2). The interviews were analyzed using reflexive thematic analysis.
Results: The longitudinal analysis generated two overarching themes: (1) Wishing for respectful individualized care and (2) The importance of receiving adequate information and sharing preferences. Additionally, one theme was constructed from T1: (1) Feeling misunderstood, isolated, and longing for support. From T2, two themes were deweloped: (1) The value of emotional and practical support from both midwives and partners during pregnancy and birth and (2) The importance of having a voice in the care process.
Conclusion: Insecurity about pain management and communication challenges were common. Open dialogue and strong connections with midwives were essential for positive care experiences. This study highlights gaps in language support, cultural sensitivity, and tailored information in Icelandic maternity care for Polish migrant women. Providing individualized care, marked by respect and clear communication, empowers women to make informed decisions and fosters a sense of control during childbirth. Addressing these gaps is vital for improving perinatal outcomes and ensuring equitable, comprehensive support for all women during this transformative life event.

- **Issue:** Migrant women often face unique challenges in maternity care, leading to poorer birth outcomes and unmet needs during childbirth.
- **What is already known:** Research highlights that migrant women may experience communication barriers, lack of culturally appropriate support, and increased vulnerability in healthcare settings.
- **What this paper adds:** This study reveals specific gaps in language support, cultural sensitivity, and tailored information within Icelandic maternity care for Polish migrant women. By interviewing the same women both during pregnancy and postpartum, the study also provides a unique perspective on their evolving needs, expectations, and experiences. It highlights the importance of addressing these areas to enhance the sense of empowerment and overall satisfaction during childbirth.

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Introduction

Midwifery support during childbirth is a critical factor in fostering a positive birth experience [1–3]. Research identifies four key elements that significantly influence women's childbirth experiences: personal expectations, caregiver support, the quality of the relationship between the woman and her caregiver, and the woman's involvement in decision-making [4]. Notably, the attitude and behavior of caregivers often have a more profound impact on women's experiences than pain levels, pain relief methods, or medical interventions during labor [4]. Thus, promoting comfort during childbirth is an integral aspect of the 'art' of midwifery care [5].

Migrant women's maternity care experiences have gained increasing attention in international research, particularly in high-resource settings where health systems are structured to provide universal care. Studies from various countries—including the UK, Canada, Australia, and Scandinavian nations—highlight systemic barriers faced by migrant women in high-resource maternity settings, including inadequate language support, limited cultural competence among healthcare providers, and disparities in care quality [6–8]. Research indicates that language barriers and a lack of culturally appropriate care contribute to communication challenges, decreased satisfaction, and poorer maternal outcomes [9,10]. Migrant women often experience heightened vulnerability in maternity care due to intersecting factors such as legal status, socioeconomic conditions, and differing healthcare expectations shaped by their country of origin [7]. These challenges underline the need for maternity care services to adopt a more culturally responsive and individualized approach to ensure equitable outcomes [11].

Iceland's population has become increasingly heterogeneous, with foreign citizens comprising 16.6 % of the population as of 2024 [12]. Among them, Polish women represent 34.5 % of all migrant women [13]. This demographic shift necessitates a nuanced understanding of the diverse needs of women within maternity care. Qualitative studies have explored the maternity care experiences of migrant women, highlighting the connection between social inequality and access to pre-, intra-, and postpartum care [14,15]. Vulnerability reflects the social context in which migrant women find themselves during pregnancy and childbirth, influenced by their expectations, circumstances, and need for adaptability [14,16]. However, maternity care often lacks the individualized and sensitive approach required to meet the needs of migrant women. Care services need to be tailored to align with these women's expectations for support while recognizing their strengths and resources [14].

This study is part of a larger project aimed at gaining deeper insights into the care experiences and outcomes of childbirth among migrant women in Iceland. Previous research indicates that migrant women are more likely than native-born women to experience obstetric interventions [17] and are less likely to utilize non-pharmacological pain relief methods, without relying more on pharmacological options [18]. Additionally, recent findings suggest that migrant women perceive lower levels of respect and autonomy in maternity care compared to their Icelandic counterparts [19]. These results raise concerns about equity in access to and quality of care [17–19].

However, there is limited understanding of migrant women's expectations regarding midwifery care during childbirth and their experiences with that care. This study aims to enhance existing knowledge by illuminating the needs, expectations, and experiences of Polish women regarding midwifery care during childbirth, as they represent the largest group of migrant women in Iceland. By situating these experiences within the broader international discourse on migrant maternity care, this research contributes to the growing body of knowledge that seeks to improve care provision for migrant women in high-resource maternity settings.

Methods

Setting

Iceland follows the Nordic welfare model, which is primarily funded through taxation and characterized by flexibility and openness to innovation in service provision. The healthcare system provides maternity care free of charge for all women, except for migrant women from outside the European Economic Area (EEA) during their first six months in the country [20]. Although continuity of care is a key principle, maternity care in Iceland is often fragmented.

Antenatal care is primarily delivered by midwives within the primary care system, with referrals to hospitals for complications or medical risks. Each year, approximately 4,500 births take place in Iceland, with over 80 % occurring at the National University Hospital, a tertiary facility in the capital, Reykjavik, where two-thirds of birthing women reside [18]. Midwives attend all women during labor, consulting obstetricians only in cases of complications.

Typically, women do not know their intrapartum midwife beforehand, although continuous support from a single midwife during labor is encouraged. The use of interpreter services in maternity care is not well-documented; however, migrant women are entitled to access these services free of charge [21].

Participants and recruitment

This study employed a longitudinal qualitative design, utilizing individual semi-structured interviews analyzed through reflexive thematic analysis [22]. A convenience sampling approach was used to recruit eligible participants through two methods. First, midwives providing antenatal care introduced the study to pregnant Polish women in their third trimester, utilizing an informational sheet outlining the study's aims and requirements. Inclusion criteria included being Polish, in the third trimester of pregnancy, over 18 years old, and planning to give birth in Iceland. Secondly, a Polish woman known to the researcher introduced the study in a Facebook group titled "Polish Women in Iceland.".

Nine women initially expressed interest, agreeing to receive additional information in Polish via email. Participants were encouraged to ask questions before committing to the study. All participants were non-native speakers of Icelandic and communicated exclusively in Polish. Each participant was scheduled for two interviews: once during pregnancy (T1) and once postpartum (T2). Recruitment ceased once sufficient rich data were obtained to meet the study's objectives.

Ethics

Ethical approval for the study was granted by the National Bioethics Committee on June 11, 2019. Participation was voluntary, and all participants signed informed consent forms prior to their interviews. To acknowledge their time and effort, participants received a €30 incentive.

Conducting research with migrant women poses unique challenges, as highlighted by global health organizations such as the WHO [23] and the European Public Health Association [24]. Migrant women often face inequities, defined as unfair and avoidable disparities stemming from systemic factors such as poor governance, cultural exclusion, and barriers to accessing equitable care [25]. These inequities can place migrant women in vulnerable positions, which may result in feelings of intimidation or hesitation when interacting with researchers. Moreover, they may perceive the research topic as sensitive or find it difficult to allocate time to participate due to their personal circumstances [26].

Longitudinal data collection presents additional ethical considerations, such as the risk of intrusion into participants' lives or fostering a sense of dependency on the research process [27]. To mitigate these concerns, participants were provided access to an independent midwife specializing in care for vulnerable women, ensuring emotional support

was available if needed. Notably, none of the participants chose to utilize this option.

Data collection

Data collection occurred between December 2021 and May 2022 during the COVID-19 pandemic. The first author, who had no connection with the care for the included women, conducted the interviews under the supervision of two researchers experienced in qualitative methodologies. A female Polish translator facilitated the interviews, which were conducted in Polish. All interviews were recorded, transcribed verbatim and translated into Icelandic. Two separate interview guides were developed by the research team—one for the pregnancy interviews and another for postpartum interviews. These guides were piloted with three migrant women from Poland, leading to revisions in language, length, wording, and relevance. The pilot interviews were not included in the final analysis due to the significant modifications made to the guides following the piloting process.

The semi-structured format allowed flexibility, with key questions exploring participants' feelings regarding childbirth, their ideal birth experiences, and their care needs during labor. Post-birth interviews focused on their experiences and perceptions of the care received, including aspects they wished had been different and their feelings of comfort during labor. Participants were encouraged to elaborate on their responses, and the first author utilized probing questions to elicit in-depth information.

Data analysis

Reflexive thematic analysis was employed [22]. The first author engaged in an extensive familiarization process with the data, repeatedly reviewing the transcripts in Icelandic before coding began. Quotations presented in this paper with an individual number per particpant, have been translated back and forth between Icelandic and English by the first author and reviewed by co-authors fluent in both languages. From the transcribed data, initial codes were generated with equal consideration for all data. Coding was conducted by the first author, with co-authors reviewing the codes and contributing to the refinement of themes. The first author conducted multiple rounds of coding, refining themes iteratively through discussions with the research team. Themes were developed from these codes to represent distinctiveness and internal coherence [28]. The research team engaged in discussions to define themes before finalizing those presented in this paper. Significant extracts from the data were organized to support the analysis where applicable.

The analysis process was conducted in two stages: first, data from T1 and T2 were analyzed seperately to identify themes within each dataset. Subsequently, a longitudinal analysis was performed, integrating themes across both time points to identify overarching patterns and changes over time. This approach ensured that both within-timepoint insights and longitudinal findings were captured. It included examining Polish migrant women's needs and expectations from pregnancy data, experiences from postpartum data, and a comparative analysis of individual interviews to understand how participants' birth experiences related to their earlier stated needs and expectations. The overarching goal was to present a coherent analytical narrative grounded in the data that addresses the study's objectives. The qualitative data analysis software ATLAS.ti Mac (Version 9.1.3 (2089)) was used to organize and process the themes and patterns identified in the interviews.

Preliminary data analysis was conducted by the first author, with contributions from all co-authors to the final analysis. The researcher conducting the interviews is a midwife of the same gender as the participants, with substantial clinical experience. Two co-authors are midwives and professors with extensive clinical and academic expertise, while the fourth is a senior lecturer in qualitative research with a background in social psychology and gender studies. This diverse expertise enriched the analysis and added depth to the study.

Results

Two themes were generated in the longitudinal analysis: (1) Wishing for respectful individualized care; and (2) The importance of receiving adequate information and sharing preferences. We generated one theme from T1, the interviews conducted during pregnancy: (1) Feeling misunderstood, isolated and longing for support. Two themes were generated from T2, the interviews conducted after birth: (1) The value of emotional and practical support from both midwives and partners during pregnancy and birth; and (2) The importance of having a voice in the care process (Fig. 1).

Overview of study participants and interview process

Ultimately, eight women completed the study, participating in a total of 16 interviews—eight during pregnancy (T1) and eight postpartum (T2). Interviews lasted between 48 and 138 min, with an average duration of 87 min. The timing and location of interviews were determined by the participants, with five conducted via Zoom and eleven in person. Participants had resided in Iceland for one to five years, with ages ranging from 24 to 35 years. Five participants were married and three were in relationships, all with Polish partners. Most lived in the capital area, with all but one being either employed or studying. Further demographic details are presented in Table 1.

Longitudinal analysis

Theme 1 –Wishing for respectful individualized care

Participants described experiencing respectful, individualized care, though they noted areas where their preferences were unmet, leading to disappointment with aspects of midwifery care. For many, continuity of care was a crucial factor in feeling supported and respected, yet it was not always provided. Some women expected continuous midwifery support during labor, but this was not consistently available, which contributed to their sense of isolation and frustration. One woman shared her distress about being left alone after previously expressing the importance of a supportive presence:

"*I felt really bad, I cried all the time, being alone, and my husband, we were, he was on the phone, you know, on loudspeaker, but its not the same and it just took away all the joy from my experience, my birth experience, in fact*" (Participant 4).

For Participant 4, the challenges were compounded by the unique circumstances of giving birth during the COVID-19 pandemic. Partner access to the hospital was restricted, with partners required to stay outside until the participant was in active labor. This lack of physical support during early labor added to her feelings of isolation and distress, underscoring the importance of continuous emotional and practical support during childbirth.

For many participants, expectations regarding pain management were not met, further impacting their birth experience. Many expressed surprise at the intensity of labor pain, which was more severe than anticipated, and some reported dissatisfaction due to a lack of available pain relief options.

Building trust with the midwife was also important to participants. Continuity of care was seen as a key factor in establishing this trust, as repeated interactions fostered familiarity and understanding. One participant explained: "*We developed a trusting relationship, which made me feel more comfortable and confident going into labor*" (Participant 4).

The role of midwives was frequently mentioned as key to a positive birthing experience. The midwiveś presence and demeanor played a key role in how the women perceived their birthing experience. The women valued kindness, warmth, friendliness, and a calm presence.

"Yes, it matters, appearance and whether the midwife is friendly and warm and so on and I thought she was" (Participant 4).

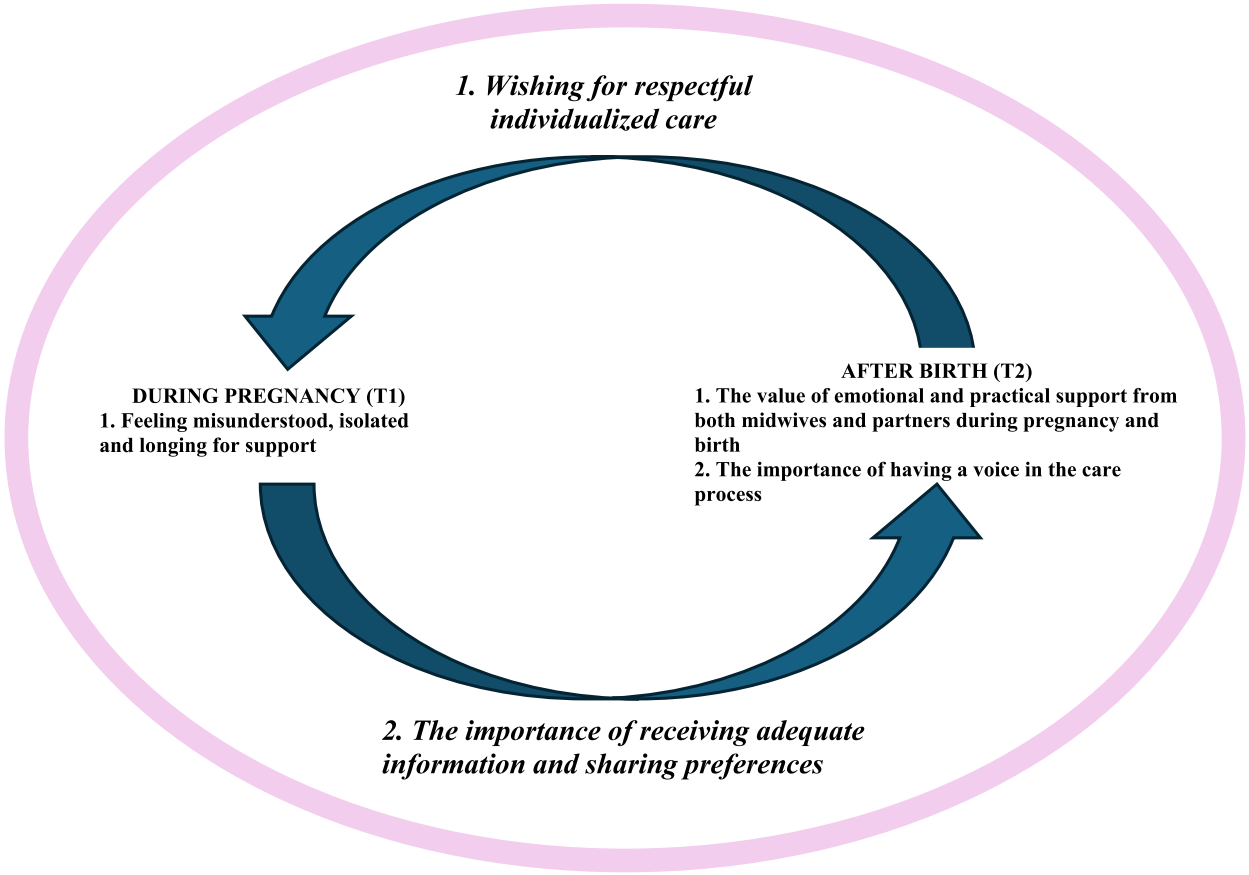

Fig. 1. Themes generated by reflexive thematic analysis.

"*It made a difference to have a friendly and warm midwife who genuinely cared about me*" (Participant 3).

When asked what contributed to a feeling of comfort during labour, the care from the midwife was a strong factor. "*You know, that Ím being cared for and that the midwives do care about me and just that we can be two in the room and just everything. You know, that she listenes and yes, this was, this is very important*" (Participant 6).

Several women highlighted how midwives met their needs and made them feel safe and supported. As one participant noted, "*The midwives made me feel secure and cared for. I felt they genuinely cared about my wellbeing, not just about the birth of the baby*" (Participant 6).

Others contrasted their birth experience in Iceland with stories from Poland, where maternity care was perceived as less personalized: *"In Poland, midwives often just check on you once an hour if your partner is present. But here, the midwife was with me most of the time, guiding me and helping me feel safe"* (Participant 5). These differences in expectations shaped participantś birth experiences, with many women expressing relief at the level of midwifery care they received in Iceland compared to Poland.

Theme 2 – The importance of receiving adequate information and sharing preferences

While individualized care and trust were essential, participants also highlighted the importance of clear communication and access to information to help them navigate the birthing process. Their expectations of the birthing process were often shaped by limited prior knowledge, cultural background, and personal or shared birth experiences. Many expressed anxiety stemming from their unfamiliarity with the Icelandic maternity care system and past experiences in Poland, which created uncertainty around aspects of labor, such as pain management and the roles of healthcare providers. One participant shared her initial anxiety about not having a doctor present during labor: "*At first, I was worried that the doctor wouldn't be there, but now, after this experience, I don't regret anything—I received all the care I needed*" (Participant 6).

Women who attended Polish-language birth preparation courses felt more informed and secure prior to birth, though several still wished for additional guidance on pain management strategies. Many women wanted to be part of the decision-making process and to have guidance throughout labor, as it helped counterbalance fears of power imbalances with medical staff, whom participants worried might act without consulting them. For many, communication with the midwife and access to a translator were essential to feeling empowered and in control of their care. The availability of a translator was essential for those who struggled with the language barrier.

"We just needed a translator. But I was so nervous before the labor started […], to go alone, but I didńt understand. I suddenly became very afraid, perhaps because there was no translator, I dońt know" (Participant 2).

Participants emphasized that good communication was essential to their care, as it alleviated their fears and reduced misunderstandings. They stressed that communication was not only about providing information but also about imparting comfort and reassurance. The women expressed a strong desire for respectful, sensitive, kind, and supportive care.

"That she would be calming me down while she would give me all the information about what is happening and just the necessary information, calmly and in a clear way. So just avoid misunderstandings" (Participant 1).

Table 1
Characteristics of participants (N = 8).

Variable	n
Maternal age at first interview	
24–29	5
30–35	3
Parity	
Nullipara	5
Multipara	3
Previous birth	
Poland	1
Iceland	1
Poland and Iceland	1
Gestation at first interview	
34–37 weeks	4
38–41 weeks	4
Time from birth at second interview	
4–7 weeks	5
8–11 weeks	3
Capital area residence	8
Reason for migration to Iceland	
Work	5
Wanted to live abroad	3
Duration of stay in Iceland	
1–2 years	3
3–4 years	4
5–6 years	1
Married/cohabiting	8
Level of education	
Secondary education	3
Higher education	5
Employed/student	7
Level of birth service	
Tertiary	8
Childbirth interventions	
Elective cesarean section	1
Induction of labour	2
Instrumental birth	0
Epidural	4

Interviews during pregnancy (T1)

Theme 1- feeling misunderstood, isolated, and longing for support

When the women spoke of their feelings about the upcoming birth, most mentioned that they felt insecure. They linked this insecurity to the uncertainty of what the birth would be like, the unpredictability of labor pain, and their interaction with the midwife. Both primiparous and multiparous women mentioned this uncertainty, with the latter sometimes connecting it to their previous experiences.

"Íts fear, just anxiety and worries about pain and uncertainty, what kind of experience it will be and how difficult it will be and what I can expect" (Participant 6).

Some women planned to rely on their partners as translators, though they worried that this dual role might overburden their partners and interfere with the support they needed. Several women were unaware of their right to have a professional translator, which affected their confidence in receiving adequate support during labor. Others expressed a desire for a supportive midwife who would be kind, sensitive, and attentive, with one participant explaining, "*I hoped for a midwife who would take good care of me and be sympathetic*" (Participant 3).

Many participants expressed concerns about their maternity care in Iceland, often comparing it to what they had heard from family and friends in Poland. Their expectations were shaped by stories from their Polish community, influencing fears about labor pain, medical interventions, and midwifery support.

"The information I got from my sister in Poland was completely different from here. There, they do ultrasounds much more often, and I feel like I always have to ask for extra tests here. Íts not automatically offered like in Poland" (Participant 1).

For some, the lower frequency of medical check-ups in Iceland compared to Poland contributed to anxiety: *"In Poland, pregnant women are constantly monitored, but here, I felt like I was not getting the same level of attention. I kept wondering if something might be wrong because they werenńt checking as often"* (Participant 6). Others worried about not having priority in the healthcare system as pregnant women, based on their expectations from Poland: *"In Poland, if you are pregnant, you get priority for everything, but here, I was waiting in the ER for 14 h with no food or drink, just to get an ultrasound. It made me feel like pregnancy is not taken as seriously here"* (Participant 1).

Interviews after birth (T2)

Theme 1 –The value of emotional and practical support from both midwives and partners during pregnancy and birth

Emotional reassurance from both midwives and partners was a critical factor in participantś sense of security during labor. Participants emphasized the importance of clear and compassionate communication with midwives, as they felt this would help alleviate their anxieties. They desired emotional reassurance from midwives to instill confidence. Most participants chose to have their partners present during labor, describing the emotional and physical support they provided as invaluable. Partners offered practical assistance, such as helping to change positions and providing food and drinks, which participants appreciated even more when this was unexpected. "*I imagined he would wait in the hall, but he stayed with me throughout the entire process, and it was incredibly supportive*" (Participant 7).

Beyond labor support, some women found that postpartum care in Iceland was different from what they had expected based on their knowledge of Polish maternity services. Some appreciated the shorter hospital stay, while others found it surprising:

"I was surprised that we were only in the hospital for about 12 h after the birth. In Poland, mothers stay for at least three days. But honestly, I liked being able to go home and rest in my own bed" (Participant 8).

"In Poland, midwives do more of the newborn care in the first hours, like dressing and changing the baby. Here, I had to do it myself right away, and I didńt feel ready for that. It was stressful at first" (Partcipant 1).

These experiences highlight the adjustments migrant women must make when navigating different cultural expectations around postpartum care.

Theme 2 – The importance of having a voice in the care process

Participants emphasized the importance of feeling respected and being active participants in decision-making during labor. Several women noted that when midwives took their wishes seriously and facilitated their choices, this contributed to a trusting relationship and a greater sense of security. Conversely, women who felt dismissed or unheard —often due to workload constraints or miscommunications—reported negative experiences. One participant described her disappointment when she was unable to access water-based pain relief, despite this being part of her birth plan: "*I asked to use the bathtub, but was told there was no room available. My husband saw an empty room with a bath, which made me feel like I wasn't being listened to*" (Participant 1).

Discussion

The primary finding of this study is that the Polish migrant women in Iceland expressed a significant sense of insecurity regarding intrapartum care, particularly in relation to pain relief and communication. This insecurity, shaped in part by narratives shared within their Polish community, remained a dominant theme throughout their birth experiences. Women's expectations for intrapartum care were influenced not only by apprehensions about the labor process and the intensity of pain but also by concerns about communication with midwives, a recurring focus in our longitudinal analysis.

In summary, these women's needs and expectations were often unmet, as evidenced by their ongoing feelings of uncertainty and

dissatisfaction. By analyzing their experiences over time, this study highlights a persistent gap between the care provided and the care these women hoped for. Despite the extensive global research on migrant women's birth experiences, our findings shed light on the unique challenges faced by Polish women in Iceland. Their concerns underscore the critical need for culturally responsive care that prioritizes effective communication and addresses their specific needs. This calls for improvements within Iceland's maternity care framework to ensure that all women, regardless of their cultural background, feel secure and supported during childbirth.

The results demonstrate that effective communication and a strong, trusting relationship with the midwife are fundamental needs among the Polish women in our study. These needs highlight not only the logistical challenges posed by language barriers but also the emotional toll of navigating labor without sufficient proficiency in the local language. Women expressed a desire for meaningful dialogue with the midwife, seeking consistent information and guidance during pregnancy and labor to support both the natural process of labor and their ability to make informed decisions. They emphasized the importance of experiencing a sense of control in their birth process, with concerns that they might be treated as passive subjects, subjected to procedures without their consent—a feeling echoed in the previously mentioned study [19].

Communication and information as determinants of birth experiences

This insecurity was often rooted in their antenatal experiences, where the extent and clarity of information provided by midwives varied significantly. While some women reported feeling well-prepared for labor due to clear guidance from their midwives, others expressed frustration at the lack of detailed explanations about pain management options and the labor process. This disparity in prenatal communication directly influenced how informed they felt during labor and their ability to engage confidently in decision-making.

Language barriers and emotional support during birth

Language barriers further exacerbated their stress, with some women refraining from requesting translators, either because midwives did not offer one or because they feared appearing burdensome. This hesitancy is a unique aspect of migrant women's experiences, suggesting that even when care protocols allow for translation services, cultural perceptions of being "a nuisance" can hinder effective communication. Ensuring clear, consistent communication throughout pregnancy and labor is therefore essential in fostering a sense of control, safety, and empowerment among migrant women.

Notably, the women in this study expressed an overarching desire for the kind of supportive, continuous presence that midwives are trained to offer but may be constrained by time and resources. While the expectations for care among Polish women may align with Icelandic women's desire for woman-centered, respectful care, migrant women face additional hurdles [23,25,29]. The women in our study valued a midwife's warmth, kindness, and attentiveness, qualities that empowered them to make informed decisions about their care and contributed to a positive birth experience. This need for a continuous, caring presence reflects findings from previous studies on midwifery professionalism and woman-centered care [30–35], but it is particularly salient for migrant women who may feel isolated or vulnerable in a foreign healthcare system.

Woman-centered care and trust in midwifery

Our findings also resonate with earlier studies [14] that highlight the significance of caring relationships, which serve as a source of strength and positively impact women's health and well-being. Woman-centered care, particularly within a cultural context, effectively meets women's needs by fostering a supportive and reciprocal relationship between the midwife and the woman. This is achieved through the creation of a safe birthing environment grounded in knowledge, as described in Berg et al.'s Midwifery Model of Care (MiMo) [36].

Participants' satisfaction with their childbirth experiences was strongly tied to the quality of communication with midwives, the degree of control they felt, and the extent to which they influenced their birth experience. Even amidst physical pain, women who felt supported by caring midwives experienced comfort and well-being, in line with Schuiling and Sampselle's comfort theory [37]. Likewise, the support of partners was essential to labour, even when they did not recognize this beforehand. This support was both emotional and physical, suggesting that healthcare professionals should emphasize the role of partners during antenatal care.

Cultural perceptions of pain management and birth interventions

Moreover, our findings echo earlier research showing that Polish migrant women in Iceland often have poorer childbirth outcomes [17] and use fewer non-pharmacological pain relief methods [18] than their Icelandic counterparts. This discrepancy may be partially explained by the communication and cultural gaps revealed in this study, which may contribute to misunderstandings about care options or impact how their pain management preferences are addressed.

The Polish migrant women's preference for minimal medical intervention and a natural birth experience is another area where our findings add new depth to understanding experiences in Iceland. In previous studies [38], Icelandic healthcare professionals perceived Polish migrant women as being more inclined toward medical interventions, a view that contradicts the expressed preferences in our study. This discrepancy highlights the need for Icelandic maternity care providers to engage in open, culturally sensitive dialogues with patients to understand their expectations and preferred approaches to labor.

Community narratives and their influence on birth expectations

One of the key findings of this study is how stories shared within the Polish community shaped womeńs expectations of childbirth. This aligns with previous research on migrant womeńs health narratives, which highlights how shared experiences within a cultural group can influence healthcare-seeking behavior and trust in medical systems [39]. Some women entered labor with strong concerns shaped during pregnancy, particularly regarding pain relief, midwifery presence, and communication barriers. For some, these concerns were validated by their experiences, reinforcing feelings of disempowerment. Others, however, reported that their actual birth experience challenged their fears, reinforcing the importance of direct experiences in shaping trust and satisfaction with maternity care.

Concluding thoughts on maternity care for polish migrant women

Ultimately, our findings illustrate the specific experiences and needs of Polish migrant women within Icelandic maternity care, reinforcing the importance of culturally attuned, language-sensitive, and supportive care. While these needs may resonate with those of Icelandic women, Polish migrant women's experiences reveal distinct challenges that must be addressed to improve their childbirth outcomes and align care with their preferences and values.

Strengths, limitations, and future directions

This study is the first to explore migrant women's expectations and experiences of intrapartum midwifery care in Iceland. The longitudinal design minimized selection bias by enrolling participants before birth, allowing for a nuanced view of their evolving perspectives. However, initial selection bias could still occur if the sample is not representative of the broader population of Polish migrant women in Iceland. Participants who volunteered for the study may have had specific concerns or experiences that differ from those who chose not to participate, which may influence the generalizability of the findings.

Nevertheless, our study's findings may have broader implications beyond the Polish community. Many of the challenges highlighted—such as language barriers, cultural misunderstandings, and limited access to translation services—are shared by migrant women from various backgrounds in high-resource maternity settings. By identifying these recurring difficulties, our study contributes to a broader understanding of the barriers that culturally and linguistically diverse women face in maternity care. Thus, while the findings are grounded in the

experiences of Polish women, they may be transferable to other migrant groups encountering similar structural and communicative obstacles in their perinatal care.

The quality of the data relies on the researchers' interpretations, though we mitigated this through critical team discussions and included perspectives from an outsider to Iceland for objectivity.

Implication for practice

Midwives play a critical role in assessing the physical, emotional, social, and intellectual needs of all pregnant women, particularly migrant women who may face additional barriers. Our findings suggest that midwives can best support migrant women by creating a safe space to express their needs and set goals, thereby enhancing their sense of control and accomplishment. This approach requires clear communication, the availability of trained translators, and a compassionate, woman-centered approach that respects each woman's unique background and values.

To provide effective care, midwives need access to professional translators and should proactively inform migrant women of this right during pregnancy. Continuity of care has been shown to empower women, especially those in vulnerable populations. Consistent [14], culturally sensitive maternal health services [40] can help secure a sense of belonging in their new country, and lead to better outcomes for both mother and baby.

In antenatal care, midwives can encourage migrant women to bring their partners to labor, inform them of available care options, and reassure them about requesting interpreters when needed. To ensure respectful and appropriate care, midwives and healthcare staff should receive training in cultural competence and anti-discriminatory practices. Such training, covering the social, clinical, and psychological needs of migrant women, can better equip staff to meet the needs of this population in light of current socio-political contexts [41].

Conclusion

This study underscores that migrant women's birthing experiences in Iceland are profoundly shaped by their ability to communicate effectively with midwives and feel connected to others throughout the birthing process. The longitudinal analysis revealed a persistent gap between Polish women's expectations and their actual experiences, with unmet needs regarding pain relief, communication, and support during labor. These unmet expectations were often rooted in antenatal care, where inconsistent or unclear guidance from midwives left women feeling unprepared for childbirth.

By identifying these challenges, the study highlights the critical need for culturally responsive, woman-centered care that prioritizes clear, compassionate communication and builds trusting relationships between midwives and migrant women. Addressing these gaps can empower women, enhance their sense of control during labor, and ultimately improve their birth outcomes.

We hope these findings will inform midwifery practice and training in Iceland, fostering a maternity care system that values diversity and inclusivity while meeting the unique needs of all women, regardless of their cultural or linguistic background.

Ethical approval

This study obtained ethical approval from the National Bioethics Committee on 11 June 2019 (VSNb2019050003/03.01).

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CRediT authorship contribution statement

Embla Ýr Guðmundsdóttir: Writing – review & editing, Writing – original draft, Resources, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Marianne Nieuwenhuijze:** Writing – review & editing, Visualization, Conceptualization. **Annadís Greta Rúdólfsdóttir:** Writing – review & editing, Visualization, Methodology, Conceptualization. **Helga Gottfreðsdóttir:** Writing – review & editing, Visualization, Supervision, Funding acquisition, Conceptualization.

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