Pregnant, away from home.

Maternal Health Care in Norway:
Exploring migrant women's experiences of the maternal health care system in Norway.

JANICE BEMAH SARPONG

SUPERVISOR
Associate Prof. Hanne Haaland

University of Agder, 2021
Faculty of Social Sciences
Department of Global Development and Planning

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Dedication

To my dear Emmanuel and Esther; I am extremely honoured to have you both in my life.

Abstract

This master thesis explores migrant women's experiences with the maternal health care system in Norway, using a qualitative research strategy. It is based on interviews conducted with migrant women living in Kristiansand, who have given birth in Norway, as well as interviews with health workers in the maternal health service. The migrant women shared their personal experiences from pregnancy to childbirth whiles the health workers also gave their personal experiences related to providing antenatal and post-natal care. This was specific to migrant women living in Norway. My study adopts the 'Quality of Care' framework with a focus on 'Experience of Care' as the basis of analysis, using women and health personnel's respective experiences.

My findings reveal that migrant women do not get the same treatment as ethnic Norwegian due to the existing barriers. The main barriers are discussed in the thesis under the headings of communication, cultural differences, and limited access to information.

Based on the data collected, the study makes various recommendations that will help improve maternal health care in Norway and make it easily accessible to everyone including migrant women to ensure equity in treatment.

Declaration

I, Janice Bemah Sarpong hereby declare and confirm that this academic work entitled; 'Pregnant, away from home: Exploring migrant women's experiences of the maternal health care system in Norway' has previously not been submitted for any academic degree in any university.

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LIST OF ABBREVIATIONS/ ACRONYMS

WHO	World Health Organisation
AIDS	Acquired Immunodeficiency syndrome
CEE	Central and Eastern Europe
HIV	Human Immunodeficiency syndrome
MMR	Maternal Mortality Ratio
UN	United Nations
UNFPA	United Nations Fund For Population Activities
UNICEF	United Nations International Children's Emergency Fund

CHAPTER ONE

INTRODUCTION

1.1 Background and Rationale

Deaths related to pregnancy and childbirth continue to be a subject of global concern (UN, 2004). Every year, about one million deaths occur due to health complications associated with prenatal and postnatal care (WHO, 2019). Out of this figure, less than four percent of maternal deaths happen in developed countries whiles developing and third world countries continue to experience high maternal mortality(ibid). According to the WHO (2019), access to quality health care during conception, antenatal, delivery, and postpartum is the prime way to curb maternal deaths. Basically, most of the developed countries that record low maternal mortality have improved and accessible health care facilities available to pregnant women and mothers both before and after birth (Starrs, 1997). Some of these countries such as Norway offer free health care services to women during pregnancy and birth at no cost (Magnussen et al., 2009). Thus, Norway is one of the countries with the lowest maternal mortality rates in the world; and continues to see a decline in maternal mortality (WHO, 2019).

As the world continues to see a rise in migration (Pederson et al., 2014), it is also important that the health and wellbeing of migrants become a concern to the host country; especially when migrant women become pregnant and give birth in their host country (Heaman et al., 2013). Norway, just like other developed countries receives a high number of migrants. According to Statistics Norway (2018), fourteen percent of the Norwegian population are immigrants. This is a relatively high percentage of immigrants considering the size of the Norwegian population (ibid). Out of this, the percentage of children born in Norway to immigrant parents is 3.2 percent (ibid). Consequently, maternal care for migrant women is a subject of debate among scholars in terms of quality, equity, accessibility, and affordability (McCourt & Peace, 2000; Heaman et al., 2013; Lyberg et al., 2012; Viken et al., 2015). Also, there tends to be a 'big disparity between migrant women's expectations and experiences'. As Hulton et al., (2000) point out, 'the fact that amenities and services are available to pregnant women does not necessarily mean they patronise it'. Neither does it also mean equity and quality are assured (ibid). Here, emphasis is being made on the unknown relationship between the provision of care and accessibility.

Although health care is available at no cost to pregnant women in Norway, concerns have been raised over migrant women's access to post-natal and antenatal care (Lyberg et al., 2012, pp. 290-291) and the existing barriers they face. The extent to which foreign women have access to maternal care services is not known as it is difficult to know whether they receive what they are entitled to by law or not.

1.2 Choice of topic

As an African woman and foreign student in Norway, I was unfamiliar with the Norwegian health care system until I received maternal care in Norway. I have had a lot of different experiences and this led me to do in-depth research on how other migrant women responded to the maternal health care system in Norway. My study sought to explore their assessments, thoughts, candid opinion, and experience during the whole process of giving birth in Norway. In my analysis, I have discussed these experiences in light of the overall framework of 'Quality of Care' developed by Hutlon et al., (2000). This research is also intended to help other migrants soon-to-be mothers and most importantly, the Norwegian Society to know how their maternal system is being perceived among foreign women in the country.

1.3 Research Problem

Having gone through scholarly materials, articles, and internet sources I (the researcher) came to the observation that most of the existing research was geared towards 'reducing risk during pregnancy among migrant women' (Smith et al., 2014). Surprisingly, there was not broad literature on how migrant women are being attended to in terms of pregnancy and childbirth. Rather, the available literature focused on 'how migrant women in Norway can adapt to the Norwegian health system and its associated challenges' (Lyberg et al., 2012; Viken et al., 2015).

Based on the above, this study addresses the gap in the literature when it comes to migrant women's experience of the maternal healthcare (from pregnancy to birth) system in Norway by way of empirical research. It also incorporates the experiences of health workers who one way or the other have provided healthcare services to migrant women. These health workers are a crucial part of the study because they bring to light what they perceive to be strengths and weaknesses of the existing system as well as potential challenges faced and potential solutions. The health workers also help us to know the extent to which the system is able to provide all patients, despite cultural differences, with the same services. Herein lays the relevance of the study as it constitutes a significant addition to the literature and the practice

field of maternal health care in Norway taking health-seeking behaviour and the context of cultural differences into account. I did this through a case study in the Kristiansand municipality in Norway.

1.4 Research objectives

The overall objective of this study is to explore how the maternal health care system works for migrant women, both from the women's own perspective and also from the health workers' point of view. This will help to map out the relationship between 'what is provided' by law and 'what is received' by the migrant. Here, the study brings to light the provisions enshrined by the government and FHI (FolkeHelse Institut) as measured with what is offered to the migrant women.

Further, using Kristiansand commune (municipality) as a case study, the research illuminates how Norway is achieving the new targets of the World Health Organisation (WHO)'s on maternal mortality. The findings add to the practice field and finally contribute to the literature addressing a topic that has received limited attention.

1.5 Research questions

The following research questions will guide me to attain my research objectives.

- How does the health system in Norway support the health and wellbeing of all women during the prenatal and postnatal periods?
- Are migrant women aware of the health care services that they are entitled to during pregnancy?
- How are migrant women able to access information on maternal care?
- What are migrant women's perceptions of the challenges and benefits of the prenatal and postnatal health care system?
- What are their recommendations for the health sector?
- How do health workers in pre- and postnatal care perceive the services provided to migrant women?

1.6 Thesis outline

I have organised my thesis into six chapters. A brief outline of the chapters are presented here;

Chapter One is an introduction to the overall topic, the background and rationale, problem statement, research questions, and the objectives of the study. In Chapter Two, I provide a literature review and present my theoretical framework for analysis, namely the Quality-of-Care theory developed by Hulton and colleagues (Hulton et al., 2000. I also include the policy framework of equal quality of care in Norway, where all women in Norway are entitled to free equal maternal health care; and my findings show that perhaps this is not what is experienced by all migrant women. Chapter Three presents Kristiansand as the study area in context. It further discusses the geographical location of the area and also the migrant population in Kristiansand. Chapter Four describes the methods I used in arriving at my empirical findings. It also discusses the key ethical considerations which the researcher adhered to in conducting this study. Chapter Five presents the empirical findings which were obtained through the data collection and a discussion of them, whilst Chapter Six provides concluding remarks as well as recommendations for further research.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This section reviews existing literature concerning maternal health care globally and in Norway. I have organised the review on the following main themes; global maternal healthcare issues, the Norwegian healthcare system and migrants' access to healthcare in Norway. Moreover, it delves deeper into the maternal health care system in Norway using the quality-of-care theory developed by Hulton et al., (2000). There are numerous sub-themes under the main themes which give a deeper understanding of maternal healthcare.

2.1 Global maternal healthcare issues

Maternal healthcare gained global attention in 1987 when the 'Safe Motherhood conference' highlighted the problems associated with pregnancy and childbirth (Bergström, 2014). The conference emphasized the need for countries to invest in maternal health to safeguard the lives of women and unborn babies (Starrs, 1997). Over two decades down the line, maternal mortality kept rising (UN, 2004). A high maternal death rate is always associated with developing countries (Starrs, 1997). The measurement of maternal death rates is the basic health tool that records the highest difference between developed countries and developing countries (ibid). About 97% of all birth-related deaths happen in developing countries (WHO, 2019).

Increasing maternal deaths in the world caused the World Health Organisation (WHO) in 2004 to come out with proposed solutions that can reduce deaths related to pregnancy. The hospital or health centre was generally recommended as one of the safest places to give birth (ibid). Globally, about two hundred and eighty women die every year due to complications in pregnancy, whiles about three million newborn babies are not able to live within the first month of birth (Oestergaard et al., 2011). Although the hospital is regarded as one of the safest places to give birth, there have been increasing reports of maltreatment and unacceptable behaviours exhibited by various health workers, which again, has negatively affected the trust women have in health facilities (Moyer et al., 2014). This points out that not all medical professionals exhibit professional behaviour at their respective workplaces. Whiles some are polite, others are rude and intolerant especially with pregnant women (ibid). A study in Northern Ghana highlighted forms of abuse some health workers met out to

women during antenatal care and labour (Moyer et al., 2014). It was realised that some women were verbally abused by some hospital staff. In extreme cases, pregnant women face physical abuse such as spanking, and canning by these health workers with the excuse that, it was the only way a woman in labour can push her baby out (ibid).

A non-governmental organisation called The White Ribbon Alliance for Safe Motherhood in 2011 was able to map forms of ill-treatment pregnant women may face from their health providers. Prominent ill measures include; lack of confidentiality when attending to patients, discrimination against patients, absence of care leading to neglect of the patient, and care that lacks dignity (Respectful Care Advisory Council, 2011). Other forms of mistreatment highlighted by the organisation include; physical attacks in the form of abuse, keeping patients in detention due to medical bills, and lastly care that is not consensual (ibid). This mapping illustrates how institutions like hospitals are not necessarily the safe spots that they are assumed to be by the health agencies such as WHO.

2.2 Maternal Mortality

My study defines maternal mortality in the context of the WHO. Maternal mortality is when a woman dies in the course of her pregnancy as a result of pregnancy-related illness (WHO, 2019). It also includes deaths that occurred within forty-two days after a pregnancy has been aborted. Maternal deaths could be direct or indirect. Direct maternal deaths often arise from ramifications and aftereffects of pregnancy and delivery (ibid). Indirect maternal deaths on the other hand occur from an existing illness aside from HIV which is worsened by pregnancy.

The problem of high death rates associated with stillbirths and pregnancy complications continues to rise over the years (Lancet, 2005). In some countries, the death rates are not properly accounted for which makes it difficult to probe the causes associated with these deaths (ibid). Out of the 1,000,000 maternal deaths and the 900,000 neonatal deaths that occur yearly, only 3% occur in developed countries. These developed countries have good information and data storage systems in place which helps account for the cause of death. In contrast to this, 98% of developing countries do not have any reliable data and as such, are not able to properly account for the loss of maternal lives (WHO, 2005). Maternal deaths make up one-third percent of all global deaths yet receive very little attention from the governments in developing countries (Lancet, 2005).

2.3 Causes of Maternal Deaths

Maternal deaths have always been associated with developing countries due to the high number of maternal deaths that occur there (Lancet, 2005). There is only three percent of maternal deaths happen in the westernised economies or developed countries (ibid). One of the main causes of maternal deaths identified is giving birth at home without any form of medical professional assistance (WHO, 2004). Although ninety percent of pregnant women in developing countries receive antenatal care to an extent, only fifty percent of them give birth in a hospital or assisted by skilled health attendants during labour (Measure, 2008).

A lot of women in developing countries are not able to give birth in a health facility because of the cost involved (Spangler and Bloom, 2010). In contrast, there is high patronage of hospital birth among wealthy women in these countries while a majority of poor women are not able to give birth in a health facility (Houweling et al., 2007). Whiles the rich can afford it, the poor on the other hand are not able to afford the services of a health facility during pregnancy and childbirth leading to birth-related deaths. This inability of pregnant women to receive antenatal care has led some of the Sub-Saharan countries to reduce the user fee associated with maternal health services (De Allegri et al., 2011). The reduction of fees associated with maternal health services has led to an increase in hospital attendance by pregnant women in Sub-Saharan Africa (ibid). At the same time, there has been a gradual reduction in the number of maternal deaths, thus confirming the positive relationship between low maternal deaths and access to antenatal and postnatal care. For instance, in Burkina Faso, a lot of pregnant women now visit the health centers after the government introduced a reduction in health user fees for pregnant women (De Allegri et al., 2011). In 2015, Burkina Faso recorded maternal deaths of 2,700 whiles the figure decreased to 2,334 in 2016 (WHO, 2019). The same applies to Ghana who recorded 2,800 maternal deaths in 2015 but had 1,167 deaths in 2016 (ibid).

Research has shown a positive correlation between the proximity of health units (Gabrysch & Campbell, 2009; Mpembeni et al., 2007; Hodgkin, 1996; Thaddeus & Maine1994) and access to maternal health care. Although most women would want to give birth in a hospital, they are unable to do so due to the bad nature of roads. They are therefore unable to get medical assistance during delivery. According to De Allegri et al (2011), women who live less than 5km away from health units often deliver in these health units as compared to those living more than 5km away from a health facility.

The role of professional birth attendants can never be underemphasized, they play a huge role in ensuring the safe delivery of both mother and child. It is therefore not surprising that Western countries record relatively low maternal deaths. In 2017, the world recorded a total of 295,000 maternal deaths with 196,000 of these deaths occurring in Sub-Saharan Africa (WHO, 2019, p. 37). This is represented in Figure 2.0.

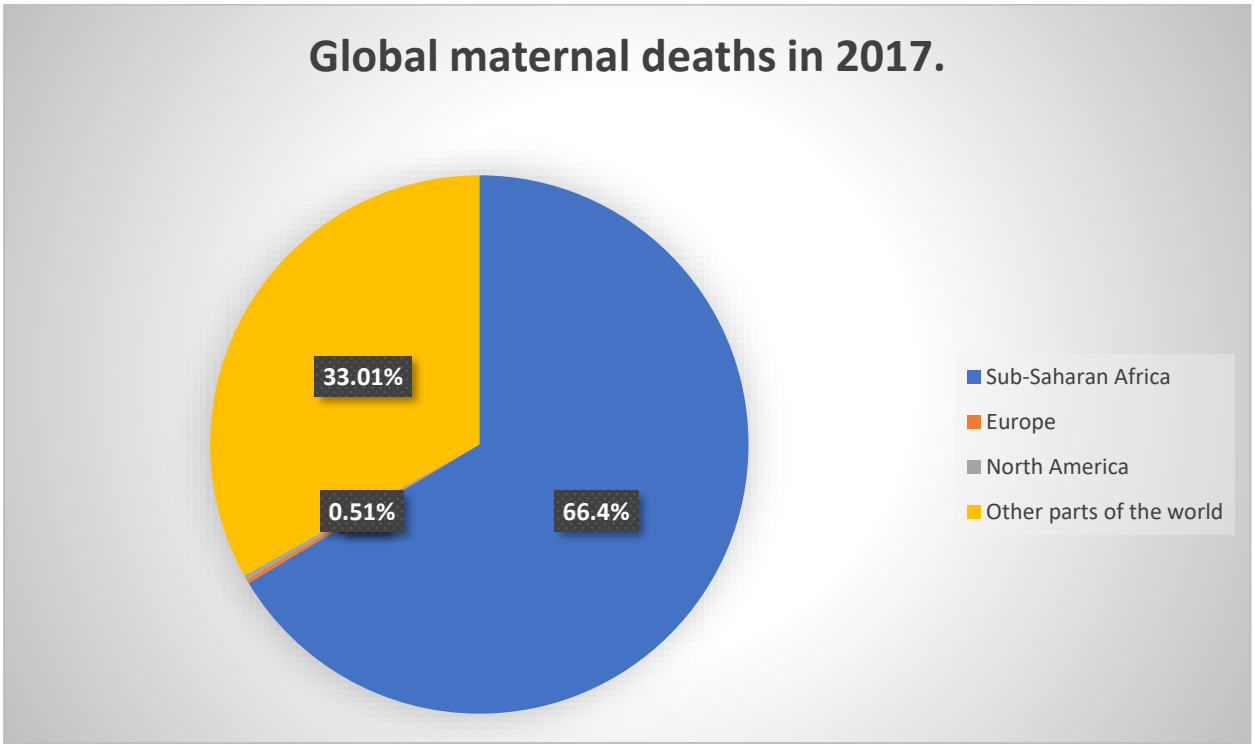


Figure 2.0

This is the author's own diagram to explain global maternal mortality in 2017 according to the WHO, 2019.

From the diagram above, Europe and North America recorded 0.25%, 0.26% respectively giving a total of 0.51% which is below one percent. Whiles only Sub-Saharan Africa had 66.4% of all maternal deaths in the world.

2.4 Maternal health care in Europe.

Developed countries continue to see a decline in the number of maternal deaths (Salanave et al., 1999). Europe is currently one of the leading continents with low pregnancy-related deaths. As of 2017, it had the second-lowest death rate of 740 whiles Oceania recorded 400 with North America having 760 (WHO, 2019). A greater number of European countries offer

equal and universal access to health care among their citizens, legal migrants, and foreign nationals (Pederson et al., 2014).

Although Europe may seem to have a low Maternal Mortality Ratio (MMR), there have been significant differences between Western Europe and the CEE (Central and Eastern Europe). Countries in Eastern and Central Europe continue to have higher death rates (Miteniece et al., 2017) in comparison with their neighbours in Western Europe. Thirty to forty maternal deaths per 100,000 live births were recorded in Romania, Armenia, and Albania in the year 2013 (WHO and UNICEF, 2014). MMR in 2013 was as high as 33, 29, and 21 in Romania, Armenia, and Albania respectively (ibid). In the same year, Norway, Denmark, Italy, and Finland had MMR of 4,5,4, 4 respectively. In addition, countries in Eastern and Central Europe continue to experience an increase in the rate of abortions. Countries like Armenia, Georgia recorded one of the highest abortion rates in 2003 (Sedgh et al., 2007).

A lot of the CEE countries are characterised by low-paid skilled staff which makes the medical profession unattractive to venture into (Mishtal, 2010). At the same time, health care coverage is not totally free as women need to have insurance packages and in addition pay for certain bills like guest attendance fees when a relative or spouse is present during delivery (ibid). Much importance is attached to spouse or relatives attendance at birth and may be difficult to have a health facility delivery without them in countries like Romania (Janevic et al., 2011). It is therefore not surprising Romania records one of the highest maternal deaths in Europe. A study by Parkhurst (2005b), revealed that health facilities were not evenly spread or distributed in Romania, Albania, Ukraine with under-staffed health workers; a barrier to quality care. In addition, new mothers do not receive adequate help as in the case of Serbia where there are not enough skilled workers to aid the women in breastfeeding after delivery (Arsenijevic et al., 2014). Although there have been recent interventions by some International agencies, there is still much to be done in ensuring universal access and quality care to women in times of pregnancy and delivery. Ukraine for example, has seen massive improvements in health infrastructure and birthing conditions in its urban areas. There is now help in breastfeeding and the choice for women to decide on their birthing position (Stepurko et al., 2013).

2.5 The existing relationship between health workers and patients (expecting mothers)

There have been issues of ineffective communication among expecting mothers and health workers (Arsenijevic et al., 2014). This often creates psychological barriers as mothers are

reluctant to seek advice/information from these health workers due to their hostility towards patients (pregnant women). This is recorded in Serbia and Romania where women have been called funny names by health workers due to the women's migrant background and have had their privacy invaded (Arsenijevic et al., 2014). Funny nicknames by health professionals coupled with the ineffective communication between these workers and their clients as well as no respect for privacy has made these victims gained zero trusts in the people who offer medical care (Parkhurst et al., 2005). Maternal care is a highly technical field that only medical professionals can adequately provide. However, due to the mistrust existing between these professionals and their clients, women now often resort to the internet to seek answers and information for their many questions regarding pregnancy and childbirth (Stepurko et al., 2013); a practice which is very dangerous as the internet does not always provide accurate medical advice.

2.6. Maternal healthcare services among migrants in Western Europe.

The term 'migrant' has been defined in diverse ways (Pederson et al., 2014) with emphasis on foreign country of origin, birth, and nationality. However, for the purpose of this study, a migrant woman is a woman who is living in a country different from her country of birth and where she was raised. In the following, I define this category as 'first-generation migrant'.

Uneven access to healthcare may exist between people born in a host country and those who are migrants (Keygnaert et al., 2016 p.4), although Western European countries may provide universal quality health care to all legal migrants residing in the country (Paxton and Wardlaw, 2011). In the field of antenatal and postnatal care, research has shown higher risks with migrants despite continuous improvement in health care where non-migrant women often have better pregnancy outcomes; with lower cases of pre-eclampsia and caesarean delivery compared to the migrants (Jacquemyn et al., 2012; Jonkers et al.,2011). Higher records of an insufficient number of hospital visits during pregnancy, poor quality of maternal health services have also been prevalent among migrants in European countries (Philibert et al.,2008; Zwart et al. 2008, cited in Pedersen et al., 2014). Almost fifty percent of the migrant women living in England seek antenatal care late; often after twenty weeks of pregnancy (Lewis & Drife, 2001). A research conducted in Sweden revealed that migrant women from Africa were at risk 18 times more than their Swedish counterparts of losing their babies less than a month after birth (Essén et al., 2002). This same study shows African migrants being at risk (13 times) of losing their baby during labour in comparison to Swedish

women. In the same trend, studies have shown that migrant women in the European Union states have a higher risk of experiencing negative effects of maternal health care compared to native European women (Zeitlin et al., 2013; Cha, 2013). Most of the studies above categorize migrant women as the primary group of people at risk when it comes to maternal health care issues.

A lot of factors account for these migrants being at risk during pregnancy. In Sweden, the risks associated with African migrants have been linked to insufficient medication, the women's delay in going for healthcare, miscommunication between the women and the health workers, and their refusal and objection to caesarean sections, among others (Essén et al., 2002). The issue of miscommunication has a big role to play in maternal deaths among migrants. In Sweden, there has been the absence of qualified interpreters who can assist in communication between the woman and the health worker (Esscher et al., 2013). The absence of interpreters makes it difficult for the migrant to explain her problem to the health worker. In the same way, medical workers are not able to properly convey messages to their patients. Interpreters are needed when the migrant is not fluent in the language spoken in the host nation (ibid). Maternal health problems continue to rise amongst migrants even in nations that offer universal access to healthcare where women do not need any private insurance or user fee for maternal health services (Esscher et al., 2013). We have countries like Portugal, Sweden, Norway that continue to provide universal access to health care but continue to record disparities between migrants and natives health (Mbanya et al., 2019; Esscher et al., 2013)

In the context of Norway, migrant women have not always been the 'highest at-risk category' when it comes to one or two issues of maternal health care. For example, Norwegian women are more at risk of contracting pre-eclampsia during pregnancy compared to migrant women (Naimy et al., 2015). Pre-eclampsia is one of the main causes of maternal deaths (Duley, 2009) around the world and it is most prevalent in Norwegian women than migrant women in the context of Norway. Norwegian women had a 3.7% prevalence rate compared to their migrant counterparts who record a 2.7% rate (ibid).

Although access to health care may exist by law in some countries, it does not always happen as stipulated (Keygnaert et al., 2016, pp.9-11). Women have the right to access care during pregnancy, but this may be different in practice in Italy, Croatia, and Greece. 'Right to Care' here may only apply during delivery and not during pregnancy or after childbirth (Network,

2010, pp.134-138). The ‘care’ starts and ends only at delivery. The health of the new mother after birth is not guaranteed, thus, posing a maternal health risk to women who may not have enough resources to visit the health facility after birth or during pregnancy. In the United Kingdom, pregnant women and newborn babies with HIV are entitled to free health services without any charges whatsoever (Curtis and Burns, 2015). However, women in Wales and Northern Ireland are sometimes required to pay before they are treated although these places are part of the United Kingdom (Keygnaert et al., 2016, p.10).

2.7 The Norwegian health care system among migrants

The 1999 Patient’s Right Act of Norway stipulates that all persons legally living in Norway have the right to quality healthcare. Thus, Norwegians and legal residents have the right to equal access to health coverage without discrimination whatsoever. However, equal access to healthcare has not been in uniformity with real and actual access to healthcare (Mbanya et al., 2019; Asaria et al., 2016). A lot of migrants have had difficulties in accessing health services in Norway, which has made some migrants seek healthcare in other European countries (Mbanya et al., 2019). The universal healthcare coverage although aims at promoting accessibility amongst all do not happen in reality as there have been existing barriers that do not ensure equity and accessibility amongst everyone living in the Scandinavian country (Asaria et al., 2016).

2.7.1 Equity versus inequity in accessing healthcare among migrants in Norway.

Migrants in Norway are not immune to the existing inequity associated with healthcare and access (Mbanya et al, 2019). When it comes to healthcare, most African migrants suffer racial discrimination at the hand of health providers (ibid) and are often seen as ‘second-class citizens’ (Sivanandan, 1976) who are inferior. Sub-Saharan African migrants in Norway often seek healthcare in other countries such as Germany and avoid the Norwegian health service due to frustrations they face before they are able to get medical treatment (Mbanya et al., 2019). The frustrations they face include, but are not limited to, issues of communication where they have difficulty in expressing themselves in Norwegian (ibid). This has led to apathy on the side of the migrants towards seeking healthcare in the country treatment (Mbanya et al., 2019). Such an act poses great health risks for the migrants and the country as well since it is not always possible to seek medical care in the shortest possible time in a different country. Most importantly, it is difficult in this Covid-19 era to seek medical care in other countries due to the risk of infection. There is therefore the need to tackle these

inequalities that exist to make the health sector quality and accessible to all as enshrined in the constitution.

There is no one factor to explain the inequality existing in the health sector but rather several factors that may be intertwined with each other (Småland et al., 2011)**.** The blockades to achieving equal health coverage as previous research shows are language barriers, insufficient knowledge on the healthcare processes, complicated health care procedures, and cultural differences (Mbanya et al., 2019; Herrador et al., 2015; Småland et al., 2011). Resolving issues of inequity among migrants is one crucial step that can ensure access to quality health care among ethnic minorities in Norway as it helps people to gain trust in the health system.

2.7.2. Insufficient knowledge of the health care procedures and processes

A study by Mbanya et al., (2019) pointed that a lot of migrants living in Norway did not have enough knowledge and information regarding where to seek appropriate heath care aside from their General Practitioners (doctors). Some of these migrants have lived in the country for over a decade but are still not abreast with heath procedures. Most of these people were those who needed help with drug abuse, psychologically related illness and trauma. They were oblivious of the existence of different health units and therefore did not know where they could get treatment, counselling, therapy, among others. These were specifically migrants from Sub-Saharan Africa (ibid). Insufficient knowledge on the heath care procedures in Norway is triggered by the fact that most of the migrants are not very fluent in the Norwegian language and therefore find it difficult to communicate (Mbanya et al, 2019). Also, the Norwegian health system is not adjusted down to suit the needs of migrants (Lyberg et al., 2012, pp. 290-291). Most of the health information cannot be found in the migrants' own language and this makes it difficult for these migrants to have access to information. In addition, most of the health workers do not have any additional education on cultural diversity about treating migrants with diverse backgrounds (ibid). A lot of strategies have been adopted in various countries to bridge the gap between quality healthcare and migration. In Spain, health workers in about thirty-three hospitals have undergone intensive training on how to provide healthcare to people from different cultures and backgrounds (WHO, 2010). They have received training on communicating and understanding people from other backgrounds which gives them the basis to offer standard care to people from ethnic minority

backgrounds. The method adopted by Spain is one of the crucial steps that can ensure equity in healthcare.

2.7.3. Maternal healthcare among migrant women in Norway

There were 790, 497 Norwegian-born children who had migrant parents (Statistics Norway, 2020) as of March 2020. The continuous increase in birth by foreign women in Norway calls for increased attention to migrant women's maternal healthcare. Previous research points to barriers that prevent these women from accessing quality healthcare (Lyberg et al., 2012). Most of the midwives pointed out that women from migrant backgrounds are not punctual at health appointments. It is either they come late or forget to show up; in other cases, they show up when they do not have any appointment with their personal midwives (ibid). In short, they do not understand the maternal healthcare system and how it works. Most of these women lack knowledge of the procedures involved in accessing maternal care in Norway.

The existing heterogeneity among women of foreign nationals is one of the challenges identified among health workers (Lyberg et al., 2012). Whiles some of the women have attained higher levels of education, others have low to no education; this disparity may exist even in women originating from the same home country (ibid). Most of the Somalian women freely communicate their feelings, problems to the health workers whiles majority of Arabian women are often shy and reluctant to discuss sensitive and vital information with their care providers (Lyberg et al., 2012). This is mostly due to different cultural traditions and norms existing between the various categories of migrant women.

In addition to the above, language barriers and difficulty in communicating often affects the quality of care (Mbanya et al, 2019; Lyberg et al., 2012; Herrador et al., 2015; Småland et al., 2011). Some of the health workers find it difficult to communicate with their migrant patients because they (patients) do not speak or understand Norwegian. In instances where both the health worker and the women do not speak a common language, an interpreter is involved. The use of interpreters has however been criticized by the health workers in situations where a male interpreter is used in conveying sensitive and vital personal information (Lyberg et al., 2012, pp. 291-293). Health workers together with their patients are not comfortable with the use of a male interpreter. The scenario is disturbing in cases where there are not enough female interpreters of a particular language. At other times, interpreters are involved over the telephone and they do not get to see or know the patient who is being interpreted (ibid). This

method in a way gives some level of comfort to the woman who is being interpreted and enables her to communicate freely.

One other problem encountered in ensuring quality and accessible health care to women from all backgrounds is the poor level of trust they have in the Norwegian public health system (Mbanya et al., 2019; Lyberg et al., 2012). A lot of migrants do not trust the public health system in Norway, and this could be due to different reasons. According to Mbanya et al., (2019, pp.7-9) distrust for the public health system in Norway is fuelled by the long waiting time involved in gaining access to health workers and also the dissatisfaction with the healthcare workers. Patients sometimes have to wait for days and weeks before they are able to see the doctor, specialist, or midwife. The unhealthy habit of taking long to seek treatment has reduced the trust migrants instil in the public health system. Also, dissatisfaction with healthcare providers may be related to issues of communication as the health providers may not fully understand migrants who are not fluent in Norwegian. However, research has proven that people who speak and understand English sometimes use English as a second language in communicating with their health providers (Mbanya et al., 2019). The level of satisfaction among migrants who use English as a second language of communicating at the health care is higher than those who speak neither Norwegian nor English.

Most of the migrant women tend to trust private health services in Norway better than the public health sector. This according to the care providers may be due to what they have heard and the influence of other migrants (Lyberg et al., 2012).

In some scenarios, the midwives believed that some migrant women decided to give birth in order to enjoy the financial support accompanied with childbirth as the state provides some level of monetary support to parents who have children in Norway (Lyberg et al., 2012, p.292). The monthly child support allowance provided by the state enables the women to support their families in their home country (ibid) and as such becomes the main motivation for having children (ibid).

2.7.4. Insufficient resources in promoting women's health and well-being.

A key problem raised by midwives is the inadequate resources in the form of funds to aid in health promotion (Lyberg et al., 2012, pp. 292-293). According to these health workers, the importance of indulging mothers and expectant mothers in activities that seek to integrate migrants in preventing isolation cannot be understated. Engaging mothers in healthy activities after birth reduces their risk of post-partum related issues and depression as it seeks to

provide companionship (ibid). Some of these programs include open kindergarten where kindergarten sessions are organised free of charge for babies and their mothers from all backgrounds. In Kristiansand, open kindergarten is available throughout the week in different areas of the municipality (Kristiansand Kommune, 2020). This activity serves as an informal meeting hub for mothers with babies; as the women get to know each other and share their experiences on motherhood. In the same way, infants are able to play, be given free meals, and learn how to be sociable as they meet other infants in their year group. Such activity is one way to integrate others and learn about Norwegian standards of raising kids. It is not compulsory that women go for open kindergarten every day but rather it is relative as some may go once or twice a week (ibid). Other initiatives that have been organised to help women integrate into the system are cookery sessions and Norwegian lessons which according to health workers have a positive impact on migrant women's health (Lyberg et al., 2012).

2.7.5 Cultural differences

Different religions and cultures have a great impact on migrant women receiving antenatal and postnatal care in their host country (Balaam et al., 2013). This is because different parts of the world have different practices associated with pregnancy and childbirth which often leads to migrant women being more vulnerable in the countries, they find themselves (ibid). In recent times, some Western countries have employed various initiatives to help vulnerable migrant women acquaint themselves with the culture of their resident country. At the same time, the health professionals also get to understand the behaviour of the migrant woman with the help of a third party. The third party is referred to as a doula.

In 2008, Sweden introduced the use of 'duolas' to aid in communication between the migrant woman in labour and the health professional (Akhavan, 2009). Duola is a word of Greek origin which literally means a female who offers help to a fellow female. Sweden introduced duolas to help in communication and provide some form of support to migrant women during labour. The initiative first started in the city of Gothenburg which spread to other parts of Sweden (Dundek, 2006).

Norway in 2017 launched a similar program under the project ''Vulnerable, pregnant and new in Norway - Safe during childbirth with a multicultural doula' at the Oslo University Hospital (Haugaard et al., 2020). The main aim of the project was to promote equal access to maternal health care using the duolas who often come from the same country or share a similar culture with the expecting mother. They explain the culture of the woman in labour to

the midwife and also explain the Norwegian culture to the migrant woman to enable her to understand the maternal system. On the other hand, the midwife is able to understand the gestures of the migrant woman due to the presence of the multicultural doula (ibid). The duolas undergo training to equip them in their role (Haugaard et al., 2020).

Research has shown a positive correlation between the use of a doula at birth and high level of satisfaction among foreign women (Mottl-Santiago et al., 2008; Dundek, 2006)

2. 8. The existing gap in the literature

Maternal healthcare has gained a lot of attention among scholars with the aim of improving healthcare conditions among migrants as well women's integration into the health care of their host country. Previous research in Norway has been skewed to migrants' maternal healthcare among the health workers. However, not much has been done in establishing migrant women's experiences with the health care system in Norway (Lyberg et al., 2012). There is therefore the need to leverage scholarly and policy insights related to how women of migrant backgrounds are coping with the healthcare system in Norway during pregnancy and childbirth (ibid). This according to Lyberg et al., (2012) is important in knowing the kind of relationship that exists between migrant women and the maternal health system in Norway. A study on this will bring out the level of trust between these two parties and as well highlights the positive outcomes and existing challenges. This will be a source of information for future migrant women who will be receiving antenatal and post-natal care in Norway and also serve as an important source of information for the health service to consider.

2.9 Theoretical framework

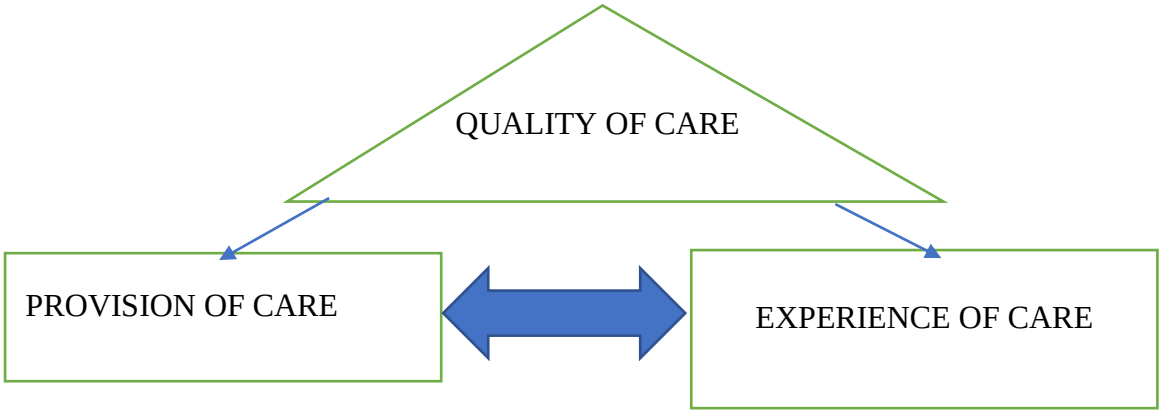
Norway has already achieved the WHO target of 'reducing maternal mortality rate to less than 0.2%. As of 2017, the country had a record of 2 per 100,000 birth (WHO, 2018) while other nations like South Sudan had a maternal death rate of 1, 150 per 100, 000 birth (ibid). A close look at the records may seem like Norway has an almost 'near-to-perfect' maternal healthcare system, which may not relatively be the case. Research points out that issues of inequality continue to exist in access to health care among migrants in Norway (Mbanya et al., 2019; Munthe-Kaas et al., 2018).

Norway is one of the countries that offer universal access to quality health care among every resident in Norway, be it native Norwegians, legal migrants, and asylum seekers (ibid). However, the issue of universal access as stipulated by law does not always exist in practice

as there have been barriers that prevent equal access to quality health care. In the same way, research has shown the existing inequity in the public health care system hampers migrant women from having access to quality maternal health (Lyberg et al., 2012).

Given this, the theoretical framework of this study discusses the maternal healthcare system in Norway using the Quality-of-care framework propounded by Hulton et al., (2000).

Figure 2.1 Quality of Care Framework



This is the author's own diagram to illustrate the quality-of-care framework by Hulton et al., (2000).

The 'Quality of Care framework' is propounded by Hulton et al, (2000). This approach describes maternal care under two main components which are; Providing Care and Experiencing Care. These are the two factors that account for the overall quality of maternal care worldwide. Providing Care has to do with the health system, procedures, institutions, and professionals who are tasked with the responsibility of offering health services to pregnant women whiles experiencing care applies to the pregnant woman who is at the receiving end.

Factors such as the availability of adequate health facilities and professionals, good and easily accessible referral systems all come to play under the Provision of Care (DeGeyndt, 1995). When it comes to the context of migration, it is not just enough to have good health services, but rather modifying these health systems to integrate the needs of immigrants (WHO, 2010).

These are known as system-level interventions. As already mentioned, thirty-three hospitals and health facilities in Spain have been modified to make them easily accessible to immigrants (ibid). This does not mean the migrants were unable to access the health facilities, but rather there were some hindrances that made it difficult for these migrants. The staff were therefore taken through series of training and courses to enable them to adopt a migrant-friendly approach when attending to migrants (ibid). However, there is no one universal explanation for the 'migrant-friendly approach' making it relative to the country in question.

The provision of quality maternal care is the crucial to the eliminate maternal-related deaths (Hulton et al., 2000). However, for the purpose of this study 'Experience of Care' will be the theoretical framework for discussing migrant women's experience of the maternal public health system in Norway.

2.9.1 Experience of Care

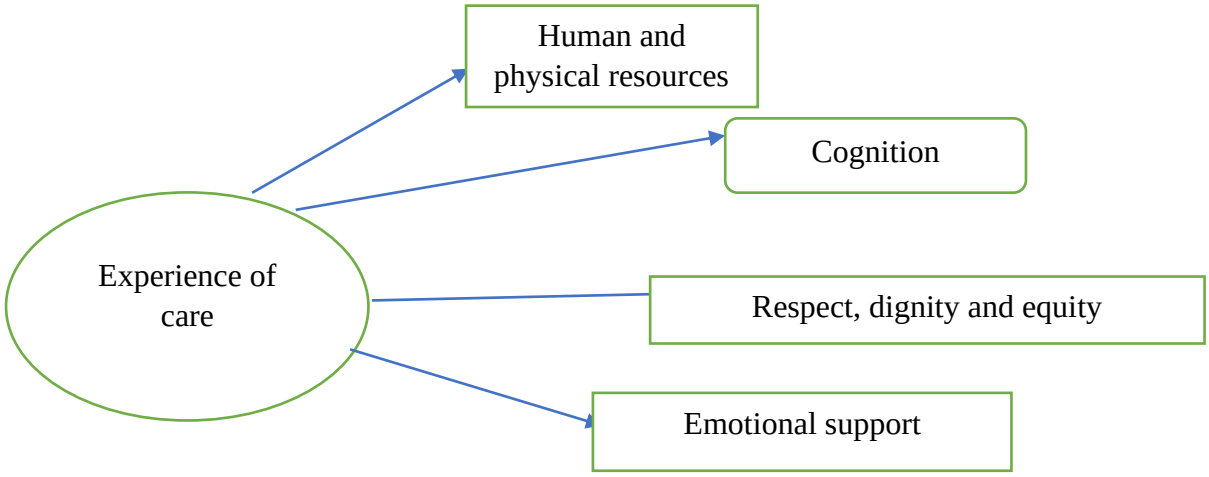


Figure 2.2 The Experience of Care theory by Hulton et al, (2000)

This is the author's own diagram to explain the Experience of Care theory by Hulton et al., (2000)

Providing good treatment to pregnant mothers is a key way of instilling trust in the health system (Okafor and Rizzuto, 1994). Thus, treating one woman right will go a long way to encourage others to seek medical treatment at the hospital and not to give birth at home (ibid). The experience of care model helps women to seek medical treatment and to avoid late antenatal care. A study in Nigeria showed that most pregnant women are expected to be ill-treated at the hospital during birth, not because of what they have witnessed but due to the

rumours that have been circulating from other women (ibid), a practice that does not encourage pregnant women to seek antenatal care.

To add to the above, women expect good interpersonal relations with medical professionals during treatment, oblivious of the available amenities (Haddad and Fournier, 1995). To the women in Zaire, being attentive to their concerns and showing them respect is what every good nurse should do (ibid).

The emphasis under the model is placed on the receiver of care who is the expectant mother or pregnant woman. There are four main factors at this stage that determines the quality of care. They include; human and physical resources, cognition, respect, dignity and equity, and lastly, emotional support (Hulton et al., 2000). The presence of these factors promotes trust and the willingness to seek maternal care amongst women. In Norway, most of the migrant Arabian women are reluctant to discuss their intimate maternal issues with their midwives (Lyberg et al., 2012). In the same vein, some of these women miss their home countries, relatives, and female friends in times of pregnancy. They find it difficult to cope with loneliness with their partners being at work for longer hours (ibid). These are some interesting issues that are associated with women of foreign backgrounds residing in Norway. The study, therefore, discusses the components of 'Experiencing maternal Care' below.

2.9.2. Human and physical resources

Availability of adequate health facilities and sufficient staff is one key indicator of quality healthcare. In Norway, the healthcare system is characterised by accessibility for all residents and universal coverage such that a resident in Norway does not need to have insurance before he or she receives medical care (Magnussen et al., 2009). As of 2016, the population of nurses in Norway was 111,036 which about eighty-five percent of them were employed in the health sector (Statistics Norway, 2019), clearly depicting a good ratio of nurses to patients. It is no doubt that countries in the Nordic regions are well endowed with adequate hospitals with modern infrastructure and technology (Magnussen et al, 2009) of which Norway is no exception. However, Hulton et al (2000) argue that not only is infrastructure key but also, the hospital environment in terms of cleanliness and the amenities provided in relation to food, toilets, and issues of overcrowding.

A study conducted in five African countries revealed that the caesarean sections of some hospitals were substandard and not fit to be used for such purposes according to the WHO

specifications (ibid). These countries; - Kenya, Namibia, Rwanda, Tanzania, and Uganda showed poor and low standard maternal infrastructure, inadequate staff, and thus out of one, generated a low mean score of 0.38 on the assessment of Quality maternal care (ibid). This is quite interesting because Norwegians may not see this to be an issue as the hospitals are always clean. However, in some low developed countries, there is not adequate infrastructure not to even talk about the availability of beds and cleanliness (Kruk et al., 2016).

2.9.2a. Resources (Physical and human) in the Norwegian context

Hulton et al., (2000) emphasised sufficient visits (time) between patients and their health care providers. In the Norwegian context, it is worth discussing sufficient medical visits and also getting the needed attention from health workers. Although the maternal health system in the country is characterised by regular appointments with midwives and personal doctors, migrant women are often not punctual at these visits (Lyberg et al., 2012, pp.290-292). The women in some cases forget about their appointments and do not show up at all while others show up later than expected. In the same vein, there is to an extent poor communication between the heath workers and patients. Most of the patients leave as soon as the medical examination is over without asking questions or seeking an explanation. This contrasts with their Norwegian counterparts who seem interested in every bit of information and are always eager to seek explanation (Lyberg et al., 2012). The midwives in Norway try their possible best to give women the necessary attention related to their pregnancy. However, some of the women (migrants) are often timid and withhold sensitive information from their health care providers (Lyberg et al., 2012). This becomes difficult for the midwives who in most cases want to help but do not have enough training and education on how to understand women from different cultures (ibid).

2.9.3. Cognition

Every woman has the right to information on her health status (Donabedian, 1988) and to seek an explanation from her health provider; be it doctor, nurse, etc. They also have the right to choose their preferred treatment in the cases of multiple options. Whiles some women may be well acquainted with the cognitive process, others may not even be informed on their health status. Cognition here is solely dependent on the provider-client exchange of information as propounded by Bruce (1990) such that doctor or health service provider must be honest in relaying information to his or her patient. At the same time, a patient's health information must remain confidential between these two parties. In discussing health

problems with clients, research has proved that most women with low literacy do not often get an explanation from their doctors on their health situation (Matthews et al., 2005). Sometimes doctors examine patients without explaining their health status to them; these doctors only act as authoritarians where they give orders to their patients and do not expect any question from them (Campero et al., 1998).

Women have a say to determine which kind of treatment they want in situations where they are multiple options available (Hulton et al., 2000). In Norway, women from Eastern Europe prefer to have caesarean sections as compared to the natural method of labour delivery (Lyberg et al., 2012). East European women perceive caesarean birth as a more modernized way of giving birth and this accounts for the rise in the number of caesarean sections by this category of migrant women.

2.9.3a. The impact of communication on cognition; Norwegian maternal health system

One of the main factors that impedes good doctor-patient relationships among migrants in Norway is the language barrier (Munthe-Kaas et al., 2018). It takes a lot of time before migrants are fully integrated into the system (ibid). As such, it becomes difficult to express themselves when they have not yet mastered the language and though most of the doctors in Norway speak English, not all migrants speak English, thereby making language a key barrier in seeking medical help.

The use of interpreters has been adopted to aid communication between pregnant women who do not speak or understand Norwegian and their healthcare providers (Lyberg et al., 2012). However, some of the interpreters are males which makes it difficult to describe sensitive, intimate information with a male person who is not your husband. In some instances, health workers employ the use of telephones with the interpreters so that they are not able to identify or recognise the patient who is being interpreted (ibid). The problem with the use of interpreters is the insufficient number of professional interpreters as most of them do not have relevant or professional training in interpreting others (Lyberg et al., 2012).

2.9.4. Respect, dignity, and equity

It is important that women, in general, are provided with an equal level of treatment irrespective of their ethnic background, nationality, level of education, age, and societal status (Hulton et al., 2000). This is what Norwegian healthcare seeks to obtain although there have been barriers that do not ensure equity (Munthe-Kaas et al., 2018).

Research highlights the importance of respect in the patient-health worker relationship (Hulton et al., 2000; Mbanya et al., 2019). Migrants who feel their healthcare providers did not show them any respect often boycotted their host country's health service to seek medical attention in other countries (Mbanya et al., 2019). In Norway, a lot of people with a migrant background have sought medical care in other countries due to the disrespect their personal doctors or other health workers offered them. They have therefore associated disrespect with the public health services and have developed zero trust in the system (Mbanya et al., 2019).

The best thing a midwife can do for a woman in labour is to accord her the necessary respect and not to be rude because she is in pain. A lot of studies point out the rude behaviour of some midwives during birth (Wedderburn & Moore, 1990). In India, some women reported issues of abuse by healthcare providers (Hulton et al., 2007). These women were either insulted, slapped, or ignored when they were in labour (ibid). There have been issues where women did not get any information on their health status from their doctors or midwives because they did not belong to a higher class or religion in society **(**Hulton et al., 2007).

Sen (2002) argues that there is a higher chance of women being disrespected due to their low level of education, such that respect is more often accorded to well-educated ones at the detriment of those who have no or low educational level. In Norway, there have been cases where migrants felt they were being treated unfairly by their healthcare providers (Mbanya et al., 2019) because they were migrants. A study among midwives in the country highlighted the essence of according to the necessary respect to pregnant women irrespective of their reserved nature, cultural background, educational level, or their inability to speak Norwegian (Lyberg et al., 2012). Receiving the accorded respect from a health worker is a way that encourages women to open up to their midwives and doctors.

2.9.5. Emotional support

It is important that during labour, spouses or close relative of the woman is present to give some form of comfort and support, so they do not feel they are all alone (Hulton et al., 2007). Denying the husband or partner access to his woman in labour also brings stress and discomfort to the man, thereby keeping the man worried and putting him under unnecessary anxiety and stress. When men are allowed to be with their spouses during labour, it generates strong social and psychological assistance and aids in reducing stress and its related cases of anxiety in the new mother (Kennell & Klaus, 1991). At the same time, providing strong and basic support to the new mother helps in reducing her risk of postpartum depression and

anxiety associated with birth. Also, it aids the woman to stay strong and healthy to take care of her new baby (Hofmeyr et al., 1991).

World Health Organisation encourages medical staff to not only perform medical services but rather be able to offer support and concern in difficult times like labour, operations, and diagnosis of deadly diseases (WHO, 1996). In Norway, spouses and some cases, a close relative are allowed to be with the expecting mother when she is in labour.

There should be equity such that what is stipulated is what should be provided. The Norwegian Institute of Public Health in their research acknowledged the fact that there is inequity in the health sector when it comes to migrants' access to healthcare (Munthe-Kaas et al., 2018).

The absence of equity when it comes to migrants may be due to language differences, sociocultural factors, and sometimes religious beliefs (Munthe-Kaas et al., 2018) and in this study, I wish to explore if there is an absence of equity and what may cause potential absence. In addition, the study explores the treatment meted out to women of foreign background and will define the relationship that exists between caregivers and recipients in the maternal health system in Norway.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter describes the procedures, methods, and channels that were used in organising the research. It consists of the research paradigm and strategy adopted, a description of my respondents and sample size, sources of data, and the sampling method. In addition, I have discussed the ethical issues involved in undertaking my research. This chapter, therefore, discusses all the methodological approach which were employed in arriving at the findings.

3.1.0 Research paradigm and epistemological consideration

In general, what informs the meaning and interpretation of research data is guided by the values and philosophies of the researcher. These philosophies and values that guide any enquiry are dubbed research paradigm or worldview or philosophical foundation (Creswell, 2014; Kivunja & Kuyini, 2017). In this study, the term research paradigm will be used. A paradigm is defined as "a basic set of beliefs that guide action" (Guba, 1990 cited in Creswell, 2014). A research paradigm can be defined as a set of theories, principles, and procedures that form the philosophical worldview which defines what valid research is and the appropriate methods that can be applied in that research (Meyers & Avison, 2002). Creswell (2014) refers to a research paradigm as the philosophical orientation about the world and the nature of research adopted by the researcher. Thus, paradigms offer values that influence the researcher on what should be studied, how it should be studied, and how the results of the study should be interpreted (Bryman, 2012; Creswell, 2014; Kivunja & Kuyini, 2017)

In conducting social research, there are four main paradigms; namely, Positivism, Interpretivism, Pragmatism, and Transformative that influence how the social phenomenon is been perceived and how the social world must and should be studied (Bryman, 2012; Creswell, 2014; Saunders, Lewis, & Thornhill, 2009). It is important to note that these paradigms are differentiated by their various epistemology, ontology, and methodology assumptions (Bryman, 2012; Saunders et al., 2009).

Epistemological consideration "concerns itself with what should be regarded as acceptable knowledge" whilst ontological consideration concerns itself with the "nature of social entities", thus to what extent should social problems be considered external or a part of social realities (Bryman, 2012, pp. 27-32). Lastly, methodology refers to the framework used to

conduct a research within the context of a particular paradigm. The debate among researchers with regards to epistemology and ontology is whether social reality should be perceived as objective, exclusive, and independent of any human influences, hence, must be studied through natural science principles i.e. *positivism*; or social problems should be perceived as socially constructed and subject to human interpretations and actions, i.e. *constructivism/ interpretivism*; there must be a mixture of ontology and epistemology i.e. *pragmatism* (Bryman, 2012; Creswell, 2014).

Given this, it is therefore appropriate that this study adopts the interpretivism (constructivism) paradigm. Interpretivism is an epistemological paradigm that holds the view that the subject matter of the natural sciences is fundamentally different from that of the social sciences; *people and their institutions* (Bryman, 2012, p. 28). Further, proponents of this orientation contend that truth or true meaning comes as a result of researchers' engagement in the real world (Crotty, 1998, p. 8). Hence, the principles and processes for the study of human behaviour and social events are not mutually exclusive, but interacts and thus make it highly influenced by several external factors. The ontological consideration to this interpretivist worldview is constructionism. Constructivism asserts that social problems or issues and their meanings are repeatedly being accomplished by social actors (Bryman, 2012). According to Agyemang (2017), human beings are the most "variable of all variables" *(meaning their behaviour at a particular point in time may not be consistent with behaviour at another time).* This implies that knowledge is produced through social interaction and is in a constant state of revision. In this regard, the main focus of my study is to investigate the experiences of migrant women concerning the Norwegian maternal care system.

To study social phenomena constructively, a qualitative approach is applied, in which data is systematically interpreted. Hence, qualitative ethnography comprising of in-depth interviews and participant observation was chosen for this research. This helped me gain an in-depth understanding of the respondents in this research work. Also, this approach made it possible to assess the participants' viewpoints in their own words on maternal care during and after birth.

3.2.0 Research Strategies

Research Strategy generally refers to the main plan that guides a researcher in undertaking a study, right from the onset to the end (Bryman, 2012, pp.35-39). According to Bryman, (2012) it is an orientation that determines the path a study should take in collecting and

analysing data (ibid). Research strategy can be grouped into two main types; qualitative or quantitative. Quantitative deals with numerical data and often follow a mathematical formula or method to generate a theory whiles qualitative is concerned with gathering data that is non-numerical (Bryman, 2012, pp.380-385) to arrive at a finding. Non-numerical data such as personal experiences, behaviours is first-hand information that helps a researcher to gain a deeper understanding of a phenomenon. I adopted the qualitative research strategy for my study to help develop detailed findings 'in accessing maternal healthcare among foreign women in Kristiansand' because it best suits my phenomena.

3.3.0 Sample characteristics.

As already outlined, I adopted a qualitative research strategy as the methodological approach to find answers to my research questions (O'Reilly, 2009) with the target group being women who have migrated to Norway from their home countries and have given birth in Norway. I refer to this sample group as first-generation migrants. I employed the use of qualitative interviews which were semi-structured and gave the respondents the freedom to discuss the topics in the interview.

First-generation migrants, for the purpose of this study, are foreigners who were born, raised, and lived in other countries before settling in Norway. Initially, I targeted 15 migrant women who have given birth in Kristiansand as my interviewees. However, only eleven migrant women partook in the interview. This is because four other migrant women did not give their consent to undertake the interview. I, therefore, interviewed only eleven migrant women.

A total of 5 health workers were interviewed on how they perceive equality of services and what may potentially cause the absence of such equality if any inequity exists. I contacted 5 health workers who all agreed to partake. I first knew one health worker, who introduced me to two other health workers. The fourth health personnel was my course mate and thus was easy contacting her and she readily agreed to participate. I also got in touch with the fifth health worker whom I got to know when I was pregnant and receiving maternal care.

3.3.1 Sources of data

I have employed the use of both primary and secondary data for my research. Secondary data is used in the literature review and the theoretical framework. The theoretical framework was based on the 'Quality of Care' theory developed by Hulton et al., (2000). Here, I reviewed the work of various scholars in relation to maternal health, migration, and quality of care. For my

data analysis, I relied on the primary data which consists of the interviews I did. The interviews I undertook were my main source of data for the findings and analysis.

3.3.2 Sampling method

I applied the purposive sampling method as highlighted by Bryman (2012, pp.418-420) to recruit my respondents. Purposive sampling is relevant when participants have a direct relationship with the research study. It is not based on generalisation but rather targets respondents whose participation are relevant and crucial for the research questions and objectives (ibid). I had two sample groups who were my target for the research. The sample groups include foreign women living in Norway and health workers in the maternal health service in Kristiansand.

Migrant women who have given birth in Norway became the first target group. Having given birth in Norway myself and knowing some potential informants, I also relied on **snowball sampling**. Snowball sampling is applied when the researcher contacts a few numbers of people who are relevant to the research, and these people in turn introduce other relevant respondents to the researcher (Bryman, 2012). Concerning my study, I knew a few women through my background as a migrant woman and they helped me to get connected with the other foreign women in Kristiansand. Thus, snowball sampling helps the researcher to locate other respondents through the few participants the researcher may know.

With this study, I first contacted three migrant women whom I already knew. They led me to other foreign women living in Kristiansand. In addition, I was able to get in touch with one of the migrant women who is a ‘duola’ in Kristiansand. The woman had just started her work as a doula when I contacted her. A doula is a fellow migrant woman who is well integrated into the Norwegian society, speaks Norwegian, and has gone through intensive courses aimed at equipping women to provide emotional, physical, and cultural support to the migrant woman in labour (Haugaard et al., 2020). She acts as an intermediary and conveys information between the midwife or doctor and the woman in labour (ibid). Her services are limited to labour.

Snowball sampling has played a crucial role in this research as it was the main way, I was able to get in touch with two health professionals who play an important role in maternal services at Sorlandets sykehuset, the main hospital in Kristiansand. One of these health workers is the patron for the newly initiated doula program in the municipality. As earlier mentioned, the doula program is set up to provide foreign women support during childbirth.

This support is in the form of a fellow migrant woman from the same culture or country who has lived in Norway for a long time and is well integrated into the Norwegian culture.

In addition, health workers who provide direct antenatal care became the second target group. Here I did not aim to interview health workers who have treated my migrant informants, but rather discuss with health workers on a more general note their perspective on equality of health care services when it comes to maternal health and what may be explanatory factors for potential inequality if any.

The researcher was able to interview other respondents through the recommendations and help of the participants. The few participants who were contacted led me to other respondents which was very helpful.

3.3.4 Interview

As already outlined, I employed the use of semi-structured interviews (Bryman, 2012, pp.211-213) which creates room for discussion so that the researcher is able to ask questions which are not closed but rather open-ended in order to solicit more information from the interviewee. In addition, this study employed the use of an interview guide which was approved by the Norwegian Center for Research Data (NSD). The interview guide consists of topics the interview has to cover. The interviewee had the freedom to express herself and this helped to bring out some vital information which were not in the interview guide. Also, the use of semi-structured interviews gave room for flexibility in this qualitative research. A copy of the interview guide can be found in the appendix below.

As already mentioned, the interviewees consist of two groups, namely; migrant women who have given birth in Norway and secondly, health workers who are tasked with providing antenatal care to pregnant women. The interview with migrant women was expected to last between 30-45 minutes just like the health care workers. However, the interviews lasted more than the supposed 30 minutes. The duration for the migrant women lasted between 45-65 minutes with the shortest interview lasting for forty-two minutes and the longest interview-, one hour fifteen minutes.

Migrant women were interviewed about their relative experience of maternal care in Norway whiles health workers, on the other hand, were interviewed to give an account of the treatment women are offered and whether there may be differences in services.

Due to the covid-19 protocols, it was not appropriate to have face-to-face interviews with three of the health workers. Due to this, three health workers were interviewed on zoom. The interview was recorded with their consent. Aside from these three health workers, all the other participants had a face-to-face interview where we observed the one-metre distance rule (covid-19 protocol).

My background was crucial in this research since I am a migrant myself who has been living in Norway for the past two and half years and gave birth here. I, therefore, happened to know a few other women who were also from other countries and have had babies here.

3.3.5 An overview of the interviews conducted.

In total, I conducted sixteen separate interviews. With this, eleven of my interviews were with migrant women who make up the first sample. In addition, I had five interviews with health professionals who make up my second sample group. One of the health professionals was interviewed twice, one as a health worker and then, secondly as a migrant woman who gave birth here in Kristiansand. This is because she fit in my two sample categories. In addition, I had the opportunity to interview a migrant woman who worked as a doula here in Kristiansand. As at the time of the interview, she had newly started her work as a doula and had already assisted in two deliveries. It was very important for me to interview both health workers and migrant women to enable me to have an unbiased approach to my research. Both the health workers and migrant women raised interesting points and vital information which added to the quality of my research.

3.3.6 The language used for the interviews.

All my interviews were conducted in the English language. I did not encounter any problem with the use of English in conducting my interviews. This is because out of the total fifteen migrant women I contacted, fourteen of them spoke and understood English whiles one of them could not speak English nor Norwegian, as she only spoke Arabic. It was therefore difficult to conduct my interviews with her since that will involve an interpreter. It was difficult to observe the covid-19 protocols with the presence of a third party and thus I did not interview this migrant woman.

The health workers who partook in my study were able to express themselves in English and this was favourable for the research. I did not face much problem conducting my research in English.

3.4.0 Validity and Reliability

Reliability in research is simply the ability of the research findings to be replicated. In other words, the findings of the research should be the same when replicated using similar or the same methods (Bryman, 2012; Lewis & Ritchie, 2003). It is often referring to as the extent to which the data can stand the test of time. The data, therefore, must be consistent when the research is repeated or reproduced (Gibbs, 2018). On the other hand, research validity can be described as the extent to which the data is genuine, realistic, trustworthy, and authentic (Bryman, 2012). Thus, the interpretations of the findings must reflect the through opinions expressed by the respondents. Hence, the researcher must be trustful and honest with the data. In other words, what the researcher is announcing was what has been professed by the respondents (Lewis & Ritchie, 2003).

In this study, to ensure reliability and validity, I, first of all, listened to all the audio recordings from the field while cross-checking with the interview guide. This was done to ascertain if all the questions were asked accordingly. Secondly, the recordings were transcribed, and every statement was written down in a word document. The transcribed documents were checked again two times while listening to the audio recordings and comparing them with the notes gathered in my research book. The core objective for step two was to avoid obvious mistakes during the coding process. Finally, the transcribed documents of three respondents were sent to them for crosschecking to prove that indeed the transcriptions echoed their perspectives on the phenomenon under study. Due to proximity, I met all the three personally and indeed they all admitted that the transcribed documents were the true reflection of their opinions. I did not in any way alter what all my respondents said and as such this research is a true reflection of all the interviews I conducted.

3.4.1 Data Analysis

Data analysis is the process of reviewing, sorting, translating, and presenting data in order to identify relevant material and draw conclusions to support research findings (Miles et al., 2014). According to Malterud (2001), qualitative data analysis involves decontextualisation and recontextualisation. Decontextualization involves studying parts of the subject matter more closely in relation to other similar issues found in the data. On the other hand, recontextualisation ensures that the similar issues identified from the data correspond to the context from which the data was gathered. The aim is not only to sustain the connections between the field and the informants' accounts of reality but also to identify related themes that correspond to the subject matter (Malterud, 2001, p. 486).

Thematic analysis was used for this study which has been identified as one of the most accepted
qualitative data analysis approaches and involves the search for recurrent themes that are of significance to the research question (Bryman, 2012). Put simply, thematic data analysis dissects and examines carefully raw information so that the researcher could determine recurring patterns (Javadi & Zarea, 2016). In other words, thematic analysis involves the identification, coding, analysis, certification of themes, and generation of the report within gathered data (Braun & Clarke 2006).

An important aspect of thematic analysis is the formulation of themes. A theme represents a category of indicators built on coded transcripts and notes, identified through data, that relates the research question and provides the study with a theoretical understanding of data (Bryman, 2012, p. 580).

In this study, data analysis was done manually. Hence, I read the transcribed statements from each respondent that relate to each research question to formulate meanings. Meanings of statements were landed after re-evaluating, reassessing, and rereading participants' statements. Afterwards, labels or codes were then allocated by the researcher manually to statements that occurred throughout the to represent a category. From this point, similarities and differences in respondents' answers emerged. The emerged answers were found to be universal to all participants' accounts to the questions asked during the interview. These formed the recurring themes from the respondents' views and explanations given to maternal health care in Norway.

3.5 Ethical Consideration

3.5.0 Overview of ethical issues

Issues relating to ethical consideration must be well tackled to make the research an honest and disciplined piece that does not violate the rights or feelings of an informant or interviewee (Bryman, 2012, pp. 130-144). I gave importance to the ethical issues surrounding the study and to the ethical requirements of conducting research as outlined by the NSD and the Norwegian National Research Ethics Committees. Because of this, this study adopted the four main criteria highlighted by Diener and Crandall (1978 cited in Bryman, 2012) which are as follows; 'privacy invasion, getting the consent of the participants, harm to participants and lastly deception'.

3.5.1 Privacy invasion

First and foremost, the study was based on informed consent such that I interviewed only those who agreed and signed to partake in the study. Initially, fifteen migrant women were contacted but only eleven agreed to participate. Given this, I interviewed only the eleven women who gave their consent for participation. This is in line with the submissions of the Norwegian National Research Ethics Committees where only migrant women who consented were involved. Also, these women's names, addresses, and other confidential identities were not shown. The researcher in the course of the interviews respected the views of the interviewee and did not force or pressure the interviewee to answer a question they were not comfortable with. I realized that some of my interviews were soo emotional that the women began to cry due to one or two discomforts they encountered with the maternal system in Norway. However, I told them it was fine for them to take some time off, relax a while and come back. I also did not force them to say anything they did not want to say. The interviews were highly consensual and confidential. I referred to my migrant women with alphabets like woman Z, woman H, and the alphabets had nothing to do with their names or initials. This was the main way I ensured their anonymity in my findings.

With the health workers, the same method was applied where only health workers who were willing to partake in the survey and signed the consent form were interviewed. The names and identities of the health workers were not revealed. However, their job positions were revealed due to the nature of the research which they agreed. Thus, a total of three midwives and two child nurses participated.

3.5.2 Getting the consent of the participants

Consent is closely related to privacy such that permission must be sought from and approved by the participant before the interviewer can proceed (Bryman, 2012, pp.18-142). First and foremost, before the researcher proceeded with the data collection, permission was sought from the Norwegian Centre for Research Data (NSD), the health care workers, and the migrant Secondly the data was collected after approval had been given by the listed agencies above. I applied for permission to undertake my research from NSD on December 07, 2020 and received a confirmation from NSD on January 15, 2021. I began my first trial interview on the same day I received the confirmation.

Before I conducted my interviews, participants involved (migrant women and health workers in Norway) were briefed about the study, its objectives, and the statement of the problem.

This is an important aspect of consent outlined by the Norwegian National Committee for Research Ethics in the Social Sciences and the Humanities (NESH), (2019). According to NESH, participants of a survey have the right to information about the research. I, therefore, explained the aim and purpose of the research and the fact that it is for academic purposes for the completion of my master's program.

After the study has been completed and submitted, it will be available on the University of Agder website meaning it will be on the internet and be easily accessible. I also intend to get a publication out of my study. I informed my participants to get their consent.

Also, some of the health workers at the hospital in Kristiansand have expressed interest in having access to my findings. Because of this, it is possible I may have a presentation on my thesis work at the department of labour at the hospital in Kristiansand.

In addition to the above, migrant women (participants) were briefed about the consequences of the research. One of the consequences of this study is that the government, agencies, and the general population will get to know how immigrant women in Norway describe their experiences of the health system are during labour and antenatal care. The strengths and weaknesses of the maternal health care system in Norway will be highlighted together with recommendations for the maternal health sector.

Consent here was in the form of a document that spells out the purpose, aims, and objectives of the research. The participants were required to sign the document to show their approval before the interviews were conducted. A copy can be found in the appendix section.

3.5.3 Harm to participants

The study seeks to do zero harm to participants (Bryman, 2012). Due to the covid-19 global situation, I resorted to three digital interviews on zoom with three of my informants who were at work. In addition to this, all the other interviews were face-face with the one-metre distance rule. This is in line with the country's covid-19 protocols. Also, the data of the participants remain discrete and confidential and was only used for the research purpose and not any other study. The participants' identities remained anonymous and instead replaced with alphabets such as 'migrant women Z', 'madam W who has given birth to two kids in Norway'. Maternal health and migration are one sensitive topic and I made sure I abstained from any kind of question or discussion that will do emotional harm to the participants. This has been briefly discussed in section 2.0 below.

3.5.4 Deception

According to Bryman (2012, p.143), a study can deceive the participants if the data collected is not used for its intended study or what the research was intended for. I, therefore, used the data collected purposely for this study and no other purpose than that.

3.6.0 Key ethical issues the researcher encountered

First and foremost because my study involves maternal care and migration, I knew I was going to face some emotional issues as some of the migrants may be reminded of how they came to Norway and others how painful labour was. To some, this may be unpleasant because a lot of migrants came to Norway to seek asylum and escape war or ethnic fights, abuse, religious attacks, and others that forced them to move out of their home countries (Mbanya et al., 2019). However, the key ethical issue I encountered with my informant was about the labour pain and how they remembered all they had to go through to bring a baby. This was the most emotional aspect of my study. More than half of the migrant women I interviewed shed tears at a point in the interview. This was very difficult for me myself since I have also gone through the pain of labour. However, I asked them to take a break anytime they started crying. I paused the recording, comforted them, and made sure they were alright before I continued with my interview.

Secondly, not all asylum seekers in Norway have received asylum status. It takes a relatively long period for an asylum seeker to be granted asylum in Norway although they may have their eleven-digit numbers and be enjoying social benefits. This is also a disturbing scenario as migrant women who are in this category may feel bad, stressed, and worried about their status in Norway. I thereby refrained from asking any issue relating to their stay in Norway, whether they have been granted their visas, refugee status, or not.

Also, when it comes to health workers, not everyone accepts migration. As Mbanya et al (2019) point out, some of the health care providers in Norway have personal resentment for migrants and most often show their dislike for these migrants by asking them why they are in Norway and in some cases asking them to go back to their home country.

For this reason, the health care providers who were interviewed were not asked to present their ideas on migrant women but rather the maternal process. Any other issue apart from the maternal procedure was not discussed.

Lastly and most importantly, some of the immigrant women and health workers felt unsafe and thought their identities will be revealed to the public. I will, however, through the consent form resolved this. I also kept informing them during the interview that their identities will not be revealed. This was the same with the health workers as some kept asking if their names were going to be revealed. I once again, assured them their details were going to remain anonymous. On the consent form, a section was made available that says, 'the identity of the participant will be made anonymous and not revealed'.

3.7.0 Covid-19 risk assessment for participants

In the wake of covid-19, this study adhered to the protocols by the Norwegian government and the WHO. I, therefore, implored the use of a zoom digital platform for some of the interviews with the health workers who were at work. Digital tools have become the safest platforms that prevent the spread of this disease. There is therefore no risk to the participants involved.

However, the majority of the interviews were face-to-face where we observed more than one-meter distance during the interviews. The researcher together with the interviewees use hand disinfectants countless times during the interview.

Participants were contacted via email and telephone calls to schedule interview dates.

3.8.0 Personal data collection

The study collected personal data for the two categories of respondents which are migrant women who have given birth in Norway and secondly health workers who offer antenatal care to women in Norway.

For the migrant women who have given birth in Norway, the following biodata was collected.

- Age: The researcher provided a category of ages where the informant was required to tick the appropriate age group applicable to her. For example, below 15 years, 15-20, 20-30.
- Marital status: Five sections under marital status were provided. These are; single, married, separated, divorced, widow.
- Country of origin: Country of origin remains an important factor when it comes to issues of migration. These countries may be developed, middle income, developing, or low-income countries. However, a section was provided for the immigrants to write their country of origin.

- Education (Highest level of education obtained): Low literacy level has often been identified with low-quality care (FHI, 2018). It is therefore important that the study gathers data on the educational level of migrants to be able to make a good analysis.
- Religious affiliation: categories were provided for the participants to choose their religious affiliation. These categories are; Christian, Muslim, Hindu, Buddhist, Atheist, and others.
- Place of residence: Although the research took place in Kristiansand municipal, it is important to know the areas in Kristiansand where our respondents are residing. They were therefore asked to state their area of residence.
- Languages spoken: The researcher provided options for the respondents to state the languages they speak, be it English, Norwegian, Arabic, and others.

The following biodata applies to the health workers who offer antenatal care in Norway;

- Age: For the purpose of this research, the ages of the various health care workers were collected.
- Occupation/Profession: The health workers were required to mention their specific profession in the health sector.
- Country of origin: This column helped to know the origins of the respondents.

There is the need to inform the respondents as earlier stated. My participants were informed through email where they could sign the consent form and reply. The NSD (2020) gives recognition for the use of email to seek consent from informants.

To both categories of respondents, an invitation to participate was sent out electronically via mail. The invitation broadly states the research title, its aims and objectives, the study area, the researcher, the methodology, and the category of participants.

3.9.0 Data storage

I recorded the interviews with a recorder and later transferred them to my personal laptop. For the interviews that were conducted digitally through zoom, they were recorded on my laptop whiles the interview was in session. The interviews were transcribed verbatim on my laptop which was safe since my laptop is my personal data machine and no other person had access to it. Personal data of respondents was used solely for the research and for no other purpose. In addition, respondents remained anonymous throughout the study, their identities were not revealed. This is in line with the NSD rules for data collection. Names of interviewees were changed with alphabets and numbers. For example, Nurse 2, woman D.

In conclusion, the study emphasized the need to pay attention to ethical issues to make the research a valid one. The researcher duly followed the appropriate procedures outlined and did not harm participants.

CHAPTER FOUR

GEOGRAPHICAL STUDY AREA

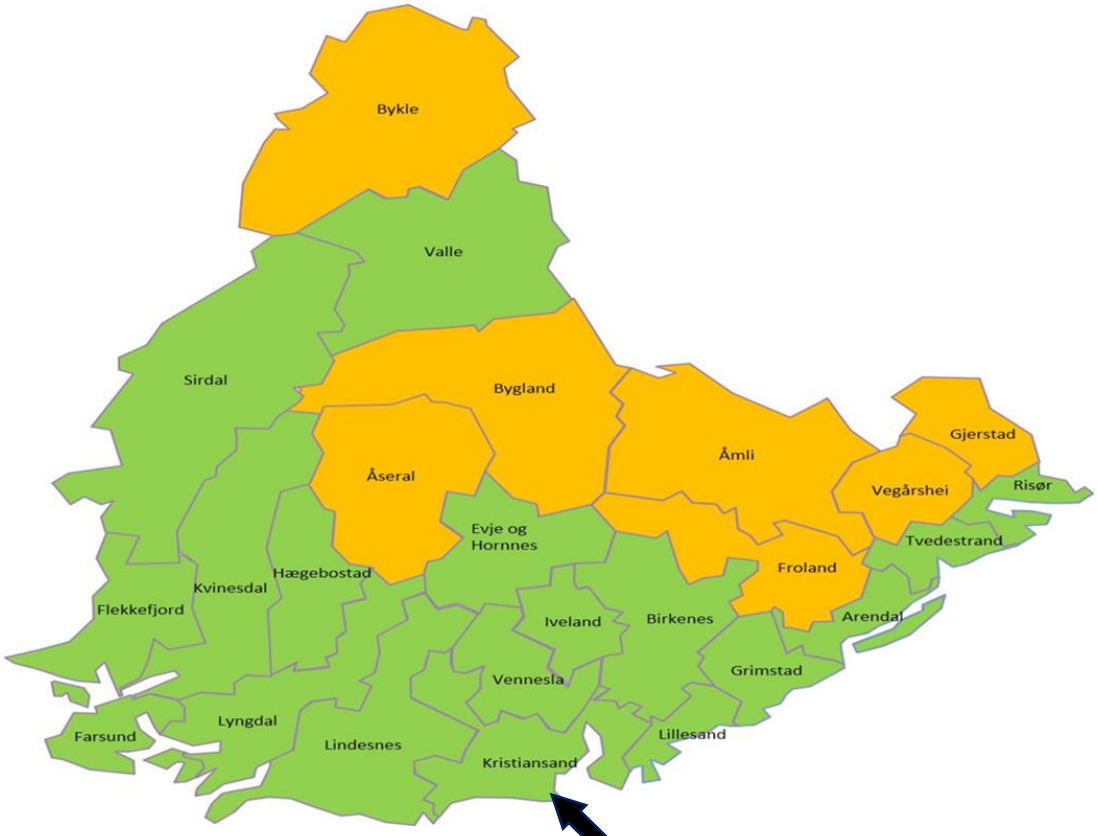
4.0 Introduction

I have briefly described the study area, Kristiansand in this chapter taking into consideration the geographical location and the migrant population.

4.1 Study Area (Kristiansand Municipal)

Kristiansand municipality is one of the municipalities in Norway and is located on the Southern coast of the country in the Agder county (Kristiansand Kommune, 2019) and about 318.3 Kilometers away from Oslo, the capital city of Norway. It covers a total land area of about 644.16 square kilometres (km²) and has a population of about 111,654 (Statistics Norway, 2020) as of 2020 (ibid). Kristiansand is the capital of the municipality and is home to one of the top universities in Norway; the University of Agder, Kristiansand also known as UiA. The main municipal hospital in Kristiansand is the Sorlandets Hospital. Geographical study area and context

Figure 4.1 Map of Agder county showing Kristiansand municipal.



Source**:** Agder fylke (Agder county, 2020) Arrow pointing to Kristiansand municipal.

The municipality is also multinational with immigrants from over 160 countries (Kristiansand municipal, 2019). This means a lot of different countries are well represented in Kristiansand. It is, therefore, conducive to conduct this research there as there are a lot of migrants. In 2019 a total of 958 children were born in the municipality (Statistics Norway, 2020).

As of December 31, 2019, a total of 16,918 migrants were living in Kristiansand and this corresponds to 18.33 percent of the total population in Kristiansand (Statistics Norway, 2020). Poland represents the country with the highest number of migrants (over 1,600) in Kristiansand followed by people from Vietnam, Somalia, Syria, Iraq, Eritrea, Kosovo, Chile, Denmark, Afghanistan, Russia, Bosnia and Herzegovina, Germany, and Sweden, in ascending order (ibid). Apart from these countries, all the foreigners from other countries living in Kristiansand are below three hundred persons per country. Table 4.1 shows the total number of migrants and children born in Norway to migrant parents in the Kristiansand municipality.

Table 4.1 Migrant population in Kristiansand as of 2019

Ascending order	Country of origin	No of residents	Ascending order	Country of origin	No of residents
1.	Poland	1,201	14.	Iran	452
2.	Vietnam	961	15.	Sweden	402
3.	Somalia	848	16.	Thailand	299
4.	Syria	832	17.	Pakistan	294
5.	Iraq	795	18.	Ethiopia	255
6.	Eritrea	711	18.	Great Britain	255
7.	Kosovo	698	20.	Lithuania	249
8.	Chile	629	21.	The Philippines	242
9.	Denmark	594	22.	Romania	227
10.	Afghanistan	587	23.	U.S.A	215
11.	Russia	583	24.	Turkey	211
12.	Bosnia & Herzegovina	482	25.	Lebanon	202
13.	Germany	470	26.	Palestine	200

Total no of immigrants + Norwegian born to immigrants – 16,918 (18.33%)
All other countries – 0 to 199 residents
This is the researcher's own tabulation to describe the 2019 migrant population in Kristiansand according to Statistics Norway (2020).

CHAPTER 5

PRESENTATION OF EMPIRICAL FINDINGS

5.0 Introduction

I have discussed and analysed my findings under the recurring themes (thematic analysis) in this chapter. As earlier mentioned, (in chapter three), my research consists of two sample groups which include migrant women living in Norway (group one) and health workers within maternal healthcare (group two). Lastly, I have provided a conclusion in relation to my findings.

5.1.0 Demographical Characteristics of The Migrant Women

Here, I present some background information about the migrant women who were interviewed (respondents) such as age, marital status, number of children, length of stay in Norway, languages spoken, educational attainment, and their religious affiliations. The results are shown using tables.

Table 5.1: Age of the respondents

Age	**Number of women**
20-29	1
30-39	6
40-49	3
60-69	1
Total no of respondents	11

Table 5.1 shows that the majority (six) of the respondents (migrant women) are between the ages of 30-39 followed by 40-49years of three respondents, with the remaining categories having one each. Notwithstanding, all the respondents are above 18 years which implies that there is no issue of teenage pregnancy and teenage motherhood.

Table 5.2.1 Children born in Norway

No of children born in Norway	No of women
1 child	7
2 children	3
3 children	1

The table above shows the number of children of respondents born in Norway. The majority of the respondents (seven) have 1 child each, three respondents have 2 children with one respondent having 3 children. The data clearly show that despite the numerous benefits

associated with birth, migrant women in Kristiansand are not giving birth to many children.

Table 5.2.2 Respondents' Country of Origin

Country of origin	
Nationality	**No of women**
Ghana	2
USA	2
Ethiopia	1
Chile	1
Sri Lanka	1
Canada	1
Uganda	1
Poland	1
Kosovo	1
Total	**11**

The table above (5.2.2) show the different countries of origin of the respondents as well as the number of children the respondents have given birth to in Norway. About nationality, the informants come from Africa (Ghana, Ethiopia, Uganda), North and South America (USA, Canada, Chile), Asia (Sri Lanka), and Europe (Poland, Kosovo). Getting respondents from different settings not only enriches the work but also ensures cultural diversity. Ghana and the U.S.A have the highest number of women participating in the study. They both record two women each while all the other countries have one woman each.

Table 5.3: Ages of Children born in Norway

Age	**Number of children**
Below one year	2
1-10 years	8
Above 20 years	1
Total	**11**

Table 5.3 explains the ages of the children born in Norway. The majority (8) of the respondents indicated that their children are between 1-10years; 2 respondents have children who are below one year, while 1 respondent has a child who is above 20 years. The ages of the children born in Norway is an important part of the study as it shows the times at which the women received antenatal and post-natal care in Norway. One of the respondents gave birth over two decades ago, at a time where the maternal system was different from the

current one.

Table 5.4: Respondent's Education

Level of education	**Number of respondents**
Tertiary	10
Secondary	1
Total	**11**

Table 5.4 explains the educational background of the respondents. The results show that 10 out of the 11 respondents have tertiary education. Only 1 respondent has a secondary level education also known as “videregaende skole” (intermediary between high school and university). Educational attainment is key because both prenatal and antenatal periods are critical stages with key instructions and advice from health practitioners. So, the ability to read and understand prescriptions and other writings is essential in maternal issues.

Table 5.5: Length of stay in Norway

Number of years	**Number of respondents**
1-5	6
6-10	3
Above ten years	2
Total	11

Table 5.5 above shows the period of stay in Norway by the respondents. The data shows that 6 out of the 11 respondents are in their early years in Norway, 1-5years whiles 3 respondents are between 6-10years of stay in Norway with the remaining 2 respondents have been in Norway for over 10 years. This gives a clear picture of the number of years they have lived in the Norwegian community. However, this is not necessarily a measure of integration into the Norwegian society.

Table 5.6: Religious background

Religion	**Frequency**
Christian	8
Moslem	1
Buddhist	1
Atheist	1
Total	**11**

The religious background of the respondents was also examined. The above diagrams show that the majority (8) of the respondents were Christian while the remaining 3 were Moslem, Buddhist, and Atheist respectively. The idea was to know if there were some particular or specific norms, practices, and beliefs associated with pregnancy and childbirth in relation to their religious beliefs.

5.2.0 Demographical characteristics of the health workers (sample two)

I have categorised the background information of all the five health workers I interviewed in Table 5.7. The data includes; age, occupation, and how long they have worked in the Norwegian maternal health system.

Table 5.7: Background information of the health workers (sample two)

Respondents (5)	Age	Occupation	Duration of work in Norway
Respondent O	Above 60 years old	Child assistant (barnepleier)	More than 20 years
Respondent F	Above 60 years old	Midwife	More than 20 years
Respondent V	Above 50 years old	Community Midwife and family therapist	More than 20 years
Respondent B	Above 40 years old	Midwife and clinical midwifery educator	Less than 20 years
Respondent T	Above 20 years old	Barnepleier, nurse	Less than 10 years

Source: Data collection 2021

Five health workers were interviewed. Three of them are midwives whiles the remaining two comprise of a nurse who previously worked as a barnepleier (child assistant) and a retired child assistant. Both child assistants worked at the barsel (newborn) department at the hospital in Kristiansand. With the three midwives, two of them had their midwifery education in Norway whiles one did not have her education in Norway. One of the midwives is also a community midwife who works at the health station. Prior to her work at the health station, respondent V worked at the labour ward at the Sorlandets hospital for many years. The two midwives who had their midwifery education in Norway are also trained nurses. To be a midwife in Norway, you must first be a qualified nurse after which you take midwifery education at the university before getting a license to practice as a midwife in Norway.

Respondent B is a midwifery teacher and is affiliated with one of the universities in the United Kingdom where she teaches and offers field training during summer school. She, therefore, has a lot of experience to contribute to this research. Lastly, the majority of the health workers who were interviewed were Norwegians whiles two were not Norwegians.

5.3 Thematic analysis

This section consists of a presentation of my data, through the various themes that have emerged as a result of my analysis and which I will further analyse and discuss.

5.3.1 First contact with the health sector after conception

This theme analyses the first point of contact with the health sector when the women realised they were pregnant. According to the migrant women, nine of them first contacted their fastlege (doctors) when they realised they were pregnant. The remaining two made first contact with their midwife. For the nine people who went to their doctors, they were living in Norway before they got pregnant and were already assigned to doctors. Whereas the other two who first contacted a midwife were already pregnant before they moved to the country. These two women are married to Norwegian citizens and it was their husbands that took them to the health station to consult a midwife. Respondent J was three months pregnant when she moved here whiles K was more than halfway through her pregnancy.

… I came to Norway when my pregnancy was three months. I could not speak Norwegian at that time, but my husband took me to helse stasjon as soon as we came to Norway and I got a midwife even before I later got a doctor. (Respondent J)

…….. when I moved here, I was 7 months pregnant with my first child. I thought it was easier with the Norwegian maternal system because my husband contacted the health station and shortly afterwards, they were like 'here is your midwife', and I said 'okay' and we got along. (Respondent K)

The above interview excerpts reveal that the two women who moved here after they got pregnant received the necessary health care because their husbands were Norwegians and thus, knew how the health system in Norway worked. Both women got midwives at a time when they had not yet been assigned a doctor.

All the eleven women who were interviewed were attended to by medical health professionals throughout their pregnancy, and even those who moved to Norway when they were already pregnant also received medical care from their pregnancy to childbirth. As

already discussed (chapter two), access to medical care during pregnancy is one of the key ways to curb maternal mortality (WHO, 2004). Globally, about two hundred and eighty women die every year due to complications in pregnancy (Oestergaard et al., 2011). Some of these deaths could have been avoided if the pregnant women had good access to medical care (Gabrysch and Campbell, 2009). Access to medical care in most countries is determined by one's ability to financially afford the cost of health care (Spangler and Bloom, 2010). This is not the case in Norway as all the migrant women who were interviewed received free health care and did not have to pay anything for all the medical care they received during pregnancy and birth. Also, each of the women received medical care to the extent that even respondent K who relocated to Norway when she was seven months pregnant got a midwife at the health station before she gave birth. This implies that the Norwegian maternal health care has sufficient human and physical resources to attend to pregnant women and that, women in Norway do not have to worry about any cost as it is free. The availability of physical and human resources is one of the four components of the 'Experience of care' framework which is the theoretical framework for my study. My interviews with the migrant women show that the maternal health system in Norway has sufficient and available health professionals and facilities. Availability of physical and human resources is one important way of also ensuring that women willingly seek health care when they are pregnant (Hulton et al., 2000) and this is confirmed in my interview with the migrant women. In this case, community midwives at the health station were available to provide maternal care to respondents J and K at a time where they have not yet been assigned their General Practitioners.

5.3.2 Procedure involved in maternal care

As explained in chapter two (literature review), the Norwegian health service has undergone series of changes and currently offers free and basic health care. However, there were no community midwives as early as 1986 when respondent F gave birth. Respondent F who has worked in Norway as a midwife for over 30 years narrated how the system was at the time when she gave birth.

… it was different, stressful at the time that I had my baby, there were no community midwives so we went to our family doctor for all the care. (Respondent F)

Respondent F believed that the maternal health system was very stressful at the time she gave birth because there were no community midwives. The fastlege (doctors) were responsible for providing all the health care. She argues that the doctors have relatively different fields of

expertise and her fastlege was specialised in sports medicine and did not show much interest in maternal healthcare. In contrast, respondent F finds that midwives are specially trained in maternal health care and they, therefore, show much interest in pregnancy-related health care.

On the other hand, the remaining ten migrant women gave birth after the year 2005 and were entitled to care by community midwives and their personal doctor as outlined by the Norwegian health directorate. However, not all the women had access to community midwives. One of the women who gave birth in Oslo in 2013 did not have any contact with a midwife at the health station before she gave birth. When asked if she knew she was entitled to the services of a personal midwife at no cost, she said;

*.. no, I did not have any knowledge about the services of a community midwife at the health station. However, I do not feel I was cheated without a midwife. I felt I did not lack anything although it was only my general practitioner***.** (Respondent A)

Respondent A is coming from an African country that has a lesser developed health sector compared to Norway. In addition, she had previously given birth in her home country before relocating to Norway and had an unpleasant birth experience in her home country. She, therefore, saw the Norwegian maternal health service to be more advanced than that of her home country. According to her, she did not have any personal doctor in her home country and was thus satisfied that she could have a personal doctor in Norway who took care of her during pregnancy and at no cost. This may explain why she was satisfied and did not feel that she had missed out on a service although she did not have access to a community midwife.

Also, the majority (10) of the women in the course of their pregnancy went to the main hospital for ultrasounds. Only one respondent did not have an ultrasound throughout her pregnancy although she was invited for an ultrasound but rejected it because she thought it was not necessary.

… they had already made an appointment for an ultrasound scan in week 18 but I declined that and did not want it. Because I did not want that to change my due date and I knew exactly when I got pregnant and when my due date was, and it was one foetus, and I did not want to know anything else about the baby and afterwards. (Respondent F)

Respondent F gave birth in 1986 and is also a health professional. She explained that, her experience in the health service influenced her decision to reject the ultrasound. She could

tell if there was a problem with her baby and thus did not see the need to go in for an ultrasound.

As earlier discussed (chapter two), equal access to healthcare has not been in uniformity with real and actual access to healthcare (Mbanya et al., 2019; Asaria et al., 2016). In this case, respondent A did not have access to a community midwife throughout her pregnancy although pregnant women are entitled to community midwives in Norway. This study cannot explain the reason why woman A was not informed about the services of a midwife at the health station. However, according to respondent V (community midwife), not all the municipalities in Norway have a sufficient number of midwives and this may be a reason why woman A never got a midwife during her pregnancy. Relating this to the Experience of Care framework (theoretical framework) points out the absence of equity because not all the respondents got community midwives. The level of inequity is, however, very low as only one woman out of all the respondents did not get in touch with a community midwife.

5.3.3 General procedure and information dissemination

According to respondent V (a community midwife), the normal procedure in Norway when a woman gets pregnant is to contact her doctor first and later get in touch with a midwife, who attends to her throughout her pregnancy in addition to her doctor. As the pregnancy progresses the woman once in a while goes for an ultrasound at the hospital. In addition, women are invited to more frequent visits to the midwife when the due time is approaching. This information from midwife V confirms the procedure outlined by the Norwegian Public Health Institute. Of my informants, nine of the women who got pregnant after moving to Norway did not have any knowledge about the health system before giving birth while two of them could speak Norwegian before they moved here. For the latter two, it was not difficult to find information because they could speak the language. Moreover, they were married to Norwegians, who could thus introduce them to the health care system. Five of my respondents were married to Norwegians at the time when they were pregnant, and it was their husbands who made them understand how the maternal health system works. With the remaining six women who were not married to Norwegians, their personal doctors were their main source of information. Their General Practitioners educated them on how the maternal health system works here and gave them the contact of the health station for a midwife. They got the information on maternal services from their doctors when they went for medical consultation. As I already said, one of my informants did not get any information about the community midwife from her doctor. When I told her there are community midwives

available for pregnant women, she was surprised. When asked if she knew the services of a community midwife was free and available to her, she said:

…no, I have no idea about that, but I do not feel cheated. I felt I did not lack anything although it was only my general practitioner; I was only attached to a midwife at the health station after birth. (Respondent A)

I asked respondent V, (a community midwife and has worked as a midwife since 1995) if every pregnant woman in Norway is entitled to a community midwife. She answered in the affirmative. She however explained that some communities do not have enough midwives. This study cannot explain the reason woman A's doctor never told her about the services of a community midwife. She was nevertheless, assigned a midwife for a short while after birth.

Access to information on health care procedures is crucial and key when it comes to migrants' health care because most of them do not know what they are entitled to (Småland et al., 2011). It is therefore difficult to seek health services that you do not know of. Inequity is more prevalent among migrant women because a number of them do not know the maternal system and how it works in Norway. They are therefore unable to ask for what they are entitled to.

In addition, a lot of migrant women are not well abreast with the system and need help concerning maternal health care services. According to my findings, nine out of the eleven women who were interviewed got the necessary briefings and information mainly from their doctor. For the two women who did not get information from their medical practitioners, one came here when she was already over seven months pregnant and the other woman was already working as a nurse and knew the system. With respondent A, her doctor never informed her about the existence of the health station, and this was the main reason she never got a midwife because her doctor was the main source of information.

5.3.4 Information about maternal benefit

Every pregnant woman in Norway who gives birth here is entitled to either a lump-sum grant or parental leave in addition to free maternal health care (NAV, 2021). Parental leave applies to women who have been actively working for more than the past 6 months while those who are not engaged in any active job get a one-time payment of 90,300 NOK per child to help the woman cater for the newborn baby(ibid). As previously discussed, one of the causes of high maternal mortality is poverty, as a lot of pregnant women are not able to bear the cost

involved in giving birth at health facilities (Spangler and Bloom, 2010) and also providing for the new baby. This is not the case in Norway due to the financial support and the free health care the state provides to new mothers.

Of my informants, a total of nine women were not working at the time they gave birth in Norway and thus applied for the lump-sum grant whiles two women applied for parental leave because they were working. Access to information was poor with the nine women who opted for a lump-sum grant. None of my respondents got information about the lump-sum from their midwives and it was only one woman who got the information from the hospital when she gave birth. She, therefore, applied for the one-time payment when she was at the hospital after birth. The majority (4) of my respondents got to know about the maternal benefit through their friends when they were over 6 months pregnant. With respondent J, she narrated that she got a call from one of her migrant friends who said she knew the health workers will not inform her.

…there are a lot of things they are not telling us. For instance, the money the mother gets when she is pregnant. We do not know anything about it. I did not know about it, it was an African friend who told me because she knew I would not get that information. I am being honest nobody told me (Respondent J).

This is coming from a woman who is married to a Norwegian man. I assumed that he had knowledge about her rights and I, therefore, asked her why her husband did not inform her about that. And this was her response;

…my husband did not know because he had not had children in a long time. My husband expected that I was going to get the information from the health station which I never got! My husband helped me to apply when my friend told me. (Respondent J)

As the statement above shows, there is no automatic link between nationality and knowledge, the fact that the husband is Norwegian does not ensure that the pregnant woman is informed about her rights. Out of the 5 women who were married to Norwegians at the time of their pregnancy, two were already working when they got pregnant whiles three were not working. Two of these three women who were not working got the information on maternal benefit from their husbands while one was informed by a friend as already discussed. Woman Q would not have applied if she had not got that information from the hospital after birth.

Tables 5.8 and 5.9 below give an overview regarding maternal benefit and its use among the interviewees.

Table 5.8 Information on parental leave and lump-sum grant

Women who have had Norwegian birth experience for the 1st time		
Those who applied for a lump-sum grant	Number of women who applied for parental leave	Total
9	2	11
Women who have given birth twice in Norway		
Those who applied for a lump-sum grant	Women who applied for parental leave	Total
2	2	4

Table 5.9 Respondents source of information regarding pregnancy benefit.

Information on maternal benefits regarding 1st Norwegian birth				
Friends	Husband/Partner	Internet/Themselves	Hospital help	Social studies class
4	2	3	1	1
Number of women who have given birth at least once in Norway- 11				

Source: This information was gathered during data collection in 2021.

My findings reveal that information about parental leave and benefits is unstructured and very limited. Of my informants, six out of eleven got the information informally from their friends whiles one respondent got to know after delivery when she was at the hospital. She thus applied for the lump-sum grant when she was at the hospital after birth. It is left with the women themselves to figure out their rights and entitlements which is difficult as they are not abreast with the Norwegian system and do not speak or understand the language. There is no standard information overview to that effect. My study shows that the community midwives often focus on the health of the pregnant woman and the baby and in so doing, offer little to no information about maternal benefits the women are entitled to. This may not be an issue for a Norwegian woman. However, it is a big hurdle for pregnant migrant women in Norway

who are left to find information on maternal benefits themselves, without the use of any proper and structured channel of information.

The absence of structured information regarding parental benefit is a hindrance to 'Experience to Care'. Cognition forms a part of the four core values of 'Experience of Care' as outlined in chapter two (under the theoretical framework). Cognition has to do with the exchange of information between the client and the health provider be it doctor or midwife and this is absent in Norwegian maternal health care. Only one out of the nine respondents who applied for the lump-sum pregnancy grant got the information from the hospital after delivery. Aside from that, none of the migrant women were informed of their entitlements by the health providers which is an affront to quality health care. In this case, the vulnerable migrant women continue to be vulnerable due to the limited and unstructured flow of information between them and their doctors, midwives. In addition, the absence of or low cognition leads to inequity as migrant women are unable to get what is due to them because of the restricted flow of information. Thus, there is the absence of cognition as well as equity which are two main factors under 'Experience of Care'.

5.3.5 Communication between the migrant women and health workers

According to the five health workers who were interviewed, the official language of communication at the hospital is Norwegian. However, the majority of the health workers are able to communicate well in English according to midwife B who is a midwifery educator at the hospital. Thus, the language of care is either English or Norwegian.

My migrant informants raised several concerns with the use of the English language. Four of my respondents were of the view that communication was restricted due to the limited knowledge of the health workers. Therefore, they often had to help the hospital staff with finding some English words and terms when they spoke to each other. Respondent M, who is a native English speaker, said that she felt the health workers she came into contact with at the hospital, were good enough in English but she realised they were not comfortable speaking it. Such was the case with her midwife at the health station during her first pregnancy which made her opt for a different midwife in her second pregnancy. The interview excerpts below illustrate the situation well:

Respondent M: be*cause I could communicate only in English, I felt that the health professionals did not like to speak much in English and so I did not get to talk much to them.*

Interviewer: *Is it because they were not fluent in English?*

Respondent M: *I think they were but they were not comfortable speaking in English. I hear that very commonly. That some older Norwegians often say;- I am sorry I cannot speak in English. They can though, but they feel they will make mistakes*.

The majority -(nine) of my respondents could not speak Norwegian at their time of pregnancy in Norway. They observed that their doctors were good at communicating in the English language. However, three of these women asserted that some of the midwives and health workers at the hospital could not communicate well enough in English. This made the communication between them and the foreign patients very limited. There is therefore restricted communication between the women (migrant) and the nurses and midwives in instances where the women are not able to communicate in Norwegian. This means that the care they receive may be perceived as inferior compared to the care ethnic Norwegian women receive. Restricted communication here applies to the everyday conversations in the hospital when they are under care. Two of the midwives who were interviewed admitted that the migrant women are not able to ask questions and to seek clarification due to the nature of communication (which is restricted). According to midwife F, most health professionals are interested in knowing that the woman understands what they are instructing her to do and often do not care much if the woman has questions or if the woman wants to know why she is being asked to do things in a certain way. There is therefore a very low response to the women's many questions which they never get the chance to ask. According to my respondents (migrant), the restricted and ineffective communication does not allow them to enjoy sufficient care which hinders the cognitive process. As already pointed out (chapter two), issues of ineffective communication among expecting mothers and the health workers often create psychological barriers as mothers are reluctant to seek advice/information from these health workers due to the limited communication (Arsenijevic et al., 2014).

On the other hand, the nine interviewees (migrant) did not experience difficulties in communicating with their doctors although they had to prompt their doctor that they could not speak Norwegian so he could switch to speaking English with them. With respondent W, she felt her doctor could speak English better than she could.

…..my doctor spoke English and was better at English than me. My midwife was also good at English. (Respondent W)

…. But with my doctor, I think the very first day I went, he started with Norwegian and I prompted him that I do not speak Norwegian and he said okay and started with English. He used to speak Norwegian anytime I get to his office, but he switches to English when I prompt him that I do not understand Norsk. As time went on, he started speaking English anytime I enter his office. (Respondent H)

The excerpts above reveal that majority (9) of the women had good patient-doctor communication and felt secured because of the free and effective communication that existed between them and their General practitioners whiles there are barriers and ineffective flow of information between nurses/midwives and foreign women due to language barriers.

The day-to-day interaction between patients (mothers) and health workers is very important as it builds trust. Of late, some women often resort to the internet to seek answers and information for their many questions regarding pregnancy and childbirth (Stepurko et al., 2013); a practice which is very dangerous as the internet does not always provide accurate medical advice (previously discussed in chapter two). In view of this, there is the need for women to gain trust and confidence in their health care providers to be able to open up to them.

5.3.6 The use of the English language with patients amongst midwives and other health workers in the Norwegian maternal health care system.

According to two of my respondents (midwives), there has been limited communication in situations where the health worker was not comfortable with the use of the English language. Three out of the five health workers who were interviewed for this study personally admitted that there were some difficulties in certain cases with the use of English. The three people who experienced some limitations with the use of the English language are all ethnic Norwegians. Not surprisingly, the other two who found no limitations in using English were not ethnic Norwegians. From the patient's perspective, it sometimes is a matter of health personnel not finding the right terms to use, where the patients have to help them in their communication. Respondent H puts it in the following manner:

….*my midwife at the health station was good in English and we were able to communicate well in English. Sometimes she struggled to explain some concepts to me in English, but I always understood her and helped her with the right English words.* (Respondent H)

Interviews with the health workers in the study showed that the younger health workers at the birth and labour departments were better at using English as a mode of communication compared to the older workers. This was not a surprise, as this reflects the use of and teaching of English in the Norwegian educational system. Health worker T, who is 29 years old was the only young respondent among my informants in the health staff. According to her most of the older hospital staff were not comfortable with the use of English whiles she enjoyed it. All the four health workers at the hospital who were interviewed agreed to this observation that the younger midwives, nurses, and assistants at the hospital were more willing and comfortable to communicate in English with patients.

…I think that it depends on the age because the younger people who are health workers speak English just as well as Norwegian but the older health workers like my age do not like it because they think they are not good enough in English. But with me you know, I do not care, I just use the little English I know. (Health worker O, a child care nurse)

Another health worker describes the situation in the following words:

….w*e have some midwives that are very fluent in English and we have some who have very limited knowledge of the English language. But if we have patients whose mother tongue is English, then sometimes I feel they are not getting equal care due to their fluency in English with some midwives who are not fluent in the language*. (Health worker B, midwife)

Midwife B admits the existence of inequity with migrant women due to ineffective communication between the health professionals and the women with the use of English. The absence of equity is a hindrance to quality care which is the main basis for 'Experience of Care'.

In addition to midwife B, the other midwives confirmed how older health workers are reluctant to communicate in English. I have provided excerpts of the interview below;

…. I have colleagues who admit that they are not comfortable speaking English and when we are working and there is a patient who speaks only English, they are like; you can take her, that is fine. (Health worker F)

… Yeah, that is absolutely true. Especially when they are older. Most of my older colleagues did not like to speak English. I find it enriching because I like to speak to people from different places (Health worker T, child nurse)

According to midwife F, some of the older health workers do not feel they can provide the needed care when the patient does not speak Norwegian but English.

Diagram 5.1

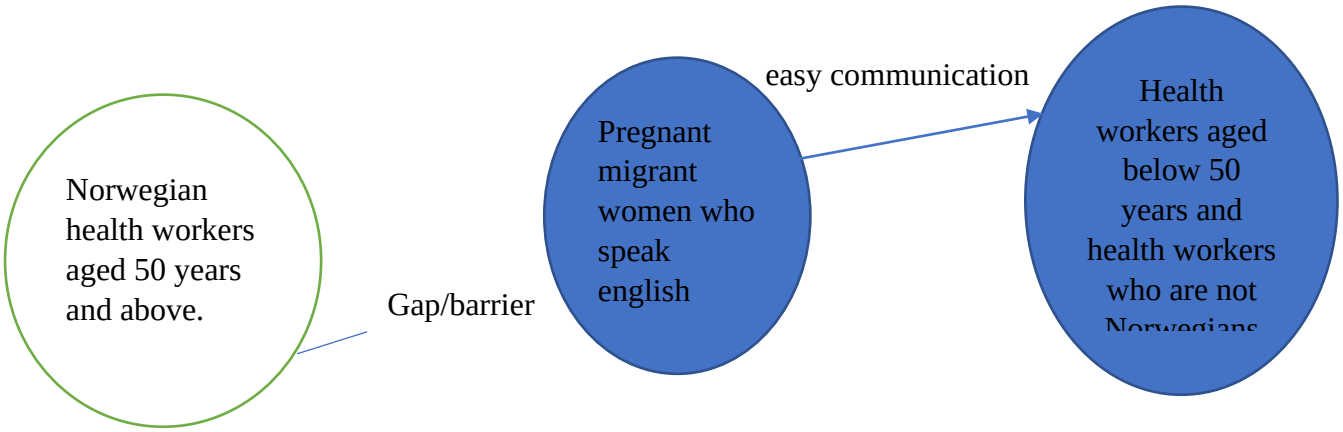


Diagram 5.1 illustrates the flow of communication between migrant women and health workers.

My findings reveal in most instances when the migrant woman uses a bit of English, then the health workers also resort to English without going in for an interpreter. There are only a few instances where interpreters have been involved with women who could not express themselves clearly in English. This is not a good tool for effective communication as there may be misunderstandings when the woman does not really understand what they are saying due to her limited knowledge of English. The misunderstanding can be greater when both the health worker and patient (migrant woman) are not good users of English. Misunderstanding in communication among health workers and patients can lead to serious implications which can distort the quality of care provided.

5.3.7 The use of interpreters

As pointed out in the literature (chapter two), some of the health workers find it difficult to communicate with their migrant patients because the patients do not speak or understand Norwegian. In instances where both the health worker and women do not speak a common language, an interpreter is involved (Lyberg et al., 2012, pp. 291-293). The use of interpreters is limited to issues of medical care when the doctor or midwife wants to examine the baby or mother and in situations where medical drugs are involved. However, interpreters are not mostly involved with the day-to-day activities regarding food and other social matters.

In relation to my findings, both the hospital and health stations employ the use of interpreters with patients who speak neither Norwegian nor English. These interpreters are mostly used on the telephone and do not necessarily live in the same city. According to Midwife B (a midwife at the hospital in Kristiansand), there are very few interpreters in Kristiansand. Also, the use of interpreters is a huge challenge because most of the interpreters are not able to accurately translate medical terms to the patient and because they are contacted on the phone, they do not have any idea about the real situation as it looks in the examination room or in the ward. In other cases, the woman in labour is unable to express herself much due to the pains associated with the contractions. In addition, an interpreter only translates words and does not necessarily provide emotional comfort to the woman. Medical personnel are expected both to communicate and provide care, so an interpreter brings in a purely technical dimension which complicates the matter. The role of the interpreter as a facilitator without care provision and comfort makes the provision of care complicated for the patient (migrant woman). The use of interpreters depicts the absence of emotional support to the woman as midwife F clearly explains in the excerpts below:

….. sometimes the quality of interpreting is very low and when we use medical terms, the interpreter might not be able to understand. It is a huge challenge. Most often the translator is just on the phone and unable to see what is really happening. It is not so easy for the woman in pain to talk on the phone to explain what she is going through. We do not have many translators in Kristiansand and often use interpreters who are not in the city and far from Kristiansand. (Midwife F)

Midwife F clearly explains the situation with interpreters which reflects the absence of emotional support to the patient. The absence of emotional support hinders equity. As earlier discussed in the literature review, emotional support is one of the four components of 'Experience of Care' which encourages the pregnant woman and gives her some form of assurance that labour will be over soon. Showing affection to the pregnant woman with comforting and encouraging words is one of the ways in which women experience good quality care. However, due to the use of interpreters, the health workers are unable to express affection and use encouraging words to the patient because they do not understand each other's language, and also, the work of an interpreter does not include providing comfort and showing affection. In this regard, women who use interpreters at the hospital in Kristiansand do not get enough emotional support and thus, undermines equity in ensuring quality health care. Another challenge highlighted earlier (chapter two) is the difficulty involved in

describing sensitive, intimate information with a male interpreter who is not your husband (Lyberg et al., 2012). Some women may withhold information due to the discomfort involved.

5.3.8 Spouses as interpreters.

One of my respondents (a migrant woman) raised an issue about how her former husband was used as an interpreter after birth when she was at the hospital for two weeks. According to her, her ex-husband only translated a tiny fraction of what was always said to her and this made her very desperate because she felt she was missing out on something. This is a person who had difficulties in her marriage with her former husband at the time she had her second baby. My study finds that women are losing important access to information if close relatives and partners are left to act as interpreters, as they may not give out all the information being carried on to the woman by the health professionals. In addition, the women become vulnerable when health personnel give partners and relatives the power to act as interpreters when they (health personnel) are not able to ensure that the woman gets all the information given.

In the same vein, two out of the three midwives who were interviewed admitted that there have been instances where they felt the husband or partner was not interpreting all they said. However, midwife V (a community midwife), said that she always asked for an interpreter even if the woman's spouse understands Norwegian and can translate to the woman. According to her, she wants to make sure the woman gets the right and necessary information to avoid doubts and fears that the women are not getting the information put across.

There have also been situations where the midwife at the health station suspected marital challenges between spouses. As pointed out by my informants, most of these women are always accompanied to the health station with their spouses which makes it difficult for them to communicate their ordeal to the midwife. Community midwife V has found a way of working around this as she sometimes asks the man to excuse them so she can have a woman-to-woman talk with the pregnant woman. Through such a conversation she tries to find out whether the woman is safe or in danger of partner violence. She points out how most women want to talk to the midwife alone and this becomes a problem when they are always accompanied by their spouses.

….. and I know that some women just want to talk with the midwife alone. So when their husbands always accompany them to their visits with the midwife, sometimes I say to their

husbands 'now we are going to have a woman-to-woman talk so you have to go out for some time;' So I accompany them out and we have a chat and I like that and they think it is okay. Midwife V (community midwife at the health station)

When it comes to using interpreters as earlier discussed, my respondents (health workers) raised concerns over the quality of translation. According to them, there is a high possibility that the interpreter may not be able to understand all the medical terms used and that affects the quality of translation especially when the interpreter is on the telephone and cannot see what is happening.

5.3.9 The shift system at the hospital

According to the three midwives interviewed for this study, the community midwives do not play any role during delivery, making their roles limited to antenatal services. The midwives at the labour ward in the hospital are in charge of deliveries and they work in shifts. This means that a pregnant woman never knows in advance which midwife will help her deliver when she goes into labour. For migrant women, this means that they are not necessarily secured a person who can communicate well with them in English if they are non-Norwegian speaking. For all women giving birth, it also means that a long labour process may indicate that they will be assigned to more than one midwife.

Six out of the eleven respondents (migrant women) gave birth between 12 to 48 hours after they got to the hospital. Three (3) gave birth shortly after they arrived at the hospital and one gave birth through a caesarean. Respondent H did not give birth at the hospital (this is explained in the next section). With those that gave birth long hours after they arrived at the hospital, four out of the six were not happy with the shift system. The fact that they had to meet different midwives while in labour was perceived as negative by the women, and they felt that the situation was made worse by their inability to speak Norwegian. One of my informants explained it in the following words:

…anytime the shift changed, you got a new person and they really did not care about knowing you. I felt I was a job and not a person. It was very difficult and my Norwegian was not very good at that time. (Respondent M)

Her statement shows the importance of being able to communicate with a common language. As discussed in chapter two, language barriers and difficulty in communicating often affect the quality of care (Mbanya et al., 2019; Lyberg et al., 2012; Herrador et al., 2015; Småland

Goth and Berg, 2011). In Norway, it takes a lot of time before migrants are fully integrated into the system. As such, it becomes difficult to express themselves when they have not yet mastered the language (Munthe-Kaas et al., 2018). Respondent M finds that, the absence of communication between her and the midwife was due to her low level of the Norwegian language at that time and thus made her feel irrelevant, more of a task, and not a human being.

Another of my informants stressed how she was feeling very uncomfortable with the many different midwives attending to her and potentially impacting the process of giving birth in a negative way:

.....in the middle of my labour, the midwife who was attending to me said; sorry, someone else is coming to take care of you my time is up'. This was the first uncomfortable thing which I disliked that happened to me in labour. I wanted her to finish with me because I believed in her and did not want her to go. I think that was the main problem. After that shift, it took 5 hours before the baby came out. (Respondent W)

The issue of feeling comfortable and trusting the midwives was also brought up by another informant:

…so I had about 4 different midwives during labour and in the end, I was very tired and frustrated. The last midwife that assisted in delivery was the person I was least comfortable with. She had a different attitude from the other midwives who had attended to me. (Respondent Z)

Respondent P shared something quite similar, like the others, stressing how one is in a vulnerable situation and that it takes time to build a relationship of trust;

…this is one of the things I did not like because it felt like I was in a vulnerable situation and then you try to build a relationship with one person that's the midwife or nurse on duty. Then when you have become comfortable with the person, then that person suddenly disappears, then you have to start all over again to be comfortable with the new person on duty. (Respondent P)

The above excerpts show the availability of physical and human resources (health personnel). All the four women were attended to by professional midwives during their labour which is one key component of 'Experience of Care'. The availability of health personnel reduces mortality and helps in safe delivery (Hulton et al., 2000), as discussed in the literature review.

However, the availability of health personnel is not enough to ensure quality care but rather the ability to freely interact with the caregivers is paramount in maternal health care (Haddad and Fournier, 1995). Respondents W, P, and Z were not able to build a relationship with the midwives who helped them deliver their babies respectively which is partly due to the shift system at the hospital. They had a long labour and as such came into contact with three to four different midwives at different periods. The main problem is that,-it was difficult for them to establish good contact with all the respective midwives, which again, affected their birth experience. In the long run, they were not happy with their last midwives that assisted them in delivery as they did not trust them as much as the earlier midwives, with whom they had built confidence and relationship. Due to this, they had low satisfaction and trust in the midwives who delivered their babies. A low level of trust impedes quality health care as it forms one of the major inputs in 'Experience of Care'. With regards to the above respondents, their low level of trust was because they did not establish cordial relationships with the caregivers.

In my conversation with midwife B, who is a midwifery educator at the hospital, she recognised the negative sentiments outlined above. She further argued how this situation was one of the reasons why they have introduced the doula project in Kristiansand.

5.4.0 Birth experience

This section describes the women's experience from the time they were in labour to the time they gave birth. Ten out of the eleven respondents gave birth in the hospital. One of the women gave birth at home and this is explained further in this section. Seven (7) of the women gave birth at Sorlandets sykehuset (hospital) in Kristiansand while two gave birth at Sorlandets hospital in Arendal and the remaining one at the Ullevaal hospital in Oslo. Of the women who had given birth twice and thrice in Norway, two of them had regular vaginal births with all their babies whiles one had a caesarean section with her first baby and a regular delivery with her second child. Of those who gave birth in Kristiansand, they did this in the period 2010 – 2020, with the women who gave birth in Arendal the period was 1986 – 2020, whiles one gave birth in Oslo in 2013 and one at home.

The majority (four) out of the seven women who gave birth in Kristiansand were not happy with their labour experience whiles the woman who gave birth in Oslo at Ullevaal hospital was very satisfied with her labour and birth experience and rated the health staff ninety percent. The only woman who gave birth at home gave a very poor rating of the hospital in

Kristiansand. In addition, one out of the two women who gave birth at the hospital in Arendal expressed dissatisfaction with her first birth whiles giving a very good rating for her second birth. This means that only three women who gave birth in Kristiansand were satisfied with their labour experience. With these three women, one had a caesarean section, while the other two had a normal birth. I have presented a few of the women's experiences below to illustrate how labour went.

…*the health professional was waiting for me at the entrance of the hospital when I got there. The first question the midwife asked me at the entrance was 'are you sure you can walk?, should I bring you a stretcher'. In the labour room, the midwives were caring and asked me to choose any birthing position I want. So I lied on my side and pushed my baby out. I pushed for a long time but nobody pressured me. The midwives explained every process to me. For instance, my water did not burst and they asked me if they can burst it or if I want to push myself*. (Respondent A gave birth at Ullevaal Hospital, Oslo)

Respondent A was very satisfied with her birth experience at the hospital in Oslo. She did not face any language barriers because the health personnel were good at communicating in English. In addition, Ullevaal hospital staff have better training and experiences with receiving foreign women due to the significant high number of foreigners who live in Oslo, which is the capital city of Norway. Also, respondent A's excellent rating of Ullevaal hospital is mainly due to how the midwives showed affection and concern when she was having labour pains. In addition, the midwives explained the process of labour to her and even offered to burst her water if she was willing. More importantly, woman A gave birth a few hours after arriving at the hospital and therefore did not meet other midwives on different shifts before she gave birth. She was attended to by the health personnel on duty and gave birth not long afterwards. This explains the reason behind her satisfaction. This, therefore, emphasizes how good interaction with medical providers and emotional support promotes quality health care as elaborated in the literature review.

Woman B shares frustration and dissatisfaction with her labour experience in Kristiansand, the opposite of Ullevaal hospital;

….I was frustrated that a student was asked to help me deliver my baby. She was constantly doing things to me without talking to me and I did not like that. She did not communicate with me, but poke a needle on me, checks my dilation and I told her if she cannot communicate with me, then I do not want her. Hours later she continued not to communicate with me. It

was very miserable. I dilated normally and they wanted her to help me deliver my baby although I protested. But the other midwives present kept on telling me how good the student was at delivering babies and she has done it a lot of times. They did not care that I said no, but she helped deliver the baby. (Respondent M)

Respondent M did not want a student midwife to help deliver her baby. This is because she felt the student midwife was not communicating with her and also did not trust the student to be qualified enough to deliver her baby. According to respondent M, the student kept putting her hands in her vagina to check her dilation without communicating to her, which was unpleasant. Woman M's main reason for not wanting the student midwife to attend to her was because there was no exchange of information. As pointed out in the literature review, women have a say to determine which kind of treatment they want in situations where they are multiple options available (Hulton et al., 2000). In this situation, there were two other midwives who were also available and thus respondent M could choose one of the two midwives. Also, every woman has the right to seek an explanation from her health provider be it a nurse, doctor, or midwife (Donabedian, 1988) in the course of medical examination. Woman M's main problem with the student midwife was due to the absence of communication. Exchange of information between patients and health providers strengthens the cognitive process where women get the necessary information about their health and in so doing develop a high level of trust in the health care system.

The other midwives in the delivery room kept on telling respondent M how good the student midwife was, although she kept saying no to let the health personnel know of her disapproval and dissatisfaction. The two other midwives in the delivery room failed to ask the reason why woman M did not want the student to deliver her baby. In the end, her views were not respected as the student delivered her baby in the end. Here respondent M's lack of trust in the student midwife was fuelled by a gap in communication which is paramount in maternal health care.

One of the respondents had a bad experience because her baby was on the wrong side and that caused her much pain. She describes her experience in the excerpts below:

…. So the pain was very unbearable. The baby was pushing on the wrong side, but they did not know. When the labour started, they did not know that but if they had known before, they could have recommended a better birthing position for me. In the middle of my labour, the midwife who was attending to me said; sorry, someone else is coming to take care of you my

time is up'. This was the first uncomfortable thing which I disliked that happened to me in labour. I think that was the main problem. Because the first one knew that there was something wrong and she told the second midwife, but she thought no, it is not that. After that shift, it took 5 hours before the baby came out. They called a lot of other medical professionals. (Respondent W)

The first midwife who attended to woman W realised there was a problem with the baby and informed the subsequent midwife who was taking over the next shift. The second midwife, however, did not agree with the first, and this caused respondent W much pain. Interestingly, they got to know what the first midwife said was true because the baby came in the wrong position. However, after delivery, the second midwife apologized for not listening to her colleague which caused woman W much pain. This is one of the reasons why the respondents expressed dislike for the shift system.

....the gynaecologist and four other health professionals were in the room with me. After I gave birth, they came to me and the midwife that delivered my baby apologized to me. She said 'it is my fault, can I hug you? I am soo sorry:' So the midwife apologised to me and said the 1st midwife told her 'I think the baby is on the wrong side' but when I touched your womb and felt the baby's head, I did not believe her. I told her it was okay. The baby was fine and nothing bad happened to her. (Respondent W)

Excerpts of the interview above revealed that the midwife who helped deliver respondent W's baby was quick to issue an apology after she realised the baby was on the wrong side. The midwife blamed herself for the harm done and was very remorseful. She showed respect and acted according to the code of ethics in medical care. The relevant point from this is the fact that the health personnel issued an apology immediately she realised something went wrong and it was her fault for not listening to her previous colleague's diagnosis. Quality of care ensures respect for patients and this was definitely a way to show respect (Hulton et al., 2000; Mbanya et al., 2019). Moreover, it made the patient feel that her needs were acknowledged and seen, even though this happened afterwards. It thus also shows the importance of personal communication.

Respondent Z also shared her labour and birth experience where she was least satisfied with the midwife who helped deliver her baby. Interestingly, the midwife was very good at communicating in English, but woman Z gave her a poor rating despite her ability to speak English. She discusses her birth experience in the excerpts below:

…*I had a very long labour and that was my first birth. The shift changed about 4 times when I was in labour. So, I had about 4 different midwives during labour and in the end, I was very tired and frustrated. The last midwife that assisted in delivery was the person I was least comfortable with. She had a different attitude from the other midwives who had attended to me. The first three I felt good about and they were empathetic. The last one was more goal-oriented and she was pushing me too much while I was not having soo much power left. She was just giving me tasks to do and ordering me around. For example, 'now you to do this, now you have to turn around'...I felt she was my boss while the other ones were more empathetic and talking to me in a nicer way. Ordering me around as if it was a task to do. I was really shocked with what was happening. I was shocked because of her attitude. Because she came and started ordering me around and that was not something that I had experienced with the first three midwives. The first three were empathetic, caressing me and telling me it was going to be fine. Whiles the fourth was more like a robot commanding me to do tasks although she was very good at communicating in English*. (Respondent Z).

Respondent Z's experience points to three things which are the shift, communication, and also social skills. With the shift, woman Z was least satisfied with the fourth midwife who helped her deliver her baby. The midwife was the last health professional woman Z came in to contact with prior to her delivery. She would have wished that one of the earlier three midwives who cared for her attended to her during delivery but due to the shift system, she happened to meet a fourth person whom she was least happy about.

Secondly, although the fourth midwife was able to speak English fluently, she did not try to build a relationship with her patient but rather was focused on making the baby come out which surprised her patient. As earlier discussed in the literature review, good communication is an essential way of providing cognition, the core element in 'Experience of Care'. It therefore negatively affects the quality of care due to the absence of cognition.

Thirdly, woman Z's experience shows a lack of social skills, which is non-communicative. Most of the women's birth experience showed that there was a lack of social skills with less interaction and negative body language. Ordering women around during labour depicts negative body language which could get the patient to easily react. It is therefore important that health workers show good social skills when attending to their patients in the labour room.

One of the informants, (respondent H), gave birth at home although she wanted to give birth in the hospital. She contacted the hospital in Kristiansand as soon as she started having contractions. A week prior to this, she had a birth discussion on the telephone with one of the midwives at the labour department. During the conversation, the midwife told her to prepare and ring the hospital when the contractions are five minutes apart. However, when she started having contractions, she called the hospital and was asked to wait for some more time. She was in pain and so handed over the phone to the husband who spoke to the health professional from the labour department. This woman was only waiting for a confirmation from the health professional so she could come to the hospital since she had her own means of transportation, but she was told to wait until she gave birth at home, by herself and unattended to and then, the hospital sent an ambulance which arrived in less than six minutes. This is a woman who was classified as high risk due to some underlying health conditions. Below is a transcribed interview with respondent H.

Interviewer: *How was your birth experience with the hospital?*

Respondent H*: there was preparation for labour which was very good. A midwife from the hospital*

> *in Kristiansand called me and gave me a talk on labour preparedness. She told me if the contraction starts, I should monitor it in the house and if it is five minutes apart, I can prepare, ring them and come to the hospital. The education was very good. But the labour itself did not go well as I expected. The whole thing was like, the reception at the hospital took a very long time to respond to us though it was on the phone. They took more than forty minutes in asking a lot of questions though I told them the baby was coming. I was not doing the talking. My husband was the one talking to them.*

According to the excerpt above, the hospital in Kristiansand delayed in giving a go-ahead to the woman in labour to come to the hospital and this resulted in the woman giving birth at home. When asked why the hospital delayed, she gives a response which has been provided below:

…that was surprising because they had my history already since I had been to the gynaecologist countless times and it was the same hospital that the midwife called me three weeks earlier to prepare me for birth. During the conversation on phone, I vomited several times and my husband informed them and they were still on the phone until she heard a baby cry. She asked my husband, did I hear a baby cry? my husband said yes, then she began

giving directives, asking me to cover the baby and sit up until the ambulance came. And for that aspect, I give them 0 out of 10! Comparing that aspect to my home country is far, far better than here because, even though we do not have a system where you need to call the hospital when you are in labour before coming, but if a pregnant woman realises she is in labour and really need quick attention, she goes there and she is never turned away until she delivers. (Respondent H)

Respondent H was a health professional in her home country before moving to Norway. She had two children, the second was born in Norway. Respondent H was of the view that her labour experience in her home country (a developing country) was more pleasant than Norway which is a developed country. In addition, respondent H was able to push and hold her baby herself due to her background as a health worker from her home country. Not all women can be able to give birth at home without any help and hold the baby until the ambulance arrived. This could be a result of communication differences where the health worker who spoke to them on the phone did not know the reality on the ground of what was happening. It could also be due to the fact that, the person her husband spoke to did not believe what the husband said, which generated a very slow response.

It is however interesting to know that respondent H did not receive any formal apology from the labour department on what happened. When I asked her if she received any apology, she said;

*….No, I did not get any direct apology but I was okay. The lady who spoke to us on the phone came to me at the hospital and she said 'I was the one your husband was talking to' and I said it is okay. Your husband did very well for staying on phone and acting on all my directives. But it looked like she showed concern. But I did not get a direct apology. (*Respondent H)

I narrated this experience to one of the health workers who is a midwife and asked about her thoughts about the woman not receiving any apology. According to midwife F, it is part of health ethics to issue apologies to patients where one or two things go wrong in their medical care. In addition, respect is one of the four elements of 'Experience of Care', and embedded in respect is an apology. As Midwife F puts it, health care ethics emphasises being empathetic and apologising to patients when a few things go wrong. Also, getting a direct

apology from the health worker involved is a way of showing respect to the woman and it helps to keep her dignity intact. (As described in the literature review).

5.4.1 Sensation of response to emergencies.

The main point of presenting the empirical data in this section is to illuminate the availability of physical and human resources in times of emergency. The 'Experience of Care' framework lists physical and human resources as one of the core elements in experiencing quality health care. This section, therefore, describes the resource availability (both human and physical) in critical and emergency situations.

According to my findings, five out of the eleven respondents had emergency cases during their delivery at the hospital. All these five women gave birth at the public hospital in Kristiansand and admitted that the hospital was very quick to act in their cases. The response to emergency by the labour department was very swift and fast with respondent H when she gave birth at home. According to her, an ambulance arrived in less than 6 minutes when she gave birth at home.

…there was a quick response after the lady realised I gave birth at home. Immediately, the lady on phone heard my baby cry, it took less than 6 minutes for the ambulance to arrive. The ambulance came with a midwife, and the midwife had to cut the umbilical cord of the baby and wrapped the baby to make sure the baby was warm before we arrived at the hospital. (Respondent H)

With the other four women, two had an emergency caesarean section with their deliveries. One of these two women (respondent M), was not able to dilate for more than 5cm in a long time when she was in labour with her first child, so the doctors and midwives prepared her for an emergency c-section where she was put on gas during the operation. With respondent J, the pressure of the baby was going down and the doctors asked for an emergency caesarean to save her life and that of her baby. These two women were very thankful that the health workers acted fast in their emergency cases to save their lives.

…they tried to increase contractions and after an hour, I had still not dilated more than 5cm so the doctors asked them to prepare me for a Caesarean section. I could still feel pain in my belly so they could not just start the C-section. Instead, they put gas on my mouth and did the Caesarean as fast as they could. (Respondent M)

*…. I was in labour for some hours and my baby started going upwards instead of coming down. Then the doctor came in. Anytime I remember that experience I always cry. The doctor came and said we should go to the theatre cos the baby's pressure was going down. I was healthy after the operation and my wound healed very fast. This is something I would forever be grateful for. The doctors and midwives did an excellent job. (*Respondent J)

The baby of respondent Z had a heart failure which was detected 48 hours after delivery at the hospital in Kristiansand. Her baby was rushed to the Ullevaal hospital in Oslo by a helicopter ambulance to receive the necessary treatment. The baby survived the operations and this according to madam Z, is one of the things she will forever be grateful for. This woman spoke about how the treatment and health workers in Oslo were super professional and very helpful.

..they immediately rushed him to Oslo Ullevaal hospital when they realised he had a heart failure. In Oslo, I feel like it is a totally different world. They were super professional. Everybody took soo good care of us and my son was being checked on every half an hour and am super satisfied with what was happening in Oslo. In Oslo, the midwives educated me on the essence of breastfeeding and encouraged me to pump my milk to feed my son though I could not breastfeed him due to his situation. We had spectacular contact with midwives and doctors. In Oslo, there are many more midwives, doctors and I felt very safe there. I felt I was in a good place. I am not saying it is not good in Kristiansand just that they do not do this stuff with kids in Kristiansand. When I saw all the equipment in Oso, I was very satisfied and felt very safe. (Respondent Z).

Respondent K is the fifth respondent to have received emergency care during labour with her second child. She got to the hospital just a few minutes before delivery without calling the labour ward first. She however managed to get in and gave birth in the elevator when the nurses and midwives were taking her to the delivery room.

…I had a different experience with my son, the second child. My water broke and I was checking my contractions until they finally got strong. So, we got into the car and went to the hospital and the door was locked. We pressed on the bell until they let us in. we went in, on the first floor, I was lying on the floor on the first floor where the mottak is. My husband kept on shouting for them. They came down with a stretcher, pulled down my pants in the hallway, and laid me on the stretcher then his head came out. They put me on the elevator, and he came out in the elevator. **(**Respondent K)

The above interview excerpts show a great sense of care exhibited by the hospital staff towards the women who were in critical health need. All the five women received good responses during an emergency at the hospital in Kristiansand. In addition, the health professionals were quick to act in the respective cases and no fatalities were recorded at the end. This shows that health workers in Norway are quick to act in cases of emergency and most often do their possible best to save the life at stake. In addition, this study finds a positive correlation between the availability of resources (both human and physical) as an important way of ensuring quality health care. This is evident in the women's experiences depicted above where no fatality was recorded due to the great sense of care by the health staff and good emergency response.

5.4.3 Administering pain relief (epidural)

My research questions did not include pain reliefs but rather, it became a recurring theme as some of the women brought up the issue of administering pain relief. It was therefore necessary for me to present my findings in that regard. As already highlighted in chapter two, maternal health care is free in Norway right from medical check-ups with the doctor to community midwives and delivery. Included in this is the administering of pain relief (epidural) which comes at no cost. The majority (ten) of the migrant women come from countries where they had to pay for the cost of epidural whiles only one of the respondents came from Canada, where they did not have to pay anything just like Norway.

Four of the women who gave birth in Kristiansand felt a lot of pain even though they got epidural. One of them (woman W) had her first baby in her home country, Kossovo where she got an epidural and did not feel pain because it numbed her whole body. However, with her second birth which happened in Kristiansand, she felt a lot of pain although she got an epidural.

…Back home in Kossovo, I took an epidural for my first birth. It numbed my body and I could not even feel my legs. But here in Norway, yes I felt every pain although I took epidural. So I told them ' can you do it more and more, because I felt every pain although I got epidural. I told them about it and they said that is all they could do. The epidural did not help. I wanted to jump out of the window because the pain was unbearable. (Respondent starts crying) It is almost a year and I still feel traumatised. (Respondent W)

Respondent M also got an epidural that did not work during her first birth. Due to this, she met with the head of the anaesthetics department before her second birth to explain her experience with the epidural during her earlier birth. The head of anaesthetics was present during her delivery with her second child to personally administer the pain relief to her. And it worked this time around. Woman M was thankful that the epidural worked during her second birth and admitted that, it helped to ease her pain. Due to this, respondent M decided to give her son the same middle name as that of the head of anesthesia as a sign of gratitude.

…*In the end, I got an epidural that failed and did not do anything with my first birth. It did not ease any pain. So I got a second epidural that worked and I gave birth through a caesarean and after that, I was incapable of sitting up because they fixed a blood patch on my spine. Failed epidural, failed spinal block, an epidural that did not work. I was in the hospital for over a week. My second birth experience was much shorter. Before birth, I had an appointment with the head doctor of epidural services and explained my first experience to him. During labour, he was there himself to administer epidural to me and I felt safe. It was partially one of the reasons my second son had a middle name the same as his although my dad also has the same name. I felt safe with him in labour*. (Respondent M).

The remaining two women who also complained about a lot of pain even though they had epidural, had not given birth before and this was their first birth. Prior to delivery, respondents Z and D thought their pains will be completely numbed after taking epidural, that was however not the case as they still felt pains after taking pain reliefs (epidural). They describe their respective experiences which are captured below:

…I thought that all my pains were going to vanish after I take the epidural but that was not the case. I did not feel the abdominal pains but I felt a lot of pain in the other parts of my body. (Respondent D)

…I do not think it helped cos I still felt the same amount of pain after they gave me the epidural on my back. The pains were unbearable. (Respondent Z)

My findings reveal that a considerable number of women experience a problem with the administering of epidural at the hospital in Kristiansand. All the four women captured above gave birth at the hospital in Kristiansand and complained of a failed epidural. One of the women, (M), before her second delivery spoke to the Head of Anaesthesia to discuss her previous experience of a failed epidural. Not surprisingly, the pain relief she received worked and numbed her pain during her second birth. The question of pain relief may not be

particular to migrant women but also to Norwegian women as well. This is because the administering of pain relief has nothing to do with communication or language, but rather, the health professionals in charge. Given my findings, the hospital in Kristiansand should pay close attention to the administering of epidurals to pregnant women during delivery to avoid cases of failed epidurals.

5.4.4 Breastfeeding help

Five of the migrant women received breastfeeding help at the hospital. Four of them gave birth in Kristiansand whiles one gave birth to all her two children in the hospital at Arendal. All the four women who received breastfeeding help at the hospital in Kristiansand mentioned one particular midwife who is also a breastfeeding specialist at the hospital. According to them, this breastfeeding specialist helped them a lot when they had problems with breastfeeding. The breastfeeding specialist and midwife they spoke of was also one of my respondents and I interviewed her as a migrant woman and as a midwife. One of the women, respondent K, declined the offer on breastfeeding consultations but later had problems as her milk was not flowing. She, therefore, had to go back to the hospital because her baby was dehydrated. Respondent K believes the consultations on breastfeeding are very necessary for new mothers.

…a midwife called F was one of the few health workers that was nice to me. She was the person that taught me how to nurse. It was after a month I gave birth, that I went for a nursing consultation and it was her that helped me to nurse my baby. She was definitely one that I felt I could talk to. She made me believe that I could. (Respondent M)

…I was also going to the hospital because there was a breastfeeding specialist there from the United States who I was the most satisfied with! The person who really helped me in Kristiansand who supported me most in my breastfeeding process was this midwife at the hospital. (Respondent Z)

…I spent five days at the hospital after giving birth. Because my milk was not coming and they assisted me in breastfeeding. I felt good and that was good for me. (Respondent Q)

…We got back to the hospital because my milk was not coming and the midwives there helped me nurse my baby. I thought we got excellent care with breastfeeding. (Respondent K)

…The midwives sent me a lot of helpful messages on breastfeeding. They sent me links to some websites which I could get useful breastfeeding information in addition. They were really nice. (Respondent P)

The above excerpts reveal all the five women were very satisfied with the breastfeeding help. The women feel they get good feedback on breastfeeding and follow-ups. This satisfaction depicts high cognition among as they are well informed in breastfeeding issues. Cognition is one key element of 'Experience of Care' because it gives the woman sufficient information and knowledge about breastfeeding.

In addition, the use of non-verbal communication in breastfeeding help could be one of the reasons why the women were satisfied because of the absence of communication barriers. The hospital also provides free courses on nursing but that is voluntary, and a mother can decide to have the course or decline.

5.4.5 Cultural differences

All the eleven women are coming from different countries with diverse norms and practices. Some of the practices in their home country are totally different from that of Norway. These cultural differences cuts across baby care and dress, food, social practices among others. As such, most the health workers find it difficult to understand why some women behave in particular ways during and after birth.

5.4.5.1 Social Practices

The health workers who were interviewed commented that women from East African countries such as Sudan, Eritrea, Somalia, and Ethiopia get a lot of visitors in the hospital after they have given birth. According to the health workers, it is very common for guests to flood in the room where the woman is with her new baby after birth. These visitors come and keep long hours often until late in the evening. The health workers who were interviewed believed that the new mothers needed enough rest, which requires that they also get some time alone with the new-born baby. Respondent P who comes from East Africa and has given birth to all her three children in Norway confirmed what the midwives said. She found it disturbing when a lot of her East African friends come to visit her at the hospital after birth because she needed to be alone with her baby for a while. She, therefore, declined the visit offers from her friends and politely told them to wait until she gets home before they could

visit her. She said that she was careful to decline the visits in a polite manner to avoid misunderstandings as that was what was done in her culture.

…for my first birth, I liked the visits very much but for the second and third, I did not like it because I wanted to be alone. I had a lot of pain and was not prepared mentally but I had to smile and talk to them. With the second and third I saw it as an invasion of privacy. I thought it as rude and shameful to refuse visits from others with my first birth but with the other subsequent births, I told my people to wait until I get home before they visit. My friends understood me perfectly well (Respondent P has given birth to all her three children in Norway)

Respondent P has lived in Norway for over two decades and has assimilated into the Norwegian norm of taking care of the individual and as such, did not want a lot of visitors trooping in at the hospital to visit her and her new-born baby. According to her, she needed to be alone with her baby for some time and therefore declined the visits from her friends. She was however careful to decline the visits since she knew those visits were important in her culture. Thus, although respondent P wanted to be alone with her baby, she still acknowledged the practices from her home country and rather asked her friends to visit her after she is discharged and is at home.

The midwives admitted that the corona situation has really helped in terms of visits to the migrant women, as visitors are now not allowed in the hospital. This according to the health workers has helped mothers after delivery as they do not have to say no to their visits because it is strictly not allowed due to the pandemic.

……It has been much better with the pandemic because there are no visitors. Before, women from Eritrea, Ethiopia, and Somalia often got a lot of visits. All the women in the community come to visit and they come whether the woman wants them to or not. She can try and say o no do not come. It does not matter. They come because it is their duty and part of their culture and they have to make sure the woman is getting enough food. (Midwife F)

The informant acknowledges cultural practices that exist amongst the migrant women. Yet at the same time she also holds strong opinions about the visitors and their behaviour as she puts it in the excerpts below;

...*but they come and observe everything and get involved and they find out things about this woman that are not part of their business. They may find out things about another patient from the same country when they visit their friend. They are quite intrusive***.** (Midwife F)

Respondent F continues by showing how much the women appreciate it now because visitors are not allowed due to the covid-19 situation. She refers to what the women themselves think in the excerpt below;

.. and now there is none of that and the women who have been the most specific about how much they appreciate other women from those communities now say 'It is soo nice, I do not have to tell them not to come because it is forbidden. It is soo easy and peaceful, just me and my baby'. Then I think, okay so what kind of cultural misunderstanding have we been allowing all these years. We should be protective and let the mother get to know her new baby well. It is up to the new-born mother when she goes home to decide which kind of people she wants to come to her home and visit. The visitors take the baby and pass it on one to the other at the hospital and the new mother just sits there waiting for them to leave but she cannot ask them to leave. Now, it is easier for them because visitors are not allowed. But especially these women from East Africa are very happy with that. (Midwife F)

5.4.5.2 Baby Care and dressing.

When it comes to cultural practices, women from East Asia are well noted amongst the health workers for having mittens on their new-born babies. The health workers point out how the babies need to move their hands during breastfeeding, and this becomes difficult because they have mittens on their hands. According to midwife F, it is very difficult to convince the East Asian women to take off the mittens from their babies' hands when they are breastfeeding.

...there are certain stereotypes I know of. Almost all the women that I meet from East Asia want to have mittens on their babies' hands. The problem is they have to take the mittens off their babies' hands so they can feed well. The babies need their hands to feed and it not always easy to convince them and say at least when you are feeding, take the mittens off the babies' hands. But they usually say o, but he might scratch his face. So what if he scratches his face? (Midwife F)

Some of the cultural practices do not help the new-born baby as midwife F sees it. Babies need their hands to feed and it becomes problematic with mittens on their hands. There is the need for cultural adjustments at some point, where health workers and patients communicate

about the diverging practices and find solutions... The informant's (midwife F) information falls under cognition, where women are given the necessary information. However, cultural practices are not necessarily adjusted by information and this becomes a problem as the Asian women do not often listen to the health professionals on mittens. At this point, there is a need for mutual understanding and adjustments. Otherwise, we are talking about a health system where people are assimilated into Norwegian health practices, and not a system where there is room for discussion about practices and cross-cultural communication.

5.4.5.3 Food as cultural practice

My findings reveal that most of the women from the Middle East and Africa are not comfortable with the Norwegian foods served at the hospital according to midwife F. However, Norwegian women do not complain about the type of food they receive at the hospital. One of the migrant women who was interviewed also complained about the food served at the hospital. Respondent J said she was not used to eating bread and cheese after birth in her home country.

*….But some people, especially from the Middle East and Africa, do not like the fact that they have to eat strict Norwegian food like bread and cheese three times a day, they really miss it because, in their home countries, they are used to relatives and friends bringing them foods, stews and what have you. Norwegian women are more used to the foods at the hospital and seldom complain about it. I think it is harder when they do not like the food and that is a sharp reminder for them that their mother is not close to them. For example, lots and lots of migrant women want to drink warm milk, but Norwegian women do not complain about cold milk. (*Midwife F)

Here, the women's cultural background heavily influences the kind of meals they take after childbirth. In addition, most of the women continue to hold on to their culture when it comes to food irrespective of how long they have lived in Norway. The women have a belief that bread is not the best meal for a new-born mother and come from cultures where hot meals are more common than the Norwegian "matpakke" (packed lunch). The cultural practices of migrant women impact the whole experience of care. To them (migrant women), childbirth is a very important moment in their lives and should be given the best treatment and hence a good meal. Because of this, most of the migrant women from the Middle East and Africa see it problematic to be served bread and cheese after giving birth. As discussed in chapter two,

culture has a great impact on migrant women receiving antenatal and postnatal care in their host country (Balaam et al., 2013).

Respondent J confirmed what midwife F said in the excerpts below;

*…Yeah, at the time I gave birth I could not move due to the operation. They were coming with food but I missed something. Most often the food is in the kitchen but you do not know when you can eat. Because sometimes you are hungry. And for me, there were telling me bread was available and I was not used to bread especially after childbirth. If the food can be a little heavier other than bread and perhaps culturally diverse. Though the food was there but I did not understand. Because I kept on thinking am I going to eat bread all the time? (*Respondent J)

It is not surprising that woman J was not happy about eating bread all the time at the hospital after birth, given her cultural background and expectations. Food thus becomes an example of a type of cultural difference which becomes challenging when it comes to expectations of caregiving. The hospital has very standardised procedures and routines and resources, reflecting the cultural practices of the ethnic Norwegian patient.

It is very difficult to meet the differences in health beliefs and cultural practices from both sides (the Norwegian health system and the migrant women). There is a need for adjustment between the two parties to promote quality health care. Also, cultural differences are not about assimilating migrant women to become like Norwegian women but perhaps, it is equally about the Norwegian health system realising that they have differences in their patient group and they need to take that into consideration when they provide services to such heterogeneous group.

Cultural norms and expectations related to delivery and birth.

My study showed that the caesarean section has become very popular in some countries. Respondents W and Q come from countries where people who can afford private hospitals go in for a caesarean section rather than a normal delivery. Respondent W who is from Kosovo said that caesarean section was more easier and most women went for that in her country because they did not have to encounter labour pains and contractions. With woman Q who comes from Sri Lanka, all her relatives and friends who gave birth recently went in for a caesarean section because that was the new norm in her country. In Norway, respondent Q requested for a caesarean with her first baby but the doctors encouraged her to go in for a

regular vaginal birth. According to midwife F, the hospital encourages women to go in for regular vaginal birth when there is no urgent need for a caesarean. It is interesting how migrant women living in Norway are influenced by what is happening in their home country. These women are having transnational relations and are closely tied to the situation and network at their home country which influences their expectations about how a 'proper birth' should be. Midwife T spoke about how some of the women (both Norwegian and migrants) are opting for caesarean sections although the Norwegian health system encourages regular vaginal delivery if there is no underlying or emergency sickness.

5.4.6 Cultural awareness and intercultural communication amongst health personnel.

Only one out of the five health workers who were interviewed had her education (midwifery) in one of the Scandinavian countries, which is outside of Norway. Three of the health workers had all their health education in Norway whiles one had her nursing education in her home country and her midwifery education here in Norway. All the four health workers who were educated in Norway had little to no education in intercultural communication and also no training in 'differences in health practices across cultures' during their study. However, midwife B who had her entire education in another Scandinavian country got a lot of lessons on cultural training during her midwifery training. Midwife F also had some education on culture during her nursing training in her home country.

My findings reveal that there is not enough training focusing on 'cultural practices, differences in such practices, and intercultural communication' available to health workers trained in Norway. This is despite the fact that more than ten percent of the population in Norway are migrants (SSB, 2020). In Kristiansand, about thirty percent of the women who give birth are migrants according to midwife B. Community midwife V said they had had only one lesson on culture since she became a community midwife (6 years ago). However, she felt it was necessary and that the lesson they had on culture was very positive. She further explained that the lesson on culture was not enough and stressed on the need for health personnel to have adequate training in intercultural communication. All the health workers admitted that it is very demanding to know the beliefs and cultures of their patients. They hoped the doula project can help in that regard.

During my interview, Respondent P spoke about an experience she had with her personal midwife when she was pregnant with her first pregnancy. It was about Female Genital Mutilation which involves the removal of the clitoris of the female due to cultural beliefs. Her

community midwife decided to check if she was circumcised, but without preparing her psychologically. Respondent P found it was very shameful when her midwife just asked her to lie down to be checked if she is circumcised or not. She felt shameful and worried but told her midwife. The midwife apologised. Below is a transcribed interview of respondent P on circumcision. The interview excerpt below illustrates this situation:

She (the midwife) asked me 'are you circumcised?'. And I told her I am not sure because we do not openly speak about it in my country. I told her am not sure because my mum says no, I have not been circumcised. You know, they do it when you are young and my family is Christian so I do not think they did it. But then, my midwife wanted to know for sure whether I was circumcised or not. Then she just said, 'okay let us check'. But I thought it is a process the way she checked it made me feel so ashamed and naked. She said 'okay take off your clothes and let us check'. This was with my first pregnancy and because it was my first I believed everything they did and I was also naïve. I took off my clothes and lied down, then she looked and I felt very disgusting. She looked and said 'no you are not, you are not circumcised, you are lucky!'. When I got home, I felt ashamed and was thinking about it. I kept wondering why she did it this way. She could have taken me through some processes and prepared me emotionally because it is not a nice experience. A lot of my friends that are circumcised, talk about it in a hurtful way and shame, and the way she checked mine made me feel ashamed for many days. Finally, I called her and talked to her about it. I told her ' the way you did it was wrong' and she understood, called me and apologised to me. This is one of the things that I felt went wrong with my first pregnancy. (Respondent P).

With woman P, she had the courage to call her midwife to explain how she felt to her but not every woman may have the courage to do so and may live with the feeling of shame for long. Insufficient cultural training makes it difficult for health workers to treat women from different backgrounds as they may not know what might be offensive or not to the woman.
Also, two of my respondents (W and Z) come from countries where women over 33 years take the Nip test when they are pregnant. The Nip test is a genetic test performed on women during pregnancy but in Norway, only women who are 38 years and above are allowed to take it when they get pregnant (Juvet et al., 2016). Respondent W travelled to Germany to have the nip test because it wasn't allowed in Norway although she was 37 years at the time she gave birth.

…. I knew about the nip test that was necessary for older women who were pregnant. I wanted to take the nip test but my midwife said 'you are just 37 and the government only allows for 38 years and above'. I was very shocked. So I told her I wanted to do it in private and will pay for it. But she said 'sorry, then you have to travel out of Norway to do that.' So I travelled out of Norway to have the flip test and the results were fine. (Respondent W)

Three respondents were very surprised that the health workers bathed them after they had given birth and could not clean themselves. These women were very satisfied with their experience after birth where the health workers cleaned them up. They found this to be amazing which was different from their home country and expressed very good satisfaction with how women are being cared for after birth at the hospital.

*… I had a very good experience after birth. The midwives bathed me and took very good care of me. This does not happen in my home country that the midwife bath you and gave me food to eat and talked to me and had a room by myself. They took very good care of my baby whiles I slept. Everything went very well except the birth. (*Respondent W).

5.4.7 The Duola project

As already explained in the literature review, a doula is a woman who offers help to another woman during delivery (Akhavan, 2009). Although a doula is not a midwife, she provides comfort and often comes from the same country of origin as the woman in labour. The doula project has commenced in 8 municipalities in Norway which are Oslo, Baerum, Akershus, Viken, Trondheim, Bergen, Drammen, Stavanger, and Kristiansand. In Kristiansand, the multi-cultural doula program began in January 2021 at the time I was collecting my data. Fortunately, two of the interviewees; one from the health workers and another from the migrant women are part of the doula project in Kristiansand. At the time I interviewed respondent P, she had newly begun her work and had already assisted two women in delivery.

…Doulas are women from other countries who have been living in Norway for some years who speak Norwegian and have given birth here themselves but do not have a health background. A doula is a woman who is helping another woman. Many of the migrants do not know the language and need somebody to support them. It is a national project and is working now in 8 towns in Norway but we are the first in Southern Norway that started it. The funding is not coming from the hospital but an NGO. It is the NGO that is paying the doulas. We finished with the course on the 6th of January 2021. With the duolas, because of

their cultures, they are able to explain to the health workers why the woman is scared about something or why the woman is thinking in a different way. So, the doula is a form of trust for the woman in labour. Midwife B (midwife)

All the five health workers who were interviewed believed that the doula project will help a lot. They were optimistic and believed the project is going to help the midwives and other health professionals to be able to understand the migrant woman.

5.7 Recommendations from the migrant women and health workers to the health system in Norway

Although the Norwegian maternal health system is one of the best in the world (WHO, 2005) in terms of low mortality, the migrant women and health workers gave some suggestions that can improve the system as the world is also advancing. Majority (nine) of my respondents (migrant women) were satisfied with the healthcare they received before and after labour. At the same time, a lot of them (seven) did not like their labour experience and felt that the hospital needs to improve with the labour services. This section, therefore, explains the suggestions given by the two groups of respondents (both migrant women and the health workers).

Majority of the women (migrant) proposed that information should be easily accessible. They further proposed that the health station give an orientation to new migrant women who have arrived in Norway and are pregnant. For instance, if a couple relocates here, the authorities can have one meeting with them to explain how the system works in Norway and where to find information. This will save them a lot of stress. According to my informants, it is not just enough to read the information on the internet, and also not all the migrant women can read and write. At the same time, when a woman gets pregnant, the doctor should take time to explain the maternal process to her. As time progresses, her midwife can also orient her on what to expect when you are in labour in Norway. The midwife should try and talk about all aspects including administering of epidural as a pain relief and how it works.

In addition, four of the women (migrant) were of the view that women should try and integrate and make friends with other women who have lived in Norway for a while. This will help them to know much about the Norwegian system and what to expect during their pregnancy. One of the ways which migrant women can integrate into the Norwegian society is by attending some community programmes such as språk kafé (Norwegian language

practising with migrants) at the library, activities organised by the Red Cross and Blue Cross, and other organisations.

Some of the migrant women also recommended that doctors and gynaecologists run a lot of checks on the pregnant woman and the baby during pregnancy to be sure the baby is healthy. According to them, this will avoid future health problems for both the mother and the child. Also, the nurses or health workers at the hospital can explain to the new mothers about the time they have breakfast, lunch, and supper and what kinds of foods to expect. In so doing, the women will not be surprised about the food they have to eat. They will also be on time to have their meals.

To add to the above, the hospital should revise its policy of coming to the labour ward when contractions are five minutes apart because labour is unpredictable. Also, migrant women should ask questions and seek for clarification when they do not understand a procedure.

Most of the women spoke about the importance of the breastfeeding course the hospital offers for new-born mothers. To them (migrant women), it is important that new-born mothers take the breastfeeding courses even if they have given birth before, because they are going to learn a new thing every time and also prevent breastfeeding problems.

Some of the midwives emphasized on the need to encourage women to write a letter to the labour ward before their time is due. This letter is to communicate their wishes during labour which will help the midwife to know what they want. One of them puts it in this way:

…I think the letters should be really encouraged especially amongst pregnant women. In Norway here, you do not get to meet the midwife until you are in labour so we use a written letter to communicate your wishes. I find that when women have a written letter, it gets read. Now, it is a different generation of midwives I think and they like it when you have a letter. They always read the letters. It will be a good idea to be conscious about it. Respondent F

All the five health workers who were interviewed believed the multicultural doula project can be very helpful to both the migrant women and the midwives. Given this, they recommended that the doula project becomes a permanent project.

*…when I heard and read about the doula, I thought it was a very good help to the nurse, midwife, and assistants. Because there will be a connection between the midiwives and the migrant woman. I am very happy about this initiative. (*Health worker O)

*...I think the Duola project will help migrant women to have a richer experience at the hospital during labour. I am looking forward to this project. (*Midwife F)

*...I hope this duola project is a good project but the psychological treatment is not very easy because of cultures. (*Community midwife V)

...I believe that the doula program is really helping the women. Midwife B

In addition, the health workers encouraged their collegues not to think about the barriers, but rather open their hearts and mind to see the real situation which will enable them to give their best.

In addition, cultural training should be a part of the nursing and midwifery education at the universities in Norway. This will give the health workers enough competence to treat women from diverse backgrounds. All the five health workers acknowledged the need for universities to include cultural education in their health courses. Also, health workers who are already working should be given enough cultural training, for instance, a two-day course in a year to give them the necessary skills to attend to culturally diverse patients.

To add to the above, the health workers raised the need for a stronger awareness of the law amongst migrant women. Women who do not speak Norwegian have the right to an interpreter but most of them are not able to voice out their rights in cases where they are not given interpreters.

Lastly, the information brochure at the hospital should be translated into many languages. This can be done nationally and distributed to all the hospitals to reduce the burden of cost on the local hospitals.

CHAPTER SIX

6.1 Discussion and Concluding Remarks

The 1999 Patient's Act of Norway stipulates that every resident in Norway has the right to health care. In the cases of pregnancy, the health system provides free antenatal, labour, and post-natal services to pregnant women living in Norway irrespective of nationality. In addition, women have access to a community midwife who monitors the progress of their pregnancy until birth. During birth, the women deliver at the hospital with the help of the midwife and other medical professionals. Although the health system propounds equal health care, migrant women are not able to receive equal care as enshrined by the law. My findings revealed an existing barrier that does not enable pregnant migrants to have equal health care. The health workers are however willing to provide equal access but due to the existing barriers, are not always able to do so. In so doing, these health workers cannot be blamed for the inequity that exists. According to my respondents (health workers), migrant women are not able to get the same treatment because of the language barriers, differences in culture and their relatively low knowledge about the Norwegian system and its way of doing things, and many more.

Of these, the main barrier has to do with issues of communication and differences in culture. Most of the women who get pregnant shortly after relocating to Norway are not able to read and understand the Norwegian language which is the official language of communication in all hospitals. Migrants living in Norway who do not speak the Norwegian language have the right to an interpreter when they have appointments with their doctors, midwives, gynaecologist, and other health professionals. However, most of the migrant women who are able to communicate in English are not given interpreters because a considerable number of health workers in Norway can speak English. With the use of the English language, the younger generation of health workers can communicate quite well whiles there is limited communication and also limited understanding when it comes to the older health workers. The majority of the older generation of health workers feel limited and uncomfortable in their work when they have to communicate in English with a patient. This again, often leads to very limited communication and thus also, a potential loss of information and care for the patients.

Interpreters are used anytime there is medical communication between health workers and women who do not speak Norwegian nor English. These interpreters are used over-the-phone

and are unable to see the actual situation on the ground. At times, some of the interpreters find difficulty in translating medical terms to the women in question, and also, the works of the interpreters are very limited and do not include emotional support or comfort. This makes it very difficult to provide comfort to women in labour who do not speak and understand Norwegian. As for women who are married to Norwegians and who do not speak the language, they are dependent on the husbands to translate important information to them. This may be challenging, particularly in situations where there are problems internally in the relationship. This again, may leave the woman in a difficult situation and she may lose out on important information and care that she is entitled to.

Secondly, the difference in culture is a big gap that may prevent migrant women from having equal care and treatment during pregnancy and labour. Migrants are a diverse group of people coming from different parts of the world. In Norway, a lot of countries are well represented here. In my data, there are people from the Middle East, Asia, North America, South America, and Africa. All these foreigners come from different cultures and have different health-seeking behaviours and practices when it comes to pregnancy and maternal health. Some of the women are coming from war zones and have been victims of rape and violence which adds a layer of difficulty when it comes to health care. Once again, some of the cultures believe that the new mother should be served special meals because childbirth is a very important phase of life. However, the Norwegian hospitals perceive bread to be a normal meal and thus often serve bread and cheese at the hospital. Most of the migrant women from the Middle East and Africa see it problematic to be served bread and cheese after birth at the hospitals in Norway. These kinds of cultural challenges emerge because there are very standardised procedures and routines that are basically aimed at catering for one type of women which is the Norwegian woman who is very happy eating bread after birth and is good at communicating in Norwegian. It is very difficult to meet the differences in beliefs from both sides (the Norwegian health system and the migrant women). There is therefore the need for adjustment between the two parties to promote quality health care. Also, cultural differences are not about assimilating migrant women to become like Norwegian women but perhaps it is equally about the Norwegian health system realising that they have differences in their patient group, and they need to take that into consideration when providing services to such heterogeneous group.

Equally important is the fact that, the Norwegian educational system provides little to no education on cultural training for nursing and midwifery students. This lack of attention to

cultural differences in general and cultural differences in health-seeking behaviour, in particular, makes it difficult for the health workers to understand the women's needs and behaviours at the hospital and creates room for misunderstandings. The differences in culture between caregivers and patients (migrant women) make it challenging in terms of providing equal treatment. Sufficient cultural training and education will equip health workers to develop the right attitudes towards migrant women when they are in labour and during pregnancy.

In other instances, a low level of education becomes a barrier between the woman and the health professional because, some of the women have very little to no education and therefore cannot read or write. It becomes difficult for the health workers because most of the information at the hospital in Kristiansand has been translated to many languages in a brochure to enable people who do not understand Norwegian read it in their own language. However, it becomes difficult in instances where the woman is not able to read or write her own language.

What my findings and discussion reveal is that the theoretical framework that I have used definitely has some shortcomings. The dimensions of culture and cultural practices, health-seeking behaviour are culturally produced and consecuted and thus need to be an integral part of quality healthcare (Balaam et al., 2013). Therefore, 'Experience of Care' (Hulton et al., 2000) needs to include the existence of intercultural communication and understanding to enable caregivers to give that quality health care and also promote equity amongst all pregnant women.

To be informed about ones' rights is an essential part of equality of care. As my data shows, most of the women do not get the necessary information they need and are entitled to receive. A typical example is the lump-sum grant unemployed women receive when they give birth in Norway. Most women get information about the health procedures from their doctors, Norwegian husbands, friends, and to a lesser extent the community midwives. There seems to be a lack of a more systematised approach to providing migrant women with the information that they are entitled to receive.

The multicultural doula project recently started in Kristiansand and seven other municipalities in Norway is the crucial way to bridge the cultural gap existing between the health worker and the migrant woman. My findings reveal that the doula is able to explain to the health worker why the woman is acting in a particular way and at the same time explain

the labour system to the woman. In addition, the doula can comfort the woman in labour using their native language which is a form of relief. All the health workers who were interviewed believed the doula project can help bridge the gap migrant women face in accessing maternal health care.

Also, the Norwegian authourities should allocate personal doctors to women who relocate to Norway within a very short time because some of the women who come here are already pregnant and do not know what to do or where to go. In addition, couples who relocate here should be given a brief orientation about how the system works and where they should go in case of pregnancy. The tax authourities can help with this.

6.2 Further research

From the findings, it was revealed that the Duola project has started in eight communities. However, this research did not have the opportunity to explore much about the doula project and its impact. A qualitative study of the doula project in Kristiansand and all the other seven communities will reveal how migrant women and health workers are being affected by the project. I, therefore, recommend further studies into the 'multicultural doula project' and its impact among the eight communities where it is adopted. On the topic itself, a comparative study with other Municipalities is highly recommended to ascertain the experiences of migrant women in those communities. Also, a large quantitative survey in across Norway will be very good inform policy implementation.

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APPENDIX 1.1

INTERVIEW GUIDE FOR MIGRANT WOMEN

Exploring migrant women's experiences of the maternal health care system in Norway

Interview Guide for participants (migrant women) by Janice Bemah Sarpong

Dear participant, this interview is geared towards the research project '**Exploring migrant women's experiences of the maternal health care system in Norway**'. The overall objective of this study is to explore how the maternal health care system works for migrant women, both from the women's own perspective, and also from the health workers point of view.

The purpose of the interview is to discuss your personal experience with the maternal health service in Norway from pregnancy to childbirth. This will be useful to the project.

You have been invited to participate because you are a migrant woman who is currently living in Kristiansand and also have given birth here in Norway.

Background information

a) Age
b) Place of origin
c) Religion

•Tell me a bit about yourself (how long you have stayed in Norway, marital status,number of children , number of children born in Norway , languages spoken etc)

•tell me a bit about the experiences you have had with the Norwegian health system (a) first contact b) what kind of contact, particularly for childbirth/maternal health c) experience with the health station d) cooperation with the midwife e) labour experience ,

-Did the experience match your expectation? ? If yes – why/if not, why not?

- Was it difficult to find information about antenatal services?

- Do Norwegian health workers treat their patients with respect? Do you find that there are difference in how they treat patients? If so, why/how?

- What was the relationship between you and the midwife, doctor and other related health professional during pregnancy? Did you find it to be a good one? Why/why not?
- Is the maternal healthcare here different from that of your home country? How? What is worse or better?
- What suggestions will you give to make the maternal healthcare in Norway better?

- What recommendations would you give fellow migrant women when approaching the maternal health care system in Norway?

APPENDIX 1.2

INTERVIEW GUIDE FOR HEALTH WORKERS

Exploring migrant women's experiences of the maternal health care system in Norway

Interview Guide for participants (health workers) by Janice Bemah Sarpong

Dear participant, this interview is geared towards the research project '**Exploring migrant women's experiences of the maternal health care system in Norway**'. The overall objective of this study is to explore how the maternal health care system works for migrant women, both from the women's own perspective, and also from the health workers point of view.

The purpose of the interview is to discuss your personal experience with migrant women as a health worker in providing antenatal and postnatal in Norway.

You have been invited to participate because you are a health worker who provides maternal health services in Norway.

Background information

a) Age
b) Place of origin
c) Religion

- Can you tell me about your occupation? How long have you worked as a…?
- Do you treat women with migrant background? If yes , can you tell me about your general experience with treating migrant women? Are there any differences between migrant women in general and native Norwegians?
- Do you find that there are any differences in culture, reactions, etc. How? Why?
- Are Norwegian health workers prepared to treat people from other cultures? Do you learn about other cultures as part of the training? Would you need such knowledge or training?
- Did you experience any difficulty in communicating? Have you treated migrant women who do not speak Norwegian? How were you able to communicate?
- From your experience, do you find that there are differences in how migrant women are treated compared to ethnic Norwegians? How/why? What may cause the differences, in your opinion? What can be done to adjust potential differences and ensure equal treatment?
- What recommendations can you give?

NB: Dear health worker please note that this interview is based on general , migrant women and not any specific person in mind.

APPENDIX 1.3

CONSENT FORM FOR MIGRANT WOMEN

Are you interested in taking part in the research project

'Exploring migrant women's experiences of the maternal health care system in Norway.?

This is an inquiry about participation in a research project where the main purpose is to *[explore migrant women's experience in receiving maternal healthcare in Norway]*. In this letter we will give you information about the purpose of the project and what your participation will involve.

Purpose of the project

The project is aimed at bringing out migrant women's experiences and their recommendations during the period they received maternal healthcare to childbirth in Norway*;*

Objectives of the study

The study primarily is to inquire, gather sufficient data and information on the migrant women's experiences about the maternal health care system in Norway.

The research also aims at exploring the systems which were put in place for pregnancy and childbirth and to establish whether these migrant women were included in the system. The research aims at highlighting the level of cooperation between migrant women and health professionals involved.

Research questions

- How does the health system in Norway support health and wellbeing of all women during prenatal and postnatal period?
- What is the existing relationship between the legal provision of care and its accessibility by immigrant women in Kristiansand?
- Are migrant women aware of the health care services that they are entitled to during pregnancy?
- How are migrant women they able to access information on maternal care??

Master's thesis

This project is a part of completing my master degree in Global development management at the University of Agder. As such, the study is for academic purposes.

The data collected will solely be used for my Master thesis project The data collected will solely be used for my Master thesis project. I however, may publish some of my findings in a recognised journal, but then the data will be anonymized.

Who is responsible for the research project?

Institute of Development Studies at the University of Agder is the institution responsible for the project.

The project will be undertaken by Janice Bemah Sarpong under the supervision of Associate Professor Hanne Haaland.

Why are you being asked to participate?

The study aims to solicit information from migrant women who have experience maternal healthcare in Norway and have given birth here. The study area is Kristiansand. You have therefore been invited to participate in the study because you are migrant woman who have settled in Norway and have experienced maternal healthcare here.

What does participation involve for you?

- The study employs interviews as a way of gathering data. The interview will last for about thirty five minutes. The interview will be deleted as soon as the data is transcribed.
- The interview will include questions about your age, how long you have stayed in Norway, your country of origin, your religion and marital status, your level of education, the number of children you have, the number of children you have who were born here in Norway, how were you able to get information about maternal health system in Norway, your experience with the health system during pregnancy, how do you rate it, the behaviour of the healthcare workers towards you and also how different or similar is the maternal healthcare system in Norway different from your home country.

Healthcare workers will also be interviewed. These are workers offering maternal services in Kristiansand.

For the healthcare workers the following questions will be asked. Nationality, occupation, how long have you been working in that field, what services do you render to pregnant women, are migrant women included, what is often the level of cooperation between the migrant women and health care workers.

Participation is voluntary

Participation in the project is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw.

Your participation in the survey will not affect your treatment at the hospital. Neither will it affect your residency in Norway. This is purely for academic purposes and will be treated as such. Your address and personal digit number will not be asked .

Your personal privacy – how we will store and use your personal data

We will only use your personal data for the purpose(s) specified in this information letter. We will process your personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act).

- The researcher, Janice Bemah Sarpong and her supervisor Professor Hanne Haaland at the University of Agder will be the only people who will have access to the information.
- In addition, you will remain anonymous through out the interview. Your names will be replaced with alphabets. For example; ‘migrant Z from Columbia who has lived in Norway for the past four years’. No person will have access to the recording apart from the names stated above. Neither will your contact information be given out. All the information collected will be discarded after the thesis has been submitted.

What will happen to your personal data at the end of the research project?

The project is scheduled to end on June 2021. All the recordings and personal data will be deleted after this day.

Your rights
So long as you can be identified in the collected data, you have the right to:

- access the personal data that is being processed about you
- request that your personal data is deleted
- request that incorrect personal data about you is corrected/rectified
- receive a copy of your personal data (data portability), and
- send a complaint to the Data Protection Officer or The Norwegian Data Protection Authority regarding the processing of your personal data

What gives us the right to process your personal data?
We will process your personal data based on your consent.

Based on an agreement with *the University of Agder,* NSD – The Norwegian Centre for Research Data AS has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Where can I find out more?
If you have questions about the project, or want to exercise your rights, contact:

- Janice Bemah Sarpong, University of Agder via janics18@uia.no on telephone number 004745560467.
- You can also contact the project supervisor; Professor Hanne Haaland at the University of Adger with email hanne.haaland@uia.no.

- Our Data Protection Officer: *Ina Danielsen, ina.danielsen@uia.no* at the University of Adger
- NSD – The Norwegian Centre for Research Data AS, by email: (personverntjenester@nsd.no) or by telephone: +47 55 58 21 17.

Yours sincerely,

Janice Bemah Sarpong
Student

Consent form

-The main purpose of this consent form is to affirm your approval and participation in this project. You are therefore required to sign at the provided space below of you have agreed to undertake this study.

I have received and understood information about the project *[Accessing maternal healthcare in Norway; the migrant women's perspective.]* and have been given the opportunity to ask questions. I give consent:

☐ to participate in *(an interview)*

I give consent for my personal data to be processed until the end date of the project, approx. *June 2021*

(Signed by participant, date)

APPENDIX 1.4

CONSENT FORM FOR HEALTH WORKERS

Are you interested in taking part in the research project

'Exploring migrant women's experiences of the maternal health care system in Norway'?

This is an inquiry about participation in a research project where the main purpose is to *[explore migrant women's experience in receiving maternal healthcare in Norway]*. In this letter we will give you information about the purpose of the project and what your participation will involve.

Purpose of the project

The project is aimed at bringing out migrant women's assessments, thoughts, candid opinion, their ratings and experience during the period they received maternal healthcare to childbirth in Norway*;*

Objectives of the study

The study primarily is to inquire, gather sufficient data and information on the migrant women's experiences about the maternal health care system in Norway.

The research also aims at exploring the systems which were put in place for pregnancy and childbirth and to establish whether these migrant women were included in the system. The research aims at highlighting the level of cooperation between migrant women and health professionals involved.

Research questions

- How does the health system in Norway support health and wellbeing of all women during prenatal and postnatal period?
- What is the existing relationship between the legal provision of care and its accessibility by immigrant women in Kristiansand?
- Are migrant women aware of the health care services that they are entitled to during pregnancy?
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Master's thesis

This project is a part of completing my master degree in Global development management at the University of Agder. As such, the study is for academic purposes.

The data collected will solely be used for my Master thesis project The data collected will solely be used for my Master thesis project. I however, may publish some of my findings in a recognised journal, but then the data will be anonymized.

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Institute of Development Studies at the University of Agder is the institution responsible for the project.

The project will be undertaken by Janice Bemah Sarpong under the supervision of Associate Professor Hanne Haaland.

Why are you being asked to participate?

The study aims to solicit information from migrant women who have experience maternal healthcare in Norway and have given birth here. Health workers like midwives, nurses and doctors who have also provided antenatal care to pregnant women in Norway will also partake. The study area is Kristiansand. You have therefore been invited to participate in the study because you are a health worker who provides antenatal care to pregnant women in Norway.

What does participation involve for you?

- The study employs interviews as a way of gathering data. The interview will last for about thirty five minutes. The interview will be deleted as soon as the data is transcribed.
- The interview will include questions about your age, how long you have stayed in Norway, your country of origin, your level of education, your occupation, how long

you have worked in the health sector and what challenges or benefits you encounter when treating women with migrant background. Other questions include; what services do you render to pregnant women, are migrant women included, what is often the level of cooperation between the migrant women and health care workers.

Participation is voluntary

Participation in the project is voluntary. If you chose to participate, you can withdraw your consent at any time without giving a reason. All information about you will then be made anonymous. There will be no negative consequences for you if you chose not to participate or later decide to withdraw.

Your participation in the survey will not affect your work at the health facility. This is purely for academic purposes and will be treated as such. Your address and personal digit number will not be asked .

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(Signed by participant, date)