UiA University of Agder

Master

Community-based Organizations and Maternal Healthcare: Refugee Women's Experiences in Kristiansand, Norway

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Abstract

Refugee women represent one of the most vulnerable populations globally, facing significant health challenges due to gender-based violence, systemic inequities, and the cascading effects of global conflicts. Maternal healthcare emerges as a critical concern, with displacement often exacerbates the risks of pregnancy complications, premature births, and stillbirths. This study narrows its focus from macro-level analyses to a community-centered investigation of maternal healthcare experiences of refugee women in Kristiansand, a city in Southern Norway. It investigates not only their individual experiences but also the role of community-based organizations (CBOs) in shaping their maternal healthcare. Through a focused-ethnographic approach, the study identifies two key findings. First, refugee women's perceptions of maternal healthcare are shaped by a complex interplay of factors: cultural beliefs and practices from their countries of origin, the support of community networks, and their engagement with the Norwegian healthcare system. Second, CBOs play a critical role in enhancing the social capital of refugee women by providing culturally tailored support that complements formal healthcare services. Informed by these, I argue that the effectiveness of their experiences within the Norwegian maternal healthcare system hinges on an institutional collaboration that brings together policy, healthcare services, and the supportive role of CBOs. This synergy not only contributes into their maternal health outcomes but also facilitates their social integration into the Norwegian society.

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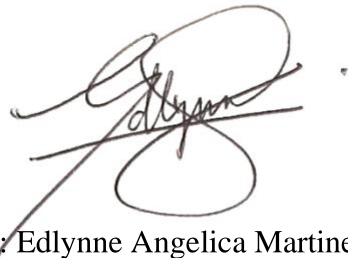
Taos-pusong pasasalamat mula sa isang Pilipinong nangangarap!

Declaration

I, Edlynne Angelica Martinez, hereby declare that this master's thesis, titled «Community-based Organizations and Maternal Healthcare: Refugee Women's Experiences in Kristiansand, Norway», is my original work. I also state that I have not submitted it to any other university or educational institution other than the University of Agder, Norway.

Place: Kristiansand, Norway



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Date: December 2024

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List of Abbreviations

CBOs	Community-based Organizations
CDC	Centers for Disease Control and Prevention
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
FE	Focused Ethnography
FGM	Female Genital Mutilation
IMDi	Integrerings- og Mangfoldsdirektoratet (The Norwegian Directorate for Integration and Diversity)
LDO	Likestillings- og diskrimineringsombudet (The Equality and Anti-discrimination Ombud)
MCHS	Maternal and Child Health Care Service
NAV	Ny arbeids- og velferdsforvaltningen (Norwegian Labor and Welfare Administration)
NCD	Non-communicable diseases
NIP	Norwegian Introduction Programme
SCT	Social Capital Theory
SEM	Socio-ecological Model
SEIF	Self-Help for Immigrants and Refugees
SIKT	Kunnskapssektorens tjenesteleverandør (Norsk senter for forskningsdata)
UDI	Utlendingsdirektoratet (The Norwegian Directorate of Immigration)
UiA	Universitetet i Agder
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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"Pregnancy is giving life; it's bringing something to the world, and people or mothers should not pay for it. I should not pay to give birth. It's nature. It's natural. It's something that just happen […]. Resources must be free of charge."

— *Interview excerpt, 29 May 2024*

CHAPTER ONE
1. INTRODUCTION

1.1 Background of the Study

Forced displacement has steadily increased because of socio-cultural bases of conflict, such as war, persecution, & ethnic and political violence. In Norway, this trend is manifested in a surge of the refugee population to 75,311 in 2022, marking the highest recorded figure to date, spurred by the Russian invasion in Ukraine and war in the occupied Palestinian territory (The World Bank, 2023). Among them, approximately 36,250 individuals have sought temporary collective protection, alongside 4,500 asylum applications. It is reasonable to claim that this figure underestimates the true scope of displacement, considering the influx of refugees from other conflict-afflicted areas of Sudan, Syria, Afghanistan – and the reality that many arrive host countries without formal registration. While precise estimates of irregular immigration remain elusive, the Norwegian Ministries (2022) disclosed that 18,146 individuals were repatriated because of the lack of legal residency. Accordingly, the process of attaining refugee status exceeds a year on average, necessitating prolonged stays in reception centers while awaiting decisions. These realities underscore the pressing need for discussions on the legal and humanitarian circumstances of refugee populations, ensuring the protection of their rights and wellbeing.

Refugees, despite the protective framework established by the 1951 UN Convention, face disruptions within the continuity of care and social services, even in affluent host countries. The process of migration and adaption to another local system presents multifaceted health challenges that extend beyond their preexisting vulnerabilities. These challenges are profoundly shaped by a range of factors, including the diverse socio-cultural and socio-economic contexts from which refugees originate, as well as the complex resettlement processes they navigate (World Health Organization, 2021). The transition to a new healthcare system often entails language barriers, cultural differences, and unfamiliarity with available services (Stein & Fedreheim, 2022).

Of particular concern are the refugee women, who represent a demographic with the highest risk of health issues because of gender-based violence and systematic discrimination. Research demonstrated that these factors significantly impact their overall well-being, particularly in

terms of mental health. Recognizing this impact, studies in Norway (Kale & Hjelde, 2009; Straiton et al., 2017) have focused on analyzing their mental health challenges, and have consistently found higher rates of post-traumatic disorder, anxiety, and depression among them as compared to other migrant groups. Efforts to understand and mitigate these challenges have led to a growing body of research and implementation of targeted interventions aimed at promoting their mental wellbeing. While the focus on mental health is crucial, I argue there is a subject that merits further critical attention: maternal healthcare.

The Global Strategy for Women's, Children's, Adolescent's Health (2018) underscores the importance of ensuring that every woman has the right to access and achieve the highest possible of health, which includes comprehensive maternal healthcare services. This commitment is particularly pertinent for refugee women, who experience heightened vulnerabilities throughout pregnancy and early motherhood. However, recent waves in migration have been linked to escalating rates of pregnancy complications, premature births, and stillbirths among refugee populations, largely attributed to the profound physical and emotional distress with displacement. More than half of maternal deaths occur in unstable and humanitarian contexts, primarily in Sub-Saharan Africa and Southern Asia, which collectively account for 87% of global maternal fatalities in 2020 (World Health Organization, 2023). Within this context, immigrant women, including refugees, have emerged as a particularly vulnerable group in accessing antenatal care, as highlighted by the Norwegian Directorate of Health (Helsedirektoratet, 2020). Studies conducted in Scandinavian countries (Bains, Mæland, et al., 2021; Vik et al., 2019) reveal significant disparities in maternal mortality and morbidity rates between immigrant and native-born populations. It is, therefore, imperative to address the specific needs of refugee women within maternal healthcare in Norway, considering the additional stressors associated with forced migration, adaptation to a new healthcare system, and childcare responsibilities.

Another crucial aspect for exploration is the specific interventions and strategies implemented by community-based organizations (CBOs) to facilitate healthcare integration for refugee women. The rise of civil society and grassroots initiatives within humanitarian contexts have influenced health systems, contributing to the development of effective health policies and programs. In Norway, despite receiving direct funding from the state, CBOs maintain their autonomy, aligning with the Norwegian government's commitment to critical and intersectional collaboration (Loga, 2018). As noted by Nessa (2023), CBOs have possessed

deep-rooted connections among refugee populations, grounded in their nuanced understanding of cultural norms, beliefs, and practices. Therefore, in addition to understanding the experiences of refugee women, it is imperative to explore how CBO-led initiatives impact maternal health outcomes and promote health integration, given the limited research in this area.

While there has been considerable focus on the roles of CBOs in refugee health integration, there remains a critical gap in examining the role of CBO-led initiatives on maternal health outcomes. Investigating how these organizations influence maternal health among refugee women is essential for several reasons. Firstly, maternal health serves as a critical indicator of overall public health and highlights broader systemic inequalities. Secondly, understanding the effectiveness of CBO interventions can provide insights into best practices that may be replicated or scaled in similar contexts.

Moreover, the current landscape of research on migrant healthcare has mostly adopted a macro-level perspective, primarily relying on quantitative methods, thereby restricting the ability to conduct in-depth and community-level exploration of refugees' experiences. In Norway, most studies are either conducted nationally or concentrated specifically in the capital city, Oslo. Through a qualitative inquiry, I aim to address this limitation by exploring the role of CBOs on maternal healthcare within a city in Southern Norway, seeking to understand their influence on refugee women's experiences and overall wellbeing. By delving into the context-specific factors that influence the provision of maternal healthcare for refugee women, I aim to contribute to the ongoing policy and program discourses surrounding healthcare integration for this particular group.

1.2 Personal Motivation for Conducting the Study

My research interest has primarily been on exploring the experiences of vulnerable groups within the healthcare system. Early in my career, I dedicated myself to understanding the intricacies of poverty in my hometown – Manila, Philippines. I navigated challenging environments to uncover everyday experiences of systematic discrimination faced by women and children in healthcare settings. I managed research projects, funded by multiple institutions, including government agencies and organizations, dedicated to addressing sociocultural contexts that shape healthcare for these vulnerable groups. My work has tackled critical issues, ranging from tuberculosis to sexual and reproductive healthcare.

Upon migrating to Norway to pursue a master's in Global Development, I became more reflective of my previous work and experiences. This transition fueled a keen interest in exploring healthcare discourses from a global perspective and applying these to healthcare policy. I became particularly interested in understanding the role of institutions in healthcare access and equity across different cultural and geographical contexts. Through my studies and research, I identified a significant gap in the literature on women's healthcare: maternal healthcare. The interest of pursuing this topic was coupled with my volunteer engagement with organizations supporting refugee women in Kristiansand. In addition to being an immigrant, I became increasingly intrigued by their migration experiences.

In essence, my thesis endeavors to bridge the gap between theory and practice, drawing upon my advocacy work, academic pursuits, and involvement with CBOs to examine the maternal healthcare experiences of refugee women.

1.3 Research Problem

The integration of refugee women into the maternal healthcare system poses multifaceted challenges, influenced by sociocultural and institutional factors. In Norway, where healthcare policies aim for inclusivity, understanding the intricate dynamics of how CBOs intersect with maternal healthcare for refugee women is essential. This study looked into the experiences of refugee women as they navigate the complexities of the maternal healthcare system in Norway. Specifically, it examined the roles of CBOs in mitigating potential barriers to access, promoting cultural competence within healthcare services, and advocating for the specific needs and rights of refugee women within maternal healthcare. Through a qualitative inquiry, this research engaged directly with refugee women, CBO representatives, and healthcare stakeholders to capture a comprehensive understanding of the challenges and opportunities in improving maternal healthcare outcomes for this particular group.

1.4 Research Questions

Following the above research problem, this study is guided by the following research questions:

a. How do refugee women perceive their access to maternal healthcare?
b. How do CBOs describe access to maternal healthcare for refugee women?
c. What are the initiatives and programs of CBOs that respond to the maternal healthcare for refugee women?

d. How do the experiences of refugee women with maternal healthcare impact their overall wellbeing and their process of integration?

1.5 Geographical Study Area and Contexts

This study revolves within five key contexts: the geographical setting, informants, integration within maternal healthcare, the Norwegian maternal healthcare system, and community-based organizations. In this section, each of these is discussed, drawing on official sources and personal field observations to provide more understanding of the scope of the study.

1.5.1 Study Area

This study is carried out in Kristiansand, situated in the county of Agder, southern Norway. It is the fifth largest city in Norway, accounting for an estimate of 117,000 residents from 161 different nations (Statistisk sentralbyrå, 2024). The diversity is not incidental but rather a result of history and deliberate efforts, drawing from its status as a port city that facilitates trade and immigration. Moreover, Kristiansand has actively participated to be a designated settlement area for refugees that hosts the greatest number of refugees in Agder (Kristiansand municipality, 2022). Kristiansand engages in both international and national refugee resettlement programs that provide support services, housing, and integration programs. These programs not only benefit refugees but also allow municipalities in Norway to access government grants. The impact of this commitment is evident in the presence of 122 registered volunteer organizations in the category of diversity and inclusion, alongside 30 organizations in the category of health in Kristiansand (Kristiansand Kommune, 2024).

As an immigrant residing in Kristiansand for two years, I have had the opportunity to participate in various cultural events organized by local organizations and municipal authorities. These gatherings function as platforms for residents to forge connections and exchange perspectives, thereby promoting community cohesion. Notable among these events are language cafés, which have allowed me to enhance my Norwegian language while interacting with individuals from diverse backgrounds. Additionally, I have engaged in support groups specifically tailored for immigrant women, which have provided valuable network opportunities.

1.5.2 Study Informants

Before delving into the specifics of the target informants, it is crucial to understand on what constitutes the status of a refugee. The universal definition of a refugee[1] is primarily drawn from Article 1 A (2) of the UN Refugee Convention (1951), which is as follows:

> Owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence, is unable or, owing to such fear, is unwilling to return to it.

In Norway, the Utlendingsdirektoratet, or the Norwegian Directorate of Immigration (UDI), defines a refugee as an individual who has been granted a residence permit based on these grounds. Refugees, therefore, are inherently entitled to "international protection"[2] as their country of origin fails or refuses to ensure their wellbeing or actively pose a threat to their safety. A key distinction of a refugee to other immigrant groups is that their motivation to migrate is based on their experiences of persecution and violence, making their circumstances particularly urgent and precarious. Initially arriving as asylum seekers, refugees undergo a process of obtaining a formal recognition for their settlement, signifying the transition from temporary residents to individuals with legally sanctioned rights within the country. It is also important to emphasize that seeking asylum is a universal human right and they should not be expelled or returned to situations of danger. This foundational principle underscores the responsibility of host nations to provide protection and support for refugees, ensuring that their rights are respected and upheld throughout the integration process.

The primary subjects of this study are refugee women that sought access to maternal healthcare in Kristiansand, Norway. Based on the definition provided, refugee women are those who have fled their home countries because of war, persecution, or human rights violations and have sought refuge in another country. Their situations and experiences vary, influenced by various factors such as the reasons for their displacement, cultural backgrounds, and socioeconomic status. Specific statistics indicate that Norway had 134,812 women with refugee background

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[1] See *Convention Relating to the Status of Refugees*, July 28, 1951, Refugee Act of 1980, Pub. L. No. 96-212, 94 Stat. 102

[2] See *Convention and Protocol Relating to the Issues of the Refugees* by the United Nations High Commissioner for Refugees, available at https://www.unhcr.org/media/convention-and-protocol-relating-status-refugees

in 2023. Unlike other migrant groups, refugee women face significant disadvantages across various societal domains, compounded by issues such as gender-based violence, cultural stigmas, and harmful practices, such as female genital mutilation, which disproportionately affect their wellbeing and maternal health outcomes (elaborated further in Chapter Two). In this context, I aim to explore the intersection of refugee status, health, and gender in relation to healthcare access within the host society, Norway.

Considering the timeliness of institutional experiences and health-seeking behavior, this study focuses among refugee women who have given birth for the past three years or less in Kristiansand, Norway. The length of their stay in Norway was not considered a criterion for selection due to recruitment challenges, which enabled for a broader pool of informants. As such, I aimed to capture a diverse range of experiences and perspectives among these women. While they were selected irrespective of their country of origin, it is important to acknowledge that their backgrounds may influence their expectations and experiences in the healthcare system. Accordingly, these women were identified through their attendance at maternity meetings and other social activities organized by CBOs (see more of the sampling procedures on Chapter Three).

This study also involves another key group of informants, referred to as the "providers". These individuals, which include healthcare professionals or development workers maintain close ties with refugee women. Considering the focus of this study, all of the providers are affiliated with CBOs, where they actively participate in delivering social services or advocating for the maternal health needs of refugee women. This group consists of professionals with firsthand experience in migrant healthcare, as well as those engaged in program management and community outreach initiatives. Healthcare providers from the hospital were initially considered for provider recruitment, but logistical challenges related to communication and scheduling led to their exclusion. The implications of this decision will be discussed in Chapter three.

1.5.3 Integration in the context of Maternal Healthcare

Integration is a multifaceted and evolving concept with varied interpretations across disciplines. To clarify its application, it is essential to establish a specific understanding of integration within the context of this study. Penninx & Garcés-Mascareñas (2016) offer a

framework for understanding integration, identifying three interrelated dimensions: legal-political, socioeconomic, and cultural-religious. These dimensions interact and collectively influence individuals' experiences within a society. The way these dimensions intersect can either facilitate or hinder the process of integration for different groups, including refugees.

Within this framework, healthcare emerges as a crucial component of the socioeconomic dimension, as it significantly impacts an individual's quality of life, productivity, and ability to participate in society. Access to healthcare impacts not only immediate health outcomes but also broader aspects of social and economic integration by influencing a person's capacity to work, pursue education, and participate in the community. For refugee women, maternal healthcare services are especially important, as pregnancy, childbirth, and the postpartum period represent critical times when healthcare access can have profound effects on both maternal and child health. The quality and accessibility of maternal healthcare can either promote social inclusion or exacerbate their vulnerabilities.

In this study, I examine the concept of integration through the experiences of refugee women within health institutions and CBOs in Norway, particularly regarding their access to, comprehension of, and use of maternal healthcare services. Integration, in this context, is assessed in terms of the availability of healthcare services, the cultural competence and sensitivity of healthcare providers, the physical and logistical accessibility of healthcare facilities, and the ability to accommodate their diverse cultural and linguistic needs. Additionally, the role of CBOs on social support networks is explored, recognizing that community engagement and peer support can significantly impact the integration experience for refugee women.

1.5.4 The Norwegian Maternal Healthcare System

Building upon the World Health Organization's definition (2017), maternal healthcare refers to the comprehensive range of services provided to women throughout the pregnancy, childbirth, and the postpartum period. These services are crucial for identifying and addressing any potential complications, and encouraging health practices prior to, during, and following childbirth. It is firmly established that maternal healthcare must prioritize the entitlement of women to dignified treatment, promote informed decision-making, and provide care in alignment with evidence-based practices.

The Norwegian healthcare system is perceived to be based on the principles of equity and universal access, surrounding the contexts of *"[...] health-promoting conditions, prevention, diagnostics, treatment of diseases and functional limitations, rehabilitation and organization and streamlining of services in the health and care sector"* (Research Council of Norway 2020a, cited in Ryen Gloinson et al., 2021). This system is primarily managed by municipalities, such as Kristiansand, while the state serves as a secondary healthcare provider. Refugees are immediately granted access to the Norwegian national insurance scheme, entitling them to free healthcare services. As such, all pregnant women in Norway, including refugees and other migrant groups, are entitled to maternal healthcare from the *helsestasjon* or the public health clinic, administered by the Maternal and Child Healthcare Services (MCHS) (Leirbakk et al., 2019). This includes a range of services[3], such as medical examinations, fetal diagnostics, and labor support which are provided for free and are typically conducted by general practitioners or midwives. Additionally, they have the right to emergency care, free abortion, and post-procedure follow-ups. During consultations[4], various topics are addressed to ensure comprehensive care, including previous pregnancies, health history, nutrition and exercise, mental health, experience of abuse and violence, and declaration of paternity. Pregnant women who have limited proficiency in Norwegian have the right to an interpreter in their preferred language. Additionally, most deliveries in Norway take place in hospitals, where expectant mothers receive comprehensive medical attention and support from a team of healthcare providers. Home births are an option that is often preferred by immigrant women, although these deliveries are still supervised by midwives trained in home delivery practices. Finally, parents in Norway are entitled to a parental leave policy, allowing for a total of twelve months of leave surrounding the birth of a child. This policy includes the option for parents to take up to twelve weeks of leave during pregnancy, with a minimum of six weeks reserved for after the birth.

[3] See more on the *National Professional Guideline* by The Directorate of Health, available at https://www.helsedirektoratet.no/retningslinjer/svangerskapsomsorgen

[4] See more on *Pregnancy Consultations* by Helse Norge, available at https://www.helsenorge.no/en/pregnancy-and-maternity-care-in-norway/antenatal-checks-and-tests/

1.5.5 Community-based Organizations

As this study looks into the role of community-based organizations (CBOs) in shaping the maternal healthcare experiences of refugee women, it is crucial to understand why CBOs are specifically selected as the focus of this research and what makes them distinct from other entities. Unlike with other entities, CBOs operate at a grassroot approach, allowing them to develop an understanding of the local dynamics, cultural nuances, and community challenges. Their proximity to the community positions them as key players in addressing localized social and health-related issues, making their impact on maternal healthcare particularly significant. As such, CBOs are often established and run by volunteers or members of the community itself.

The choice to focus on CBOs is because of the aim to explore community-level interventions and support structures in Kristiansand. This community-centered perspective allows for an examination of how grassroots efforts contribute to the health and well-being of refugee women, providing insights into the potential for CBOs to serve as models for enhancing maternal healthcare in similar settings.

1.6 Thesis Structure

This paper is organized into six chapters: (1) introduction, (2) literature review, (3) methodology, (4) empirical findings, (5) analysis, and (6) conclusion and recommendations.

Chapter one introduces the study by outlining its background, purpose, research gaps, research problem, and questions. It also highlights the geographical and demographic relevance of the study's context. This chapter explains the rationale for examining the role of CBOs and refugee women's experiences in maternal healthcare, along with my personal motivation for conducting the study.

Chapter two reviews the key literature and outlines the main theoretical and conceptual themes relevant to this study. It begins with a broad discussion on the history and public perceptions of immigration in Norway, gradually narrowing down to the current framework of integration. The chapter then focuses on refugee women, highlighting studies on their vulnerabilities, experiences, and legal challenges, including the Norwegian context. Following this, it presents critical issues within maternal healthcare and discusses the individual and institutional factors affecting it. This chapter not only provides an overview of existing research but also identifies gaps, specifically the need for further study on the role of CBOs in refugee women's maternal

healthcare experiences. Ultimately, it presents the theories and conceptual framework that underpin this study.

Chapter three outlines the methodological decisions made during the study's design, sampling, strategies, and implementation. It begins by addressing the epistemological and ontological considerations of the study. The chapter also outlines the research design and data collection procedures, highlighting the challenges faced and the actions taken in response. The chosen approach for data analysis is discussed. The chapter concludes with a thorough examination of the ethical considerations relevant to the study.

Chapter four presents the key findings of the study based on insights from both refugee women and healthcare providers. The chapter is structured around the research questions and are developed through themes and sub-themes identified through thematic analysis. It also examines important indicators of satisfaction, challenges refugees face in accessing maternal healthcare, and the role of CBOs in supporting their integration. The chapter begins by detailing the maternal healthcare experiences of refugee women, followed by the perspectives of providers on their roles within CBOs and their efforts to assist these women.

Chapter five presents the analysis by situating the findings within two key theoretical perspectives: Social Ecological Model and Social Capital Theory. This chapter deepens the understanding of refugee women's maternal healthcare experiences by exploring the multi-layered factors that affect their access to and quality of care. It also examines the significant role that CBOs play in shaping these experiences, acting as support networks for refugee women.

Chapter six presents the conclusions drawn from the data and offers an in-depth analysis of their implications for practice and policy. It includes recommendations to inform future efforts in addressing the identified issues. This chapter also details the study's limitations, providing context for the findings and highlighting areas where further research is warranted.

CHAPTER TWO
2. LITERATURE REVIEW

This chapter is primarily focused on the themes of immigration, integration, refugee women, and maternal healthcare. Drawing from peer-reviewed articles and other scholarly works, I build upon the interrelationship of these variables and their relevance to the objectives of this study. Each topic is explored through distinct sub-themes, as I highlight key discourses surrounding the experiences and vulnerabilities of refugees across host societies concerning maternal healthcare, with a specific emphasis in Norway. Following this, I present the theories used to understand maternal healthcare within refugee populations. The final section elaborates on the conceptual framework I developed, which integrates the theories to offer context for the subsequent analysis.

2.1 From Immigration to Integration: Norway as an Asylum Destination

On examining scholarly discourse on European immigration, I find its origins from the effects of the World War II, a time marked by widespread destruction, displacement, and political instability that forcibly displaced millions from their homes (Kraler Albert et al., 2022; Nyrud, 2019). This set the stage for the development of modern asylum policies, shaped by international conventions and the need for humanitarian response. Norway, as a destination for asylum seekers, offers a unique case because of its distinct immigration policies, welfare state model, and socio-cultural dynamics. This section aims to synthesize the history and role of Norway as an asylum destination, examining both the challenges and successes in the integration process.

2.1.1 The History and Formation of Public Perceptions on Immigration

Norway, akin to its European counterparts, has undergone distinct waves of immigration. The initial wave, emerging in the 1960s, was propelled by the demand for labor because of the discovery and economic upswing of oil reserves. This period saw an influx of predominantly male immigrants from Turkey, India, and Pakistan to fulfill labor demands. It is crucial to highlight this historical context, as the 1973 Oil Crisis significantly influenced immigration patterns in Norway. This crisis shifted labor market dynamics, leading to the perception of immigrants as potential competitors for employment and social services (Eriksen, 2013). For example, Garvik & Valenta (2021) mentioned that policymakers leveraged public concerns arising from the economic downturn of the crisis to endorse stricter immigration measures.

These measures, often coupled with the promotion of populist narratives, emphasized on the welfare of native-born Norwegians over immigrants. By historically looking into how societal attitudes are shaped towards immigrants, we gain insights into the contemporary perspectives of immigration and its inherent challenges to integration.

A study by Pittaway & Bartolomei (2001) explored the concept of "othering" among refugees in European countries. This notion suggests a perceived devaluation of refugees in comparison to the ethnic population, making integration efforts challenging. In Norway, where societal dimensions are relatively small and cultural disparities between Norwegians and refugees are significant, this concept holds particular relevance. Studies indicate persistent stereotypes associating refugees with threats to Norwegian identity and the welfare system, many of which are rooted in a lens of a certain religion and race, fueled by media representations and political rhetoric. For example, Døving's (2020) content analysis revealed a prevalence of Islamophobic perceptions, often associated with terrorism and extremism. Fangen (2006) discussed that Somali refugees in Norway face discrimination because of the wearing of hijab, perceived by some as a symbol of refusal to integrate, contrasting with the secular and gender-equal values held by many Norwegians. Additionally, the list of nationalities that often experience discrimination in the Norwegian labor market are commonly from Muslim-majority countries, particularly in the Middle East and African countries (Eriksen, 2013). Considering these, the intersection of culture and healthcare integration among this specific demographic presents an intriguing avenue for further investigation.

Furthermore, immigration continued to be prominent because of the family reunification scheme, which marked the second wave of immigration in 1975. This cohort primarily consisted of women and children with ties to early migrant workers, underscoring the intergenerational nature of migration within these communities. The enduring prevalence of women among immigrant populations persists to this day, shaped in part by the imposition of martial law where men are often conscripted into warfare. For example, the United Nations (2023) stated that 90% of the 8 million refugees who have fled the conflict in Ukraine are women and children, illustrating the gendered impact of displacement. While the family reunification offers a lifeline for many displaced individuals, it also presents unique challenges for women who arrive in Norway without their husbands or male relatives. The complexities faced by refugee women will be further explored in the subsequent sections of this review.

The current wave of immigrants was due to a myriad of factors, with heightened conflict and political persecution as primary drivers. In the beginning of 1980s, an increase of asylum seekers dominated the Norwegian immigration statistics (Thorvaldsen, 2020). The collapse of Saigon in 1975, which ended the Vietnam War, created lasting regional instability and contributed to a refugee crisis. Concurrently, escalating violence in Somalia reached a peak with the onset of the Somali Civil War in the late 1980s, resulting in widespread displacement. The immigration landscape continued to evolve in response to global conflicts, such as the Syrian Civil War that began in 2011. This conflict led to Norway accepting around 31,000 asylum seekers in 2015, with Syrians comprising a significant portion. More recently, Norway has faced a new wave of immigration, with the ongoing war in Ukraine, leading to the arrival of around 50,000 Ukrainian refugees by mid-2024, making them one of the largest groups to seek refuge in such a short time frame.

Amidst these global conflicts, the Norwegian government has tightened immigration policies in response to the increasing refugee movements, aiming to balance humanitarian responsibilities with integration challenges. Historically, Norway's immigration policy has been influenced by a desire to align with the practices of its Scandinavian neighbors, particularly Sweden and Denmark (Fernandes, 2015). Similar to Sweden, reports (Brochmann et al., 2012; Eriksen, 2013) indicate that there has been a greater emphasis on policies that prioritize language acquisition and workforce participation. These measures are intended to ensure that immigrants can actively contribute to the economy and society, thus preventing Norway from being viewed as a more accessible destination within the region, which could lead to an increase in asylum seekers.

However, this emphasis raises questions about whether the approach genuinely prioritizes the well-being of immigrants or if it is driven by economic considerations. For instance, the Progress Party (Fremskrittspartiet, FrP) advocated for tightening asylum rules during the 2015 European migrant crisis by reducing benefits for asylum seekers and expediting the deportation of those who do not meet protection criteria, citing concerns about preserving Norwegian cultural identity and managing limited resources (Bangstad, 2015). These policy debates prompt further scrutiny about their impact on the ground. Do these approaches resonate with the broader community, and how do they affect refugees' experiences with integration and accessing essential services like healthcare?

2.1.2 The Norwegian Framework of Integration

Integration, a multifaceted concept, receives varying definitions from scholars in the basis of policies and states. Nonetheless, a recurring theme in the academic discourse is that integration is a two-way process between immigrants and their host society (Anna Karlsdóttir et al., 2020; Korteweg, 2017). It encompasses a mutual adaptation where immigrants become active participants in their new society, and the established population supports this inclusion. As emphasized by Putnam (2000), this process must extend beyond mere assimilation as it should encompass the development of a shared collective identity between immigrants and the host society. This identity is shaped through experiences of inclusion, exclusion, and discrimination, highlighting the dynamic and ongoing nature of integration.

Heckmann (2006) further classified integration into four dimensions: structural, cultural, social, and identificational. Structural integration refers to the quantifiable aspects of immigrants' participation in the core institutions of the host society, such as education and income levels, including access to healthcare. I highlight this dimension as it serves as a prime example of the Nordic welfare model, characterized by substantial investments in welfare systems, often described as "generous welfare state" and "universal welfare services" (Djuve & Kavli, 2019, p. 26). This model ensures that all residents, irrespective of their socioeconomic status, age, and background, are entitled to equitable access to the same level of services and welfare benefits. It, therefore, becomes evident that there is an increasingly number of studies (Mbanya, 2019; Thorvaldsen, 2020) that recognize Norway for its high-quality of welfare, inclusion, and provision of humanitarian assistance; and further examining how refugees' experiences intersect with this model, particularly with healthcare access, could provide invaluable insights.

More specifically, Norway upholds its commitment to integration through the Norwegian Introduction Programme (NIP), a program that provides "comprehensive support" for newly-arrived refugees. The NIP includes the instruction of the Norwegian language, Norwegian societal norms, and job market preparation, alongside financial support for the participants to concentrate fully on their integration (IMDi, 2019). The program's success is assessed by the participants' transition to employment or education and their ability to achieve financial self-sufficiency. Therefore, some municipalities in Norway have been reported to focus almost exclusively on on-the-job training as part of this initiative (Ugreninov & Turner, 2023). Despite

its objectives, the NIP's two-year duration and its one-size-fits-all approach present significant challenges. As noted by Rambøll (2019), integration initiatives that promote "fast track" have failed to yield better outcomes. Similarly, the standardized approach often fails to account the diverse background and experiences of refugees, which can hinder effective integration. Ugreninov & Turner (2023) stated that many refugees struggle to enter the highly-skilled labor market even after the completion of the NIP. While the NIP's focus on economic contribution is understandable, this emphasis may inadvertently neglect other essential aspects of integration. For instance, I believe the absence of a dedicated healthcare component in the NIP is a significant oversight. I have yet to come across any studies that examine the intersection of the NIP and health, particularly in understanding how refugees access information about the Norwegian healthcare system.

Despite the increased scholarly attention on refugee integration, much research and contemporary discussions are concentrated towards their participation to the labor market. As argued by Stein & Fedreheim (2022), the prevailing political discourse of integration in Norway is mostly tied to employment, seen as a means for immigrants to achieve economic self-reliance. This is rooted towards the history of immigration, shaped notably by the expansion of the oil industry and the commitment to uphold the Norwegian welfare model. Scholars (Djuve & Kavli, 2019; Nessa, 2023) have, therefore, emphasized that such narrow focus overlooks the sociocultural and psychological aspects inherent in the integration process. This limitation extends to the domain of health, where factors such as access to healthcare services, cultural competence in healthcare provision, and socioeconomic determinants of health is paramount to a more holistic approach to integration.

2.2 The Refugee Women: Vulnerabilities, Experiences, and Legal Challenges

This section centers on the primary subjects of this study – the refugee women. It delves into their lived experiences, discussing the specific vulnerabilities they confront, and substantiates these by citing relevant cases both on an international scale and within Norway. This review examines the contexts that differentiate refugee women from other migrant groups. This review also critically evaluates legal frameworks – or their notable absence – that are intended to address their needs, with a particular focus on the deficiencies within instruments like the 1951 Convention.

2.2.1 The Gendered Experiences of Refugee Women

Throughout history, discussions about refugees have predominantly centered on men, emphasized by their motives for fleeing and their role in the labor market of their host country, while neglecting narratives that deviate from the heteronormative male perspective (Kofman & Raghuram, 2022; Morokvašić, 2014). Evidently, as discussed in earlier sections, much of the historical discourse on Norway's immigration has predominantly focused on the influx of male immigrants because of labor demand, followed by family reunification schemes that involved women. This bias is tied in the long-established perception of women's dependence on men, and often results to the grouping of "women and children" under generic terms in academic discourse concerning migrant groups (Carpenter, 2005). Women are often depicted solely within the context of family units, defined primarily as mothers, wives, and sisters in need of male protection.

Nevertheless, the academic discourse surrounding this topic has evolved when there was a growing indication that women are more subjected to gendered forms of discrimination and violence in conflict zones. The Women's Refugee Commission (2019) contended that the experiences of women throughout the process of migration are significantly different from those of men. Refugee women and girls have been classified to as part of the "minority" or "vulnerable", influenced by distinct challenges from pre- to post-migration processes (Oliver, 2017; Pittaway & Bartolomei, 2001; Rai & Paul, 2021). This includes systematic atrocities – such as rape, sexual harassment, domestic violence, and forced marriage – that are often institutionalized from the country where they came from (Freedman, 2016; Pittaway & Bartolomei, 2001). By way example, Oliver (2017) highlighted how refugee women are often used as a weapon of intimidation and control, with rape used to undermine opposing cultures. In Rwanda, the international criminal tribunal classified rape as an act of genocide where nearly all women survivors experienced it alongside other forms of sexual violence (Refugee Council, 2009). This pattern persists in contemporary conflicts, such as in Congo, where approximately a thousand Congolese women are raped daily, and young girls under 18 years account for 65% of the victims (Lugova et al., 2020). More recently, the Ukrainian Women's Congress (2023) reported that 26% refugee women in Ukraine have experienced violence after fleeing the country.

Another context that exacerbates to the vulnerability of refugee women is the continued acceptance of traditional gender roles and societal imposition of "low status", which restricts self-autonomy, decision-making positions, and representation at every level (Oliver, 2017; Pittaway & BartoRai & Paul, 2021). These conceptions are deeply entrenched in their cultural norms and values which prioritize male dominance and limit the roles of women. Scholars, such as Freedman (2016), Moghadam (2004), and Zetter & Ruaudel (2014), emphasize that these norms are not only culturally ingrained, but also reinforced through formal and informal institutions in their countries of origin. As a result, refugee women carry these attitudes that often clash with the norms of their new environment, even in progressive host societies where gender equality is strongly advocated. For example, Moghadam (2004) contends that religious conservatism in the Middle East often reinforces doctrines that emphasize household responsibilities and discourage women's participation in public and economic life. This leads to expectations that women should prioritize family responsibilities, limiting their support systems for broader integration. Nessa (2023) mentions "reverse integration", arguing that refugees face barriers to employment, education, and training due to challenges with language acquisition and network development. The study also revealed that many women took maternity leaves during their time in the NIP, further limiting their opportunities to practice the language and often requiring them to start over upon returning (p. 7). This situation contributes to employment gap, as the IMDi (2022) reported that refugee women are less likely to be employed as compared to their male counterparts and ethnic Norwegian women.

The perpetuation of this issue is exacerbated by the lack of representation of refugee women in leadership positions and decision-making processes that target their specific needs and perspectives within their host society. This exclusion perpetuates a cycle of disempowerment and limits their opportunities for personal and economic development (Oliver, 2017; Rai & Paul, 2021). A report from the Norwegian Ministry of Culture (2019, p. 51) underlines the depth of this problem, as it states that there is still underrepresentation for women, young adults, and individuals with immigrant backgrounds across the political sphere in Norway. It is, therefore, crucial to have policies that encourage diversity and ensure everyone has a fair chance to be heard in decision-making. This is especially important to empower refugee women and break the cycle of exclusion they face.

2.2.2 The Refugee Women within Legal Frameworks

Despite the growing indication of their vulnerabilities, the challenges of refugee women in host countries are incompletely understood, leading most interventions and integration programs to be gender neutral. Notably, the 1951 Convention does not designate any form of instrument that addresses gender and discrimination against women (refer to the universal definition of a refugee on p. 9). This challenge primarily stems from the argument that gender-based violence is perceived as a private matter beyond the jurisdiction of international law. Additionally, proponents of this perspective argue that including gender to what constitutes as a refugee just creates exclusionary category that overlooks other social groups who seek protection. It is, however, important to note that during the convention, all immigration judges were men with limited knowledge of gender-based violence – and even today, men are still overrepresented, making up 60% of immigration judges (Shapiro, 2022, p. 804). The UNCHR (2002) recognized such limitations, as it concedes, *"historically, the refugee definition has been interpreted through a framework of male experiences, which has meant that many claims of women and of homosexuals, have gone unrecognized"* (p. 2).

Scholars advocated for gendered aspects into the 'social groups' and 'political opinions' of the 1951 Convention. Indra (1987) offers a compelling critique, advocating for a reevaluation of the refugee definition to include persecution based on sex and gender. This redefinition is crucial as it acknowledges situations where an individual, such as a woman in Iran, faces mortal peril from societal institutions for challenging prescribed gender roles or diverging from oppressive sexual norms. As exemplified by Indra (1987): while someone risking their life due to their minority religion, like the Bahá'í in Iran, may be recognized as a refugee under the Convention, a woman facing similar dangers solely based on her gender is not afforded the same recognition. (p. 2).

It is only in recent years, particularly during the thirty-fourth session of the UN General Assembly, where international and legal frameworks were mentioned that focus among refugee women. A notable example is the adoption of the UNCHR's (1990) "Policy on Refugee Women and Guidelines on their Protection" where it advocates for their protection and involvement in decision-making within refugee camps. Another significant framework is the UN Security Council Resolution 1325 on Women, Peace, and Security (UNSCR 1325) (2000),

which promotes the role of women across all stages of conflict resolution, from prevention to post-conflict reconstruction. It also stipulates the integration of a gender perspective in all peacebuilding efforts and calls for the development of a national action plan by member states to prioritize this aspect. While these frameworks mark important steps forward, it is crucial to acknowledge that many countries have yet taken additional steps to enact domestic legislation and adopt gender-specific guidelines to address the needs of refugee women within their borders.

2.2.3 Norway's Approach to Refugee Women

Norway's commitment to upholding women's rights and advancing gender equality in its development policies and humanitarian response has garnered international recognition (Ministry of Foreign Affairs, 2018; UNCHR, 2021). This commitment is evident in its collaboration with the UNCHR on the transfer and admission of refugees based on medical cases, emergency cases, and unallocated sub-quota. In this scheme, Norway prioritizes to admitting vulnerable groups, especially cases of women and girls at risk, who account for half of the total placement (UNCHR, 2021). Another key step was the ratification of Norway with the Istanbul Convention, reaffirming its determination to combat gender-based violence against women, including refugees. This acknowledges the heightened vulnerability of refugee women to displacement and associated risks. Further reflecting this commitment, Norway implemented a localized guideline in 1998 that incorporates a gender perspective on the grounds for refugee status (Justis- og beredskapsdepartementet, 1998). Although Norway follows the Convention's criteria for designating refugees, it places women as part of a "particular social group" under the Convention. As noted by Holth, (2004), "*women who faced persecution for violating social norms could be recognized under the Convention as part of a social group and granted asylum*" (p. 40).

Despite these measures, a critique persists regarding the guidelines' lack of specificity in evaluating women asylum seekers from a gender perspective. The 1998 guidelines introduced the concept of gender-based persecution but offered little practical guidance on protecting women persecuted for breaking social rules. They merely acknowledge that gender can be a relevant factor in application of the definition in the Convention. Holth (2004) similarly argues that the guidelines fail to address the diversity of asylum applications with gender-related

aspects, focusing solely on future-oriented gender-based persecution. Referencing a case from Holth's (2004) report:

> An applicant from Somalia endured raped, resulting in pregnancy and forced childbirth. She faced social ostracism and feared for her life due to societal norms. However, the Directorate's decision did not recognize her ordeal as persecution under the Convention. While she received asylum through individual assessment due to heightened risk of harm upon return, the rape was rather deemed as a criminal act rather than persecution based on protected grounds like race, religion, nationality, membership of a particular social group, or political opinion (p. 69).

This case, along with others involving sexual assault, were not granted asylum because the assessment of persecution focuses on future-oriented threats. Even with the guidelines, any claim of assault must demonstrate that the individual faces a credible threat of persecution if returned to their country of origin, based on the conditions outlined in the Convention. This limitation in the asylum process highlights a critical gap in protection for refugee women and other marginalized groups. It exemplifies their difficulties in testifying about trauma and often results in institutional insensitivity towards their experiences (Oliver, 2017).

This context prompts crucial inquiries into how providers of maternal healthcare can effectively respond to the specific needs and experiences of refugee women. It is imperative to determine if providers are equipped to handle the physical and psychological needs of these women, who may have endured significant trauma. My intention is to contribute to address these through this study.

2.3 Problematizing "Access": Determinants of Maternal Healthcare

Access to healthcare is a fundamental right, yet refugee women often face substantial barriers to obtaining adequate services. These obstacles can be particularly acute in the context of maternal healthcare, where timely and effective medical attention is critical for women and their offspring. This review aims to critically analyze the various determinants that affect their healthcare experiences. Considering the relevant findings I gathered from other research, it is essential to recognize that health outcomes are influenced by more than just medical care; factors such as living conditions and social connections play a crucial role. To understand these, I structured this analysis into two main areas: individual and structural determinants of healthcare, with an additional focus on maternal healthcare within the Norwegian context.

2.3.1 Individual Determinants

Individual determinants refer to personal attributes and circumstances that affect one's ability to access and utilize healthcare services (Tzenios, 2019). These determinants are especially significant in maternal healthcare, as they directly impact the quality and effectiveness of care that pregnant women and new mothers receive. For refugee women, key individual determinants include limited income, lower levels of education, language barriers, and cultural differences (Lyberg et al., 2012). These challenges can significantly hinder their access to necessary maternal healthcare.

2.3.1.1 Health Literacy

Health literacy is the ability to "access, comprehend, appraise, and apply health information in order to make judgments and decisions about healthcare, disease prevention, and health promotion to improve health throughout life" (Broucke et al. as cited in Bello et al., 2022, p. 1). In maternal healthcare, health literacy assumes even greater significance due to the complexities associated with pregnancy, childbirth, and postpartum care. Studies (Bains, Sundby, et al., 2021; Bello et al., 2022) show that women with higher levels of health literacy are more likely to engage in positive health behaviors, such as attending prenatal appointments, adhering to medical advice, and recognizing early signs of complications. These behaviors contribute to better maternal and infant health outcomes. Conversely, women with limited health literacy may struggle to comprehend medical instructions and signs of labor, & delay seeking care when complications arise, thereby increasing their risk of maternal mortality and morbidity (Egge et al., 2018).

The literature consistently highlights that health literacy is often constrained among refugee populations, particularly among those with limited educational background and those who have experienced conflict in their home countries. Refugees tend to prioritize immediate survival needs rather than of preventive healthcare due to the pressing demands of adjusting to a new environment (Kraler Albert et al., 2022; Oliver, 2017). The complexities of navigating healthcare systems – understanding eligibility criteria to navigating bureaucratic procedures – demand a level of literacy that many refugees frequently lack from the studies I reviewed. For instance, Gele et al. (2016) found considerable disparities in health literacy among Somali women in Norway, with many having limited awareness of preventive measures such as vaccinations and regular primary care visits. Other studies (Harakow et al., 2021; Lyberg et al.,

2012) indicate that refugee women often struggle to identify appropriate healthcare providers and may underestimate the seriousness of their symptoms. This tendency reflects past negative healthcare encounters from their home countries, where services are often inadequate or inaccessible, leading to a deep mistrust of medical professionals and reluctance to seek care even when it is available. While specific studies on maternal healthcare and health literacy in Norway are scarce, it is plausible, based on existing research, that refugee women encounter obstacles in navigating maternal healthcare. This inference is reflected by a growing body of studies from other host countries in Europe as well, which report similar issues among refugee women.

Moreover, Edwards et al., (2015) argued that health literacy is directly linked to one's social capital, encompassing networks and community ties. Their findings indicate that immigrants with strong social integration tend to have better health outcomes due to the support they receive to advocate for their rights and health needs. This correlation is also reflected in the study of Almeida et al. (2014), presenting that limited protective networks in refugees' communities of origin can negatively impact their access to critical resources, such as guidance on navigating healthcare systems, emotional support, and practical assistance like transportation services. For example, Lyberg et al. (2012) found out that migrant women had to participate in networks and informal dialogues to further understand the maternity care in Norway. In other cases, migrant groups are hesitant to engage with healthcare services due to perceived power dynamics and intimidation from healthcare professionals. This leads to further alienation from essential healthcare services. It is, therefore, crucial to investigate whether similar dynamics persist today and whether refugee women can easily establish initial contacts and engage in discussions about the Norwegian maternal healthcare.

A noteworthy theme that emerged from the local literature is the language barrier faced by refugee women in healthcare settings, primarily due to their difficulty in conversing in Norwegian (Abebe, 2010; Kjøllesdal et al., 2023; Leirbakk et al., 2019; Lyberg et al., 2012; Vangen et al., 2002). Certainly, language proficiency is a critical factor in effective patient-provider dialogue, and its absence can significantly hinder effective communication between refugee women and healthcare providers. Growing research strengthens the argument that seeking healthcare outside one's country of origin requires advanced vocabulary and comprehension to describe one's situation and medical history accurately (Kjøllesdal et al., 2023). This challenge is further exacerbated for migrants who cannot converse in English, as

shown in studies that poor language skills are associated with poor health outcomes. Djuve & Kavli (2019) found that only few immigrants pass low-level language tests upon arrival in Norway, making it difficult for them to navigate the healthcare system. It is, however, important to note that interpreters are currently offered in the healthcare services in Norway. Local studies (Mehrara & Young, 2020) have yielded positive results with the use of interpreters, improving the quality of care given to migrant groups . This raises the question of whether similar positive outcomes are observed in maternity care. Given its unique needs and challenges, assessing the impact of language barriers and the use of interpreters in this context is crucial which I also aim to explore.

2.3.1.2 Sociocultural Norms and Beliefs

Beyond health literacy, the sociocultural norms and beliefs of refugees play a crucial role in shaping their interactions with the healthcare systems of host countries. These beliefs are deeply rooted in their countries of origin and often differ from those of the host country. Studies on migrant healthcare (Attanapola, 2013; Mbanya, 2020) consistently highlight that the increase of diversity in population presents substantial challenges for healthcare systems. Refugees frequently bring traditional health beliefs and practices that may conflict with the medical approaches prevalent in their new environments. In most of the reviewed studies (Moghadam, 2004; Olwig, 2011), healthcare decisions within refugee communities often involve consultation within extended family members or community elders that contrast the individualistic approach of the healthcare seeking behavior in Norway. The collective decision-making process can lead to delays in seeking care and be particularly detrimental, as multiple parties must agree on the course of action.

This issue is especially pronounced in women’s healthcare, where traditional gender perceptions and behaviors significantly influence healthcare interactions. The Refugee Council (2009) contends that refugee women are often reluctant to seek medical help for sexual and reproductive health issues due to the stigma surrounding these topics in their communities. Given the prevalence of violence in their home countries, the hesitancy to address their health concerns increases their risk of sexual diseases and psychological trauma (Freedman, 2016; Vu et al., 2022).

This reluctance also extends to maternity care. For example, Garnweidner-Holme et al. (2017) found that immigrant women seeking antenatal care at MCHS often struggle to disclose their history of intimate partner violence. These women tend to miss medical appointments due to fear of discrimination. Additionally, other cultural contexts conflict with the normative model of maternity care; for instance, some refugee women may prefer home births attended by traditional birth attendants rather than hospital-based maternity care (Bains, Skråning, et al., 2021; Lyberg et al., 2012).

Perinatal complications are also attributed to female genital mutilation (FGM), which involves the total or partial excision of clitoris and it is culturally practiced in some African countries, notably Somalia. The increased migration of Somali women to Norway has brought attention about FGM within Norwegian maternity care. Vangen et al., (2004) linked FGM to adverse pregnancy outcomes, including prolonged labor and emergency cesarean sections, which are more common among refugee women as compared to ethnic Norwegians. FGM also poses challenges for healthcare providers in Norway, many of whom lack knowledge about the practice (Lyberg et al., 2012). This lack of awareness can lead to misunderstandings and inadequate care for affected women. Although FGM was criminalized in Norway in 1995, it remains a sensitive issue rarely discussed in the maternal healthcare system (Vangen et al., 2002; Vik et al., 2019). This sensitivity is compounded by the reluctance of refugee women to disclose their FGM status due to fear of discrimination or legal repercussions, further complicating their access to appropriate care.

Despite these challenges, the Norwegian maternity healthcare system has acknowledged these issues and responded with increased awareness in patient management. Research suggests a commitment to honoring women's birth preferences, crucial for fostering institutional trust among immigrants, particularly refugee women. This culturally sensitive approach involves interpreters, personalized care plans, and a supportive environment that respects diverse cultures. However, it remains crucial to continually understand how these practices are implemented and their impact on refugee women's healthcare experiences. I aim to delve into these particularities, investigating whether these experiences are consistent among my informants.

2.3.2 Structural Determinants

Structural determinants are the factors that influence the accessibility and allocation of healthcare services, including policy and regulatory frameworks, thereby influencing health outcomes of a population (Tzenios, 2019). In the context of maternal healthcare, it looks into whether women are able to access timely prenatal care, skilled attendance at birth, and essential postnatal services within a certain geographical location. These policies not only define the operational environment for providers but also determine the rights and entitlements of pregnant women, including those from refugee backgrounds, within the healthcare system.

2.3.2.1 Health Governance and Policy

Health governance and policy are critical structural determinants impacting maternal outcomes. Health governance involves the processes and structures through which authority in health systems is exercised, including the creation and enforcement of policies. Even so, the World Health Organization, (2018) states that the right to health obligates governments to provide necessary infrastructure and conditions for everyone to achieve optimal health. Reviewing the literature, Norway consistently emerges as an exemplary case of how effective health governance can significantly improve maternal healthcare and reduce disparities (Attanapola, 2013; Norwegian Ministry of Culture, 2019). Norway's approach, following the social democratic model, ensures that health benefits extend to all women (Ryen Gloinson et al., 2021). Norway employs progressive taxation to mitigate economic inequality and fund extensive public services, including healthcare. For instance, the 1999 Patient's right Act of Norway stipulates that all individuals are entitled to receive high-quality healthcare services, including maternal healthcare. This legislation also ensures that pregnant women, regardless of their legal status or background, have access to essential prenatal care, delivery services, and postnatal support to promote maternal and child health (Bains, Mæland, et al., 2021).

Moreover, Norway has implemented anti-discrimination and equality laws through the Equality and Anti-discrimination Ombud (LDO) (Norwegian Ministry of Culture, 2019). These laws prohibit discrimination in healthcare and other sectors, ensuring that minority groups have equal access to healthcare services. The LDO (n.d.) also oversees Norway's adherence to international human rights conventions, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) – an international treaty that constitutes discrimination against women. This framework is crucial for the maternal health experience of

refugee women and other minority groups, as it addresses cultural and systemic barriers to healthcare access.

Conversely, an insightful policy analysis by Mehrara & Young (2020) highlights the challenges faced by immigrant women in Norway's maternal healthcare system. By critiquing the universal welfare ideology and, by extension, the universal health and welfare policy, they argue that despite its aim to treat everyone equally, the policy is unrealistic and tends to maintain inequality because it is based on a single cultural perspective. They concluded that Norway needs to incorporate multiculturalism into its welfare policy and distribution principles to ensure equality. Without this adaptation, as Norwegian society continues to diversify, they argue that inequality will increase and reliance on private services will grow.

2.3.2.2 Health Infrastructure and Resources

Health infrastructure and resources are also critical structural determinants that affect maternal health outcomes. This includes the physical and organizational frameworks, as well as the capital necessary to provide healthcare services. The quality of healthcare infrastructure varies across regions and is significantly influenced by healthcare policies and governance (World Health Organization, 2017). Reports show that Norway demonstrates a strong health infrastructure, reflected in high antenatal care coverage and low maternal and infant mortality rates (Helsedirektoratet, 2020; World Health Organization, 2019). Similarly, Norway invests heavily in modern facilities and human resources to achieve high-quality care for maternal health conditions.

One of the standout features of the Norwegian maternal healthcare system is its comprehensive prenatal care coverage. All pregnant women are entitled to free prenatal care, which includes regular check-ups, screenings, and consultations with healthcare professionals (Leirbakk et al., 2019). Helsedirektoratet (2020) contends that these ensure early detection and management of potential health issues, contributing to the overall well-being of both mother and child. Additionally, the vast majority of births in Norway are attended by skilled health professionals, ensuring high standards of care during delivery (Bains, Mæland, et al., 2021).

Furthermore, Norway emphasizes on midwifery-led care models that aim to provide personalized and continuous support for women. These models are renowned for offering care

tailored to every woman's unique needs and preferences (Bains, Mæland, et al., 2021; Egge et al., 2018). Notably, during the initial stage of my data collection, I discovered the significant role of doulas within the Norwegian maternity care model. While doulas differ from midwives in their scope of practice, they play a crucial role in providing emotional and informational support to expectant mothers (Erga-Johansen & Bondas, 2023). Doulas in Norway often share the same cultural and linguistic background as the women they support to foster deeper connection towards the healthcare system. A qualitative study by Erga-Johansen & Bondas (2023) highlights the positive impact of doulas on enhancing the childbirth experience for women, most especially with immigrant background. Similarly, the presence of doulas has been associated with numerous benefits to other cases, such as positive psychological outcomes and reduced need for medical interventions (Falconi et al., 2022). In the United States., doula services are widely promoted, with some insurance companies covering the cost, particularly for low-income families. The U.S. also has community-based doulas who differ from traditional doulas. They are trusted members of the communities they serve, connecting women with local resources and conducting pre- and postpartum home visits (Bakst et al., 2020). This model ensures that women receive comprehensive support that extends beyond the clinical setting, addressing both medical and social needs.

Despite these advancements, the role of doulas in the Norwegian maternal healthcare experience remains an underexplored area. Exploring this further, especially within specific demographic contexts like refugee communities, promises to enrich our understanding and potentially improve maternal healthcare practices in diverse settings. I intend to contribute to this gap by also examining how refugee women experience doula support, given that it is a key program offered by the CBO involved in this study.

2.4 The Role of Community-Based Organizations on Healthcare Integration

As this study focuses on the role of Community-Based Organizations (CBOs) on maternal healthcare integration, it is crucial to review existing research and refine our understanding accordingly. CBOs are often non-profit groups that operate at a local level and design their programs based on deep familiarity with community's experiences (Loga, 2018; Wilson et al., 2012). This grassroots approach leverages voluntary labor and operates free from the constraints of bureaucratic management methods. Scholars (Agonafer et al., 2021; Bakst et al., 2020; Wilson et al., 2012) argue that the localized knowledge and trusted status of CBOs enable them to address specific community needs. Their commitment often intersects with political

activism, social movements, and philanthropic endeavors, setting them apart from the development machinery of larger organizations. Accordingly, studies (Bakst et al., 2020; Wilson et al., 2012) consistently highlight the role that CBOs play in healthcare integration by acting as intermediaries between healthcare providers and the community, addressing service gaps and enhancing access to care. CBOs frequently offer culturally sensitive education and support, which I argue are essential for promoting maternal healthcare practices within diverse communities.

The role of CBOs becomes even more pronounced in areas where formal healthcare systems are under-resourced or insufficiently equipped. These regions often experience recurring socio-political conflicts, which push public health concerns to the margins of national priorities. In such contexts, CBOs step in to fill the gaps left by formal systems, often complemented by international organizations that support these local initiatives (World Health Organization, 2016). Ethiopia, which faces some of the highest maternal mortality rates globally, provides a compelling example. The Ethiopian Midwives Association (EMA), a CBO, focuses on enhancing the skills of midwives and educating women about childbirth and newborn care (Datiko et al., 2019). The EMA also collaborates with government bodies to influence health policies, ensuring the integration of midwifery services into the national healthcare system.

The descriptors for CBOs can also vary significantly based on the specific sectors they serve. For instance, the literature extensively examines CBOs involved in HIV/AIDS service, such that most people living with HIV/AIDS represent some of the most stigmatized and marginalized groups (Agonafer et al., 2021; Wilson et al., 2012). Unlike hospitals, CBOs often focus on community education, such as conducting workshops and disseminating information about HIV prevention methods. They also offer psychosocial support that target other public health areas. Even recently, CBOs have expanded their efforts to address non-communicable diseases (NCDs), including community-based NCD detection, mental healthcare, palliative care, and rehabilitation services (World Health Organization, 2016).

CBOs are also identified in high-income countries, where they support marginalized groups such as refugees. In Norway, many CBOs are operated by immigrants who intimately understand the unique challenges that these communities face which are crucial for integration (Loga, 2018; Nessa, 2023). A prominent example is SEIF (Self-Help for Immigrants and Refugees), a key organization dedicated to improving healthcare integration for immigrants

and refugees in Norway. SEIF offers essential services such as healthcare navigation assistance and interpretation services, as it aims to improve healthcare access and outcomes for marginalized communities, contributing to a more inclusive healthcare system.

Despite these, it is important to manage our expectations regarding the contributions of CBOs. Li et al. (2015) indicate that CBOs can sometimes be influenced by emotional biases, which may affect their responses to issues. CBOs also struggle to interact with larger institutions due to differing theoretical perspectives and approaches. Their operational capacities can be limited, and their ability to implement sustainable initiatives is frequently hindered by the uncertainty of resources, as they rely heavily on donations from informal networks, which can be inconsistent and unpredictable (Anderson & Walker, 2020; Li et al., 2015). Therefore, understanding these challenges is particularly important in sectors like maternal healthcare, where CBOs can play a significant role in providing essential services. Further research is needed to explore these in depth and develop strategies to enhance the effectiveness and sustainability of CBOs within healthcare integration.

From these observations, it is evident that CBOs are continually evolving to address diverse health challenges, playing a crucial role in complementing and enhancing formal healthcare systems. However, a notable gap is the limited focus on the role of CBOs in maternal healthcare, especially within European contexts. This indicates a need for further research to understand how CBOs support maternal health, given their effectiveness in other areas of public health, as evident in the literature.

2.5 Theoretical Frameworks

This study uses two theoretical orientations to construct its conceptual foundation: the Social Ecological Model and the Social Capital Theory. These theories are used to bridge macro and micro contexts that shape the maternal healthcare experiences of refugee women, encompassing their interactions with the institutions of their new host society, including CBOs.

2.5.1 Social-Ecological Model of Health

The Socio-Ecological Model (SEM) traces its origin to Emile Durkheim's idea (1895) that social phenomena, or "social facts", exist independently of individuals and exert a coercive power over them. His argument highlights that social structures, norms, and values collectively influence individual behavior, akin to elements within a system interacting produce emergent

properties. Building on this foundation, Urie Bronfenbrenner (1979) expanded this model to emphasize the importance of considering individual development within the complex system of relationships that form one's environment. Bronfenbrenner introduced multiple systems – macro (e.g., social norms, policies), meso (e.g., relationship to social institutions), micro (e.g., age, gender, ethnicity) – each dynamically interacting based on the contextual nature of an individual's life (Bronfenbrenner, 1979; Golden & Earp, 2012; Kilanowski, 2017).

The SEM of health emerged as a comprehensive framework that incorporates these insights, understanding health as influenced by the interplay of interpersonal, community, and institutional factors. Even so, the World Health Organization (WHO) adopted this into their constitution on implementing various global health strategies, shifting the focus of health from mere biology to the larger recognition of social determinants of health (Dadaczynski et al., 2022). For instance, the WHO (2022) initiated a program in the field of migrant health, the Health and Migration Programme (PHM), to improve the capacity of health systems for migrant populations. In here, it targets macro systems through policy development and research but uses evidence-based approaches to understand micro systems, such as the specific health challenges faced by migrants and refugees. Similarly, the Centers for Disease Control and Prevention (CDC) (2007) adopted the SEM for public health promotion efforts, advocating for policy changes to reduce health disparities, such as improving access to healthcare and health literacy. The CDC developed a four-level model represented as a series of concentric circles, with the individual at its center, surrounded by multiple layers of influence that include the society, community, and relationship (see Figure 1).

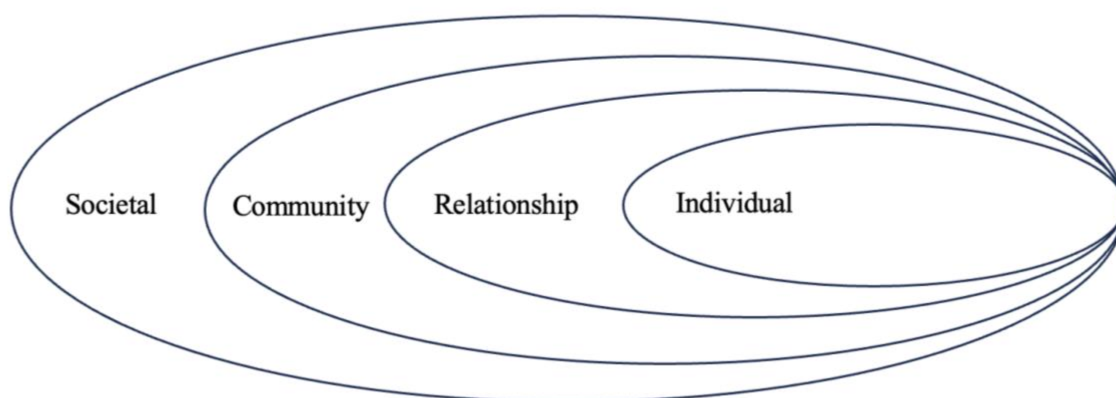

Figure 1: The Socio-ecological Model of the CDC

Drawing from this model, we can identify a comprehensive range of factors that contribute to the maternal healthcare experience of refugee women in their new host society. At the individual level, characteristics such as age, religion, and gender, along with past experiences from their country of origin, shape their health behaviors, perceptions, and needs. For instance, a refugee woman's previous encounters with healthcare services, her understanding of maternal health, and any pre-existing health conditions play a crucial role in her current maternal healthcare experience. At the relationship level, the support refugee women receive from their social circle – including friends, family, and others – influences their perceptions and behavior. These relationships are vital for providing emotional support and practical assistance in navigating a new healthcare system. At the community level, factors such as neighborhoods, schools, workplaces, and local organizations play a significant role. Specifically, this may include the CBOs and the presence of healthcare providers that influence the quality and accessibility of maternal healthcare services for them. At the societal level, broader structural factors shape the maternal healthcare experiences of refugee women. This includes healthcare policies, legal frameworks, and societal attitudes toward refugees. These various levels and their impact on maternal healthcare, as identified in this study, will be further discussed in detail in the succeeding chapters.

In addition to the level-specific influences, it is important to recognize that the SEM views each level as more than just a static setting. Instead, SEM provides a framework for designing and developing interventions that target both individual and environmental factors (Kilanowski, 2017). For example, addressing individual factors can enhance personal knowledge and skills, while addressing societal factors can improve social relationships and organizational structures. As such, Golden & Earp (2012) contends that effective interventions often emerge through collaborations with a variety of entities, including organizations, churches, neighborhoods, and government agencies. This collaborative approach not only leverages the strengths of diverse partners but also ensures that interventions are contextually relevant and sustainable. It is here where the role of CBOs is crucial in this process, where they act as bridges between individuals and broader societal structures (Wilson et al., 2012). CBOs can facilitate community engagement, mobilize resources, and tailor interventions to meet local needs.

2.5.2 Social Capital Theory

The Social Capital Theory (SCT) examines the impact of social networks and relationships on individuals and communities. The concept of social capital was first developed by Pierre Bourdieu (1986), presenting social capital as a critical resource akin to economic and cultural capital. Bourdieu defined social capital as the benefits and resources that individuals derive from their networks, which can be leveraged to achieve personal and collective goals. Further developed by James Coleman, social capital was perceived as a resource that contributes to the effectiveness of social institutions and the well-being of individuals. Coleman (1988) investigated how social networks and norms of reciprocity impact various social outcomes, particularly in education and family life. While both theorists recognize the significance of social capital, Bourdieu's work is more focused on its role in perpetuating social structures and inequalities, whereas Coleman's work emphasizes its role in facilitating social cohesion through norms and trust.

The SCT continued to evolve and expand, extending its influence beyond sociology. In health research, social capital is recognized for its influence on health behaviors and outcomes. This impact can either be beneficial or detrimental, depending on the prevailing norms within a social network. Scholars (Eriksson, 2011; Wind & Villalonga-Olives, 2019) widely contend that strong social connections help individuals navigate the healthcare system more effectively, adhere to medical advice, and engage in preventive health practices. As such, strong social networks contribute to improved mental and physical well-being and better access to healthcare.

Drawing from this premise, I argue that the implications of SCT are particularly profound when evaluating maternal healthcare for refugee women. As observed in the literature, establishing and sustaining social networks are crucial for integration, particularly given the difficulties faced in navigating unfamiliar systems within their host societies (Edwards et al., 2015). The disruption of their pre-existing networks due to displacement heightens the urgency of forming new and supportive connections to ensure adequate access to social services, including maternal healthcare. SCT posits that social capital, in the form of trust, norms, and networks, facilitates coordination and cooperation for mutual benefit (Coleman, 1988; Eriksson, 2011). For instance, these networks can help women understand their rights, connect them with healthcare providers who are culturally sensitive, and offer practical assistance such as transportation to medical appointments. However, it is essential to recognize that social capital

can have a dual effect. When social networks perpetuate harmful practices, misinformation, or cultural barriers, they can obstruct access to appropriate healthcare and lead to negative health outcomes (Almeida et al., 2014).

The SCT also stipulates the concepts of bonding social capital and bridging social capital, both of which are used to understand how refugee women establish their networks (Putnam, 2000). *Bonding social capital* refers to the strong ties and close-knit relationships that are formed within homogeneous communities. These ties involve family members, close friends, and individuals who share similar ethnic, cultural, or religious backgrounds. For refugee women, these relationships are important, as they provide essential emotional support, facilitate resource sharing, and foster trust among individuals who have experienced similar challenges and transitions. Contrarily, bridging social capital involves the social networks and relationships that connect individuals and groups across diverse social and cultural boundaries. It is characterized by weaker ties, which may not have the same emotional intensity but are equally significant in fostering broader connections. These relationships can lead to new opportunities, access to different resources, and exposure to diverse perspectives, which are invaluable for refugee women as they seek to integrate into their host societies.

Moreover, under SCT, there is an ethical obligation for host societies to facilitate the rebuilding of these social networks. CBOs are particularly crucial in this process, as they are often deeply embedded within communities and positioned to strengthen social networks that foster positive social capital. The literature highlights the role CBOs play in this regard, emphasizing their ability to engage with and support refugee populations at a grassroots level. Additionally, SCT offers a valuable theoretical framework for understanding how CBOs can strategically harness social capital to improve health outcomes among refugee women.

2.6 Conceptual Framework

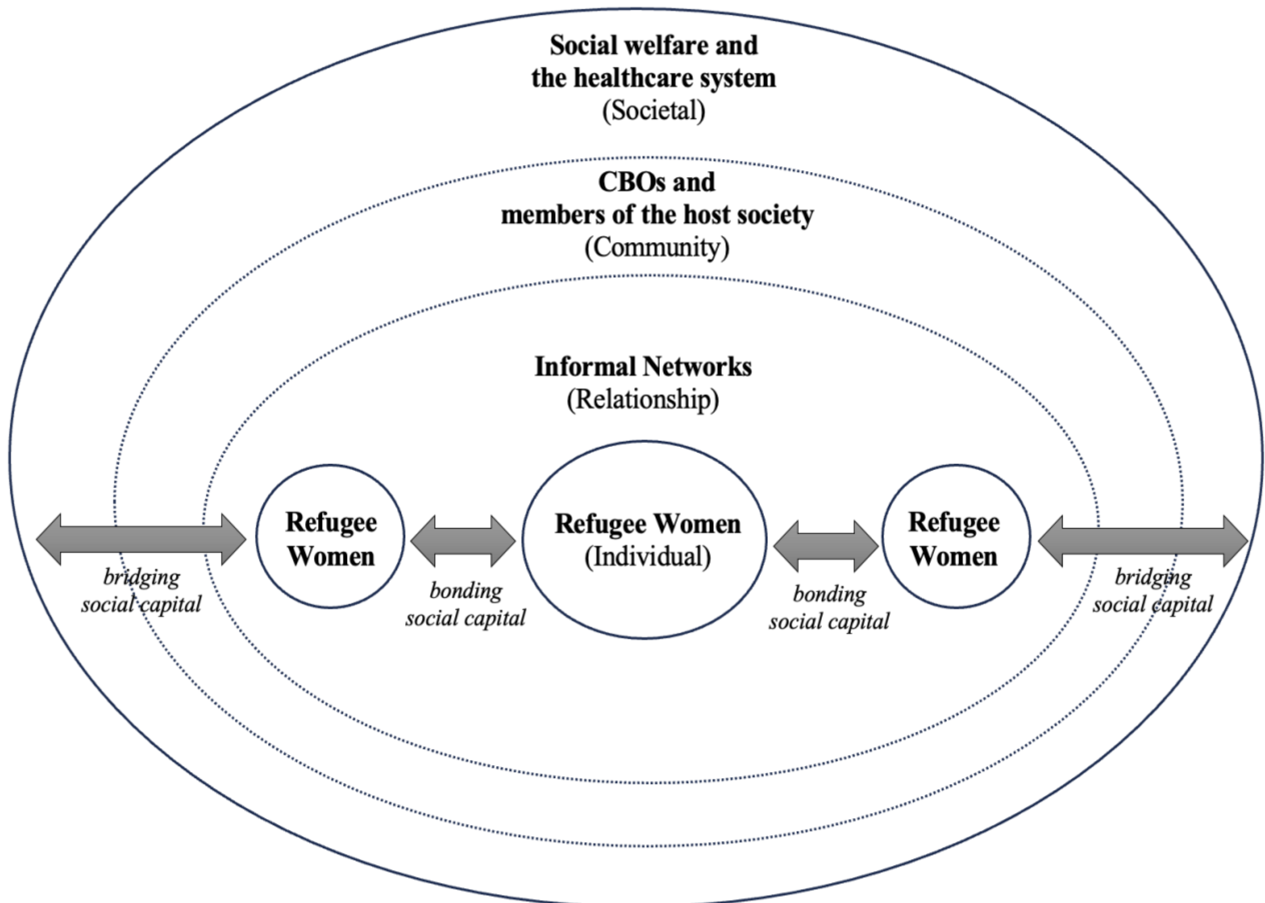

Figure 2: Conceptual Framework using the Socio-ecological Model and the Social Capital Theory

The figure above presents the conceptual framework I developed using the socio-ecological model and the social capital theory to explore refugee women's maternal healthcare experiences. At its center is the individual level, represented by refugee women whose healthcare experiences are influenced by social connections at multiple levels. Bonding social capital represents close ties among refugee women, providing immediate emotional and practical support for maternal care. Bridging social capital refers to broader, external connections with host society members, such as Norwegians, and CBOs, which help women access additional resources and integrate into healthcare systems. The model’s layers – relationship (informal networks), community (CBOs and host interactions), and societal (welfare and healthcare systems) – illustrate how individual, community, and systemic factors intersect to influence refugee women's healthcare experiences, emphasizing the importance of both internal bonds and expansive external networks.

CHAPTER THREE
3. METHODOLOGY

This chapter outlines the methodological decisions made throughout the design, sampling, strategies, and execution of this study. I begin by discussing the philosophical underpinnings, including epistemological and ontological considerations. Following this, I thoroughly outline the research design, data collection procedures, challenges encountered, and the corresponding actions. The selected approach and procedure for data analysis are also discussed. Further sections scrutinize the ethical considerations within this study.

3.1 Epistemological and Ontological Considerations

Epistemology delves into how knowledge is acquired and justified, exploring processes like perception and reasoning, while ontology delves into the nature of existence, questioning what exists and how entities relate (Bryman et al., 2021, p. 118 and p. 134). Considering these, it is crucial to articulate the philosophical assumptions of this study to provide insights into how knowledge was constructed, validated, and applied.

This study adopts interpretivist and constructionist stances, which posits that knowledge is not discovered but interpreted, and are continually reconstructed through social interactions and experiences. These approaches contrast with positivist methodologies that seek objective truths through empirical observation (Bryman., 2021, p. 123). Interpretivism is particularly well-suited for exploring the complex and multifaceted realities of refugee women, as it highlights subjective meanings shaped by cultural backgrounds, personal histories, and the specific socio-political contexts they encounter. Similarly, constructivism aligns well with interpretivism as it acknowledges that these experiences are dynamic and evolving (Bhattacherjee, 2012, p. 103). This perspective enables a deeper understanding of how refugee women's interactions with CBOs and the Norwegian healthcare system continuously shape and reshape their perceptions and experiences.

In keeping with these principles, I acknowledge the significance of reflexivity as a key component of interpretive stance. I recognize that my personal background, notably my identity as an immigrant woman, may inadvertently influence my interactions with the informants, and may impact the validity of this study. Consequently, I engage in continuous self-reflection of

my role, positions of privilege, and inherent biases as a researcher. By critically reflecting on my interactions with the informants, I aim to navigate these complexities with transparency and accurately represent their perspectives.

3.2 Research Design

This study uses qualitative research design through focused ethnographic approach, enabling the collection of rich textual data. Focused ethnography (FE), or what Bryman et al., (2021, p. 1282) has termed as micro-ethnography, aims to examine a problem in a certain context within a sub-cultural group rather than of a bigger group (Rashid et al., 2019). FE applies a shorter timeframe of intensive fieldwork, that is in contrast to the traditional ethnography, making it more feasible for the timeframe of this study. I selected FE as it offers rich contextual insights into how refugees navigate maternal healthcare systems, including the interplay of sociocultural, political, and institutional factors. The immersive nature of FE facilitated trust and rapport with my informants, which were crucial for gathering authentic and comprehensive data. By engaging closely with my informants, I was able to obtain narratives and observe behaviors in real-time. Additionally, FE allowed for a nuanced exploration of refugee women's access to maternal healthcare, their shared experiences, and health-seeking behavior – areas often overlooked in most quantitative studies. I used the following ethnographic techniques for this study: semi-structured in-depth interviews, participant observation, and field notes. The detailed application of these techniques will be further elaborated in the data collection procedures section.

3.3 Sampling Methods

Non-probability purposive sampling technique is applied to ensure that the participants are of theoretical importance to the objectives of this research (Bhattacherjee, 2012). To recruit informants, I sought assistance from CBOs that work with refugees for the recruitment of informants. These CBOs were identified and selected based on my online research, with a particular emphasis on their work in healthcare and integration. A total of two CBOs were involved in this study.

The target population of this study encompasses two distinct groups: (1.) refugee women, and (2.) providers based in Kristiansand, Norway. Following non-probability purposive sampling, a criterion is followed with the informant selection for the relevance and timeliness of the research. This process and its results also provided an idea for policymakers and researchers

about what may be adopted and contextualized based on the problem of the study. A total of nine refugee women and six providers were interviewed.

The refugee informant should either be pregnant or have experienced childbirth for the past three years in Kristiansand, Norway. This timeframe ensures that their experiences are recent and contextualized within the local healthcare system. Additionally, they should be of legal age, defined as individuals aged 18 or over. Although I recognize that there are cases of refugees with childbearing age, the reason for the age grouping is intended to address ethical concerns related to engaging with minors who are also refugees. Lastly, they were selected regardless of their ethnicity to uphold diversity and inclusivity within the sample group. This allowed for capturing a wide range of perspectives and experiences within the refugee community. It is also worth noting that I initially considered the length of stay of five years or less as part of the criterion. However, due to recruitment challenges, this was discarded, allowing for a broader pool of informants.

The provider informant was selected based on the nature of their position and the extent of their engagement with the refugee informants. These providers ranged from a development worker to a healthcare professional who are engaged in direct service provision or advocacy efforts that target refugee women's maternal health needs. They include professionals with firsthand experience with migrant healthcare, as well as those involved in program management, policy development, and community outreach initiatives, specifically tailored to the needs of refugee populations. The providers were selected through their involvement in the CBOs. Additionally, some were contacted through e-mail, identified by online research that highlights their work on maternal healthcare and refugee integration. While initially considering hospitals as potential sources for provider recruitment, logistical hurdles in communication and scheduling were encountered, leading to their exclusion. The challenges within this decision will be further explained in the subsequent section of this chapter.

3.4 Data Collection and Research Strategies Procedures

The duration of the fieldwork was from January 2024 until August 2024. The initial phase involved logistical preparations preceding data collection. This commenced with emails to CBOs wherein I introduced myself and explained the purpose of the research. Consequently, in-person meetings were arranged with the CBOs to provide detailed explanations of the study and obtain permission to engage with their programs. As a focused ethnographic approach, the

data collection methods included participant observations, field notes, and semi-structured interviews.

3.4.1 Participant Observation and Field notes

The participant observation was performed by engaging in gatherings organized by CBOs. Most of these gatherings were maternity meetings, commonly known as "barseltreff" in Norwegian. Additionally, I participated in women cafés and seminars related to integration. Over the course of my fieldwork, I attended a total of 20 meetings. As a "participating observer", I immersed myself in the core activities of the group, striving to "enter the everyday world of the other in order to grasp socially constructed meaning" (Laine, 1997, p. 147). While my role as a researcher was known to the participants (Bryman et al., 2021, p. 1304), this dual role enabled me to gain insights into their experiences and interactions towards the providers and the CBOs. My consistent presence at the gatherings helped me build trust and rapport with my informants, which was essential for recruitment and for gaining an understanding of how the programs support their integration. Additionally, engaging actively in discussions and activities allowed me to not only observe the interactions, but also the perceptions of the participants with the support they receive.

To ensure the accuracy and richness of my observations, I supplemented my participation with detailed field note-taking, avoiding overreliance on memory (Bryman et al., 2021). To maintain consistency, I prepared a structured template for my notes, including the sections of date, time, location, activities, participants, observation, and analysis. Each field note entry was completed promptly after every meeting. This practice allowed me to capture patterns and themes more effectively.

3.4.2 Semi-structured Interviews

I used semi-structured interviews to engage with my informants, framing these interactions in an open-ended manner that encouraged free expression while still adhering to an interview guide aligned with the study's objectives (Bryman et al., 2021, p. 1381). This approach allowed for in-depth exploration, enabling informants to express their thoughts, perceptions, and experiences in their own words. The interview guides were tailored to reflect the specific target populations of this study: providers and the refugee women.

For the providers, the interview guide was designed to elicit insights into the programs of the CBOs focused on maternal healthcare and to capture the institutional perspective on the health-seeking behaviors of refugee women. Conversely, the interview guide for the refugee women concentrated on their perceptions and experiences regarding access to maternal healthcare. It included questions about their interactions with healthcare providers, the challenges they encountered, and the support they received from CBOs. This dual focus allowed for a comprehensive understanding of the dynamics between service provision and the experiences of refugee women. To enhance the depth of interviews, I occasionally supplemented the interview guide with additional questions based on the new information from the literature and my direct engagement with the CBOs.

All interviews were recorded using a portable voice recorder that was not connected to the internet, ensuring the security and confidentiality of sensitive information (University of Agder, n.d.). This precaution was essential to minimize the risk of unauthorized access and to protect the privacy of the informants. Additionally, the use of a portable voice recorder provided a reliable means of capturing the complete and accurate responses of informants, which was crucial for the subsequent analysis phase of the study.

The interviews with the refugee women were conducted in the language in which they felt most comfortable, ensuring clear and effective communication. This approach necessitated collaboration with translators to accommodate the diverse linguistic backgrounds of the participants. Despite these efforts, I acknowledge that there were still challenges arose during the interviews, including potential nuances lost in translation and varying levels of fluency among the translators. These challenges will be further discussed in the subsequent section of this chapter to provide understanding of their impact on the interview process.

3.4.3 Data Gaps and Presentation of Data

The final phase of the data collection process involved conducting follow-up interviews with the informants to address any revisions and gaps identified during the initial data collection. This iterative process ran concurrently with data analysis and continued until the study was completed. These follow-up interviews ensured that I gained a thorough understanding of the informants' perspectives and clarified any ambiguities, ultimately enhancing the quality and depth of the research findings.

Moreover, I maintained an open and transparent communication with the informants, keeping them updated about the study's progress. Upon reaching the conclusive stage, I revisited the CBOs to facilitate discussions regarding the study's findings. This approach not only closed the loop but also ensured transparency throughout the research process.

3.5 Challenges, Risks, and Actions Taken

All informants were duly informed of the risks posed by their participation of this research. In this section, I enumerated the risks of this study and the actions I have taken to minimize these:

3.5.1 Re-traumatization of experiences

Pregnancy and childbirth entail physical and emotional changes that may, for some, lead to mental health challenges. As established in the literature review, these changes are heightened for refugee women because of the unique challenges they face, including forced displacement, family separation, and exposure to sexual and gender-based violence. The status of being a refugee may carry prior and ongoing trauma that can make them feel hesitant to express their needs and emotions. For instance, interviews may account difficult experiences, and introduce sensitive and personal information, that can pose ethical dilemmas for this research. Certainly, Seagle et al., (2020) argued that it is concurrently difficult to collect quality data and protect the wellbeing of refugee informants. Nonetheless, I recognize, and other studies have emphasized, that examining the in-depth experiences of refugees is more than crucial to significantly improve models of health service delivery and produce evidence-based interventions. Similarly, excluding them because of their vulnerability go against the principle of justice on social research.

Therefore, fostering a sense of security and trust towards the informants was essential. I took on the responsibility of being vigilant and prepared to manage potential emotional reactions during interviews. Prior to my fieldwork, I thoroughly reviewed the informed consent documents and interview guide to ensure clarity and sensitivity in my approach. At appropriate moments, I used empathic statements during interviews, albeit maintaining professional boundaries. Recognizing the emotional weight of the topics discussed, I prioritized the well-being of the informants by allowing for breaks and rescheduling interviews when necessary, always respecting their expressed needs and preferences. This approach not only prioritized

their autonomy but also contributed to a more comfortable and trusting environment, enabling for a more open and honest dialogue.

3.5.2 Scheduling of Interviews

The scheduling process within the hospital and with refugee women posed significant challenges, which contributed to the extension of the data collection timeframe to eight months. These challenges stemmed from various reasons, including the demanding schedules of healthcare professionals and the urgent nature of their responsibilities, as well as the complexities involved in coordinating interviews with refugee women who had varying levels of availability and comfort.

Despite obtaining ethical approval for research procedures within the hospital and establishing contact through emails with follow-ups, securing appointments with healthcare professionals remained a challenge. The demanding nature of their schedules, compounded by the urgency of their professional responsibilities, made it exceedingly difficult to arrange interviews. After four months of persistent attempts, the inability to secure appointments led to the exclusion of the hospital as a source for recruiting informants for the provider group. As a result, this study shifted its sole focus to the context of CBOs. This decision was made after careful consideration of the study's objectives and acknowledges the practical limitations inherent in the research process.

This study may have disrupted the everyday routine of the informants, such as the disruption of work and household commitments, due to the time required for interviews. Scheduling interviews with refugee women presented challenges, particularly as their schedules were often dictated by work, family responsibilities, and other pressing commitments. However, my active involvement with CBOs significantly enhanced access and facilitated the process of securing interview appointments with the informants. I also prioritized flexibility in the data collection process. I made a concerted effort to allocate time slots that aligned with their preferred days and times for the interview.

3.5.3 Language Barrier

Language presented a substantial challenge during the interviews, as the diversity of languages spoken by the informants often hindered effective communication and complicated the data

collection process. My limited proficiency in Norwegian and the informants' varying degrees of fluency in English necessitated additional measures to ensure clear and accurate communication. To address these challenges, I collaborated with two translators throughout the data collection and analysis phases. One translator was fluent in Ukrainian, while the other was proficient in Tigrinya, the primary language of Eritrea. This collaboration ensured that the refugee women could articulate their thoughts and experiences fully and accurately.

In instances where translation was not required, I conducted them independently using either English and Norwegian, depending on the preference and proficiency of the informants. Although my Norwegian proficiency ranges from A2-B1 level, the informants engaged effectively with the questions. I also had a Norwegian translation of the interview guide prepared beforehand. Such measures not only helped in overcoming the language barrier but also ensured that the informants felt comfortable and understood, thereby enriching the depth of the information gathered.

3.5.4 Risk as a Researcher

As a researcher, one of my primary challenges was managing health risks and potential exposure to communicable diseases associated with frequent physical contact with patients in refugee camps and healthcare institutions. Ensuring my health and fitness throughout the fieldwork was essential to conducting research effectively. Additionally, conducting interviews posed a significant risk of mental and emotional strain, as the distressing nature of the informants' accounts raised the possibility of experiencing secondary trauma during both the data collection and subsequent thesis writing phases.

To mitigate the risk of secondary trauma, I was prepared to seek psychological support or counseling through the university's health services, should the need arise. This approach was essential not only for my well-being, but also for maintaining the integrity of the research process and ensuring that I could provide the necessary support to informants while minimizing the impact of their traumatic experiences on my own mental health.

3.6 Data analysis

Given the qualitative design of this study, the collected data is predominantly textual. Consequently, all interviews were transcribed verbatim and subsequently translated into English to maintain the authenticity of the textual data. I undertook the translation of the

transcripts manually, as the constraints of funding for this study precluded the use of professional translation services. This approach provided greater control over the translation process; however, it also presented challenges in preserving the original meaning and context of the informants' responses. I endeavored to maintain fidelity to the original text throughout the translation.

An inductive thematic analysis was conducted which follows four phases, as outlined by Bryman et al. (2021, p. 82) – familiarizing the data, re-reading the data, reviewing the codes, and developing linkages among the codes. The transcriptions were coded manually through closed and open coding to identify themes, concepts, and localized theories (Bryman et al., 2021; Clark T et al., 2021). Closed coding employed a pre-established set of codes derived from the literature review, ensuring a grounded framework for analysis. In contrast, open coding was used to generate new codes that emerged during data analysis and occasional re-evaluations of the field notes, allowing for a more nuanced understanding of the data. This dual approach facilitated a comprehensive exploration of the data, ensuring that both existing and emergent themes were thoroughly examined.

3.7 Ethical Considerations

Ethical procedures were followed to secure the welfare of the informants and ensure the methodological rigor of this study. These procedures were guided by the code of practice established by the University of Agder and the ethical guidelines set forth by the Norwegian National Research Ethics Committee. Before initiating the study, I obtained an evaluation from the Norsk senter for forskningsdata (SIKT) regarding the research's handling of personal data, including data processing and storage. Additionally, when the data collection period was extended, I promptly notified SIKT to secure the necessary permissions for the continuation of the research.

3.7.1 Informed Consent

Following the guidelines of the National Committee for Research Ethics in the Social Sciences and the Humanities of Norway, this study strongly upholds the integrity, safety, and wellbeing of the informants (Etikkom, 2019). It is guaranteed that their participation was based on information and consent, taking into account that *"members of disadvantaged and vulnerable groups may wish not to be subjects of research, for instance for fear of stigmatization or other*

negative consequences" (Etikkom, 2019, section 31). As such, in preparation for the study, informed consent forms, informational letters, and the interview guide, were handed over to CBOs. Consequently, all informants were provided with informed consent forms that clearly outlines the purpose of the study, the nature of their participation, and their rights. This informed consent is designed to be (1) context-based and (2) emphasizes the voluntariness of their participation.

By context-based, the informed consent considers the characteristics of the informants and the methods used to communicate with them (Bryman et al., 2021, p. 407; Etikkom, 2019). As the study focuses on refugee women, the informed consent was designed to be both gender-sensitive and culturally appropriate, ensuring it did not conflict with their beliefs or values (Seagle et al., 2020). I used simplified and culturally relevant terminology to explain the study's purpose, procedures, potential risks, and participants' rights. This entailed adjusting the language of the consent based on what is comprehensible for them. To reinforce this, I collaborated with a translator during the data collection process, ensuring clear communication and thorough understanding of the consent. The translators were briefed extensively on the study's goals, ethical considerations, and their responsibilities. While the consent form was originally written in English, it was explained orally in the informants' preferred language with the help of the translator. This process was documented either in writing or through audio recordings, reinforcing my ethical responsibilities as a researcher and ensuring accountability in the consent process.

By following the principle of voluntariness, the informed consent process made it clear that informants were free to refrain from answering any questions they found uncomfortable and could withdraw from the study at any point without consequence (Etikkom, 2019). It is crucial that the informants fully understood the nature of their involvement was paramount, and their participation was strictly based on informed choice, free from any form of coercion. Additionally, I acknowledge that the informed consent is an on-going process in which the autonomy of the informants was continuously respected through constant consultation, ensuring their willingness to participate (Etikkom, 2019). I maintained an open line of communication to my informants regarding their concerns and questions throughout their involvement in the study. The informants were given the opportunity to correct or clarify their assertions where possible, further ensuring that their statements were accurately represented. Finally, the timing and location of the interviews were decided by the informants themselves,

and I made every effort to accommodate their preferences. This flexibility created a more comfortable and respectful environment, reinforcing the voluntary nature of their participation.

3.7.2 Internet Usage

I acknowledge that the use of the internet introduces potential risks of data breaches and unauthorized access. While the primary data for this study was collected through face-to-face interactions with the informants, there were instances where the internet was used during the data collection. This primarily involved communication with CBOs and translators through direct messaging on WhatsApp, as this channel was the most convenient for them. Given the sensitivity of such platforms, I exercised caution and adhered to strict ethical guidelines regarding the nature of the information exchanged (Fossheim, 2015). Discussions were limited to logistical matters, such as scheduling and coordination, ensuring that no sensitive information or interview-related questions were shared online. Additionally, I used best practices to protect the confidentiality of all communications, including secure messaging protocols and adherence to privacy settings, to minimize the risk of unauthorized access to the data.

3.7.3 Personal Data Protection

The data collected for this study, primarily textual in nature, was obtained through semi-structured interviews and field notes from participant observations. All interviews were audio recorded using a portable voice recorder to ensure that no devices with internet connectivity were involved, thereby minimizing the risk of data breaches (University of Agder, n.d.). Participant observations were documented through field notes, and only those who provided consent were included (Etikkom, 2019). Confidentiality and privacy were paramount throughout the study. All personal information and research content were handled with strict confidentiality in accordance with ethical guidelines (Etikkom, 2019; University of Agder, n.d.). Informants were anonymized, including the random assignment of pseudonyms for names. Additionally, no identifiable information was disclosed unless explicitly approved by the informant. By adhering to these protocols, the study ensured that informants' personal data was safeguarded, preserving both the ethical integrity of the research and the trust established with the informants.

This study involves two types of data storage: printed and digital. The printed data, including signed informed consent forms and the interview guide, were securely stored at my residence, and shredded upon completion of the study. The digital data, including audio recordings, transcriptions, coded data, and other research materials, were securely stored on an encrypted drive of my OneDrive account, adhering to the University of Agder's (n.d.) information security management guidelines. This data was uploaded and encrypted immediately following each day of data collection to ensure timely and secure handling. Strict access controls were applied to the digital files, and no data was stored on personal devices, ensuring that only approved platforms were used for storage. Additionally, the data was not retained longer than necessary for the analysis, and deletion procedures were followed upon the study's conclusion.

The dissemination of this study's findings is targeted toward three primary groups: academia, healthcare providers and policymakers, and key informants. For academia, the results are disseminated through this master's thesis, as well as potential journal publications and conference presentations. Healthcare providers and policymakers can use the study as baseline data for stakeholder dialogues, policy briefs, and interventions aimed at improving maternal health outcomes among refugee women. In accordance with the "rights of access by the data subject" under the GDPR (n.d.), the study results will be shared with key informants. Throughout all dissemination processes, the use of anonymized data ensures the privacy and confidentiality of participants is maintained.

CHAPTER FOUR
4. EMPIRICAL FINDINGS

This chapter presents the key findings of the study, drawn from eight months of field observations with CBOs, along with qualitative interviews conducted with fifteen informants, including refugee women and providers. The findings are organized around the research questions that guide this inquiry (see page 4), and are developed through themes and sub-themes identified during the thematic analysis. The chapter explores critical indicators of satisfaction, and the challenges refugees encounter in maternal healthcare, as well as the role that CBOs play in facilitating their integration. To illustrate these findings, quotations from interviews are incorporated. The chapter begins with the presentation of the maternal healthcare experiences of refugee women, followed by the perspectives of providers on their roles within CBOs and their efforts to support these women.

4.1 Informant Demographics

The refugee informants in this study represent a diverse range of ethnicities and cultural backgrounds, each of which plays a significant role in shaping their healthcare experiences. As outlined in Chapter Three, I planned to include those with a length of stay in Norway of five years or less as a selection criterion. However, due to recruitment challenges, this criterion was broadened to include refugee women who have lived in Norway for longer periods. This adjustment not only addressed the recruitment difficulties but also provided a more comprehensive understanding of how varying lengths of residence influence maternal healthcare experiences. Factors such as cultural adaptation, language proficiency, and familiarity with the Norwegian healthcare system vary widely among these women, further impacting their interactions with providers. I, however, emphasize that all refugee informants have given birth within the last three years in Kristiansand to ensure the relevance of their institutional experiences. They were primarily recruited through my engagement with CBOs in Kristiansand, Norway. The table below summarizes the informants' country of origin, age, and length of stay.

Country of Origin	Age	Length of Stay in Norway
Ethiopia	35	2 years
Eritrea	34	7 years and 6 months
Eritrea	41	4 years

Somalia	34	13 years
Syria	31	7 years
Syria	27	1 year and a half
Ukraine	35	1 year
Ukraine	25	2 years and a half
Zimbabwe	33	4 years

4.2 Maternal Healthcare Experiences

As established in the literature review, maternal healthcare is a critical component of public health, focusing on the health and well-being of women throughout pregnancy, childbirth, and the postpartum period. Building on this understanding, this section begins by exploring the informants' previous maternal healthcare experiences, some of whom gave birth in their countries of origin before relocating to Norway. By comparing these earlier experiences with their current ones, we gain insights into the adjustments they made and the expectations they bring into the Norwegian healthcare system. The discussion then shifts to a detailed examination of the informants' experiences within the Norwegian maternal healthcare system. It highlights instances where the system succeeded or even exceeded their expectations, while also experiencing challenges, including cultural differences, language barriers, and the complexities of navigating a new healthcare system.

4.2.1 Previous Maternal Healthcare Experiences

Maternal healthcare experiences vary significantly across countries, influenced by healthcare infrastructures, policies, and cultural norms. This is evident from the accounts of four informants who gave birth in their home countries before moving to Norway. Each recounted notable differences between their birth experiences abroad and in Norway, particularly those from conflict-affected regions. The informants faced significant challenges such as limited access to healthcare facilities, insufficient prenatal and postnatal care, and societal norms that often relegated women's health to a lower priority. One informant from Syria, for example, shared:

> “In my home country, I have to think a thousand times (before) having a child. Here in Norway, I don't think so. For example, how can I raise my children, like money, clothes, food. Also here, I feel safe. That is the most important here. Because in my home country, there is a war. It is expensive to think about the future of the children.”

The challenges faced by women were further exacerbated by the prohibitive costs associated with maternal healthcare. Informants detailed how the ongoing conflict in her home country rendered public hospitals unreliable and understaffed, compelling many women to turn to private clinics for care. However, access to and the quality of care in these private facilities were largely dictated by one's financial resources, leading to disparities in maternal health outcomes based on socioeconomic status. Informants shared:

> "Private clinics are common. Not all women go to the hospital. I think if you want to have a child, you pay more. It's very expensive, but here (in Norway), you don't need to pay anything."

> "Where I come from, there is a huge difference between the public hospital and the private hospital in terms of maternal care. So, if you want a good and comfortable delivery, you know – when the nurses will comfort you and they will not scold or hit you, you need to go to the private hospital, but you need to pay a huge sum of money. But then for those who are poor or have a lifestyle like me, you need to go to the public hospital. Very horrible, where I came from. It's so many people."

Due to the high economic cost of quality maternal healthcare, many women often compel to rely on inadequate health infrastructure, which negatively impacts their well-being. For example, one informant, a mother of six who gave birth to five of her children in Eritrea, described the challenges she faced accessing maternal care. Due to the considerable distance to the nearest hospital, she opted to deliver three of her children at home. She explained:

> "It is a long way to go to the hospital. I gave birth to two of my children at the hospital, but the others, I gave birth at home, because it is one hour to drive to the hospital."

This hindered her to attend regular prenatal check-ups, thereby limiting access to consistent maternal care. The necessity of long-distance travel to healthcare facilities, compounded by limited transportation options, have intensified the physical and emotional burden she experienced during her pregnancy.

Another informant provided insight on the healthcare infrastructure by recounting her childbirth experience in Somalia. She described the overcrowded hospital conditions, where she was required to share a room with other new mothers. This overcrowding not only compromised her privacy but also created a stressful environment that hindered her postpartum recovery. In contrast, her experience in Norway was notably different, where the conditions allowed for greater comfort and privacy during her postpartum period. She shared:

> "I must be somewhere else. Outside, for example. But when you give birth in Norway, the baby is in the room. You also have a single room. It is better to give birth in Norway. You get your own room. When you're in Somalia, it's a really big room, a lot of people are there."

Another key difference in the maternal experiences of the informants lies in the cultural expectations placed on women regarding childbirth. Beyond the physical challenges of pregnancy and labor, women often face societal pressures dictating their roles as mothers. These expectations extend beyond simply prioritizing motherhood; they shape how women are expected to experience and respond to pregnancy, childbirth, and parenting. One informant recounted the intense pain she endured during childbirth in her home country due to cultural norms that discouraged women from expressing pain. She shared:

> "In Somalia, they say, don't cry out for pain. When I gave birth there, I wasn't allowed to scream, but here, you can. There is a big difference in culture here."

These accounts show the influence of healthcare systems, cultural norms, and socioeconomic factors on maternal health experiences. By looking into the informants' past experiences, we gain valuable insights into their perceptions of care in Norway. Additionally, this understanding enables us to examine the contrasts between their previous healthcare experiences and the features of the Norwegian healthcare system. The informants' experiences within this system will be further discussed, examining key differences in care that not only improve maternal health outcomes but also reflect societal values regarding women's health and well-being.

4.2.2 Indicators of Satisfaction within the Norwegian Maternal Healthcare

Indicators of satisfaction with maternal healthcare are crucial metrics for assessing the quality and effectiveness of care provided to expectant mothers. For refugee women, satisfaction with maternal healthcare is particularly significant, as it reflects how well the Norwegian healthcare system accommodates their circumstances and challenges. This section discusses these indicators, drawing on the findings from the interviews, that influence refugee women's satisfaction with maternal healthcare in Norway.

4.2.2.1 Quality of Care Received

Quality of care encompasses critical dimensions, including the effectiveness, efficiency, accessibility, and safety of healthcare services. This is particularly crucial in maternal healthcare, where the quality of care directly affects both the mother and child's health and well-being. The significance of this becomes even more apparent when considering the experiences of the informants who highlighted the role of free healthcare services in their maternal care. For many, the ability to access comprehensive maternal care – such as ultrasounds, blood tests, and regular check-ups – without financial strain was not merely beneficial but transformative because many come from countries where healthcare is prohibitively expensive. The financial freedom allowed them to focus entirely on their health and of their children, alleviating the stress that often accompanies healthcare expenses. An informant from Somalia emphasized on this:

> “It's free here. You also have a doctor and midwife who follow you every time during and after three to four weeks. They want to check if the baby is okay. [...] There are so many things. I am very, very pleased. This is also where I had my first ultrasound. You don't pay so you don't have to worry so much.”

Some refugee informants reported similar positive experiences regarding maternal care in Norway, emphasizing their rights to make informed decisions about their own health and treatment options. One notable case involved an informant who expressed her surprise at the level of care, especially in comparison to her home country where certain medical interventions, like epidurals, are prohibitively expensive. She shared:

> “In my country, when you’re having an epidural, you are rich because that injection is very expensive, so, I was surprised. They say, ‘whatever you request in the delivery time, we will give it to you. Even if you say you want a donut, we will give it to you. Even if you want some juice, we will give it to you. We will pamper you. We will give everything that you need. We will make sure you’re as comfortable as possible.’”

In addition to epidural analgesia, other pain management options are available, both non-pharmacological methods (e.g., breathing techniques, water births) and pharmacological methods (e.g., nitrous oxide, opioids). This aligns with existing literature on Norwegian maternity care, which emphasizes informed choice, encouraging women to engage in discussions with their healthcare providers to select the pain management strategies best suited to their needs and preferences. Access to these services is not merely a matter of convenience

but is crucial in ensuring equitable care for refugee women, irrespective of their economic background.

Another critical aspect of quality maternal care is the interpersonal relationships between refugee women and healthcare providers. Informants emphasized the significance of respect and compassion in these interactions that fostered a sense of trust with healthcare professionals, such as their doctors and midwives. Most informants reported feeling valued as individuals. For instance, informants spoke about healthcare providers who took the time to listen to their concerns, patiently explaining medical procedures and offering reassurance. Notably, none of the informants recounted instances of racism or discrimination during their maternity care interactions, a finding that infers the positive environment fostered by healthcare professionals. One informant shared a reflection on her experience, stating that the supportive nature of her interactions with healthcare staff made her feel both respected and understood:

> "They're very sweet. They're very welcoming. […]. I think their job is to really make you feel comfortable. I have never felt degradation. It was only on my mind. I (went) to my midwife. I thought I was gonna face a form of racism because of my skin color. And she was like, 'I don't want you to have those thoughts. You are a human being, and you are bringing life into this world. And we will treat you accordingly like (any other) person here'. It was (just) on me."

In this account, the midwife's response reframes the woman's fears, acknowledging the dignity of her experience. Such compassionate interactions exemplify a therapeutic relational dynamic that goes beyond clinical care. This approach shows a deliberate effort by healthcare professionals to address not only physical but also emotional and psychological needs, which are often heightened by the trauma and isolation many refugees endure.

4.2.2.3 Timeliness and Continuity of Care

Timeliness and continuity of care are critical components of effective healthcare delivery, ensuring that patients receive consistent and coordinated treatment over time while minimizing the risks associated with delays. For refugee women, who often face significant disruptions in their healthcare due to displacement, the seamless integration of timely and continuous care is critical for maintaining their overall health and well-being. This importance is clearly reflected in the experiences of the informants as they reported feeling secured and confident in their treatment when care was provided promptly and without interruption. The informants emphasized that timely access to healthcare not only helped prevent potential complications

but also significantly reduced the anxiety that comes with waiting for critical care. An informant shared:

> "It's not just okay. It's very good. I am very satisfied. I had access to maternity service even when I was in the reception center. I had check-ups once in two weeks."

Timeliness of care is especially critical in the later stages of pregnancy and during the postpartum period. One informant shared her positive experience, emphasizing how attentive and thorough her healthcare providers were throughout the entire process. She felt reassured by the doctors' commitment to regular monitoring and follow-ups, which contributed significantly to her sense of safety and trust. She described an instance in which the doctor noticed a small detail that might have gone overlooked in a less attentive setting. She shared:

> "The doctor noticed a pimple on the kid's body. I stayed in the hospital for one more day for them to examine it. I also got appointments with the health center even after childbirth and I am satisfied."

Aside from the necessity of prompt care, the informants emphasized the critical importance of consistent follow-up, even beyond regular hospital hours. These follow-ups were not just routine check-ins; they served as a source of reassurance during a particularly vulnerable time of pregnancy. Many informants expressed that they developed a trusting relationship with their midwives, whom they could contact at any time with questions or concerns, whether through phone calls or in-person visits. One informant recounted her midwife's dedication, noting that she received monthly check-ins and additional visits as necessary. She stated:

> "The midwife calls every day and she's just like, 'how are you?' She called me just to check with the children. Every day, two hours, just to check on the hospital and check with the children, 'how's the children?' They have many responsibilities for us. They focus a lot on food, vitamins, minerals, and blood tests."

This ongoing accessibility contributed to her sense of security. It shows that effective healthcare for refugee women must extend beyond immediate treatment, offering ongoing and dependable support. In this context, the role of midwives extends beyond their clinical responsibilities, as they assume a crucial role in offering emotional and psychological support.

4.2.2.4 Communication and Information

Effective communication and access to information are cornerstones of quality maternal healthcare, and for refugee women, these factors are even more critical due to language barriers, cultural differences, and limited familiarity with local healthcare systems. For these women, healthcare providers, primarily doctors and midwives, served as their primary source of health information during their pregnancies. It was primarily through them where they were able to know more about the Norwegian maternal healthcare system, which can be daunting for those unfamiliar with its structure, regulations, and services. For most informants, the details and instructions they received from their healthcare providers were sufficient to address their immediate concerns and help them manage their pregnancies. Accordingly, most of the informants learned from their healthcare providers that maternity care in Norway is provided at no cost, an important information for women who may have come from countries where healthcare is expensive or inaccessible.

Beyond the provision of medical advice, the informants highlighted the profound impact of empathic communication from healthcare providers. This compassionate approach not only made patients feel more comfortable but also encouraged open dialogue, allowing them to express their concerns and ask questions freely – an essential aspect during the vulnerable period of pregnancy. As previously noted, one informant shared that she established a close, ongoing relationship with her midwife that extended beyond hospital hours, providing her with continuous support. Similarly, other informants reported maintaining consistent contact with their midwives throughout their pregnancy journey, which enhanced their sense of security. For instance, an informant shared that her midwife provided valuable information and connections to support groups for pregnant women. She reflected on how this additional support significantly improved her access to resources and service, stating:

> "My midwife is doing a lot of stuff for me. Whenever she finds like a thing, something interesting, she just text or call me. I'm grateful for her. She also introduced me to this doula. […] I came to know about these organizations because of my midwife. It was her who (introduced me), and it's doing good so far."

Another crucial aspect that contributes to this sense of comfort is obtaining informed consent, especially given that many refugee women come from backgrounds where healthcare practices differ, or where they may have experienced trauma. Consent provides a sense of control and

respect in the patient-provider relationship, helping to alleviate anxiety during medical procedures. An informant said:

> "'This is very cold. I am now putting it on your tummy. Can I touch you?' They ask those questions. If you don't want to be touched, they will find other means to help you."

Moreover, informants reported that their interactions with healthcare providers often include recommendations for trusted online resources, allowing them to seek further information from home. This practice has gained particular significance in the context of Norway's increasing dependence on digital health platforms. For instance, hospitals offer online courses through their websites, such as those provided by the *barselavdeling*[5], which help prepare expectant mothers for childbirth and postnatal care. Many informants acknowledged a reliance on these online resources not only for obtaining medical knowledge but also for gaining a clearer understanding of their rights and the range of services available within the healthcare system. An informant shared how access to information became more manageable due to the availability of online sources. She remarked:

> "It wasn't difficult considering that here in Norway, you do things online. You need to check online to navigate the system, like what's gonna happen when I get pregnant, what's the next step, where am I going after I inform those people, whatever the case may be. The information is on the website."

Hospitals also provide translated materials that address essential aspects of maternal health that are available in multiple languages to ensure patients can access information in their native language. These resources are also accessible through their website, making it convenient for them to find and review information at any time. During their check-ups, healthcare professionals offer professional interpretation services in immigrants' native languages to overcome language barriers. Such services are to ensure that patients fully understand maternal healthcare information, including prenatal care guidelines, birthing options, and postnatal support plans. Interpreters also prevent misunderstandings that could otherwise compromise the quality of care. The importance of these is particularly emphasized by informants who gave birth in Norway shortly after arriving and were not proficient in Norwegian or English. For instance, an informant from Ukraine, who has recently lived in Norway for 1 year, emphasized the critical role of these interpretation services in their healthcare experience. She noted that an interpreter was consistently available during her check-ups, which allowed her to express

[5] A hospital ward where the mother and baby are transferred approximately two hours after birth.

concerns, ask questions, and provide feedback about her pregnancy and maternal experience. She shared:

> "Knowing my status, I was always given an interpreter and if I want to speak Norwegian, an interpreter was still there just to make sure I understood everything. The doctors want to make sure I understood. They repeat it for me several times. They wanted to make sure."

Additionally, one informant who was proficient in English noted that communicating with healthcare providers was relatively straightforward, as English is widely spoken and understood in Norway. This linguistic overlap facilitated her interactions within the healthcare system. She expressed how fortunate she felt to have healthcare professionals who could engage with her in English, stating:

> "I am very lucky that my midwife speaks English, and my GP is the same, so we just do our conversation in English. I am very lucky because I don't need an interpreter for that, so we just do all our communication in English."

Some informants mentioned the presence of doulas during their check-ups, which further enhanced their understanding of medical information. Two pregnant informants were given the opportunity to have a doula during their labor and delivery. This arrangement not only facilitated clearer communication between the patients and healthcare providers but also ensured a more supportive and reassuring environment. While doulas primarily offer emotional support, they also assist in translating medical advice from midwives or doctors. The role of doulas and their impact on maternal care will be explored in greater detail in the subsequent section of this chapter.

4.2.3 Perceived Challenges within the Norwegian Maternal Healthcare

Despite the positive feedback from informants regarding their experiences on the Norwegian maternal healthcare system, significant challenges remain. This section discusses these challenges, drawing on the findings from the interviews to determine how these challenges impact the maternal healthcare experiences of refugee women. I will also explore how these affect access to care, patient-provider communication, and overall health outcomes.

4.2.3.1 Social and Familial Longing

Transition to a new country often means separation from close family members and established support networks, which can significantly affect the well-being and maternal experiences of refugee women. This sense of social and familial disconnection can manifest in various ways during pregnancy and childbirth. Some informants emphasized that the absence of immediate family members led to heightened feelings of isolation. One informant, who spent her pregnancy in a reception center, shared how the lack of familial support amplified her loneliness. She recounted:

> "It was very difficult because all my life, I was with my parents and my friends. I don't know anything about marriage and being pregnant. It was difficult for me because of the new country, new language and I still can't do anything here.

Her isolation was further compounded by the uncertainty of waiting for a decision on her immigration status throughout her pregnancy. Despite her husband's presence in Norway, she was required to stay in the reception center during her pregnancy, which intensified her loneliness. She recounted:

> "It is difficult for me. For seven months, it's difficult to go and sleep. I became so sensitive. So, I needed my husband more. I want him all the time. I don't want to be in the reception center. Different language, different country, different traditions in the reception center. I didn't like it."

In addition to the emotional toll, the absence of familiar support systems can have practical implications. Most of the informants came from countries where family plays a central role during pregnancy and childbirth. In these familial cultures, family members are deeply involved, where they offer hands-on support with childcare and managing household responsibilities. This support is not only for emotional well-being but also for reducing the physical burden that accompanies pregnancy and early motherhood. However, in their new environment, informants found themselves without this support. Some noted that, in their current circumstances, they could not rely on anyone but themselves. Informants have shared:

> "I remember when I had my son, my husband wasn't here. He traveled to Italy. There are no Eritrean women here (who I knew). I was alone. I got the baby. It came after ten months. It is also important to have someone you spoke the same language with."

> "I really don't have a huge family here. It's just me and my husband. I only have my husband and close friends, but these close friends, they also have their own lives. They cannot put their lives on hold just because I'm pregnant."

The lack of familial support during such a crucial period often led to intense feelings of isolation. For some, their partner’s demanding work schedule meant they bore full responsibility for household duties, amplifying their stress. The combination of managing everyday tasks, adjusting to the physical demands of pregnancy, and navigating heightened emotional sensitivities have imposed a significant burden and exacerbated feelings of isolation during a critical life stage.

4.2.3.2 Sociocultural Barriers

Sociocultural barriers in maternal healthcare arise from significant differences in beliefs, customs, and traditions regarding pregnancy, childbirth, and women's health. These barriers are embedded in distinct cultural norms, values, beliefs, and social practices, all of which shape individuals' perceptions and interactions with healthcare services. Although Norway is recognized as a progressive society with a strong commitment to gender equality, its liberal approach can sometimes conflict with the beliefs of particular cultural or religious communities. In Agder, where Kristiansand is situated and often referred to as the “Bible Belt” of Norway, religious conservatism is especially influential, potentially shaping attitudes towards women’s health and the use of related services. A provider informant highlighted this cultural dynamic:

> “Agder or in Kristiansand can be described as a conservative region as compared to other places in Norway. We have strong –, I can say that many of the cultural expectations are based upon on certain religious views. Many of the women that I talked to said that they don’t feel welcome in other organization activities because many of the organizations that are huge here are based on religion.”

For refugee women, sociocultural barriers can also be profound, as many of their cultural practices, deeply rooted in their countries of origin, often stand in stark contrast to the healthcare system in Norway. As such, some informants recounted varied situations that show cultural disparities, revealing how their expectations can shape their perceptions of maternal care. One informant shared her experience of struggling with the lack of access to halal food during her hospital stay. Reflecting on this, she expressed her discomfort and frustration with the hospital’s food options, noting that the absence of culturally appropriate meals added to the stress of her maternal healthcare experience. During the interview, she highlighted the

importance of catering the diverse dietary needs of patients, particularly those who observe religious dietary restrictions. She stated:

> "My recommendation is that... you know, we Muslims, we don't see food that is halal. We are different. They will serve, for example, meat. They don't have halal food. Sometimes during dinner, we only eat bread."

Dietary restrictions are just one aspect of the broader cultural disconnects refugee women face. Informants also shared stories of how traditional remedies, often passed down through generations, were met with skepticism with the established medical practices in Norway. An informant discussed her experience with the use of ginger. She stated:

> "Especially the use of ginger. I was really shocked because I have tons of ginger in my fridge, because it was normal for me. I can see many pregnant women from my country, whenever they are having the heartburn, the acid or whatsoever, they just crush the ginger to make it as a juice and drink, then they will be fine the next day. But then, I told my midwife, 'I've been drinking ginger juice for three days'. She was like, 'why did you do that?'. Then she started touching the baby, touching me here. You know –, like she was freaking out. She was panicking […]. I need to follow it blindly, whether I like it or not."

This statement shows how ingrained cultural practices can be challenged in a foreign healthcare setting. While the midwife's reaction was likely stemmed from a concern for safety, the lack of open dialogue about the use of traditional remedies created uncertainty for the informant.

A similar sentiment was expressed by an informant, who shared how certain traditional practices related to childbirth are absent in Norway. Although these rituals may not hold medical necessity, they carry emotional significance, serving as an essential part of the birthing experience for the informant. She shared:

> "And in my country, there are certain –, it's not really rituals, but it's something that you do when you're approaching your days to deliver. You start to drink some herbs. You start to do some funny things. You know how culture is? In order to prepare (for) the coming of the baby. But here, I've never had that."

A provider informant also reflected on her experience working with immigrant women and their expectations for newborn care. She highlighted how cultural practices, such as cleaning the newborn immediately after birth, can sometimes lead to misunderstandings, particularly when patients come from backgrounds with distinct traditions surrounding childbirth. She explained:

> "In some culture, when the baby gets out, it needs to be cleaned and washed. But in Norwegian, or (the) broader European culture, the baby is placed directly on the mother's breast right after birth. We have some women who don't want that, they want the baby to be cleaned. In Norway, this practice is discouraged because it's believed to benefit the baby's health and help the mother connect. We had discussions about this. My leader took it up to her leaders, yeah? […] In the end, it's the mom's choice. Small changes can be done."

These accounts show the complexities of addressing cultural barriers in maternal healthcare. They reveal how deeply held cultural practices can create tension when they intersect with standardized medical care. While healthcare providers may prioritize safety and medical guidelines, patients' cultural needs must be acknowledged and respected. Additionally, this reveals a critical need for greater cultural awareness and sensitivity among healthcare providers to ensure equitable and culturally competent care.

4.2.3.3 Linguistic Barriers

Despite the positive feedback of the informants with their experience on communication and access to information in the hospital, linguistic barriers were still present. These barriers arise from differences in language and communication styles between the informants and healthcare providers. Of the nine informants, two were unable to speak Norwegian, while the others demonstrated limited proficiency in the language. While English is widely understood and spoken in Norway, it became evident during maternity meetings and interviews that not all providers in the CBO felt comfortable or proficient in communicating in English. This was also the case in my interviews with some providers, who expressed difficulty fully articulating their thoughts in English and often had to revert in Norwegian. As such, for patients with limited Norwegian or English proficiency, critical health-related information may be lost or misunderstood. This includes important discussions about treatment options, procedures, and patient rights. An informant shared:

> "It is difficult to understand Norwegian, right? For example, I go to the doctor, they need to translate a talk which I was trying to say. I have a little problem with oral because I was just 2 years in Norway (when I got pregnant)."

Moreover, communication with healthcare providers extends beyond in-person interactions, such as phone calls. For the informants, this poses challenges, particularly in the absence of interpreters. Two informants reported difficulties in expressing their concerns and articulating

their needs during phone calls with healthcare providers, largely due to language barriers and the lack of immediate linguistic support that they get from the hospital. An informant shared: .

> "When I came to Norway, I was pregnant. I was in the reception center. It was difficult for me because I cannot understand and I'm having a problem with the language. I'm not sure how can I describe something. It is difficult in the phone. I cannot understand what they are saying. It is not the same when you are in the place. They can hear me. They can repeat."

Another critical aspect of linguistic and cultural adaptation is digital literacy, especially within healthcare access in Norway. As the healthcare system increasingly relies on digital platforms to facilitate communication and manage appointments, patients are expected to navigate online portals and access essential information regarding their care. While this approach streamlines services, it creates barriers for individuals who may lack the necessary technological skills or familiarity with Norwegian digital systems. For refugees, mastering these technological demands adds another layer of complexity to an already challenging adaptation process. One informant highlighted this:

> "If you don't have the technological knowledge, you don't know how to get information online, it would be difficult, because each and every stage, you want to book an appointment with the midwife or whatsoever, and if you don't know what's gonna happen next month or in the next trimester, whatever outcome when the baby comes, you need to know online."

This digital divide can heighten the sense of vulnerability felt by many immigrant mothers, who often experience limited support networks. The dependence on digital platforms places added pressure on them who are also grappling with language barriers, cultural dislocation, and, often, a lack of close family support. Combined, these challenges can make essential healthcare services feel out of reach, further compounding stress during a period when support is most crucial.

4.2.4 Coping Mechanisms and Support Systems

Given the significant challenges faced by the informants, they draw upon a combination of informal networks and community support systems to cope with the adversities they encounter and navigate institutional challenges, particularly with the Norwegian healthcare system. These coping strategies are essential as they not only provide emotional support but also practical solutions in a foreign environment. This section discusses the significance of these informal support networks, examining how they foster resilience and community solidarity by using

these networks to gather information and share resources. Additionally, I will examine the role played by CBOs in facilitating these networks.

4.2.4.1 Informal Support Networks

Most informants reported that their family and friends from their country of origin are not present with them in Norway. In the absence of close personal ties, they turn to informal support networks as a resource to the challenges of being a refugee. These networks are often made up of fellow immigrants or individuals who have undergone similar experiences. In many cases, these informal connections serve as the first point of contact when individuals face difficulties or require guidance. One informant noted the importance of these networks. She expressed her desire to have a baby but felt overwhelmed by the healthcare system in Norway. It was through her friends, who have already experienced giving birth, that she found reassurance and support.

> "I have friends here, and they told me, you will be comfortable, and that everything will be okay; they will help you a lot. For that, I was little relaxed. I felt safe."

Immigrants also establish communities centered on shared ethnic and cultural backgrounds. This is a common phenomenon in Norway, where they find support within these communities. These groups provide a sense of belonging and facilitate the sharing of important information about navigating life in a new country. One Eritrean immigrant shared her experience:

> "We have a community here. They are also good on giving information. When they know I'm from Eritrea, (they will be like) 'Hi. How are you?' Everyone greets each other and give information with one another."

Another notable aspect is the role that informal networks play in disseminating essential information among immigrant communities. These networks can serve as a primary source of guidance regarding Norway's welfare system. An informant shared how she learned from her networks about the possibility of receiving financial support, particularly known as *engangstønad*[6], from NAV[7] after childbirth to assist with baby-rearing expenses, stating:

> "I just knew about that when I was in 4 months of my pregnancy. You know, when you are surrounded by people, they start to ask, 'Oh did you already apply for the money?'

[6] A lump-sum grant or one-time financial benefit for parents that do not qualify parental benefits. See more about the lump sum grant, available at https://www.nav.no/engangsstonad
[7] A government agency responsible for social welfare programs, employment services, and health-related benefits.

> Money for what? And people now start to say, 'You are pregnant here, you need to apply'. And I didn't know about those stuff."

This statement shows the importance of social connections for immigrants, particularly in the context of information sharing. The informant further revealed that she did not receive any guidance about this from her healthcare providers, despite its potential significance for her situation. Accordingly, the informant noted the importance of sharing common experiences, particularly the challenges related to learning the Norwegian language. Many within these communities rely on English as a shared language, which further facilitates information exchange and mutual understanding. Through these networks, individuals can learn about their rights and available social services, benefiting from the collective knowledge of those who have navigated similar experiences. She further shared:

> "Some other immigrants, pregnant mothers, there's the language barrier (in the system), because (we're) still learning the Norwegian language. You know, you can pick some, here and there on what they are saying."

The informants also affirmed that it was through their engagement in CBOs where they primarily build their informal support networks. These networks become crucial for those seeking information about health services, childcare, and other relevant areas, compensating for the limitations in formal healthcare interactions. This topic will be explored further in the following section.

4.3 The Role of CBOs on the Maternal Healthcare of Refugee Women

In addition to exploring the maternal experiences of refugee women, this study also aims to examine the role of CBOs in shaping these experiences. This section begins by introducing the CBOs involved in the study, highlighting their initiatives and programs that address maternal healthcare for refugee women. It further explores how these organizations perceive and facilitate access to maternal healthcare for this particular group. I will also cover the responses of the informants to these programs, assessing their impact on maternal healthcare outcomes. This will be drawn from the interviews with both refugee women and providers, as well as my participant observation at approximately 20 engagements with CBO interventions. The table below outlines the role of the providers involved this study.

	Role
1	CBO Project Leader

2	Retired Nurse/ CBO Project Leader
3	Midwife/ Doula Project Coordinator
4	Retired Nurse and Midwife/ CBO Volunteer
5	Doula/ Organizer of Maternity Meetings
6	Doula

4.3.1 CBO 1: Maternal Healthcare Programs for Refugee Women

The first CBO involved in this study is committed to advancing women's health in Kristiansand. It was founded after thorough research aimed at addressing the specific health needs of local women. As an affiliate of a nationally recognized organization, the CBO aligns with its broader mission but tailors its programs to focus on a range of women's health issues, including reproductive, migrant, and maternal healthcare education. The CBO is driven by a volunteer network, working closely with healthcare providers and community members to ensure its programs are both relevant and impactful. Throughout my volunteer engagement and fieldwork with the CBO, I had the opportunity to participate in their daily activities aimed at supporting migrant groups. These include the women's café, language training sessions, homework assistance, and yoga classes. These activities not only provide essential services, but also create a space for immigrant women to connect with one another. The women's café offers a casual environment where participants can engage in meaningful conversations, while the language training focuses on practicing Norwegian. As such, the CBO's mission goes beyond providing information about health and the healthcare system; it aims to cultivate a sense of community and facilitate the creation of supportive networks among women. As such, the CBO recognizes the importance of the participation of refugee women in civil society, understanding that such engagement can be transformative most especially in maternal healthcare, where shared experiences can significantly enhance support. The provider informant further shared:

> "As a pregnant woman, you go to appointments at the helsestasjon[8]. After birth, you also get the chance or opportunity to be a part of the group, barselgruppa[9]. Women said that they don't feel included in that group. So, we saw the need for the civil society to have women with minority backgrounds that don't feel included in those groups."

[8] Translates to public health clinic.
[9] Translates to maternity group. These groups are organized to help mothers who have recently given birth connect with others in similar situations.

Moreover, the CBO aims to enhance access to critical healthcare services, raise awareness, and empower women to take control of their health. The CBO places an emphasis on educating women, most especially immigrants, about their rights and helping them navigate the healthcare system. They regarded themselves as a vital resource in providing information that complements governmental efforts. A provider informant said:

> "Like the Introduction Program, they have this standardized program for refugees to let them know what their rights are, but you know, they don't have the capacity to go into detail on what rights you have. So, I think it's very important to do this information awareness programs."

In the context of maternal health, the CBO is partnered with the doula program that is aligned with the broader goal of expanding the initiative across Norway to enhance maternal health outcomes for immigrant women. This program provides crucial support to expectant mothers, offering personalized care and guidance throughout pregnancy, childbirth, and the postpartum period. On a smaller scale, the CBO organizes weekly maternity meetings that serve as space for women and their babies to connect and share experiences. These gatherings not only provide practical support and information but also create an environment where women can find encouragement. These initiatives will be further explored in the subsequent sections, highlighting their impact and the ongoing efforts of the CBO to enhance maternal health for refugee women.

4.3.1.1 The Multicultural Doula Program

The term *doula*, which etymologically translates to "a woman who serves", has its origin in ancient cultures where women supported each other during childbirth. This practice grew from the belief that birth is a shared experience, requiring hands-on care and emotional support to nurture both the mother and child (Bakst et al., 2020). While the role of a doula has evolved over time, it remains a crucial aspect of support for pregnant women in many cultures worldwide.

In Norway, the doula program was first introduced in Oslo in 2017, followed by Agder in 2021. This initiative was influenced by a similar program in Sweden that began in 2008. Initially, the Swedish doula program focused on providing language assistance to immigrant women. When adapted in Norway, the program broadened to offer non-medical care and emotional support to pregnant women who have lived in the country for five years or less. Accordingly, a doula

in Norway is a woman who has given birth in the country, is fluent in Norwegian, and has completed fifty-six hours of specialized training. The training equips them with understanding of the healthcare system and skills needed to provide maternal support, including comfort measures such as breathing techniques and movement support. While doulas work alongside midwives and doctors, they do not replace medical professionals, instead offering a personalized level of care that tailors to the mother's emotional and physical needs. Doulas usually meet with mothers one to five times during pregnancy and one to two times during the postpartum period. Of the nine refugee informants, three reported having a doula, and all expressed their satisfaction with the support they received. They noted that having a doula provided not only a sense of emotional security but also practical assistance, helping them feel more prepared and confident during their childbirth experiences. An informant said:

> "The doula has the job to be visiting you, making sure you're okay, if she's gonna help you with groceries, she will help you with some cooking and maybe you get the depression, the after-birth depression. She will tell the nurses and the midwife, 'I've been experiencing this with the mother […]'. The doula will be present more than the midwife."

Another important aspect of the doula's role is how it facilitates the integration of refugees into the Norwegian healthcare system. Doulas play a crucial role in helping refugee women integrate into the system, particularly during pregnancy and childbirth. Many refugees may initially feel unfamiliar with the system, but doulas help bridge this gap by offering support. Although doulas are seldom present during medical consultations, they provide valuable support by helping mothers better understand healthcare procedures, ensuring they are well-informed and comfortable throughout the process. This not only reassures the mothers, but also builds their confidence in using healthcare services. An informant shared:

> "The doula gives us information. When I was pregnant, the doula has become a mother to me also. I am very satisfied and happy. We went to the hospital for two or three times for her to guide me with the doctor. We have a very good contact."

The doula also serves as a cultural mediator, bridging the gap between the healthcare system and the diverse cultural backgrounds of the women they support. In this role, doulas convey essential cultural nuances to healthcare providers while guiding mothers and their families through unfamiliar medical processes. This extends the doula's role beyond direct care, encompassing the often-overlooked family dynamics that may not be recognized in a standard healthcare setting. As such, doulas can help families feel at ease, which can be particularly

significant for refugee women experiencing the anxiety of childbirth in a new environment. A doula informant shared an instance:

> "I help them. I speak with them. Everything. I must follow. I tell them on what they should do. (I also tell) the husband to go out, take some air, because in Eritrea, it is not common for the husband to be in the hospital. He should go out. I tell them to go out and think, go eat."

From the doulas' perspective, they expressed a sense of fulfillment in their work with expectant mothers, emphasizing the connection they form through their shared experiences of childbirth in Norway. The doulas found meaning in being able to relate to the emotional and physical challenges faced by pregnant women, especially within the context of the Norwegian healthcare system. They highlighted the rewarding nature of their role, noting that their presence helps create a more relaxed and confident birth experience for the mothers they support. A doula informant said:

> "For me, I was happy. If it's volunteer job or paying job, I was gonna take it anyway […]. I know how difficult and sensitive the time is when you get pregnant and give birth. It's a very vulnerable time. And as an immigrant, I understand that 'cause I've been in that situation, and I know how difficult it was. Although I could speak the language and had friends and everything, I felt lonely. When I got my first child, I felt alone, and so when I talk about it, I was thinking how it is gonna be for those who doesn't know the language, (who) maybe don't have a man and friends and will be there by their own."

The fulfilling nature of their role in the program helps doulas build connections with other women, creating a sense of community based on shared understanding of the childbirth experience. Their work often goes beyond the typical responsibilities, as they strive to help others feel included and supported during a crucial time in their lives. A doula informant said:

> "For example, I live here, right? If someone from Eritrea that I know gave birth to a baby and they are alone, they call me. 'Oh, someone got a baby. Can we visit you?' They don't need to be worried. They can just go and visit."

While valuable, the role of a doula can sometimes be overbearing, particularly when there is a risk of imposing advice or practices that the mother may disagree with. A provider highlighted this as a challenge they encountered in the program. In one instance, a doula developed particularly strong opinions, which created tension with the mother, who felt that her own preferences were being overshadowed. This situation calls for a balance that doulas must maintain between offering guidance and respecting the mother's autonomy. As such, the

provider emphasized the importance of ongoing trainings on facilitating conversations that allow mothers to make informed decisions rather than feeling pressured. The provider informant said:

> "They feel that the doula is from the other part –, like other group, that might affect them to say yes, and that they meet the person, and they get the sense that she's opposing me, and then they don't want to continue, so there might be those issues. As well as if the doula has a lot of own opinions, and if they are not professional, then of course you can have problems."

Nonetheless, the doula program in Kristiansand aligns with the national objectives and has been recognized as a successful initiative. Presently, Kristiansand has twenty-one doulas with different ethnicities, reflecting the diverse immigrant population in the area. For instance, prior the war in Ukraine, there was no Ukrainian doulas; however, the recent influx of Ukrainian refugees has allowed the program to include a Ukrainian doula to further strengthen its reach and inclusivity. Another significant indicator of the program's success is the active involvement of CBOs and individuals who are embedded into the local community, making recruitment for the program more effective. During my participant observation at the CBO, I noticed the abundance of promotional materials related to the doula program, reflecting its visibility and accessibility to the community. These materials were translated into the languages that are most spoken by immigrant women, such as English Arabic, Ukrainian, and Swahili. A provider informant also noted:

> "I would say that in Kristiansand, it has been a big success, and there are many factors why it has worked so well here. One reason is that we have a coordinator who basically has been working (for) so long in the development work that –, people who are working in the community, who are recruiting these people, the refugees who are coming –, taking part of this doula program."

Although the doula program receives most of its funding from the national government, other institutions, such as CBOs, are actively involved to ensure that the services are accessible to local communities. In some Norwegian municipalities, local governments also contribute by supporting or partially funding doula services, especially through pilot programs designed to improve maternity care outcomes for immigrant women. Therefore, securing sustainable funding is essential not only for the program's long-term success but also for expanding it to other regions across Norway. However, despite the program's current momentum and broad support, concerns persist about its future funding stability. A provider informant expressed her apprehension, sharing:

> "We have huge challenges because of the economic situation. In the beginning, it was funded by a different project. Like small project funding. Now first –, last year, they got more national funding, but it has been so unclear for us who have been running this, if are we are able to run this project for next year or not […]. It has been so much back and forth, and it has been a lot in the media as well."

This statement reflects the tension between the program's promising outcomes and the financial uncertainties that jeopardize its sustainability. Given the program's positive impact, as evidenced by both informants and supporting studies, securing sustainable funding is crucial. This funding would not only uphold the program's existing services but also accommodate Norway's growing immigrant population, which increasingly relies on such culturally sensitive support for expectant mothers.

4.3.1.2 Maternity Meetings

One of the more community-focused initiatives organized by this CBO is called *barseltreff*, which translates to maternity meeting. This program provides a supportive environment for new mothers to connect, share experiences, and access resources during the postpartum period. Participants are encouraged to bring their children, as the meetings feature a designated play area for children to keep them engaged. Pregnant women are also encouraged to attend, allowing them to gain insights and prepare for the transition into motherhood.

During my data collection, I attended approximately 15 of these maternity meetings, which facilitated close observation of participant interactions and group dynamics. The majority of the attendees are immigrants. Notable countries of origin include Afghanistan, Somalia, Eritrea, Turkey, the USA, and Syria. This diversity enriched the discussions and provided cross-cultural perspectives on motherhood and related experiences. Majority of the participants were introduced to these meetings through personal recommendations from friends who have previously attended, while a smaller number knew it through social media platforms. Collectively, the group attending these meetings is known as *barselgruppa* which translates to maternity group. On average, each session has an attendance of 5 to 10 mothers. When asked how the CBO sustains attendance, the provider informant explained that they engage mothers by initiating activities designed to spark their interest and encourage participation, stating:

> "Like some of these programs, the woman wish –, for something. We're gonna have like yoga – mommy yoga. One of the women would be like "oh, I wish we have yoga". And there is this woman, she said she doesn't know about first aid, first aid – kids, for

> baby. So, we talked to them and asked, “what do you want?” Some of them would (say) what they want because they don’t have experience, you know?”

The structure of the maternity meeting begins by singing songs for the children, creating an engaging atmosphere for both mothers and their children. This is followed by a period of informal socializing where women converse and share their experiences. Throughout my participation, I encountered a wide range of topics that discussed aspects of maternal health, childcare, and overall wellness. These discussions are often focused on practical themes such as breastfeeding, infant nutrition, emergency care for babies, and the transition to kindergarten. These meetings not only provide valuable information, but also empower mothers to make informed decisions about their children's health and development. Additionally, these are facilitated by community workers and volunteer healthcare professionals who guide and maintain the flow of discussions. Occasionally, external experts are invited to speak on specific topics like women's health or child development to provide specialized insights. These expert-led sessions deepen the discussions that complements the peer-driven support and shared advice within the group. A provider informant noted that many women receive limited information during hospital visits, often focused solely on their immediate issues or circumstances. In contrast, these meetings offer a broader perspective, equipping mothers with understanding of their health and well-being. A provider informant who organizes this meeting shared:

> “I think it is important to have this barselgruppa, and not just the svangerskapskontroll[10]. This group is important for women who may lack a supportive network and find themselves isolated at home. There are many themes we need to discuss once you move to Norway, particularly concerning healthcare. Many participants come with traumatic experiences from their home countries, and the cultural shift can be overwhelming. They often arrive with little information about their bodies and health.”

This statement highlights the necessity of peer support beyond conventional healthcare services, suggesting that discussions within the group can address critical issues often overlooked in standard medical consultations. Conventional healthcare, while essential, may lack the cultural understanding that immigrant mothers need as they navigate a new environment. The provider further emphasized the open and safe atmosphere of the group:

[10] Translates to prenatal or antenatal check-ups in Norway.

> "I think the women here feel safe and they are not afraid to ask questions, that they might be afraid to bring up with healthcare professionals. It's a safe space where no questions are stupid."

Norwegian mothers also participate, albeit a few. In one notable session, there was a higher number of Norwegian participants, which the attendees from other ethnicities benefited from their input. The Norwegian mothers shared practical advice, such as ways on how to access discounts on baby products and recommendations for nutritious foods. These informal discussions provided valuable information about postpartum health and infant care – topics that are often not covered in formal healthcare settings. This kind of peer-led communication fills knowledge gaps for refugee women, offering practical advice that complements institutional care. Therefore, their participation also aids in the integration of these women into the community. One informant provider emphasized the significance of presence of a Norwegian:

> "I think the language sometimes is difficult because they can't understand. So my experience is that it is important to have a Norwegian friend with you because if you don't understand, you will just be (feeling) skeptical."

In other cases, these meetings facilitate interactions among specific ethnic groups, allowing them to connect and share culturally relevant experiences. For instance, I observed a considerable number of Somali participants who were able to connect and discuss their experiences, reinforcing community ties. These interactions not only create a sense of belonging, but also facilitate the sharing of knowledge and resources related to maternal healthcare, particularly in areas of parenting practices and cultural traditions surrounding childbirth. This also becomes helpful, in a way that it reduces feelings of isolation, as participants find common ground with others who have similar backgrounds and circumstances with.

4.3.2 CBO 2: Maternal Healthcare Programs for Refugee Women

The second CBO examined in this study is dedicated to supporting the integration of immigrants, particularly in helping them adapt to life in Norway. It is affiliated with a national religious organization and offers both spiritual and practical assistance to newcomers. Despite this formal affiliation, the CBO was primarily founded due to the personal passion of its founder, a retired emergency nurse. Her experiences in healthcare and community work made her acutely aware of the challenges immigrants face, prompting her to establish the CBO to address these needs. The founder's vision was built around the relationships she has cultivated

with people from different cultural backgrounds. This social network enabled her to understand the needs of immigrant women. She shared:

> "I did not receive trainings and supervisions, but I just have a lot of friends from other countries. We saw that there are women from other countries who are just at home and do not learn Norwegian because they just gave birth. I (also) think it's a bit difficult for (them) because they always need to ask others (about the system). They have children and husband (that needs help) for interpretation. That's why my friend and I started this, so that we can help them speak Norwegian […]. So I think, this is a good place. And sometimes, we have a helsesøster[11] here. 'Why do we vaccine?' We invite them to come teach."

A key aspect of the CBO's role is facilitating immigrants' understanding of and engagement with important facets of the Norwegian society. Among its programs, Norwegian language training stands out as a central component of its integration efforts. During my observation of one such session, I noted the significance of this program, especially for Ukrainian refugees. Many of these individuals were not enrolled in Norway's Introduction Program for newly arrived refugees. For these individuals, the language training offers a crucial alternative, providing access to integration resources that they might otherwise lack due to limited availability of state-sponsored programs. This program not only enhances linguistic abilities but also fosters social interaction, enabling individuals to meet and connect with others who share similar experiences. One informant highlighted the program's significance during her postpartum period, sharing her personal experience of attending classes at the CBO while caring for her baby, stating:

> "If it wasn't for the (CBO), I would just stay home and forget the language. At home, we only speak Somali. But here, I hear the language, and I meet other immigrants (that has) the same situation as me, so I also speak Norwegian. You have a clear mind here. I don't know what I would do if I stayed home. I've been coming here for two years, and it has helped me build a network."

Moreover, the CBO hosts social activities that provide immigrants with opportunities to ask questions and learn about various aspects of the Norwegian system, such as social welfare programs, healthcare access, education, and employment regulations. These activities promotes both practical learning and community building, further assisting immigrants in their adaptation to Norwegian life. It is also through their social activities where the maternal healthcare aspect of integration is evident. I will delve deeper into this in the next section.

[11] A qualified nurse who provides health assessments and guidance to children and young people aged 0-20, as well as their families, focusing on health promotion and disease prevention.

4.3.2.1 Social Activity for Women and Children

The CBO previously held maternity meetings specifically designed to address the needs of mothers. However, these meetings were discontinued in favor of a more inclusive social initiative aimed at supporting immigrant women and children. Currently, these activities take place three times a week, where women and children of all ages can socialize and engage in activities. Around 30 women participate in this program. Despite the broader focus, these gatherings continue to incorporate essential elements of maternal healthcare integration, allowing women to access information and resources related to maternal health. Notably, many participants are former attendees of the maternity meetings, often bringing their children along. A significant portion consists of refugee mothers, fostering a supportive network where participants can connect over shared challenges and experiences. One informant remarked:

> "All are very kind. All women give information about pregnancy in Norway. They help a lot; what can you do in the hospital or if you get a baby. They help me a lot because almost all the women here are mothers."

Moreover, the CBO established a designated play area where children can engage in safe and supervised activities. This dedicated space not only ensures the children's safety but also provides mothers with a valuable opportunity to socialize. This is beneficial, as the CBO operates in a manner akin to a kindergarten, providing an atmosphere that fosters learning and social interaction for both mothers and children. A provider informant shared:

> "For example, two women from Syria, their husbands are here in Norway, and they got a family. This area doesn't have a kindergarten, (so) they asked if can they come here and stay hear to learn Norwegian. Then they got pregnant again. They can't go to school, so they were here for two years."

This sentiment highlights the dual role of the CBO as both an educational resource and a community hub. This was reaffirmed by a refugee informant:

> "The organization is very friendly with immigrants. When I had my first baby in Norway, I just went to them. I can't go to school either, so I just spent my time there."

During one meeting I attended, the CBO facilitated a clothing giveaway for babies and children. The clothes were collected through a donation drive and were made available to participants with young children. This initiative proved to be beneficial, as it provided essential clothing items for participants they might not otherwise afford. In addition to clothing, the CBO

offers a range of practical support for families, including renting essential baby equipment like strollers and cribs. An informant shared:

> "If the application of the money that I mentioned (lump-sum grant), if it comes maybe later or there's some complications happening –, and, you know, if you gave birth early, they could assist you with baby clothes and other stuff. You can rent baby bed, baby stroller. You can rent until the baby is old enough. And then you can return it so that another person can use it as well. So, I think these organizations, they are doing a great work in assisting pregnant mothers, especially immigrants."

As such, this initiative becomes valuable as it allows families to access costly, but necessary, items without the need for substantial upfront investment. It alleviates some of the financial and logistical pressures that often accompany pregnancy and early parenthood. Similarly, this system strengthens social networks and helps alleviate some of the pressures associated with early child-rearing, ultimately contributing to a communal system of resource sharing.

CHAPTER FIVE
5. ANALYSIS OF THE FINDINGS

This chapter presents the analysis of the findings by framing the empirical findings within two key theoretical perspectives: Social Ecological Model and Social Capital Theory. It seeks to provide an understanding of the maternal healthcare experiences of refugee women, examining the multi-layered factors that influence their access to and quality of care. Additionally, it analyzes the role that CBOs play in shaping these experiences, functioning as critical support systems among refugee women.

5.1 Maternal Health of Refugee Women: Individual Determinants

The Social Ecological Model (SEM), at the individual level, emphasizes the significance of personal characteristics, knowledge, attitudes, and behaviors (Bronfenbrenner, 1979; Golden & Earp, 2012; Kilanowski, 2017). As such, a refugee woman's background – including her personal history, education, and socio-cultural context – influences her health outcomes and integration into the society. These histories do not exist in isolation; they interact dynamically with various individual-level factors.

Firstly, the informants' identity as refugees profoundly influences their experiences and perceptions. For some, the challenging encounters they faced in their countries of origin, as well as their prior healthcare experiences, significantly shape their perception of safety and well-being in maternal health. For instance, an informant recounted a profound sense of insecurity in her home country, noting how the fear of conflict weighs heavily on her decision to have children (p. 49). This fear was compounded by the practical concerns of affording child-rearing in such an unstable environment. Similarly, an informant shared that the ongoing conflict in her home country made public hospitals unreliable and understaffed, forcing many women toward expensive private clinics to receive adequate care (p. 50). These experiences contribute to the perception that quality maternal healthcare is often inaccessible for most women. Such accounts also illustrate how refugees' past encounters with conflict and healthcare systems shape their current views on the accessibility and affordability of maternal healthcare.

Moreover, the traumatic experiences shared by the informants are intertwined with the rigid gender norms that shape refugee women's health-seeking behaviors and overall experiences. Many of the informants come from societies where patriarchal structures dominate, positioning

women in subordinate roles. As similarly argued by scholars (Freedman, 2016; Oliver, 2017; Pittaway & Bartolomei, 2001), these socially constructed gender norms dictate what behaviors are deemed acceptable for women, particularly regarding health-related issues. Within these contexts, traditional expectations often inhibit women from asserting their needs or expressing discomfort (Rai & Paul, 2021). For instance, an informant proclaims how cultural norms require women to suppress expressions of pain during childbirth (p. 51). This internalization of expectations can deter women of exerting self-autonomy and decision-making, potentially compromising their well-being. In contrast, the informants' experiences after resettlement in Norway represent a shift in norms and healthcare expectations. The ability to freely express pain and communicate with healthcare providers without restrictions enabled them to engage more actively in their health decisions. This shift allowed for greater self-autonomy and supported a patient-centered approach where their needs and experiences were recognized.

Individual determinants are also tied to biological dimension, such as genetics and health status, that influence women's health and wellbeing (Hawkins et al., 2021). In the context of this study, the biological dimension refers to factors that influence psychological wellbeing and hormonal fluctuations associated with pregnancy and childbirth. The psychological wellbeing of the informants is shaped by a range of experiences, notably those preceding and following migration to Norway. Some informants described experiencing a profound sense of isolation stemming from traumatic experiences during war. The loss of close family members, coupled with separation from established social support networks, further exacerbates these feelings of isolation (p. 58). Additionally, the stress associated with adapting to a new environment can aggravate pre-existing mental health issues, making it even more challenging for these women to navigate the healthcare system.

Another critical aspect of the SEM is culture where it significantly shapes individuals' interactions and decision-making processes regarding health (Golden & Earp, 2012). These cultural influences affect how people navigate social expectations and respond to health challenges. As such, the informants recounted several ways in which their health practices from their countries of origin differ significantly in Norway. For instance, some expressed a preference for traditional medicine, which is embedded in their cultural identity, over biomedical approaches. Likewise, cultural practices related to childbirth, such as immediate cleaning of the newborn after delivery, may not align with the standard procedures in Norway (p. 61). These accounts show the complexities of addressing cultural barriers in maternal

healthcare and how deeply held cultural practices can create tension when they intersect with standardized medical care. While healthcare providers may prioritize safety and medical guidelines, patients' cultural needs must also be acknowledged and respected.

Health literacy emerged as a significant theme in the literature, serving as a key determinant of health-seeking behavior (Attanapola, 2013) This theme is substantiated by the study's findings, highlighting the essential role of language proficiency in accessing healthcare services. Most of the healthcare information were predominantly available in Norwegian, presenting challenges for the informants. As a result, some informants reported experiencing uncertainties when initially navigating the healthcare system. Local studies (Kjøllesdal et al., 2023; Lyberg et al., 2012) support these findings, presenting language proficiency as a critical factor in effective patient-provider dialogue.

Despite such barrier, the findings indicate that the informants' health literacy improved over time as they became more acquainted with healthcare institutions, and with hospitals functioning as their primary source of health-related information during pregnancy (p. 55.) This aligns with previous research (Bains, Sundby, et al., 2021; Bello et al., 2022), which found that women with higher levels of health literacy were more likely to engage in positive health behaviors. Healthcare providers were essential in this process, delivering information that allowed participants to better comprehend the structure, regulations, and available services within the maternal healthcare system. The provision of interpreters and translated informational materials further facilitated this improvement, thereby enhancing the informants' ability to access, understand, and utilize healthcare services. These resources contributed not only to an increased level of health literacy but also with improved health-seeking behaviors, demonstrating the importance of linguistic accessibility in promoting equitable healthcare outcomes.

5.2 Maternal Health of Refugee Women: Interpersonal Dynamics

The SEM emphasizes the importance of interpersonal relationships and connections within its framework. At the interpersonal level, SEM examines on how individual behaviors are influenced by social interactions and the surrounding networks (Golden & Earp, 2012). This examination encompasses the influence of family dynamics, friendships, and peer relationships, all of which are crucial in shaping the attitudes, beliefs, and behaviors of refugee women (Hawkins et al., 2021).

In parallel, the Social Capital Theory (SCT) complements the SEM by further emphasizing the role of social networks and relationships in influencing health. The SCT posits that social capital, comprised of the resources and support embedded within a community's social networks, affects health outcomes (Eriksson, 2011; Wind & Villalonga-Olives, 2019) Social capital encompasses various forms of social support, including emotional assistance and informational resources, which can mitigate health risks and promote well-being. As highlighted in the findings, coupled by the literature (Edwards et al., 2015; Lyberg et al., 2012), access to supportive networks is particularly important for refugee women, as these networks can provide essential guidance and resources for navigating complex healthcare systems.

Drawing from this, the findings underscore the crucial role of informal networks – often comprised of fellow immigrants or individuals who have undergone similar experiences – on shaping the health-seeking behavior of the refugee women. Most informants emphasized the value of these connections which serve as emotional support in a foreign environment. For example, one informant shared her aspirations to start a family but admitted feeling overwhelmed by the healthcare system. Despite facing language barriers and unfamiliar procedures, it was through her network of friends – who have already gone through the experience of giving birth – that she found the necessary reassurance and practical guidance (p. 63). These friends shared their personal experiences with accessing maternity care which helped the informant feel more prepared and confident in seeking medical assistance.

Another significant aspect is the sharing of essential information within immigrant communities. For instance, one informant described how she learned through her network about the availability of financial support to help cover baby-rearing expenses after childbirth (p. 63). This informal exchange of knowledge also extends beyond childcare, offering refugee women valuable insights into healthcare access, employment rights, and legal protections. By pooling their collective experiences, the study reveals that refugee women can empower one another, promoting resilience and enhancing their well-being as they adapt to life in a new society.

Moreover, the informants affirmed that their engagement in CBOs further built their informal support networks, which in turn influenced the interpersonal dynamics within these groups. These networks were crucial for those seeking information about health services, childcare, and other relevant areas. Certainly, my involvement and observations during maternity meetings, organized by the CBOs, revealed that most attendees were introduced to these

meetings through personal recommendations from friends who have previously attended. This word-of-mouth recruitment is a key example of what sociologist Robert Putnam (2000) refers to as the *bonding social capital*, where strong ties within a close-knit community facilitate access to social resources. For instance, I observed a significant number of Somali participants who were able to connect and discuss their maternal experiences through these meetings (p. 72). These interactions not only created a sense of belonging but facilitated the sharing of knowledge and resources related to maternal healthcare, particularly in areas of parenting practices and cultural traditions surrounding childbirth. In addition to bonding social capital, *bridging social capital* was evident in the involvement of Norwegian participants. This concept refers to the social networks and relationships that connect individuals and groups across different social and cultural boundaries (Putnam, 2000). During one session, Norwegian mothers shared practical advice, including tips on accessing discounts for baby products and recommendations for nutritious foods (p. 72). These informal discussions enabled them to expand their networks beyond their immediate communities and promoted cooperation among different groups.

5.3 Maternal Health of Refugee Women: Community and Organizational Influences

At the community and organizational level, it highlights the significance of the broader social environment in shaping health behaviors and outcomes, particularly through access to resources and social support systems (Golden & Earp, 2012). In this study, the focus is on the role of CBOs, as they actively engage with the community to develop healthcare programs and fill resource gaps for refugee women. While previous discussions examined the impact of CBOs on interpersonal relationships, the community level of the SEM extends beyond individual and close-relationship influences, encompassing the collective structures and actions facilitated by CBOs.

The findings indicate that CBOs act as connectors between refugee women and the broader community. In general, they organize language classes and social activities that not only provide participants with essential skills but also foster social connections and a sense of belonging. This aligns with existing literature, which highlights how CBOs leverage their localized knowledge and trusted status to meet specific community needs through culturally sensitive education and support (Agonafer et al., 2021; Bakst et al., 2020; Wilson et al., 2012). Such initiatives strengthen trust and solidarity within the community, which are key components of successful integration.

Moreover, as discussed, the SCT in this context emphasizes the role of CBOs in fostering social capital for refugee women. Given this, the findings indicate that most CBOs' initiatives prioritize the enhancement of social capital through social gatherings, which facilitate the development of both bonding and bridging social capital. CBOs strengthen bonding social capital by creating opportunities for refugee women to connect with others who share similar backgrounds, experiences, and challenges to enhance maternal health outcomes. This is exemplified in maternity meetings where participants frequently extend invitations to acquaintances from their own communities to participate (p. 70). Concurrently, CBOs promote bridging social capital by connecting them to a wider range of resources beyond their immediate social circles. This may include partnerships with the local community e.g., Norwegians, healthcare providers, and other resources related to maternal healthcare. As an example, one CBO organizes specialized seminars on topics such as women's health and child development (p. 71). These expert-led sessions not only provide in-depth knowledge but also enrich the peer support shared within the group.

The multicultural doula program, initiated by one of the CBOs serves as a compelling example of promoting both bonding and bridging social capital. By matching pregnant women with doulas who share their ethnic and cultural backgrounds, the program strengthens community ties, while simultaneously integrating refugee women into the broader social and healthcare systems. The cultural commonality offers a sense of comfort and ease for refugee women. Accordingly, the doulas do more than facilitate access to healthcare; they serve as a bridge to a wider network of community resources, social activities, and support groups. For instance, they offer personalized assistance and advocacy during medical appointments, ensuring that refugee mothers fully understand health procedures, prenatal care, and postnatal recovery. Their support extends beyond the clinical setting, encompassing practical daily needs such as finding affordable baby supplies, locating childcare services, and participating in family-oriented activities. This kind of hands-on support is important for those who may face language barriers, lack of familiarity with healthcare systems, or cultural differences that could otherwise limit their access to quality care.

5.4 Maternal Health of Refugee Women: Institutional Determinants

The SEM, at the institutional level, emphasizes on the role of systematic structures, policies, and practices that influence health behaviors and outcomes (Hawkins et al., 2021). Key institutions, such as healthcare facilities, government agencies, and civil society, influence

health outcomes through policies, resource allocation, and service delivery. For refugee women, access to maternal healthcare is influenced by factors like the availability of services in hospitals, the role of CBOs in providing support, and government policies that regulate healthcare access. These institutional factors collectively determine the accessibility, quality, and equity of maternal health services for refugee women, shaping their health outcomes. The figure below illustrates the institutional contexts outlined in this study, depicting how key factors converge to influence the maternal healthcare experience of refugee women.

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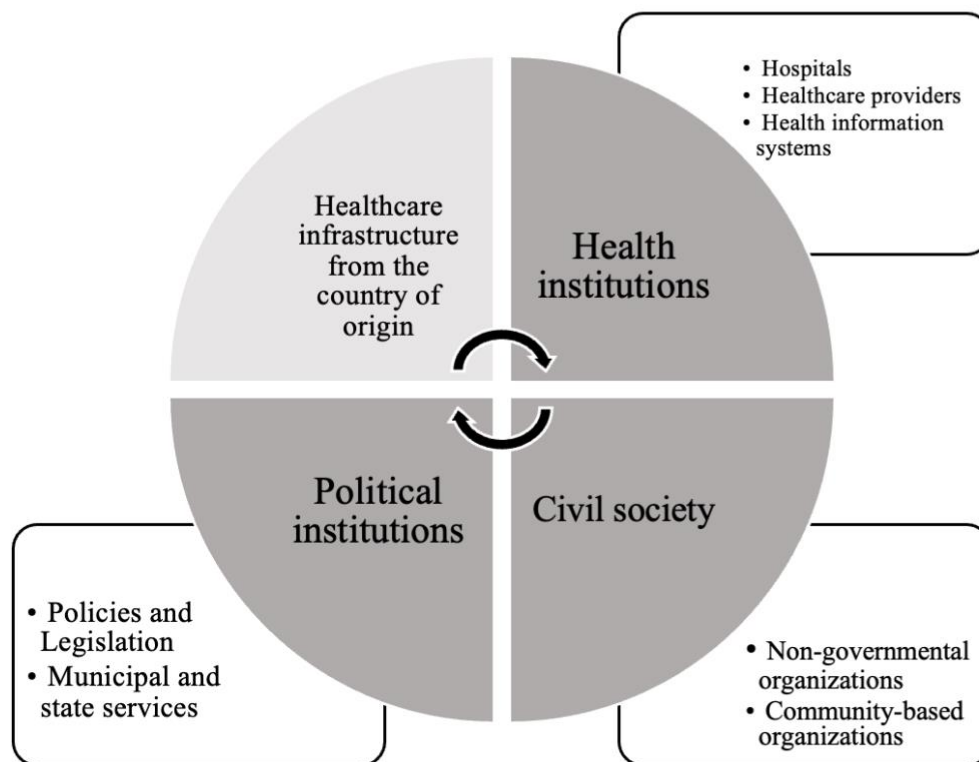

Figure 3: Institutional Factors that affect the Health Behavior and Outcomes of Refugee Women

The findings of the study underscore the impact of the Norwegian maternal healthcare system on the experiences of refugee women. The satisfaction expressed by the informants reflects the extent to which the system effectively addresses their needs and circumstances. The Norwegian health policies are grounded in a social democratic model that guarantees all women should have access to maternal health services at no financial cost, and with no discrimination based on legal or refugee status (Djuve & Kavli, 2019; Leirbakk et al., 2019). This financial accessibility allows women to prioritize their own health and of their children, alleviating the stress often associated with medical expenses. An informant, for instance, shared her surprise

at being able to discuss the availability of pain management methods with her healthcare provider, including epidural analgesia, that is tailored to her needs and preferences (p. 52). This practice supports the notion of patient empowerment, which is integral to the institutional policies that foster respectful maternity care. Accordingly, such efforts are reflected in Norway's high antenatal care coverage and low maternal and infant mortality rates (Helsedirektoratet, 2020; World Health Organization, 2019). This instance, along with others' positive experiences, have significantly shaped the informants' perceptions of maternal healthcare, particularly given that many come from countries where maternal healthcare systems are less accommodating and may lack similar structures or resources. As such, the contrast between their experience in their home countries and in Norway reshaped their expectations and experiences of maternal healthcare.

The satisfaction reported by the informants extends beyond the overall structure of the healthcare system and was evident in their interactions with the healthcare providers. At the institutional level, healthcare providers – midwives, nurses, doctors – serve as link between refugees and the healthcare system, addressing language barriers, cultural differences, and bureaucratic complexities. Informants shared positive experiences with their healthcare providers, where they ensured their understanding of essential topics like prenatal care, birthing options, and postnatal support. One notable example involved an informant who described how healthcare providers showed and explained trusted resources for health information, acknowledging Norway's increasing reliance on digital health platforms (p. 56). Certainly, education and training opportunities offered by institutions further contributed to shaping behaviors by raising awareness and expanding knowledge on health topics, enabling informed decision-making and adding valuable to social capital (Dadaczynski et al., 2022; Wind & Villalonga-Olives, 2019). The informants also emphasized the importance of empathetic communication from healthcare providers, noting that these compassionate interactions enhanced their overall perceptions of the maternal healthcare services they received. To further address language barriers, hospitals offered professional interpretation services in patients' native languages to ensure full comprehension of maternal healthcare information.

Moreover, the quality of healthcare extends beyond mere access to services. It includes collaborations between health institutions and other institutions, such as social support services e.g., NAV and civil society groups e.g., CBOs. These collaborations can leverage additional resources, cultural knowledge, and specialized expertise to enhance maternal health services.

For example, incorporating counseling and culturally sensitive programs mitigated challenges related to trauma, social isolation, or language barriers, which often impact refugee women's wellbeing. A noteworthy example is the multicultural doula program. An informant who is a beneficiary of this program affirmed that her doula not only provided labor support, but also emotional, informational, and cultural support tailored to her needs. The doulas also often advocate for the refugee women’s needs within the healthcare system, ensuring that the care provided is respectful and aligned with their cultural values and preferences. The positive impact of this program is further supported by findings from other studies (Erga-Johansen & Bondas, 2023; Falconi et al., 2022) exploring its effects on migrant groups. Additionally, CBOs lead various initiatives that supplement traditional healthcare services, such as parenting seminars, breastfeeding support, women's cafés, and language training that are often unavailable in health institutions.

Ultimately, the experiences of refugee women within Norway's maternal healthcare system illustrate that success hinges on institutional collaboration. When policy, healthcare services, and the supportive contributions of CBOs are seamlessly integrated, the result is a more inclusive, equitable, and effective approach to maternal healthcare.

CHAPTER SIX
6. CONCLUSION AND RECOMMENDATIONS

This chapter discusses the conclusions drawn from the data, providing analysis of the implications for practice and policy. Recommendations are presented to guide future efforts in addressing identified issues. Additionally, the chapter outlines the study's limitations, providing context for the results and acknowledging areas where further investigation is needed.

6.1 Concluding Remarks

The growing refugee population, driven by ongoing conflicts, demands a more inclusive and gender-sensitive approach to address their needs. Refugee women, in particular, continue to encounter significant barriers to accessing healthcare due to intersecting challenges such as gender-based violence, discrimination, and the compounded stressors associated with migration. Among the most critical areas requiring targeted intervention is maternal healthcare, as these women experience higher risks of complications and health disparities. Recent waves of migration have been linked to increasing rates of pregnancy complications, premature births, and stillbirths, largely due to the severe physical and emotional distress associated with displacement.

In response, community-based organizations (CBOs) have made important strides in bridging healthcare gaps, offering targeted support and services to refugee women. However, I highlighted that there remains a critical need to evaluate the effectiveness of their interventions on maternal health outcomes. Existing literature on migrant healthcare also takes a macro-level approach, which often obscure the detailed, community-level experiences of refugees. Building on this need, through a qualitative inquiry, I focused on the role of CBOs on the maternal healthcare of refugee women in a city in Southern Norway, Kristiansand. The unique aspect of this study lies on my active engagement in the field which included regular participation in maternity meetings organized by CBOs and several months of data collection. Through a focused-ethnographic approach, this exploration not only highlighted their experiences but also identified strategies that could be replicated or scaled in similar contexts to enhance healthcare delivery and integration for refugee communities.

Guided by my research questions, I focused on four key objectives: (1) refugee women’s perceptions of their access to maternal healthcare, (2) CBOs perspectives on maternal

healthcare accessibility for refugee women, (3) initiatives and programs led by CBOs to support maternal healthcare, and (4) the impact of these healthcare experiences on refugee women's overall well-being and integration processes. These were analyzed through two theoretical frameworks: the Socioecological Model, which considers the interplay of individual, community, and systemic factors impacting health-seeking behavior, and the Social Capital Theory, which examines the role of social networks of refugee women.

The findings of this study provide valuable insights into the experiences of refugee women within the Norwegian maternal healthcare system, highlighting both the challenges and successes they encounter. The results reveal a significant shift in recent years, highlighting considerable improvements in the country's healthcare services. Overall, informants reported high levels of satisfaction with the care they received, particularly those from conflict-affected regions where maternal healthcare is often limited or inaccessible. These positive experiences contrast with earlier local studies that emphasized the barriers immigrants face in accessing healthcare. These shared experiences align closely with prior policy recommendations, reflecting progress in areas such as the quality of care, cultural sensitivity, and communication.

Drawing from this, the informants expressed their satisfaction with the universal access of the Norwegian maternal healthcare services, which not only ensured timely medical check-ups at no financial cost, but also empowered them to actively participate in treatment decisions. A key factor in the quality of care was the respectful and compassionate interactions with healthcare providers, which built trust and made them feel valued. Informants felt secure and confident when care was prompt, consistent, and accompanied by follow-up appointments, even outside of regular hospital hours, providing reassurance during vulnerable times. Empathetic communication further enhanced their comfort, facilitating open dialogue and the expression of concerns. Additionally, the availability of interpretation services in their native languages addressed language barriers, ensuring full understanding of maternal healthcare, and contributing to a more inclusive and supportive experience.

While the informants highlighted various positives, they also identified significant challenges. Foremost among these was the pronounced social and familial longing experienced during pregnancy and childbirth. In most of their culture, family members play a pivotal role, providing practical help with childcare and daily household tasks. Another major challenge was navigating sociocultural differences. The practices and norms familiar to many informants

often stood in contrast to the Norwegian healthcare system, sometimes creating situations where cultural expectations shaped their views on maternal care. Additionally, linguistic barriers were still present. These barriers arise from differences in language and communication styles between the informants and healthcare providers, particularly during phone calls where there was no access to interpreters.

In response to these challenges, CBOs play a crucial role in supporting refugee women by building informal support networks and fostering social connections. These organizations provide access to valuable information on healthcare, childcare, and other essential resources. Often, participation in CBO activities, such as maternity meetings, is initiated through personal referrals, showcasing the power of bonding social capital by linking individuals within tightly connected communities. For example, Somali women could exchange maternal experiences and cultural practices, cultivating a sense of belonging and shared knowledge. Moreover, CBOs facilitate bridging social capital by involving Norwegian participants who offer practical guidance and share resources, promoting cross-cultural understanding and collaboration.

A notable initiative emphasized in this study is the multicultural doula program. By pairing pregnant women with doulas who share their ethnic and cultural backgrounds, the program reinforces community bonds and integrates refugee women into broader social and healthcare systems. This comprehensive support is invaluable for women facing language barriers, unfamiliar healthcare practices, or cultural differences that may impede access to quality care.

In essence, maternal healthcare services are particularly important for refugee women, as the periods of pregnancy, childbirth, and postpartum care are times when access to quality healthcare can significantly influence both maternal and child well-being. The availability and quality of these services can either promote social inclusion or exacerbate existing vulnerabilities. This study highlights that, despite certain challenges, the Norwegian maternal healthcare system plays an essential role in supporting refugee women, regardless of their cultural, linguistic, or social backgrounds. Furthermore, CBOs have demonstrated their value in enhancing the social capital of these women, empowering them to better navigate the healthcare system and build social connections that complement the formal care they receive in hospitals.

The findings lead me to two key conclusions. First, the perception of maternal healthcare among refugee women is shaped by a complex interplay of factors. These include personal experiences and beliefs rooted in their countries of origin, the influence of community networks, and their direct interactions with the Norwegian healthcare system. These factors collectively create a multifaceted view of maternal care, which can influence how refugee women navigate the healthcare system in Norway and the quality of care they receive. Second, CBOs play a critical role in enhancing their social capital by providing culturally tailored support that complements formal healthcare services. By providing resources, such as language assistance, cultural orientation, and emotional support, CBOs complement and strengthen healthcare services, helping to address the specific needs of refugee women. Therefore, I argue that the success of the experiences of refugee women within the Norwegian maternal healthcare system depends on institutional collaboration that integrates policy, healthcare services, and the supportive role of CBOs. This collaboration not only improves their maternal health outcomes but also aids their social integration into the Norwegian society.

6.2 Limitations of the Study

Due to the challenges inherent in data collection, the pool of informants was limited. First, logistical constraints led to the exclusion of healthcare professionals, such as doctors and nurses, as informants. However, including these professionals could provide crucial insight as they interact closely with patients and have valuable frontline perspectives on care delivery, patient needs, and systemic challenges. Incorporating their viewpoints could enrich the study's findings, offering a more comprehensive understanding of the healthcare experience of refugee women. Additionally, this study is limited by the number of refugee informants and CBO providers. This restriction not only narrows the range of perspectives represented but may also overlook critical aspects of the refugee experience, such as cultural differences in healthcare access and utilization. Future research should strive to include a broader and more diverse array of informants, particularly those who work directly with refugee populations. By expanding the informant pool, future studies could better capture the complexities of healthcare interactions and the multifaceted challenges faced by refugee women in accessing care.

The interviews were conducted in either English or Norwegian, neither of which were the informants' native languages. This language barrier may have impacted their comfort level and fluency, potentially influencing their ability to fully convey experiences, emotions, and personal insights. The choice of language might also have affected the depth and detail of the

information shared, as informants may have struggled to find precise words to express complex thoughts and cultural nuances.

6.3 Recommendations

This section outlines strategies to improve the effectiveness and inclusivity of maternal healthcare for refugee women. The focus is on addressing current challenges and building on successful practices within the Norwegian maternal healthcare system and the support for CBOs.

6.3.1 Sustainability of CBO programs

To secure the longevity and potential expansion of the multicultural doula program across Norway, it is essential to address its financial uncertainties. Currently, funding for the program lacks stability, putting its future in jeopardy and limits its ability to expand. Given the program's demonstrated positive impact, supported by the feedback of the informants and studies, sustainable funding is a critical need. Stable financial support will not only allow the program to continue serving its existing communities but also enable its integration into mainstream maternal healthcare. This integration would create a more inclusive and supportive healthcare environment for all expecting mothers in Norway. Policymakers can help institutionalize culturally sensitive doula services within the healthcare system, ensuring that diverse maternal care needs are met nationwide.

6.3.2 Engaging the Local Community

The involvement of Norwegians in maternity-related programs has shown significant benefits, particularly in promoting integration and cultural exchange for refugee women. Despite these benefits, participation from the local Norwegian community remains limited. To enhance the impact and inclusivity of these programs, it is recommended that efforts be made to actively encourage greater involvement from the Norwegian community. This can be achieved through a combination of targeted outreach initiatives, strategic partnerships with local organizations, and incentives designed to attract Norwegian volunteers. Additionally, incorporating structured mentorship opportunities, where Norwegian participants serve as cultural and social guides, could significantly deepen the program's effectiveness. Such efforts would contribute to building a more inclusive society by bridging gaps between refugee and local populations.

6.3.3 Continued Cultural Sensitivity Training for Providers

To enhance culturally sensitive care, it is essential for healthcare providers, including midwives and doulas, to receive ongoing cultural competency training. While current practices reflect positive efforts, continuous professional development is necessary to address evolving cultural dynamics and improve provider-patient communication. This sustained focus on cultural competence will strengthen trust, reduce barriers, and better understand the diverse backgrounds of refugee women.

6.3.4 Formalizing Recognition for CBOs in Healthcare

To maximize the effectiveness of CBOs, it is crucial to grant them stronger formal recognition as key partners in maternal healthcare. This recognition should include strategic partnerships, dedicated funding, and opportunities for collaboration with official health services. By formally acknowledging CBOs' roles, we can enhance their capacity to provide culturally sensitive support, improve health literacy, and increase access to maternal care for refugee women. Concrete steps, such as defining their roles through policy measures, establishing formal agreements like Memoranda of Understanding (MOUs) with healthcare facilities, and securing consistent funding, are vital to this process. Additionally, public acknowledgment through campaigns and involvement in health forums will help elevate their contributions. Such actions would validate the essential work of CBOs and foster a more coordinated healthcare system that benefits both healthcare providers and refugee women alike.

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8. APPENDICES

8.1 Appendix 1: Informed Consent

Are you interested in taking part in the research project

"Experiences of Access to Maternal Health for Refugee Women in Kristiansand, Norway"?

Purpose of the project

I am Edlynne Angelica Martinez, a Master student of Global Development and Planning from the University of Agder. You are invited to participate in this Master thesis project where the main purpose is to examine the experiences on access to maternal healthcare for refugee women in Kristiansand, Norway. I specifically aim to examine the personal and systematic experiences of refugee women towards the Norwegian healthcare from pregnancy to childbirth. This study is specifically guided by the following research questions:

1. What are the interventions and services that respond to the maternal healthcare of the refugee women?
2. How do providers describe access to maternal healthcare for refugee women?
3. How do refugee women perceive their access to maternal healthcare?
4. How do local civic organizations respond to the maternal healthcare of refugee women?
5. How do their experiences impact their overall wellbeing and their process of integration in Kristiansand, Norway?

This Master thesis project is mainly for the completion of my degree. However, through what I can write, a localized framework can be developed to significantly contribute on drafting relevant policies, programs, implementation guidelines to improve interventions and maternal healthcare services provided for refugees and other migrant groups. The production of this thesis can be used for journal publication and conference presentation.

Which institution is responsible for the research project?

Universitetet i Agder, Fakultet for samfunnsvitenskap / Institutt for global utvikling og samfunnsplanlegging is the institution responsible for this Master thesis project.

I, Edlynne Angelica Martinez, am the researcher of this Master thesis project. I will be under the supervision of Associate Professor Hanne Haaland.

Why are you being asked to participate?

This study examines the access to maternal healthcare for refugee women in Kristiansand, Norway. Maternal healthcare covers the services given to women during the period of pregnancy, childbirth, and postpartum. You are invited to participate in this study as you are

either (1) a refugee woman who experienced/ received maternal healthcare, (2) or a provider who works closely with refugees or in the health sector.

What does participation involve for you?

- If you choose to take part in this project, you will be interviewed as a way of collecting data. The interview will take 30-45 minutes. The interview will be recorded using a portable voice recorder. If the answer is too personal or private, you may not answer the question.
- If you are a refugee, the interview will include questions about your background information (e.g., age, ethnicity, educational attainment, marital status, number of children, number of months/ years of residency in Norway) and your experience of access to maternal healthcare in Kristiansand, Norway.
- If you are a provider, the interview will include questions about your professional background (age, role as a provider, number of months/ years as a provider in Norway) and your perceived experience of access to maternal healthcare.
- I will observe events or gatherings of local organizations you may be participating with that relates to interventions on maternal healthcare. I will take notes during this process. You may decline if this process is uncomfortable for you.

Participation is voluntary

Your participation in this project is entirely voluntary. If you choose to participate, you can withdraw your consent at any time without giving a reason. All information about you will be made anonymous. There will be no negative consequences for you if you choose not to participate or later decide to withdraw. Your participation in this project will not affect your rights and affiliation to the health facility/ hospital or local civic organizations. 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 here in this consent. We will process your personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act).

- I, the researcher, Edlynne Angelica Martinez, and my supervisor, Professor Hanne Haaland, of the University of Agder are only those who will have access to your personal data.
- In any case that the informant cannot converse in English, a professional interpreter will be present during the interview to ensure accurate communication and understanding. The interpreter will also have access to your personal data.
- You will remain anonymous throughout the interview. Your name will be replaced. All outputs for this study will use your anonymized identity.

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

The planned end date of this project is on December 2024. All the interview recordings and personal data will be deleted at the end of this project. All information collected will be discarded after the thesis has been submitted.

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, The Data Protection Services of Sikt – Norwegian Agency for Shared Services in Education and Research has assessed that the processing of personal data in this project meets requirements in data protection legislation.

Where can I find out more?

If you have questions about the project, or want to exercise your rights, contact:

- Edlynne Angelica Martinez, project researcher and Master student of the University of Agder via eamartinez@uia.no or +47 920 347 93
- Associate Professor Hanne Haaland, project supervisor via hanne.haaland@uia.no or +47 381 423 62
- Our Data Protection Officer: Trond Hauso via trond.hauso@uia.no or +47 936 016 25 at the University of Agder

- If you have questions about how data protection has been assessed in this project by Sikt, contact: email via personverntjenester@sikt.no or by telephone: +47 739 840 40.

Yours sincerely,

Edlynne Angelica Martinez
Student/ Master Thesis Project Researcher

Associate Professor Hanne Haaland
Supervisor

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 that you have agreed to undertake this study.

I have received and understood information about the project *"Experiences of Access to Maternal Healthcare in Kristiansand, Norway"* and have been given the opportunity to ask questions. I give consent:

¨ to participate in *(an interview)*
¨ to participate in *(events or gatherings of local organizations that relate to interventions on*

maternal healthcare where the researcher will observe and take notes in the process)

I give consent for my personal data to be processed until the encd of the project, approx. December 2024.

(Signed by participant, date)

8.2 Appendix 2: Interview Guide for Refugee Women

Background Information

1. Age
2. Ethnicity
3. Educational Attainment
4. Marital Status
5. Number of Children
6. Number of Months/ Years of Residency in Norway

Experience of Access to Maternal Healthcare

1. What is your expectation of a quality maternal healthcare service? Have you achieved this on seeking access to maternal healthcare in Norway?

2. What interventions and services have you received in seeking access to maternal healthcare in Norway?

3. What sources of information do you draw from about the healthcare system and maternal healthcare in Norway? (Probes: fellow refugee/ immigrant, healthcare professional, organizations/ institutions, online sources, etc.)

4. What sources of information do you draw from on making decisions related to your pregnancy and maternal healthcare? (Probes: family member, fellow refugee/ immigrant, healthcare professional, organizations/ institutions, online sources, etc.)

5. How was your overall experience on seeking access to maternal healthcare in Norway? (Probes: first contact with the institution, antenatal check-ups, labor experience, postnatal period)

6. How would you describe the treatment you received from the providers? (i.e., midwife, nurses, doctor, and other related professional) Have you observed or experience any difference of treatment related to your ethnicity or residence status in Norway?

7. What challenges have you faced when accessing maternal healthcare as a refugee woman in Norway? (Probes: language barrier, cultural differences, healthcare costs, distance, prejudice/ community stigmatization, limited health information)

8. What direction do you want to see from the government, health providers, and the community to improve the maternal healthcare in Norway?

8.3 Appendix 3: Interview Guide for Providers

Background Information

a. Age
b. Profession/ Role as a Provider
c. Number of Months/ Years as a Provider in Norway

Perceived Experience of Access to Maternal Healthcare

a. How would you describe the maternal healthcare in Norway? What are the interventions and services available?

b. How would you describe the quality of maternal health interventions or services of this organization?

c. How would you describe the extent of maternal healthcare provided for migrant groups? Are there instances as to which they are treated differently or have received different quality of care?

d. Have you received trainings or supervision in relation to engaging with patients of different background? (Probes: cultural sensitivity, patient management) If yes, how would you describe these? How did it help on your role as a provider?

e. How was your overall experience on providing maternal healthcare for migrant groups? (Probes: first contact with the institution, antenatal check-ups, labor experience, postnatal period)

f. What challenges have you faced in dealing with migrant groups as they seek access to maternal healthcare? (Probes: language barrier, cultural differences, health illiteracy)

g. What recommendations can you give to improve the maternal healthcare in Norway, specifically for migrant women?