Crossroads at the Cradle

Negotiating Postpartum Care, Social Support, and Well-Being among Second-Generation Immigrant Women in Norway

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Abstract

"Crossroads at the Cradle" explores how new mothers with immigrant parents in Norway (often referred to as "second-generation immigrants") navigate postpartum recovery, support, and care through six semi-structured interviews with women in Norway with parents from Africa, Asia, and the Middle East.

The postpartum period is a critical and vulnerable time for new mothers, whose physical and psychosocial health and well-being depend on managing the various resources necessary to meet their baby's needs in addition to their own as they recover from childbirth and transition to motherhood. Yet postpartum care in Norway has been linked to lower satisfaction compared to maternity care overall, as health management policy has driven down length of stay in hospital after delivery, shifting the burdens of postnatal care increasingly onto municipal healthcare providers and the private sphere. Evidence shows that migrant women in Norway experience significant maternal health disparities, but public health- and social science research on second-generation immigrant women, now increasingly entering their family-forming years, remains very limited. The increased scrutiny of Norway's system of care for postpartum mothers, as second-generation immigrant women are increasingly joining their ranks, makes the aims of this study, which offers an essential cross-cultural perspective on postpartum support and care configurations, gaps, and mobilization strategies in an increasingly multicultural Norway, both timely and compelling.

The qualitative data from this study shows that securing the social support necessary for recovery and transition to motherhood can be a complex and at times contentious process for women with immigrant parents. The participants drew upon support from different members of their social network for instrumental, informational, emotional, and appraisal support. The mothers experienced that traditional postpartum care practices carried out by their families and kinship networks, which often center on maternal recovery and health promotion, provided significant instrumental support, but reported being poorly prepared for the difficulties of the postpartum period, such as pain symptoms, breastfeeding, and challenges to their emotional well-being.

Mothers in the study described high motivation and internalized pressure to breastfeed, but experienced lack of guidance from health personnel and advice from family members that did not support or affirm their breastfeeding. Individualized guidance from health personnel was desired as a valuable source of both informational and appraisal support, but insufficient health personnel capacity and competency often made this support inaccessible, putting a greater onus on new mothers to appraise and negotiate guidance from online resources and their families. Guarding their parental authority was a key motivation in mothers' negotiation of support from family and kin. Mothers looked to partners for emotional support, and peers for appraisal support. The women's experience demonstrate that belonging is an important condition for deriving appraisal support, and lack of belonging may impede the supportive value of mother's groups to women with multicultural backgrounds. The findings in this study suggest a need for service provision that better prepares expectant mothers for the challenges of the postpartum period, provides individualized care, support, and guidance during the postpartum period that promotes their ability to mobilize and negotiate support from their social networks and meets their instrumental, informational, emotional, and appraisal support needs.

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Table of Contents

Introduction

The summer I left New York for Oslo, a lot of women in my life were having babies. Two days before my nephew was born, my parents briefly stopped by the apartment I was packing up so my stepmother could say goodbye to me before they continued on their nine-hour drive to Ontario, Canada, their car filled with all the supplies she needed to tend to her daughter for the month to come, in accordance with the Chinese traditions of postpartum confinement. Several of my possessions found a new home in the nursery of a close friend who came home from the hospital with her newborn shortly before I boarded the nearly empty, late pandemic-era flight to Gardermoen; her postpartum support team included a doula, and her sister, whom she enlisted to stay with her for the first two weeks.

I arrived in Norway on the tails of intensifying national discourse and increasing activist mobilization around the quality of maternity and postpartum care, fueled in part by pandemic-era policies that blocked partners from labor and maternity wards, but also by longer-term challenges in the health system: shortages of midwives, closures and cuts to maternity wards and midwife-led units around the country, and an ever-decreasing postpartum length of stay. Many of the critical voices in these debates denounced a societal disregard for the needs of new mothers and mourned the disappearance of Norwegian postpartum folk customs and wisdom (Mortensen, 2022; Tronsen, 2022). Historical texts state that in Nordic agrarian societies up until the earlier half of the 20th century, new mothers were commonly brought *barselgrøt,* a rich, restorative porridge, rested in bed or at home for 40 days, and attended by relatives and other women in the community, according to postnatal customs passed down from the Middle Ages (Eberhard-Gran et al., 2003; Mortensen, 2022). As childbirth was gradually institutionalized between the early to mid-1900's, the lying-in period at the maternity ward lasted eight to 14 days, and many households received subsidized household assistance from a *husmorvikar*, a substitute housewife (Eberhard-Gran et al., 2003; Mortensen, 2022; Tronsen, 2022). Today, the average postpartum length of stay has dropped to two and a half days, while the average age and percentage of new mothers with high-risk factors such as high blood pressure, pre-eclampsia, and gestational diabetes have risen (Folkehelseinstituttet, 2023a).

While *barselgrøt* and the other postpartum folk traditions may have faded into folklore for most Norwegians, similar customs live on in many other parts of the world, especially Asia, the Middle East, Africa, and Latin America – as well as their diaspora communities in the West – where confinement, restorative diets, and community-facilitated respite often remain in practice alongside biomedical maternity care (Kaluza, 2018). The experiences of women who have migrated to and given birth in Western countries have received some attention in existing maternal health research, including in Norway, in which increased risk of adverse maternal outcomes and challenges navigating the health system have been the chief focus. Considerably less is known about the experiences of mothers who have grown up in Norway with immigrant parents, whose unique position between spheres of cultural influence offers an essential cross-cultural perspective on postpartum support and care configurations, gaps, and mobilization strategies in an increasingly multicultural Norway.

> *"It was right, like, the perfect amount we needed. Mom would come, drop food, she would do some cleaning and then she would just leave! She wouldn't even sit, she'd obviously hold the baby for like five minutes, but she wouldn't just like be here for hours or bother us or anything like that. My mom is very like, aware in that sense, that you need to leave people be. So yeah, it was like exactly the right amount that we needed." [Tania]*

> *"It's very tough. Very tough to be so tired after the birth and (…) it always hurts, and then you kind of have to 'put on a brave face' and smile through the company. It's very exhausting. I wish that they could understand that you can't visit someone so soon after they have come home from the hospital. But I absolutely felt that I couldn't say no. It was not possible for me to set boundaries that are, in a way, so against my culture."[1] [Edna]*

This master's thesis explores the postpartum experiences of six mothers who were born in or immigrated to Norway as children, with immigrant parents from Africa, Asia, and the Middle East. As illustrated by the quotes from Tania and Edna, above, these experiences were wide-ranging and complex, encompassed both positive and negative encounters with the formal health system and with their informal support networks, and highlighted moments of warmth and nurturance as well as of grief, alienation, and distress.

Chapter One provides an overview of how Norway's public health system structures and delivers postpartum care, explores the features and cultural configurations of postnatal care and support practices found in many non-Western societies, and identifies some of the underlying tensions

and conflicts within both. It also introduces the study population, children of immigrants in Norway, their increasing demographic relevance, conceptualization as a category, and some of the observed socio-cultural patterns and characteristics that are distinct in this group as they enter adulthood, form families, and embrace parenthood.

In Chapter Two I describe the study's objectives and design, and the qualitative methodology used to collect and analyze the empirical data, which was generated through seven semi-structured interviews. I also reflect upon the challenges, limitations, and strengths of the study in this chapter, provide a description of the key demographic characteristics of the sample, and explain the ethical considerations that went into the project's design, recruitment, data collection, and analytical stages.

Chapter Three introduces relevant theoretical and conceptual frameworks. Social support theory provides the key conceptual framework for this study, and this chapter provides a general overview of how social support is theorized as an important health promotion factor, and of its relevance for promoting health and well-being in the postpartum period. Acculturation theory, specifically the concepts of dissonant and segmented acculturation, was identified as another theoretical lens through which to analyze the experiences of well-being, belonging, access to social support, and transition to motherhood distinctive for the selected study population, children of immigrants.

Chapters Four and Five introduce the empirical data and provide a foundational overview of the participants' experiences of postpartum recovery, describe the care and support they received from both health personnel and their families, focusing primarily on the physical well-being aspects of postpartum, and begin to explore the ambivalence and complexity of participants' appraisal of the methods and effectiveness of both configurations of care. The key themes examined in these chapters illuminate participants' pain and exhaustion, difficulties with establishing breastfeeding, feelings of being inadequately prepared for the realities and difficulties of postpartum and new motherhood and left on their own at the hospital due to insufficient capacity or competency. Chapter Five explores some of the health-promoting postpartum care practices employed by participants' families, and the medical beliefs they are

grounded in, and demonstrates how the new mothers regarded these practices with both deep appreciation and skepticism.

Chapter 6 applies the social support framework to the participants' postpartum experiences by mapping their interactions with the different care providers and members of their social support network according to the four categories of social support: instrumental, informational, emotional, and appraisal support to highlight areas of unmet need or conflict. This analysis draws upon a key conceptualization of the social support mechanism, particularly the assertion that negative experiences with social support, in which support desired does not align with support received, either in terms of support type or source, can present a stressor for new mothers.

Chapter 7 examines three areas of how the participants managed social support in ways that embody key renegotiations of roles and relationships that are particularly meaningful and distinctive to second-generation parents. Finally, Chapter 8 focuses on postpartum emotional well-being and highlights experiences that participants identify as acutely distressing: struggling to rise to Norway's high expectations of breastfeeding, and processing and reconciling negative birth experiences. This chapter also address new mothers' perspectives on perinatal mental health experiences and treatment, the importance of being "seen and heard", and examines encounters in which their needs and concerns are undermined by discourses of gratitude within both the health system and their family networks.

Chapter 1: Background and literature review:

1.1 Contemporary maternity care in Norway

All pregnant women in Norway are entitled to free maternal health care. In general, public healthcare for Norwegian residents is covered by the National Insurance Scheme, financed through general taxation, employer and employee payroll contributions, and user co-payments. Health service delivery is decentralized, with primary health care services financed and administered at the municipal level, and specialist and hospital services financed and administered at the regional level. Maternal health services are therefore distributed across both systems: antenatal care is delivered by midwives at municipal child and maternal health centers (*helsestasjoner*) or by primary care physicians (*fastleger)*, while care during the intrapartum and early inpatient postnatal care is delivered by hospital maternity wards or midwife-led birthing centers. After hospital discharge, responsibility reverts to the primary health service, which provides a home visit by a midwife and a public health nurse, and subsequent infant check-ups at the health center. The municipal health center also typically invites pregnant women to take part in parenting and infant care classes, and to join a support group with other expecting mothers, often referred to as a *barselgruppe* ("postnatal group") or *termingruppe* ("due date group").

This structure has resulted in what is often described as a fragmented system of maternity care in Norway, which persists in contravention of research linking continuity of care with better patient satisfaction and outcomes, and has increasingly drawn criticism from patients, advocates and health personnel (Aune et al., 2021; Barimani & Vikström, 2015; D'haenens et al., 2020; Kemp et al., 2013; Lyberg et al., 2012). In Norway, as in many other high-income countries, patients report higher dissatisfaction with postnatal care compared to other care components within the maternity care continuum (Aune et al., 2021; Barimani & Vikström, 2015; McLachlan et al., 2008). Responsibility for postnatal care has increasingly been shifted away from hospital maternity care wards and toward the midwives and public health nurses in municipal community health centers as a consequence of efforts to cut costs by reducing hospital length-of-stay following childbirth. The effectiveness of this model is not only disputed, but also contingent on new mothers' ability to navigate the transition to community-based services and to access and mobilize personal support resources, i.e., help and support from partners and family (Aune et al.,

2021). Evaluation research on families' satisfaction with this model has found that parents' confidence and access to high quality midwife and nurse home visits, as well as their access to practical help and support from family, are key factors that positively enable early discharge (Aune et al., 2021). These findings indicate that the fragmentation of postnatal care places demands on the mother and her partner, obliging them to draw upon their ability to maneuver available services and deploy personal support resources. This raises the question of to what degree these enabling resources are broadly accessible or encompass adequate, quality support.

A key issue in the current state of Norwegian maternity care is what has in recent years been dubbed the "midwife crisis" (Evjen, 2021; Føleide, 2023). Increasing workloads, insufficient staffing, increased fragmentation, and increasing trends in the medicalization of maternity care and devaluation of the midwifery framework of care have contributed to increasingly untenable labor conditions for midwives, diminishing their capacity to deliver quality care, and leading to high rates of attrition (Kay, 2022; Thomassen, 2022). In Oslo, where this study was primarily conducted, ongoing restructuring of the hospital system (Oslo University Hospital - OUS) has been a source of criticism, controversy, and conflict between national and local leadership, with healthcare workers and advocacy groups arguing that hospital financing policies and cost-saving measures negatively impact the quality of the already-overburdened maternity care infrastructure at both the specialist and primary care levels. (Eian, 2023; Evjen, 2021; Ingulstad & Thomassen, 2023)

1.2 Traditional postnatal care practices

Beliefs and care rituals around the postpartum period in many non-Western countries in Asia, the Middle East, and Latin America are often rooted in humoral medicine traditions that conceptualize health through a framework of the four fundamental elements (earth, fire, water, and air), in which good health is maintained through bodily equilibrium between hot and cold, while illness or disease is attributed to imbalance between hot and cold. Although some elements of humoral medical theory can be found in European folk traditions, its influence persists to a greater degree among African, Asian, and South American societies, frequently in coexistence with biomedical models (Dennis et al., 2007; Eberhard-Gran et al., 2003; Manderson, 2003; Selin & Stone, 2009).

Despite considerable variations in birthing practice across cultures, "near universally in cultures with a humoral medical tradition, parturition is believed to deplete the woman of heat and place her in a state of especial vulnerability to cold" (Manderson, 2003, pp. 138-141). Traditional postpartum care practices consist therefore of interventions to remedy this imbalance and excessive "coldness" by replenishing and maintaining the woman's heat, through a prescribed period (between 20-40 days) of rest and confinement during which "hot" foods are consumed and "cold" foods are to be avoided (both temperature-wise as well as according to classifications from the humoral tradition), bathing and exposure to cold air are avoided, and general exposure or proximity to warmth is encouraged. Neglecting these interventions is believed to cause poor health for the mother, both short- and long-term. (Manderson, 2003; Winson, 2009)

Since rest and confinement are an essential component of traditional postpartum recovery regimes, the new mother is usually cared for during this time by her family or community. Traditionally it is the mother's mother or mother-in-law, or other female kin, who fulfills this role, and it may even be normative for an expectant woman to move back to the home of her parents when she approaches full term in order to facilitate access to her mother's care postpartum (Harvey & Buckley, 2009; Nguyen et al., 2022; Yanigasawa, 2009). In some contemporary contexts, such as in South Korea, the caretaker role is outsourced to institutions (hospitals or care centers) and/or paid workers (postpartum nannies or nurses) (Song et al., 2020). These regimes demonstrate reverence towards and social recognition of the postpartum period as a time of rest, recovery and transition, firmly establishing the role of new mother as a care recipient and mobilizing resources within her network or the greater society to provide that care.

Nevertheless, research reveals that the family-centered nature of traditional postpartum recovery regimes can also be experienced by new mothers as repressive and a form of social control:

> "The custom of *zuoyuezi* ['sitting the month'] is so persistent that even Chinese women who emigrate out of the country and resist the practice can still find themselves pressured by relatives into complying. …[a Chinese immigrant to Canada] described the custom as one full of suffering and "bitterness" and discarded it as "traditional Chinese culture". Despite this resentment…the social pressures from her kin left her no choice but to follow

> it – even from the other side of the world. …*Zuoyuezi* persists (…) largely because of its interconnectedness with the role of elderly mothers who, because of their age, have the authority to override the salient modernistic discourse and instead impose traditional customs to control the younger woman's actions during this month" (Harvey & Buckley, 2009, p. 65)

The potential for great contrast in perception of traditional postpartum care is illustrated by a survey conducted in an American health center serving Asian immigrant populations, which found that while the majority of respondents described the traditional postpartum care regime as enjoyable and helpful, respondents who were born in the U.S., spoke English at home, or had immigrated over 20 years ago, were more likely to describe postpartum care regimes as stressful, described being pressured by older generations to participate, and were less likely to have sufficient family and childcare support compared to recent immigrants from China and Vietnam. (Nguyen et al., 2022)

The survey also noted how conflicts between traditional postpartum care and American economic and healthcare structures sometimes arise. 18.5% of respondents also described not being able to fully participate in the postpartum care regime because they had to return to work, and 23% said traditional postpartum care practices prevented them from seeing their doctor in the month after childbirth, as is standard in the U.S. and most Western countries (Nguyen et al., 2022: p.1253). A number of common traditional postpartum care practices (bedrest, remaining indoors, refraining from showering, and drinking rice wine) may come into direct conflict with many postpartum recommendations promoted in the Western biomedical establishment, which for example, encourages physical activity to prevent blood clots and constipation, going outdoors to prevent depression, and showering to prevent infection and soothe breast pain, while discouraging alcohol consumption when breastfeeding. A systematic review also identified the influence of traditional postpartum care practices as a factor that influences uptake of formal postpartum services in low- and middle-income countries (Sacks et al., 2022).

These examples illustrate how traditional postpartum care practices can simultaneously provide new mothers with valuable care and social support but also bring forth tensions due to migration processes, intergenerational differences, social hierarchies, family conflict, economic demands, and the structures within biomedical systems of care.

1.3 "The second generation"

Children of immigrants are a growing share of the population in Norway. In 2023 Statistics Norway measured the number of Norwegian-born children of immigrants at over 200,000, or four percent of the total population, projected to grow to over 500,000 by 2060 (Statistics Norway, 2023). Between 2008 and 2019 the percentage of babies born to two immigrant parents doubled from 11 to 22 percent, and in 2022, one in four babies in Norway was born to an immigrant mother. (Kirkeberg et al., 2019; Statistics Norway, 2023).

This population of children of immigrants is not only growing fast, but growing up, now reaching adulthood, and entering the childbearing, family-forming stages of their lives in greater numbers; one in four of Norwegian-born children to immigrant parents is now over age 20 (Steinkellner et al., 2023). Though often scrutinized in social science and political discourse as an indicator of the "successful" integration of immigrant groups, it is only in very recent years that this population has aged into adulthood in substantial numbers and thus begun to draw the attention of social science, and to a lesser degree, public health researchers. Although there is broad consensus that the children of immigrants in Norway, both those born in their country of residence and those who immigrated in their childhood or teenage years, trend closer to their majority-population peers in socioeconomic outcomes, attitudes, and family-forming behaviors, there is also compelling evidence of their exposure to persistent disparities and discrimination across social, educational, economic, and health domains (Aarset et al., 2021; Dinesen & Hooghe, 2010; Handulle & Vassenden, 2021; Kirkeberg et al., 2019; Kitterød & Nadim, 2020; Nadim, 2014; Wiik, 2022). This indicates a need to examine this category with greater consideration of the ways in which they differ from and position themselves in relation to both first-generation immigrants as well as the Norwegian majority, and the unique challenges that may arise from this positioning and belonging during the medically and psychosocially vulnerable postpartum period.

For this study I choose to use both the term "children of immigrants" and "second-generation immigrants" as proxies for both the category officially defined by Statistics Norway as "Norwegian-born with immigrant parents" ("*Norskfødte med innvandrerforeldre"*), and for

individuals who migrated to Norway as children, together with their parents (sometimes referred to as the 1.5 generation). I recognize that the term "second-generation immigrant" is imperfect, contested, and criticized as exclusionary, and is in some contexts gradually being replaced by the arguably more accurate and inclusive term "children of immigrants". I utilize both terms interchangeably to situate my research in both the existing, transnational literature base and in public discourse, where they are widely used both colloquially and academically, both in English and in Norwegian, as well as to distinguish my primary research subjects clearly and consistently from their own children and their "first-generation" parents. In doing so I also follow the lead of other researchers whose work centers children of immigrants specifically within the context of their roles and identities as parents, and who defend its usefulness "when referring to a specific generational position between the immigrant grandparent generation and a new generation of children, a position characterized by the duality of being both minority and citizen" (Smette & Aarset, 2023, p. 2).

Norway has been characterized as a "young" migration destination, and adult children of immigrants in Norway are mainly linked to two migration waves: labor migrants from Pakistan, India, Morocco, and Turkey in the late 1960s and early 1970s; and refugees and asylum-seekers from Vietnam, Sri Lanka, Somalia, Iran, Syria, and the Baltic countries from the late 1970s onwards (Aarset et al., 2021; Friberg, 2019). Many of these countries are associated with more traditional norms around family formation, such as universal and early marriage, high fertility, and patriarchal family patterns, which may be transmitted to and maintained among children of immigrants by their families concurrently with socialization via majority institutional and cultural contexts of their country of residence (Wiik, 2022; Wiik et al., 2021). The characteristics of what is sometimes termed the "socio-cultural middle ground" (Foner 1997 in Wiik 2021) can be seen in Norwegian demographic statistics indicating a mixed adoption of "traditional" marriage and family-formation behavior among children of immigrants, as well as a great deal of variation between country-of-origin groups. For example, the vast majority (80 percent) of children of immigrants choose spouses with immigrant background, in other words either fellow children of immigrants, or immigrants themselves, suggesting a preference for endogamous marriage (Amundsen, 2019). However, Norwegian-born women with immigrant parents tend to give birth later than Norwegian women without immigrant background (Ibid). Rates of dual

workforce participation and attitudes towards gender equality in work-family life also vary by family country of origin (Amundsen, 2019; Kirkeberg et al., 2019; Nadim, 2014). These variations underscore the heterogeneity and multi-faceted and multi-directional nature of the acculturation process (Wandel et al., 2016) among children of immigrants. As noted by Wiik (2022, p. 3):

> "…family adaptation across migrant generations and duration of residence varies with sociocultural distance between countries of origin and residence…Whereas some migrant-background individuals are socialized into mainstream culture and otherwise are socially and economically integrated, others may be more marginalized and influenced by a minority subculture, preserving the values, norms, and behaviors of their countries of origin."

Although heterogenous, it is this shared experience of navigating the "socio-cultural middle ground" and "negotiating a sense of belonging in political landscapes where they tend to be considered foreigners" (Aarset et al., 2021, p. 83), often with the "double-consciousness" entailed in occupying a "double position as minority and citizen" (Ibid), that makes "the children of immigrants" meaningful as a category.

Aarset et al. (2021, p. 81) conceptualize parenthood as a "vital conjecture" which "brings together past, present, and future horizons" which, for children of immigrants, demands a "renegotiation of belonging" between "different and often conflicting understandings and practices in the intersections between the parental generation, Norwegian society, and transnational social fields" (Ibid, p. 88). The demands of managing discordance between contemporary Western and traditional non-Western attitudes toward postnatal care and these generational shifts in parenting and gender role norms (Kitterød & Nadim, 2020; Smette & Rosten, 2019) can add an additional layer of distress for new mothers during the postpartum period. Mamisachvili et al.'s (2013) research from Canada finds that both first- and second-generation women reported conflicts and stress due to discordance between their parents' recommended practices and their own, and asserts that new mothers are vulnerable to developing postpartum mood problems when they do not meet the "expectations of maternal role fulfillment…mediated by ideals of motherhood and gender roles held by cultural contexts" (Mamisachvili et al., 2013, p. 168). These findings suggest that for second-generation immigrant mothers in Norway, the "renegotiation of belonging" may compromise the protective potential of support received from both formal and informal sources, and points to a critical need for insight

into how they navigate their affinity to the expectations of two normative frameworks for postpartum care, while drawing upon the conditional support offered by both.

Chapter 2: Methodology

2.1 Study Objectives and Design

There were two primary aims for this study. The first was to gain insight into the postnatal recovery, support, and care experiences and needs of second-generation immigrant mothers in Norway, and how they negotiated both formal and informal social support. The second aim was to produce cross-cultural knowledge of effective postnatal social support to inform efforts to promote better psychosocial well-being for all mothers in the postpartum period. Poor satisfaction with postnatal care has been a pressing public health issue in Norway, and the health system has been the subject to criticism and accusations of neglecting its responsibility for women's health and well-being after birth. At the same time, migration has transformed the makeup of Norway's birthing population, and women with migration background are beginning to encompass a larger share of new mothers. Women who are born or raised in Norway with immigrant parents have a unique perspective on postpartum care, having been socialized and shaped by the country's dominant institutions, systems, and cultural norms while often also retaining access to values and traditions transmitted from their parents' countries and cultural contexts of origin, many of which have retained traditional knowledge, practices, and community-based frameworks of care for postpartum women.

Based upon these two aims, the study had several objectives. The first was to explore the participants' experiences with postnatal recovery and care within both the Norwegian healthcare system, and the traditional postpartum care frameworks facilitated by their families and ethnic communities. The second objective was to understand the participants' social support experiences, desires, interactions, and networks against the four domains of social support proposed by the social support conceptual framework. The third objective was to explore how the participants navigated and negotiated social support and the norms and expectations of new motherhood from both their families, and the majority Norwegian society. The fourth objective was to identify areas of tension, unmet need, and protective influence created by participants' experiences with both care structures and highlight their impact on the participants' postpartum well-being and adjustment to motherhood.

Qualitative methods were identified as the clear choice for fulfilling the objectives of this study. Recent years have seen growing recognition in the field of global maternal health that a historical emphasis on quantifiable health measures, such as maternal mortality, has limited more holistic conceptualizations of maternal well-being, accompanied by calls for more research centered on women's experiences (Miltenburg et al., 2023; Say & Chou, 2018). Qualitative methods are best suited for producing knowledge on lived experiences and social processes, the social and cultural dimensions of health and health care, and the "why and how" of health behaviors, all of which are central to the objectives of this study (Green & Thorogood, 2018; Lambert & McKevitt, 2002). Green & Thorogood (2018) also note that qualitative methods facilitate a more explorative approach that highlights and gives voice to overlooked groups; research on Norway's second-generation immigrant population is still highly limited, and within a postnatal care context more limited still. The focus on context specificity and "empirical particularity" that is key to anthropological methods also offer insurance against inappropriate generalizations (Lambert & McKevitt, 2002), a consideration that is especially vital to this study given the heterogeneity of its study population, and the propensity for misapplied findings on migrant populations to contribute to stereotyping.

Semi-structured interviews were selected to establish some main parameters for the conversation while still allowing participants to direct the flow of the discussion and shape the data produced (Bernard, 2011). To enhance the richness and validity of the data generated, the individual interviews were preceded by two informal pilot interviews to test and refine the interview guide, and supplemented with a mother-daughter dyad interview to provide triangulation. This enhances the validity of the project's findings when combined with reflexivity, or the critical reflection on and recognition of the influence of the researcher's positionality on data generation, interpretation, and analysis. The dyad interview also provided an additional perspective on how postnatal and infant care attitudes and practices can be transmitted across generations, how and which points of tension surface and are negotiated, and how immigrant women's experiences navigating maternity care and motherhood in Norway influence their daughters' perceptions and expectations. The original study design intended to provide greater triangulation with additional mother-daughter dyad interviews and a follow-up focus group interview with the individual participants. However, these components were ultimately omitted based on consideration of the

practical challenges this would have presented to the participants in the form of geographical distance and need for childcare, the likelihood of successful re-engagement after a prolonged and challenging recruitment and main data collection phase, and the richness of the data produced in the individual interviews.

Thematic analysis was selected as the primary method used to code and analyze the interview data as its flexibility enables a "contextualist method…which acknowledges the ways in which individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'" (Braun & Clarke, 2006, p. 9). Analysis was abductive; some codes were generated by the data itself, while others identified from analysis of discursive materials on the postnatal care experiences of the Norwegian majority. Provisional coding was used to inform additional data collection (particularly the mother-daughter dyad interview). Mapping, a feature more typically associated with situational analysis, was also used for portion of data analysis corresponding with the social support framework to analyze the actors in each woman's network of support, examine interconnections between each of the nodes of the network, and ground the interview data in social support theory and acculturation theory (Clarke et al., 2015; Green & Thorogood, 2018). The incorporation of this method was useful as situational analysis lends itself well to policy research and critical feminist and anti-racist research by enabling knowledge to be captured from the "bottom-up" and "from the outside in", giving voice to lived experience, and delineating all stakeholders to highlight often-invisible actors (Clarke et al., 2015).

2.2 Participant Selection and Sampling

Initial recruitment efforts were aimed at outreach to Oslo municipal maternal and child health clinics, focusing on boroughs with high densities of residents with migration backgrounds. The researcher visited 10 of these clinics to share information about the project with staff in-person, and where permitted, to post information on notice boards. Additionally, outreach was made via email or in-person visit to low-threshold city programs targeted at families with babies: drop-in kindergartens (*åpne barnehager*), music classes at the Norwegian parishes (*babysang*) and events at the public library branches (*baby på bib*) and programs run by the Norwegian Women's Health Association. Program leaders identified and put me in contact with four potential

participants, all but one of whom unfortunately either declined to participate or were later unresponsive to follow-up contact.

Due to the poor response from these sources, recruitment pivoted to social media platforms and the recruitment criteria was loosened. Initial recruitment criteria were limited to Norwegian-born mothers with immigrant parents from non-western countries who had given birth to their first child within the previous year. The focus on non-western immigrant descent was established, and retained, due to the study's objective of gaining insight on the transmission of traditional postnatal care practices more commonly retained in those cultural contexts, and because the group makes up the largest share of both first- and second-generation immigrants (Statistics Norway, 2023). The other criteria were determined to be too restrictive given the relative size of the target population. Based on reflection on the goals of the project and review of broader conceptualizations of the "second-generation generation" used by similar studies, the recruitment criteria were then revised to include all children of immigrants from non-western countries, i.e., to include mothers who had immigrated as children with their parents. Participation was also opened up to anyone who met those criteria regardless of parity and how long ago they had given birth.

Posts were made on the social media platforms of *Ammehjelpen*, *Barseloppрøret*, and *Landsforeningen 1001 dager*, national organizations that provide advocacy and guidance around breastfeeding, maternity care, and perinatal mental health (see Appendix E). Three participants were recruited via these social media posts, and two additional participants were recruited via the researcher's own contacts. Further, unfruitful social media outreach was done via other Facebook groups for parents. In total, six participants agreed to be interviewed and five prospective participants withdrew or declined to participate.

Despite the small sample size and challenges with recruitment, the final sample was highly heterogeneous and fulfilled many of the sampling goals that I had originally hoped to achieve via purposive or loose quota sampling, an approach that is appropriate for studying cultural domains and hard-to-find populations (Bernard, 2011). Because the focus of this study was not on the cultural practices of any specific group, but the experiences of second-generation immigrant mothers as a diverse group, I aimed to include a mix of countries of origin with the largest adult

populations of Norwegian-born children to immigrant parents: Pakistan, Vietnam, Somalia, Sri Lanka, and Turkey (Kirkeberg et al., 2019) and a mix of migration backgrounds among their partners.

Characteristics of sample		N			N			N
Parity			Family background			Partner's background		
	1	4		Pakistan	1		Ethnic Norwegian	1
	2	2		Somalia	1		Immigrant (EU)	1
Age at birth of first child				South Korea	1		Immigrant (non-EU)	1
	18-21	1		Syria	1		Child of immigrants	3
	21-26	2		Turkey	1			
	27-34	1		Vietnam	1			
	35-39	2						

2.3 Ethical Clearance and Consent

The study proposal was submitted for pre-assessment to the regional committee for medical and health research ethics (REK). This pre-assessment from REK determined that the study fell outside of the committee's mandate and therefore did not require REK approval (Appendix H) Notification form outlining project objectives, study population, and personal data to be collected was submitted to the Norwegian Centre for Research Data (NSD, now Sikt), alongside the participant consent form, and received clearance for data collection (Appendix G).

Sensitivity to the risks to participants' privacy, autonomy, and emotional well-being were carefully considered at every stage of the study, given the sensitivity of the data generated by these interviews, in which participants were prompted to reflect on their physical and psychosocial well-being and disclose potentially contentious interactions with providers, family members, and other individuals and institutions in a position of power. The recruitment process was designed to maximize participants' autonomy and minimize coercive influence by encouraging prospective participants to contact the researcher rather than vice versa. Participants were advised of their rights (including the right to withdraw from the project at any time) and the risks of participation at multiple junctures and given ample time to review the project's information sheet and consent form (Appendix B and D) before giving informed consent.

All personal data and recordings were stored securely in TSD and pseudonymized to maintain anonymity. Participants' names and contact information were stored separately from the

interview data. Inclusion of any relevant demographic information about the participants was scrutinized and generalized to ensure their anonymity when transcribing the interviews. Interview recordings will be destroyed once the project has been completed. Given the scope of the research question, the collection and protection of third-party personal data was determined to be relevant and has been carefully considered. Participants were asked to refrain from referring to any individuals by name during their interviews. To ensure anonymity, any names mentioned in the interview were omitted from transcription. The dyad interview was conducted in a way such that contents of the individual interview were not revealed.

The interviews took place in participants' homes and at libraries, which offered varying degrees of privacy. Participants were encouraged to choose the location and language (English or Norwegian) of the interview with consideration for their privacy, convenience, comfort, and physical and emotional safety, and were informed in advance that I didn't speak fluent Norwegian. Two interviews were conducted with complete privacy, two were conducted in semi-public spaces, two had partners intermittently present, and two had their (18 months or younger) children with them.

Another key ethical consideration in undertaking research on this population in Norway is the representation of immigrant and minority groups. As an individual with lived experience of both first- and second-generation migration, it was important to me that this research produces a nuanced and complex view of the participants and their families. Although participants' cultural backgrounds are relevant to their personal experiences and were considered to ensure a diverse and representative sample, care has been taken to place the findings in their appropriate structural and cultural context to avoid generalizing or stereotyping particular groups.

2.4 Data Collection and Analysis

The interviews were conducted between December 2022 and July 2023. Significant adjustments were made to refine the interview guide (Appendix A) during this process, as early interviews made it apparent that participants had a lot to say, and the nature of the subject matter, and the interrelatedness of the questions, made a detailed interview guide cumbersome to follow while remaining agile and responsive to the flow of discussion. The original interview guide was then distilled into a shorter list of key questions. The content flow varied significantly, and the length

ranged from 109 to 157 minutes. The interviews were projected to take between 1-2 hours, and these parameters was communicated with participants, and I expressed my desire to be respectful of their time but also that I would give them however much space they desired to speak on the topics covered.

The mother-daughter dyad interview took place after the first five individual interviews were conducted, and the content of this interview guide (Appendix B) was developed based on the "negative space" (what was left unsaid) detected in all the individual interviews, and not solely the individual interview with the daughter. Half of the participants enthusiastically chose to be interviewed in English and the other half were interviewed in Norwegian. The mother-daughter interview was conducted in Norwegian after the daughter's interview had been done in English. There were no obvious direct issues with language comprehension in either case, but I eventually noted concerns that the language factor diminished my agility somewhat in following-up and probing. This reflection made me prioritize noise isolation in subsequent Norwegian interviews and made me conscientious about ensuring that the experiences of the women who chose to be interviewed in Norwegian were equally well-represented in the analysis phase.

The interviews were all recorded via the University of Oslo's encrypted, direct-to-TSD "Dikafon" mobile application, and then stored in and transcribed word-for-word, including sounds and tones, using the F4 transcript application in TSD by the researcher. The Norwegian interviews were transcribed with the assistance of Whisper, an automatic speech to text transcription tool that is embedded in TSD and approved for use with sensitive data. This choice was made in consultation with the researcher's thesis supervisor to strengthen the accuracy of Norwegian transcriptions. Whisper produces an auto-generated plain-text file, which the researcher then manually reviewed and corrected. Whisper also has the capacity to translate Norwegian audio into English text, but I chose not to use this feature and the Norwegian interviews were analyzed in Norwegian to remain close to the source material. The excerpts translated from Norwegian transcripts were reviewed by the researcher's thesis supervisor for accuracy and are presented in the original Norwegian in the appendix.

The anonymized transcripts were then coded using thematic content analysis. The initial phase of this analysis was done via a close reading and re-reading of the transcripts to identify

commonalities and significant themes. I then used Nvivo to openly code sentences or paragraphs with text codes. Some of this coding was grounded in the study's conceptual underpinnings, such as such as types of social support ("informational support", "practical support") and support actors ("midwife", "partner", "Ammehjelpen"). Some codes were derived from text analysis of media discourse around postnatal care in Norway ("lack of capacity", "lack of competency"). Many codes were "in-vivo" or grounded in the data itself ("in a fog", "wanting privacy and space", "unsolicited help"). This approach mean that many sections were double- or even triple-coded. These codes were grouped and combined to form larger themes ("healthcare perceptions", "contrasts and conflicts"). The extracts were then reviewed in relation to their assigned theme and the data as a whole. In this stage I also used Nvivo's network matrix function, which identifies intersections between codes, in the "mapping" analysis of participants' postpartum support networks. These steps helped to refine the themes and their titles. The analysis continued into the write-up stage, where selection of excerpts sometimes crystallized the theme's key significance. For example, the initial code "setting boundaries" became the intermediate code "defending", which was then grouped with other codes such as "avoiding" under the theme of "negotiation strategies". After further review and analysis this evolved into its final theme "enforcing parental authority".

The themes were finally grouped into five main categories for writing-up, which culminated in the five findings and discussion chapters of this thesis. The themes discussed in Chapter 4 concern the participants' experiences with the healthcare system in the postnatal period, such as being unprepared for the physical challenges of postpartum, such as pain and breastfeeding, and positive and negative encounters with healthcare personnel. Chapter 5 explores participants' experiences, attitudes, and interpretations of both the ethos and specific care practices of traditional postpartum care regimes promoted by their families and especially their mothers, containing themes such as "food as medicine" , "vulnerability", and "reconsideration". Chapter 6 dissects the "mapping" analysis findings and applies the social support conceptual framework to participants' supportive and non-supportive postpartum encounters to identify who is providing what type of support, and where support is lacking or unwanted. Chapter 7 examines the strategies and emotional labor involved in participants' attempts to shape the kinds of support they do and do not want from family, and their partners. Finally, Chapter 8 reveals the

experiences and encounters highlighted as burdens to their postpartum mental health and emotional well-being.

2.5 Strengths, Limitations, and Reflections from the Field

As a qualitative study, the main limitation of this study is that its conclusions cannot be generalizable at a population level. Indeed, its conclusions should not even be generalized to its segment of the population, given the heterogeneity that exists within the categories of the "second-generation", or children of immigrants. The key strength of the study is in the power of the methods employed to generate rich data that center the voices of an often invisible-yet-visible population and its unique position in what is often a physically and emotionally challenging life stage. Throughout the research process I was repeatedly reminded of this group's invisibility, from the countless clarifications of my recruitment criteria, to the responses from coordinators of programming for women with "multicultural" backgrounds explaining that their service population was limited to first-generation migrant women, to even a couple of my participants themselves, who wondered aloud during their interviews about the meaningfulness of the project's focus on culture and their generation. In meeting the obligations of reflexivity in qualitative research I must admit that, as a "second-generation" woman from the U.S., these moments sometimes took a toll, sparking flickers of doubt about the meaningfulness of my identity as well as the value of my research.

My personal background can be regarded as both a strength and weakness to this study. Having moved to Norway less than a year before I embarked upon the first phase of this research certainly impeded my ability to navigate certain social networks, imposed limits on the communication and mutual understanding with my participants, and forced me to repeatedly deconstruct, examine, or re-learn the health system, migration history, and tenor of discourse on race, identity, and belonging in a Norwegian context. However, my insider-outsider status as an ethnic minority woman and second-generation immigrant in my home country might have smoothed the path to building rapport with my participants due to shared experiences of being raised in a Western country by non-Western parents, and as an ethnic minority/woman of color, and could have perhaps enabled participants to be more candid than they might be with a

researcher who is White or ethnically Norwegian. That I am not a medical professional, do not belong to any of the largest immigrant groups in Norway, and have never given birth myself, allowed me to position myself as a "novice" seeking knowledge from my "expert" informants, an often-fruitful approach in anthropological research, while also ensuring I could avoid the ethical risks of role confusion and maintain the appropriate distance from my research subjects and topic.

The challenges with recruitment are another important limitation to consider, as the failure to recruit more openly via the municipal health clinics meant that my sample size was not only small, but largely recruited from the social media followings of maternal health advocacy groups, who are therefore highly engaged in the subject matter, and my network, which is mainly academic, and therefore very highly educated. Two of the participants were public healthcare workers, which may have also introduced bias, or limited candor in their interviews. Malterud et al., (2016) asserts that small sample size can still produce high information power when combined with high sample specificity, strong interview dialog, and rare or specific experience. While high educational attainment aligns with social science research that characterizes immigrant communities as "education-driven" due to high rates of college- or university-level educational attainment and aspiration among children of immigrants in Norway (Amundsen, 2019), it may also present a bias to the data, as the "integration paradox" asserts that immigrants with high education report more experiences of discrimination and lower satisfaction with maternity care than those with lower education (Bains et al., 2021; Smette & Aarset, 2023).

Chapter 3: Conceptual Framework

3.1 Social support as a determinant of health

There is substantial literature supporting the positive association between social support and both physical and mental health across a wide variety of geographic settings and health conditions. The prevailing theoretical understanding of social support's influence on health asserts that social support acts as a buffer for individuals when facing stress and promotes positive health behaviors and outcomes by increasing personal competence, health maintenance and coping behaviors, sense of stability, and decreased anxiety and depression, among other measures of psychological well-being (Langford et al., 1997; Oommen et al., 2011).

As a concept, social support has been broadly applied but not very consistently defined, despite extensive and long-standing recognition, but can be generally understood as an individual's access to assistance, care, or protection. There is some variation in how different aspects of social support are named and categorized, but for this study I have chosen to focus on the most common categories applied in postpartum care literature: emotional, instrumental (also referred to as practical), informational, and appraisal (or affirmational) support (Leahy Warren, 2005; McCourt, 2009; Zlotnick et al., 2023). Following Langford et al. (1997), "instrumental (practical) support" is defined as the provision of tangible goods or concrete assistance, including money and labor. "Informational support" is defined as information given during times of stress to assist with problem-solving. "Affirmational or appraisal support" is communication that contributes to positive self-evaluation and affirms or validates the individual's actions or statements. "Emotional support" refers to communication or actions that convey being cared for, loved, liked, respected, and being valued; in some conceptualizations this includes perception of acceptance and belonging.

Some contested conceptualizations of "social support" assert that it is reciprocal or transactional (Langford et al., 1997). The application of the social support concept in this study includes this as one possible but not absolute dimension of social support, recognizing that social support can be derived from both informal sources (e.g. family and friends) and formal sources (e.g. institutions and service providers) (Ibid; McCourt, 2009; McLeish et al., 2021) and conditional on the individual's social network, social embeddedness, and the social climate. It is further

conditional upon the presence of enough significant people to provide the social support, a level of connectedness of the individual to these significant people sufficient to derive their support, and an environment that fosters the exchange of help and protection: "Without a structure of people (network) with the quality of connectedness (embeddedness) required to generate an atmosphere of helpfulness and protection (social climate), social supportive behaviors cannot occur" (Langford et al., 1997, p. 97). This conceptualization of social support highlights that accessing and deriving benefit from it is a complex process requiring negotiation, navigation, and management of implied or explicit contingencies.

Perceived social support is also theorized to play a significant role in well-being, and some social support researchers have proposed that *perceived* social support has an even higher impact on mental health and well-being than actual social support (Inekwe & Lee, 2022), and highlighted that failure to align support received and support desired can reduce its protective effect, or become a stressor in itself (McLeish, 2021). Social support can in some cases be perceived as a threat to autonomy and privacy, and thereby become a burden or form of social control (Boutin-Foster, 2005; Floyd & Ray, 2016). Despite ample research concerning the manifold positive aspects of social support, relatively limited attention has been paid to its costs (Lincoln, 2000) and its potential to "create problems as well as solve them" (Floyd & Ray, 2016, p. 12).

3.2 Postpartum social support

During the postpartum period, women are faced with both physiological and psychological stressors as they cope with the demands of transitioning to motherhood, mastering infant care, breastfeeding, and recovery from childbirth, placing them at increased risk of mental health disorders, such as postpartum depression and anxiety. There is substantial recognition of the important role of social support on mothers' health, well-being, and functional status after birth, especially as protective factor against postpartum mood disorders, as well as long-term mental functioning (Alstveit et al., 2010; Negron et al., 2013; Persson et al., 2011; Sampson et al., 2015). Social support improves mothers' ability to cope with both the mental and physiological stressors of postnatal recovery and transition to motherhood role. "Social support enhances women's confidence in caring for an infant, coping with childcare, and her functional status after birth. Maternal competence is reduced when women feel isolated, and the risk of post-partum

depression is increased when they experience poor social support" (Alstveit et al., 2010, pp. 113-114). Conversely, being denied social support, or not receiving the social support one has expected, is recognized as an additional stressor and has been shown to negatively impact maternal mental health and competence and impair maternal-infant bonding (Alstveit et al., 2010; McLeish et al., 2021; Persson et al., 2011; White et al., 2023). According to Negron et al. (2013): "Low levels or inconsistent social support have been found to be a strong predictor of post-partum depression and dissatisfaction with social support may increase the risk for clinical and subclinical depression during the post-partum period" (p. 616).

There is great inconsistency in the degree to which social support is recognized as a fundamental aspect of nursing and midwifery care in modern healthcare structures. While in principle, social support has been "central to the caring goals of nursing" (Norbeck in Langford et al., 1997, p. 99) and "central to midwifery practice…there is concern that its role has diminished in the recent past because of continuing fragmentation and medicalization of care" (McCourt, 2009, p. 191). Desire for more social support from healthcare providers is a frequent theme in the literature (McLeish et al., 2021; Oommen et al., 2011; Razurel et al., 2011; Salonen et al., 2014). Previous research in Norway has shown that while midwives see social support as part of their professional role and skill set, rationalization has increasingly made this work a secondary or, deprioritized part of their roles in contemporary medicalized health systems and in health management (Aune et al., 2021; Kay, 2022). Advocates have argued that current health financing structure neglects to account for the work of providing social support in maternity care, fail to include it in reimbursement models, and thereby disincentivize and devalue it (Ingulstad & Thomassen, 2023; Perrenoud et al., 2022). Studies indicate that understaffing within health settings is perceptible by new mothers and discourages them from seeking out care (Aune et al., 2021; Sacks et al., 2022).

One study in England found that not only did mothers receive little direct practical support from health professionals, the maternity ward's policies and environment in fact obstructed access to support from informal sources by restricting visiting hours or deterring partners from staying in the hospital overnight (McLeish et al., 2021, p. 457). Partner support has been identified as an important influence in new mothers' sense of security (Persson et al., 2011, 2012) and the hospital's apparent disregard of this appeared to further heighten mothers' distress (McLeish et

al., 2021). Furthermore, the systematic reduction in postnatal length-of-stay and shift of postnatal care responsibilities from the public sector to the private sphere is in many ways contingent upon the active cooperation of partners:

> "If women must travel home earlier from the hospital, it is at least just as important to involve the partner in the first postpartum period at the hospital, not just during the birth…. How can we without this expect that a new father or co-mother who has not received any training nor has experience will be able to helpful for a postpartum woman and a newborn?" (Mortensen, 2022, p. 31, translated from Norwegian).

Significant normative shifts in expectations of fatherhood and the increased involvement of fathers in childbirth and caregiving have led to men in Norway and many parts of the world occupying a more significant role in the postnatal period, both as a caregiver and support to a recovering partner, but also as a new parent in their own right. However, the cultural legacy of birth and postpartum as women's spheres, combined with the biomedical organizational framework oriented around "patients", often excludes fathers and partners to the detriment of both the mother and the family as a unit (Feenstra et al., 2018; Høgmo et al., 2021; Solberg et al., 2021).

The importance of belonging and social embeddedness on the perception and efficacy of support is confirmed by research showing new mothers participating in antenatal or postpartum group programs more easily accessed social support from other mothers with a similar background (Price et al., 2018). In Norway, the *barselgrupper* organized by municipal mother-child health clinics, allow mothers to "compare[d] themselves and their child with other mothers and children, which appeared to confirm them as mothers" (Alstveit et al., 2010, p. 116), a process which reassured the women that other mothers had similar struggles and problems: "For the most part, contact with peers seemed to confirm the normality of their experiences and emotions" (Alstveit et al., 2010, p. 117). However, this comparison-making can also be anxiety-inducing or alienating for mothers for whom peer experiences were not actually affirming: "If the woman's experiences differ from those of the group, the feeling of isolation and being a failure can increase, thus challenging her maternal identity and sense of self....First-time mothers [need] to have peers with whom they can identify, as well as to share understandings and experiences" (Alstveit et al., 2010, p. 117).

The considerations outlined above are highly relevant when considering minority and second-generation immigrant populations. While diminished access to social support is generally a well-recognized dimension of vulnerability for first-generation immigrant women in Norway, the quality of social support available to women in the second generation is perhaps taken for granted. Second-generation immigrants undertake a "renegotiation of belonging" and are often conceptualized as "pioneers maneuvering between different and often conflicting understandings and practices in the intersections between the parental generation, Norwegian society, and transnational social fields" (Aarset et al., 2021, p. 88). Studies have shown that in terms of educational attainment, socioeconomic status, and attitudes towards family formation, children of immigrants trend closer to the Norwegian majority. However, second-generation immigrants still encounter significant discrimination and inequity in many aspects of Norwegian or Nordic societies, including in some cases poorer pregnancy outcomes (K. S. Bakken et al., 2017) and mental health (Munk-Olsen et al., 2010), which set them apart from their ethnically Norwegian peers. This suggests that the values and lived experiences of second-generation immigrants differ from both their parents and their Norwegian-majority peers, creating complex dimensions to their social embeddedness.

Assistance intended to be supportive can also be experienced as a "burden, hassle, or threat to the parenting authority" (Sampson et al., 2015, p. 51) of new mothers. Norway's legacy of disproportionate child welfare scrutiny on immigrants has created apprehension in many immigrant communities, and many minority parents have reported adopting performative parenting strategies in response to perceived surveillance (Handulle & Vassenden, 2021; Smette & Rosten, 2019). Previous studies have asserted that health visiting, specifically of new mothers, can be construed as a way of surveilling and policing mothers' behavior (Frederiksen et al., 2021; Peckover, 2002). Among minority families who are already conscious of scrutiny and discrimination from authority figures, the supportive benefits of services may be outweighed by the added stressors of potential policing and bias (Solberg et al., 2021).

The social support associated with traditional postnatal care practices may be counterbalanced or negated if new mothers perceive that support is delivered alongside scrutiny, conflict, or the need to appraise family-recommended practices against those recommended by healthcare personnel and other authoritative actors of the dominant society.

3.3 Selective and dissonant acculturation

The concepts of "selective acculturation" and "dissonant acculturation" became salient in the later data collection and early analytical stages of this project, as tools to interpret how the study participants appraised and negotiated the postpartum knowledge and norms promoted by their families alongside those promoted by the dominant Norwegian society and the healthcare system. Acculturation theory asserts that children of immigrants, "go through the processes of both assimilation and accommodation" (Harris & Chen, 2023, p. 1750) as they reinterpret, reevaluate, and even replace the cultural values and practices transmitted by their parents in response to experiences in the host society and its normative institutions. Differences in socialization between the parent and child generations, referred to as an "acculturative gap" or "dissonant acculturation", can lead to intergenerational conflict and damage parent-child relationships, which has been associated with poorer mental health outcomes among children and youth (Abdulhamed et al., 2022; Harris & Chen, 2023; Kalmijn, 2019; Liversage & Ottosen, 2017).

Although intergenerational conflict also occurs in majority populations, within a migration context it has more unique, profound implications, and can perceived by the parents' generation as a threat to "solidarity with the immigrant group" (Kalmijn, 2019, p. 1422) or to their parental authority, leading to distance between parents and their children, and exerting pressure on their relationship. For example, research on adult children of Turkish and Moroccan origin in the Netherlands (Kalmijn, 2019) found that that higher cultural and social integration with the majority society was associated with weaker ties, more conflict, and less contact between parents and children (Ibid). More recent theoretical interpretations of acculturation emphasize heterogeneity in the adaptation processes of children of immigrants along a spectrum from assimilation to accommodation, and consonant to dissonant intergenerational relationships (Harris & Chen, 2023). Emerging acculturation theories have challenged the assumption that integration always offers the most favorable odds to ensuring positive well-being. Selective acculturation, or the partial retention of identity linked to the parent's home country via preservation of language and core customs and values, has been proposed as a more favorable adaptation in "assimilationist contexts" where structural inequalities, discrimination, and hostility pose obstacles to integration, such as in Norway, where earlier research has linked

integration to negative mental health among ethnic minority youth (Sam 2000 in Cavdar et al., 2021; Friberg, 2021).

Ethnic capital, or the "material resources and information available through bonds of solidarity and cohesion within the ethnic community" (Friberg 2019, p. 2847) is theorized as playing a central role in selective acculturation by partially compensating for the mainstream economic and cultural capital that immigrants and their descendants often lack. Friberg's (2019) research on children of immigrants in Norway identifies ethnic capital and the preservation of "emotional bonds and a normative alliance with their parents" (Ibid., 2848) that are derived by "maintaining an orientation towards the immigrant culture and identity" (Ibid.) rather than eroded by full acculturation, as the key mechanism by which selective acculturation confers advantage. The selective acculturation framework is supported by findings that demonstrate positive associations between ethnic identity affirmation and self-esteem, psychological well-being, and advantages such as social support and belonging, and negative associations with depression (Cavdar et al., 2021; Smith & Silva, 2011).

Applying the selective acculturation concept to postpartum care would suggest meaningful benefits in terms of both social support and mental well-being for second-generation women with the mainstream cultural capital to access the resources provided by Norwegian systems and institutions while embracing their immigrant culture and identity and alliance to their parents and ethnic community. Conversely, those who hold their immigrant culture and identity at arm's length, or whose family bonds are strained by an acculturation gap, may lose out on ethnic capital and valuable social support. Empirical evidence from the Nordic countries suggests, however, that the careful balance of ethnic and mainstream cultural capital engendered by selective acculturation is elusive and precarious for ethnic minority children of immigrants. Friberg (2021) observes that "youth with immigrant parents from Asia and the Middle East appear to adopt a national identity as Norwegians even faster than youth with immigrant parents from Western Europe and North America, despite their lack of acceptance as Norwegians by others" (p. 38). Smette & Aarset's (2023) and Gilliam's (2022) studies of second-generation immigrant parents in Norway and Denmark, respectively, found that both engaged in a typically middle-class, intensive, reflexive, and cultivational parenting approach, appeared ambivalent towards participation and belonging in their parents' ethnicity-based networks (Smette & Aarset,

2023, p. 13), and distanced themselves from first-generation parents to manage threats to their Danish belonging (Gilliam, 2022, p. 11). Abdulhamed et al. (2022) argue that "living in between cultural and normative expectations and continuously adjusting one's behavior is not sustainable for mental health" (p. 195) and question whether youth from immigrant families receive sufficient support with this process. They ground this assertion in earlier studies that characterized Swedish youth with immigrant families as "living in double-loneliness" (Ibid from feeling understood neither at school nor at home, and finding that Finnish adolescents with immigrant parents reported increased anxiety and depression symptoms and were two to three times more likely to lack "someone to discuss personal worries with" (Ibid) than Finnish-background youth.

While the concept of "selective acculturation" proposes that outcomes for the acculturation processes of children of immigrants are highly context-dependent, with a range from harmony/effectiveness to conflict/stress (Berry, 2005 in Cavdar, McKeown, and Rose, 2021) Abdulhamed's (2022), Friberg's (2021), Gilliam's (2022), Smette & Aarset's (2023) studies suggest that dissonant acculturation, and its negative implications for intergenerational relationships, is the more prevalent phenomenon in the Nordic context. Given that previous experiences of depression and lack of social support are both key risk factors for postpartum depression, the disadvantages associated with the dissonant acculturation intergenerational dynamics bear worrying implications for the postpartum well-being of second-generation immigrant mothers in Norway.

Chapter 4: Postpartum physical health and care experiences

Most of the women I interviewed entered postpartum after a challenging, exhausting, and in some cases traumatizing labor and delivery experience that had both physical and emotional implications for their postpartum recovery and transition to motherhood. Some of the women had lengthy labors, up to 48 hours. One of the women spent an entire night laboring without health personnel supervision due to inadequate capacity on the ward, another did so without her husband due to COVID-19 pandemic policies. Over half of the women had experienced significant blood loss and/or required blood transfusions, including one who had a postpartum hemorrhage severe enough to require operative repair. One of the women had undergone an emergency caesarian section. They bore the fresh physical and emotional wounds of these experiences with them as the responsibilities of caring for a fragile new life were thrust upon them.

This chapter will focus on women's experiences of their physical well-being in the postpartum period and their experiences of care from health personnel. The key themes that were identified regarding the women's physical health and needs were pain and exhaustion, difficulties with establishing breastfeeding, and feeling inadequately prepared for the realities and difficulties of postpartum and new motherhood. Challenges with breastfeeding were a dominant, wide-ranging theme in this study, and will be highlighted in some of the experiences discussed in this chapter but examined in more depth in Chapters 6 through 8. Participants highlighted positive interactions with supportive and responsive health personnel, but feeling "left alone", and perceiving that health personnel did not have sufficient capacity or competency to meet their needs were also prominent themes.

4.1 Postpartum recovery

> "*I never expected that the first time you go to the bathroom it's going to be like giving birth again." -Tania*

Many of the women described coping with painful physical ailments in the weeks and, in some cases, several months after giving birth. The pain issues that were mentioned most frequently in the interviews were related to constipation and perineal wounds. These problems are often characterized as "normal" and "common" postpartum ailments in public health discourse

(Helsenorge, 2019a), yet it was clear in the interviews that they were also extremely painful, distressing, enduring, debilitating, and moreover, unexpected:

> "I literally cried at some point during her [my mother-in-law's] presence because I had so much pain in my pelvis after birth. I had pain every day for at least four months post-partum and I still experience some pain every evening eight months post-partum." [Selma – follow-up email]

> "I felt that I was very little prepared for the phase after birth…There was no one who told me about 'the physical discomfort' first of all, the psychological part, and…concretely, in a way, how much an infant would demand."[2] [Edna]

> "I never expected that the first time you go to the bathroom it's going to be like giving birth again. It's so painful. I don't know if it was just me or if it happens to other people as well, but it was so bad. I never heard anyone talk about it or tell me or prepare me. And I remember I was just crying and screaming in the bathroom because it was so bad. (…) You get so many issues that no one really talks about. No one really talks about those really disgusting sides of postpartum!" [Tania]

Tania attributed her surprise at just how difficult and painful postpartum constipation could be to a dearth of frank discourse about the negative and unpleasant consequences of giving birth. Kim also echoed that she was "shocked at how constipated I was, and then that the stitches were so painful" even though she and her husband had taken a private birth preparation course, read a book about postpartum, and been given advice on what to expect from her sister. She also suffered pain from a nerve issue, and edema (swelling) in her feet, which made it difficult for her to move.

The trials of recovery were further compounded by exhaustion and sleep deprivation after difficult delivery experiences. Jina, who had endured contractions with no sleep for 48 hours, emphasized how "completely beaten up" she felt postpartum, and highlighted the frustration of trying to understand and meet the needs of her new baby when she was simultaneously coping with her own profound exhaustion and pain:

> "[The greatest challenge] was actually to recover, that my body was supposed to recover after the birth. That was very bad. And I have thought in retrospect now that…if I had slept in the 48 hours before I gave birth, I think I would have recovered a little easier. But they do say it takes one to two years, before the body gets well completely. I think that was the hardest. (…) My head was pounding, yeah, beaten up, my body was much more beaten up. (…) [Especially] when the child was supposed to sleep but didn't want to sleep. And I was extremely tired at that time. And that…the baby possibly cried because he was hungry, tired,

> couldn't calm down…but at the same time as I had to, be in pain, you know. And unable to be there for the baby all the time."[3] [Jina]

Tania, to whom an emergency cesarian section had come as a real shock, expressed disappointment and loss at how the lengthier and more intensive recovery process limited what she was physically able to do in the postpartum period and early months of motherhood in comparison to mothers who had given birth without complications and were able to be on their feet more quickly:

> "I saw women just checking out [of the hospital] the next day because they gave birth like naturally, I saw women on their feet, walking around holding their babies. I couldn't do any of those things! (…) I spent three months recovering from my c-section. I couldn't get up from the bed, I couldn't carry anything, I couldn't carry [my baby] much. Whenever I held her, I had to sit and hold her. So...it really takes away from your, like, *barselperiode* [postpartum period] […] being nice." [Tania]

The women's reported symptoms of postpartum pain and discomfort are commonly characterized as "normal" by health literature (Helsedirektoratet, 2014; Helsenorge, 2019a). Nevertheless, nearly all the women described being shocked by both how the extent and intensity of their postpartum physical symptoms exceeded what they had anticipated, and the impact these symptoms would have on their ability to embrace new motherhood. At the same time, the normalization of discomfort and painful recovery after childbirth sometimes discouraged help-seeking in the postpartum period:

> "When I think back, oh my god, it is very strange that I didn't seek help (…), I just assumed that was how it was. Because there was no one who, kind of, mentioned to me that it wasn't normal to be in pain all the time. (…) So I endured, I never mentioned my pain, even when I went to my six-week postpartum checkup. (…) They just said, 'How's it going?' and then, 'It's fine," I just said, "Yeah, it is indeed painful, it's uncomfortable, but it's kinda, yeah, that's totally normal." As if it was totally okay. So I didn't seek out anyone myself, because I just assumed that was how it should be."[4] [Edna]

For Edna, the unchallenged assumption that it was "completely normal" led her to accept the constant pain she endured postpartum without question and without fully conveying it to health personnel. This normalization of postpartum pain and discomfort could delay diagnosis and treatment of complications. For example, Kim recalled repeatedly encountering skepticism from health personnel that her symptoms of persistent pelvic discomfort and dysfunction were anything out of the ordinary:

> "…six months after, I felt that things were still not normal. And I asked my midwife whom I trusted, "Could you have a look?" because she's so experienced. (…) Because when I went to the doctor for the normal six-week checkup, they said, 'Ah, [unconcerned tone] everything looks fine.' So I just thought it was fine. (…) That was a really bad experience because six months afterwards you're supposed to have fun with your baby, you're not supposed to be in super pain and go through that. (...) First when I went to [the hospital] I think there was a doctor [who was] just kind of suspecting me of this being something psychological because she saw [my history]. But nevertheless, I felt really that she was suspecting me of not having actual pain. Because she said, 'This functions.' I'm like, 'It's not a question of function, it's painful! So there is something wrong.'"

Kim described coping with painful symptoms for six months before finally getting access to a specialist doctor who was able to confirm and repair her perineal suturing. Not only did she have to undergo yet another procedure and recovery period, but the entire situation repeated itself with her second birth, despite Kim's attempts to prevent a recurrence by informing health personnel.

The women's experiences illustrate how this normalization of and lack of open discourse about the intensity and array of postpartum recovery symptoms, especially extreme or long-term pain and exhaustion, often leads to such conditions being trivialized and overlooked, both by the women themselves and by health personnel. Not only did this inhibit the ability to establish realistic expectations and plan accordingly for the challenges of postpartum before the birth, it also impeded help-seeking and access to effective treatment after birth. These experiences align with recent research from Sweden showing that new mothers with persistent pain after birth felt it was not taken seriously by health personnel, and often did not seek treatment at all because of the widely-held conception of pain as a "natural" part of postpartum rather than a disease or illness, leading to their belief that "it is 'normal' to have pain after childbirth and that it will disappear spontaneously with time" (Molin et al., 2024. p. 6). Molin et al. (2024) also highlights the long-term implications of this failure to diagnose postpartum pain issues at an early stage, including increased risk of postpartum depression and of developing more difficult-to-treat chronic pain conditions. Assertions of both racial and gender bias in healthcare providers' perception and treatment of patients' pain suggests an even greater, intersectional risk for ethnic minority women (Bever, 2022; Wang & Jacobs, 2023).

4.2 Inpatient care and support

Four of the women I interviewed received early postpartum care in the maternity wards before being discharged between two to six days after birth. One of them was able to get a family room in the maternity ward, which enabled her husband to stay with her. Two other women spent five to six days in the maternity ward in shared rooms – where partners cannot stay overnight – and COVID-19 restrictions at the time prevented one woman's partner from visiting at all. The two others were transferred to the postpartum hotel, where they reported with great appreciation that their partners were able to stay overnight with them, and personnel allowed them to remain until breastfeeding was well-established. Overall, participants reported a wide range of generally positive, ambivalent, and negative perceptions of the postpartum care they received at the hospital or postpartum hotel.

The women who described a generally more positive early postpartum experience praised the responsive care of the midwives, nurses, and other health personnel:

> "I felt very well taken care of (…) I had really great pains right after the birth (…) and so I just said like that I needed pain relief medication, and then they came with some more, and paracetamol. That was very good, so every time I needed something, then they came and brought it to me."[5] [Jina]

> "We did get several visits from the nurses. They came in all the time to check on both the baby and me….I was at the hospital for two days, and those two days I felt that I was well taken care of. I could just call them if there was anything, and they came immediately to help and answered. And before I left, then they took a kind of last check to see if everything was in order. And then a midwife came by and talked a little with both me and my husband and gave us a little information about what might await us after awhile, and they were sure that we were…well-prepared, kinda, to go home. (…) I felt that it went pretty well, such that we felt pretty ready."[6] [Ada]

These participants had also been able to secure private family rooms at the maternity ward or postpartum hotel for all or most of their stay. This was a feature they were keenly aware of as not guaranteed in Norwegian hospitals, and for which they were grateful:

> "I remember that we walked past the maternity ward also, there were several people who shared rooms, several mothers with fathers, (…) and I think that would have been seriously stressful."[7] [Jina]

> "We reserved a family room. Then you pay a bit extra, and then my husband can stay and sleep there with me…if there's space. If it's full, then he would have to go home at night. But luckily he was able to stay with us the whole time."[8] [Ada]

Kim had initially been in a shared maternity room due to the need for closer observation, and her husband had to go home for the first night before she was cleared to move to a family room in the postpartum hotel. She praised personnel at the postpartum hotel for supporting her as she struggled with delayed milk production due to heavy blood loss, providing positive assurance that her milk would eventually come in with sleep and rest, helping her to pump, and encouraging her to remain for as long as it took to establish breastfeeding. She appreciated that her sister and mother were also able to visit, enabling her to benefit from their support and guidance as well.

Most of the women perceived that capacity at the hospital was less than optimal and that health personnel often appeared overextended, busy, and rushed:

> "I think they were very good with me at least. I have nothing to comment on. The only thing I noticed was that they were very busy. There weren't only midwives who were there, there were like students also, that I had in addition. So, I did notice that."[9] [Jina]

Despite describing herself as generally satisfied with the care she received, Jina took note of insufficient staffing at the hospital and the postpartum hotel, and recalled returning for outpatient follow-up and having to wait for a long time because health personnel were busy and had to prioritize inpatient care. Advocacy groups have reported that midwives are frequently reassigned from the postpartum to the birthing wards to fill critical shortages, and replaced with nurses and medical students without sufficient postnatal care experience or specialized training, particularly in the busy summer months, leading to competency loss in the postpartum ward (*Innspill Fra Jordmorforbundet NSF*, 2020; Thomassen, 2021a, 2021b). Many of the participants' accounts, in which health personnel at the postpartum ward lacked the time, experience, or knowledge to deliver needed informational support, support these criticisms.

Tania, who had delivered via emergency caesarian section, reported severe pains in her shoulder and difficulty breathing while she was recovering postpartum, and getting nothing more than a painkiller from the responding nurse, whom she perceived as equally confused by the symptoms:

> "It's called air bubble pain, you have it after a C-section. (…) It really hurts, it's like indescribably painful. (…) I suddenly got it here in my shoulder and I couldn't even reach like that red thing to call someone. And I didn't even know what was happening, I thought I was having a heart attack or something. (…) I didn't know what was happening. (…) [I told the nurse], 'I'm having pain, I can't move, I can't breathe because of it', and she was like 'Uh, uh...', like she was all [laughs] confused and she didn't even know what was going on, and she went out and she asked someone else and she came back and she's like, 'I'm just going to give you a painkiller.' And I was like, 'Okay but what is this?' And she never told me.
>
> I remember calling my husband, and I asked him, 'What the fuck [laughs] is going on?' and he called, like he talked to his like aunt, who told him like this is called air bubbles. So I had to like find that out from someone else because (…= either that nurse didn't know or she just...didn't see it as that important, telling me what it is. I wanted more of an explanation of what's going on, right?" [Tania]

The lack of information was further compounded by the fact that Tania's cesarian section was very unexpected due to her age and good health during the pregnancy, so she was completely unfamiliar with the post-surgery effects, such as "air bubbles" (trapped gas), and Covid-19 restrictions at that time meant that she was at the hospital without her partner.

> "I do see it, they were overworked, all of them, it was the pandemic, there was a lot of births [laughter] going on, and yeah. So...that was that. But otherwise I would say, like, I got my food on time, they would take care of my baby if I needed that. There wasn't much of the...how do I say, the emotional...support that you would want like right after you have given birth especially when you can't even have anyone with you. (…) I don't know if that's just like the standard in Norwegian hospitals. Because the culture here...is a bit, it's not that warm [laughs], it's cold." [Tania]

Selma also perceived that health personnel at the hospital were insufficiently responsive when it came to managing the pain she was suffering, and lacked the competency to provide individualized, adaptive guidance on breastfeeding in a position that would offer some relief from the pelvic pain:

> "I was also in a lot of pain, because I got an episiotomy as well. And I felt like, it was really like excruciating [laughs] pain. And that also made it difficult to breastfeed. It was really hard sitting upright. (…) At one point I remember, I had to bite my lip so I can distract myself from the pain because it was really painful to sit. And I was often even, 'Do you have like any cream, or gel, or anything?' (…) I don't know if they gave me painkillers at that time, maybe they did. But there was also like, 'Put a pack of ice. Put a pack of ice.' And I did that, but it didn't help so much. (…) And I asked tons of times, could I have guidance in breastfeeding while lying down? And everyone was like, 'Well, you don't need

> to,' or 'I'll get someone else to teach you, I don't know this well enough,' and 'Breastfeeding lying down is not so easy anyway,' or something like that. So I felt like, okay I have to sit. But it was just so painful." [Selma]

In addition to a general shortage of information, several women reflected on how the care and guidance they did receive was not always conveyed effectively or delivered with consideration for how their comprehension and memory were impeded by exhaustion and other cognitive effects from postpartum recovery. Jina recalled that at the first night after the birth, she and her husband were exhausted and left on their own by health personnel at the postpartum hotel, to be chastened the next day for not having known to feed their newborn:

> "So we were really tired, all of us, so we did sleep through the whole night. And then I remember that the midwives who were at that postpartum patient hotel, they kind of left us alone at that point. And that was actually nice. But actually, as we found out the day after, we were actually supposed to have nursed, or that we should have given the baby milk then. So we got kind of…a bit of a dirty look, but it was okay. Then there was another midwife who came and talked with us afterwards and said it was fine, so long as it was just the first night and everyone was tired."[10] [Jina]

Both Jina and Selma had struggled with breastmilk production after strenuous births, and received unclear or inconsistent guidance at the hospital on pumping. Tania recalled initially being given a breast pump without being shown how to use it, and Selma was shown only once, to discover later that she had been using it incorrectly. In their interviews both reflected on how disoriented they were, and how they were left to navigate the hospital and the heavy mental load of new motherhood on their own:

> "…walking from my *barselrom* (hospital room) to that NICU (neonatal intensive care unit), I remember once I got lost (…) I was obviously kind of…still affected by the medicine, I was kind of not myself. (…) I remember calling my husband like, 'I don't even know where I am in the hospital, can someone help me?' and it was the middle of the night and…I just went to her to breastfeed her, cause I really wanted to make that, at least, work." [Tania]

> "When I came back from the operation room, I was of course in a fog, and I was still under the anesthesia, the effect of anesthesia and everything. There's a lot of information in the room. So there's (…) like a paper hanging on the door about mealtimes and everything. There's actually a folder, a big folder, I don't know, somewhere in the room, the shelf or something. Which says everything about breastfeeding, milk production, how to feed the baby, how to change the baby, all these different things. The basics. I wasn't - nobody told me, 'Read this stuff.' Nobody told me there's information here, anything. And even if somebody would tell me - like hello? Fog. Like…[laughs incredulously]" [Selma]

The presence of these materials appeared to set an implicit expectation for Selma that she should be studying written information on her own, something that seemed to unrealistic and not feasible while recovering from a traumatic vacuum-assisted delivery and hemorrhage repair surgery in which she had been under general anesthesia. Several of the women also reported a sense of "fog",[1] "fuzziness", and disorientation in the first week after childbirth, which manifested as difficulties with memory and struggling to process or retain the information that was given to them – in a period that coincided with their discharge from the hospital and return home.

The national guidelines for postpartum care state that planning for discharge and returning home should be done by health personnel in collaboration with the new mother/family on an ongoing basis throughout the hospital stay. Prior to the family's departure from the hospital, the mother is entitled to a final examination and "*utreisesamtale*" (exit consultation) to discuss what to expect and to address any outstanding issues or questions (Helsedirektoratet, 2014; Helsenorge, 2019). There were mixed responses from the women about whether the content of this meeting was sufficiently comprehensive or individualized.

> Tania: "I had a going-away conversation. (…) the nurse came, she pressed my belly, checked if my uterus had gone back to its position. And she...that's pretty much it. (…) So there were no complications post-c-section at least at that point. And they just told me that if you have any signs of infection just call us."
>
> Researcher: "Did they go through the signs for you to look out for?"
>
> Tania: "Yeah, I think she did mention that if there's any kind of pus coming out, if it's inflamed...and she told me that you can take off this bandage on that day. It was like kind of things around my scar and (…) when you give birth by c-section your milk comes in like...it can be delayed." [Tania]

Kim recalled that it was mostly reading and taking private courses prior to the birth, and support from her family, that gave her any sense of being prepared to go home, and that she had received little guidance at the hospital about her own recovery, including any danger signs:

> "No, I don't really remember the hospital giving so much, no, guidance. No, not really. (…) I felt like at the hospital they were mostly concerned about the baby

[1] Participants' use of the term "fog" may relate to a common Norwegian vernacular expression, "ammetåke", translated literally "breastfeeding fog", used to describe forgetfulness and sluggishness in the postpartum period, often attributed to hormonal changes and sleep deprivation (Hansen, 2010).

> and not so much with me. And if it was with me, it was mostly because of the baby [laughter]." [Kim]

Selma recalled that the discharge checkup was never directly offered to her by health personnel, and that she might have left the hospital without it had she not seen it mentioned in the written informational materials and made inquiries.

> "So when I got the *samtale* [discharge meeting], it wasn't like, about anything, how to take care of myself. It was more like (…) a briefing, in a sense. 'How do you feel now? Your blood percentage is this much now, this is normal.' (…) She gave me some advice on breastfeeding, like some parenting advice, like a pep talk, 'be calm' and 'he picks up on your energy', but it wasn't anything about me and my wellbeing and my rest, and everything. Not that I remember." [Selma]

> "I have to say that I am very surprised about how little information I actually got from the maternity ward. (…) I remember I took my baby home with me, and then you just think, 'Ok, what shall I do with this little child here?'"[11] [Edna]

The experiences of feeling "left on my own", "in a fog", and poorly prepared to go home, is evocative of earlier research of women's experiences with hospital postpartum care from Norway and highlights the pervasive, long-standing nature of these issues. Eberhard-Gran et al.'s (2000) research suggested that measures to promote breastfeeding by "rooming-in" newborns together with their mothers, concurrent with economic efficiency measures and low staffing led to "an unfortunate possible consequence…that much of the responsibility for care of the child has been left to the mothers alone, around the clock" (Eberhard-Gran et al. 2000, p. 3, my translation), contributing to nearly half of new mothers in Norway reporting exhaustion and sleep-deprivation during their hospital stay. Valbø et al., (2011) also found that health personnel underrated the importance of overnight assistance with childcare, and overrated the quality of teaching of childcare skills, in comparison to postpartum mothers' evaluation of the maternity ward, and highlighted the need for greater focus on these areas to improve postpartum quality of care.

4.3 Outpatient postnatal care and support

Upon discharge from the hospital, responsibility for follow-up care reverts to the primary healthcare service, i.e. the woman's primary care doctor or the municipal health centers (*helsestasjon*), who provide prenatal and pediatric care. National guidelines recommend one home visit within three days of discharge for women with "good early experience of birth,

breastfeeding, and postpartum" (Helsedirektoratet, 2014b, my translation) and additional home visits in the course of the first week after birth for those with "difficult start of breastfeeding, complicated delivery, ambulant or home birth, or families in at-risk situation" (Ibid). Ideally, continuity of care is promoted by designating a set midwife and nurse for the mother and her child, respectively. However, reports have shown that many municipalities struggle to maintain the capacity needed to meet these standards of care and have reduced this service offering (Helsedirektoratet, 2014b; Isachsen, 2022)

The women in this study who received home visits and continuity of care spoke positively about these features, and often described receiving more attentive and individualized care from the midwives at the municipal health clinic than they had at the maternity ward. They also noted that the health clinic midwives had a more holistic approach, and took a greater interest in the psychosocial elements of their health and well-being:

> "…at the *helsestasjon*…I don't know if I was particularly lucky with my midwife, which I do think is true, I felt very well taken care of. And it was really proper, honest, and very thorough care." [Kim]

> "At the municipal clinic (…) they are more occupied with how it is at home. Therefore, they come on the home visit and talk about the more general things. So, for example, sleep, new routines, relations between me and my husband, that kind of thing. While at the hospital it was more like, breastfeeding, the time after the birthing part with the mom, how it's going there, the different health checks, that kind of thing."[12] [Jina]

Tania praised the effectiveness of the individualized, hands-on breastfeeding guidance she received from her midwife from the municipal health clinic, while simultaneously expressing frustration at not having received that kind of guidance in the hospital, when she was struggling early on with getting breastfeeding and milk production established:

> "[My midwife] was like, 'Okay [Tania], show me how you're going to breastfeed her, show me how you do it.' (…) I literally sat here and I was doing it and she's like, 'Okay, let me adjust your arm here, put your pillow here, do this, and put her entire mouth' (…) and that was the first time and I was like wow, and it worked and it was amazing and that was the technique like I did for the next one or two months (…) Just one thing by that midwife, changed my entire breastfeeding game. And I feel like that should happen at the hospital. Cause that's when it's crucial to get your milk in, the first few days, (…) you would literally lose your production in those days, before you would get any help. (…) My midwife at the *helsestasjon* was great, all midwives are not gonna be like that! So I feel like the hospitals should like, be equipped with that. And it's such basic knowledge. If

> you're a nurse and you work in the *barselavdeling* [the postnatal ward] (…) you have to know these things, why do you not convey that knowledge to new moms?" [Tania]

Relational continuity of care has been associated with increased provider-patient trust, and improved maternal outcomes and provision of individualized care (Aune et al., 2021). Most of the women spoke positively about having a designated midwife or nurse who knew them and had bonded with them over the course of their pregnancy and postpartum period; conversely, lack of provider continuity was construed as a negative:

> "[With the same midwife] I didn't have to tell the same things. Though they have it registered, then you get a bond. They know you from since your stomach was small, then it gets big, and then you have a baby. They have been through the same things, during that period. I think that was nice."[13] [Ada]

> "…actually talking with the public health nurse after the birth, that has helped a lot. The only thing is that, we were supposed to have one permanent person, but now it has been so busy at their jobs, that now we have had different people all the time. [laughs] And that does do something, that the health personnel or public health nurse doesn't know the child, or us. So then it becomes kind of like a new meeting every time. So that has been, what I have to say, that maybe can be a little, yeah negative maybe. Otherwise, I am satisfied."[14] [Jina]

As with the maternity ward, staffing shortages at the municipal clinics limited the time and capacity of health personnel to provide the kind of care the women expected or needed. Edna, for example, was supposed to have a home visit, but instead had to go to the health clinic herself for the baby's check-up. Although Selma did receive a home visit from the midwife she had seen during her pregnancy, the hourlong visit failed to adequately address the issues she needed help with, having had a postpartum hemorrhage and difficulties breastfeeding. She recalled struggling to remember explicit guidance from the midwife, who had documented in Selma's patient record that she should pump eight times a day to increase her milk production, but did not leave her written instructions to refer to:

> "I criticized my *jordmor* [midwife] although I really liked her. (…) They all know women are in a fog! They all know this, regardless of postpartum hemorrhage, and especially if you've had hemorrhage and a traumatic birth, you're definitely in a fog then. Why couldn't they just write things down?"

The national guidelines highlight the increased importance of home visits to maternal and child outcomes, particularly in light of declining length of stay in the hospital ward, and in fact recommend *extra* home visits for mothers like Selma and most of the women in this study, who

experienced difficult deliveries and breastfeeding challenges (Helsedirektoratet, 2014b). Between 2017 and 2020, less than half of new mothers in Norway received a home visit within three days of discharge, although improved rates have been reported since 2021 (Statistics Norway, Isachsen, 2022; Ludvigsen, 2021). That the four women who had given birth in the 18 months before the interview all received a home visit, while both multiparous women reported only receiving one after their second birth, seems to reflect this trend.

It is important to note that home visits are not compulsory, and previous research suggests that vulnerable and ethnic-minority groups may perceive health-visiting as a form of surveillance and feel threatened by a healthcare worker's presence in their home and power to involve child welfare authorities (Smette & Rosten, 2019, Frederiksen et al., 2021; Peckover, 2002, Solberg et al., 2021). Most of the participants did not remark on this dimension, but Edna's reflection on the home visit illustrated the mixture of feelings and dilemmas it presented for her. On the one hand, it would have enabled her to adhere to Somali postpartum confinement traditions. On the other hand, she felt nervous being exposed to the judgment of the public health nurse, even though she was by then both a second-time mother and in many ways a system insider, as a healthcare worker:

> Edna: …maybe if I knew better, with my first, then I would have asked that the nurse could come home to me instead of that I had to go out again so early. (…)
>
> Researcher: Was it okay for you to have a nurse at your house?
>
> Edna: That was very strange…because then I felt that I suddenly had to also present my home…regardless of how much knowledge I had then and there, and how much education I had then and there, I always had a feeling that, 'Ok, what are they going to say if they see my home? Will they think that this is not fit for children? Do they think this is not good for an infant?' So I felt, yes, a kind of pressure to…present a front, so that they wouldn't get a bad impression of me. (…) Even though, deep down, I knew that isn't what is decisive for that child protection will come in and take my child away.[15]

As part of this Edna deliberately kept the extended family members who were a constant presence in the postpartum period away for the duration of the home visit, in fear of what the nurse would think of "seeing six other family members at home". Her apprehension not only speaks to the potency of the fear and authoritative power the Norwegian child welfare agency holds over the Somali community (Handulle & Vassenden, 2021; Wandel et al., 2016), but also

illustrates another dimension of the importance of trust in patient-provider relationships. That even Edna felt the need to "present a front" and an "edited" presentation of her lived reality is notable; second-generation mothers in a more marginalized position might perceive the home visit with even greater unease, or yet be deterred entirely and decline the service. Wandel et al. (2016) notes that "minority group status" often made the Somali-Norwegian mothers in her research "feel particularly vulnerable in their encounters with health personnel" (p. 490). This suggests that aspects of health services that promote trust, such as continuity of care, may have even greater stakes for mothers for whom fear of racial bias adds an additional obstacle to trust, and by extension, access to care.

Chapter 5: Traditional postpartum practices

This chapter will explore second-generation mothers' experiences and attitudes towards the postpartum care practices and traditions promoted by their families. Nearly all the women I interviewed described robust care configurations and specific beliefs around the postpartum period which heavily influenced their experiences of support and recovery in the postpartum period. Despite great geographic and national diversity in the participants' family origins, which spanned East Africa, the Middle East, and East, South, and Southeast Asia, there was significant commonality across the traditions and care practices they described, as well as consistency with existing literature describing traditional postpartum practices in non-Western cultural contexts. These traditional postpartum recovery regimens shared an emphasis on rest, confinement, and warmth, on promoting healing and milk production through diet, and on recognition of and reverence for the physical costs of childbirth and vulnerability of in the postpartum period. Mothers and mothers-in-law were the gatekeepers and facilitators of these recovery regimens, providing regular home-cooked meals, help with housework and infant care, and physical company, as well as transmitting experiential knowledge and advice, which their daughters received with a mixture of ambivalence and appreciation.

5.1 "You have kind of died and come back to life."

Most of the women referred to a culturally prescribed period of rest and recovery after birth. The length of this varied somewhat; for three of the women, the period was one month, while for two others it was 40 days. All of them reported being urged, especially by their mothers, to rest as much as possible, insofar as they should not exert themselves beyond breastfeeding and holding their babies. This prescription was facilitated and reinforced by family members' assuming most other forms of household labor:

> "In our culture, my parents are from Pakistan, (…) we take care of the woman after she gives birth and we like, we do all these services for her, she's the center of attention after she gives birth because she's done a huge deal." [Tania]

> "I think there's this ancient tradition where you understand that a woman needs to rest after birth. But I think it's so important and then that you need community and then you need, you know, connection, and then you need to rest! Yeah. And it kind of respects the job that it takes to actually recover after a birth and to connect with your baby. And that that needs time, which is really valuable, I think." [Kim]

Tania's and Kim's interpretations of the cultural attitudes towards postpartum held by their families imply a reverence for the "huge deal" of childbirth and recognition of the conditions needed to promote well-being for the new mother and baby. Other women described their families' conceptualization of postpartum as a physically weakened and vulnerable state, and of the new mother as in need of protection and nurturing:

> "(…) I didn't do anything other than breastfeed the baby and sit there with the baby, as it was always them [my female kin] who took care of everything, they cooked, they cleaned the house, they took care of the baby when I wanted to take a shower (…) If the baby cried they held it so I could sleep a bit longer, for example. Also you're told that you shouldn't go out, because they believe that for so-so many days after the birth, you have to be inside, like completely traditionally speaking in Somalia, you're inside for 40 days. While here it's not doable, since you have to go to the health center, but at least the first week, it's just, you don't go anywhere, you kind of have to stay inside."[16] [Edna]

> "It was mostly my mother and father who said, 'When you've given birth then you must be inside for a month. Don't go out, just take care of your body. Just build up your energy, because now (…) you've kind of died and come back to life. Try not to do anything. If there's anything I can do, then you can just tell us, whether it's cooking, or cleaning at home. Don't think about it, just think about getting healed.' All I was supposed to do, in a way, was breastfeed and hold the baby."[17] [Jina]

A perception of postpartum vulnerability and depletion also undergirds the recommendation that postpartum women "stay inside". The purpose of the practice of "staying inside" might be presumed to underscore the need to avoid physical exertion, but the participants often related it to another prominent theme: "staying warm" or "avoiding cold" in order to protect one's health:

> "In Turkish tradition and culture, then it's very important the first 40 days. (…) I've always gotten tips about not getting cold, you have to keep yourself warm. You have to take care when you go out. You have to dress yourself rather warm even if it's warm out as it is, you know."[18] [Ada]

The rationale for avoiding cold and going outside was not always explained – or perhaps even fully understood – by the women interviewed but included concerns for both short- and long-term health. For example, Kim's mother warned her against going outside, fearing that she would "catch a cold [and get] a breast infection", and Jina's mother warned her thus:

> "'When you go out right after the birth and don't get rested, your skeleton becomes porous. Because the wind blows so hard on you and you get stiff, you get so much pain in your whole body. And it lasts many, many years.'"[19]

Even though most of the participants' mothers had themselves given birth to some or all of their children in Norway, clear parallels are still evident between the postpartum recovery and care beliefs and care behaviors that they conveyed to their daughters, and the practices of postpartum rest and confinement that continue to be common or normative in many contemporary Asian, Middle Eastern, and African cultural contexts (Dennis et al., 2007; Manderson, 2003; Mrayan et al., 2016; Winson, 2009).

5.2 "Eating yourself to health."

All of the participants mentioned that food was an important feature of their family's care in the postpartum period. Several of them reported that their families, most typically their mothers, made daily or weekly deliveries of home-cooked food throughout the traditionally defined postpartum period, and sometimes beyond:

> "[…] my mom cooked a lot. I mean, she, oh my god, she cooked, like we didn't cook a single meal for two, three months, she's like cooking all the time. She was bringing like, food in containers, and we had a huge freezer out there on the balcony and she was putting them there." [Selma]

> "During the whole pregnancy, and then after the birth too (…) you are waited on, you are, in a way, simply 'taken care of'. […] Also they express the way they take care of you with food. Everybody comes with food. It doesn't matter if you don't want it…everybody comes with food. It's kind of their love language: food, food, food."[20] [Edna]

Several participants characterized their families' motivations as not merely the fulfilment of a basic need or sparing the new parents the labor of food preparation, or expression of love and care, but as a health promotion strategy:

> "From my mom, it was very like, 'I'm taking care of my daughter.' (…) Her priority was making nutritious food for me so that I eat myself to health, literally, because that's what they think in that generation, they think that you literally eat yourself to health." [Tania]

Many of the participants described their mothers preparing specific postpartum dishes or encouraging them to consume certain types of food to regain strength and recover from childbirth. For example, both Jina and Selma were urged by their mothers (from South Korean and Syria, respectively) to eat meat to restore their iron levels after losing blood during

childbirth. Kim was given papaya and vegetable soup to promote milk production and expel fluids by her mother (from Vietnam), and other traditional, iron-rich postpartum recipes. Tania recalled that her mother prepared "special broths to increase my energy", as well as *panjeeri*, a Pakistani dish comprised of ghee and nuts, to increase her milk production.

Stimulating and maintaining breastmilk production to ensure nourishment for the newborn was the other often-cited consideration for how postpartum women were fed by their families. Ada named "eating well so that I had enough milk and (…) had enough energy to take care of [my baby]"[21] among her postpartum priorities and was urged by her mother, from Turkey, to take heed of her cravings: "if there's something I get a craving for I have to eat it at once, or I'll stop having milk".[22] Both Ada and Kim described their mothers as eager to cater quite literally to their daughters' every whim, when it came to what they wanted to eat. Edna recalled that her mother and mother-in-law, both from Somalia, encouraged her to drink tea with milk and consume foods heavy in fat and sugar so that her baby would put on weight and appear well-fed, whereas the only nutrition-related guidance she received from health personnel was to drink plenty of water so as not to become dehydrated from breastfeeding:

> "… I think in my culture […] the greatest motivation for them, when they were feeding me so much food, was that I would produce a lot of milk so that the child would be big, and that the baby should be a visibly, visibly big baby, you know, which would then mean that you had […] a successful postpartum. And that was maybe what they worked hardest for, I would say…"[23] [Edna]

Edna's experience is consistent with findings from Wandel et al.'s (2016) study on breastfeeding experiences among Somali-Norwegian mothers in Norway, who often reported that friends and relatives conveyed a preference for chubby infants and praised mothers if their babies met this ideal. Similarly, Jina recalled being given "vitamin drinks" by her parents and receiving dietary advice from her mother that contrasted with the recommendations promoted by health personnel: "When I talked with the midwife that I got via the municipality, then she said like, 'We must eat *nutritious* food, not only meat." [laughs] While my mother was like, 'You have to eat meat, get a lot of iron, you don't look well in your face, you're totally white.'"[24]

The keen focus on postpartum diet and nutrition that the participants ascribed to their families stands in contrast to general postpartum health guidelines in Norway, which highlight the importance of adequate Omega 3-fatty acid, iodine, iron, Vitamins D, C, and B12 intake but

generally recommend that breastfeeding women eat a "healthy and varied diet", follow the same nutritional guidelines that apply to the general population, and avoid strict dieting or aggressive weight loss (Helsenorge, 2017, 2019a). The significant emphasis that is placed on this last point, including underscoring the risk to nursing infants, may speak to an implicit normative expectation that a *certain* degree or pace of weight loss is healthy and desirable for postpartum women. This contrasts with the experiences and perspectives conveyed by many of the participants in this study, such as Edna, who reported putting on even more weight postpartum than she had during her pregnancy, and Jina, who framed her initial significant postpartum weight loss as an indicator of poor health and eventual weight gain as a positive sign.

5.3 Attitudes towards traditional postpartum practices

Many of the women expressed a degree of ambivalence or skepticism towards some of the traditional recovery practices encouraged by their families, and recalled elements or beliefs that they resisted, rejected, or – in many cases – *regretted* dismissing and reconsidered. The prescription to stay home in the first weeks or month of the postpartum period was frequently highlighted as challenging to reconcile with the new mothers' beliefs, wishes, or needs. For example, both Kim and Jina described ignoring their mothers' warnings against going outside postpartum:

> "The first days after birth, when I was strolling around with the baby stroller, [my mom's] like 'You should not do that!' and […] like "You need to stay warm" but it was in July, you know. So I was just like, 'It's nice, it's warm.'" [Kim]

> "I was outside maybe like two weeks later, and walking then. But I noticed quite quickly afterwards that I should have listened to Mom. Because I became really, really tired afterwards, and I think I got postpartum arthritis afterwards too. That's like when you feel all your joints, that you're unable to move. I did stay at home at that point, at home for a month, I believe, after that. You think like, when you have given birth, then you want to show off your baby, go out, get a bit of fresh air and meet people again, you know? But…yeah. Now I'm getting better."[25] [Jina]

Beyond the new mothers' personal desires to get outside, adherence to postpartum confinement was, as Edna noted, often incompatible with the health system's protocols for postpartum and pediatric check-ups:

> "I had to go to the health station a few days after the birth. And that, oh indeed, my mother-in-law, for example, didn't like that, nope, you know, because that time, it was still a bit cold (…) so their opinion was that it wouldn't be good for either the baby or me to go out so early after birth. (…) I did have to tell them that that's how it is, and I have an appointment, that I kind of have to follow the appointments I've gotten at the health center. And fortunately, they are very like…those who dare not do something wrong in the system, so then it was just, 'Fine, it's fine, you can just go.'"[26] [Edna]

The conflict that Edna describes is evocative of Nguyen et al.'s (2002) research in the United States, which found that traditional Asian postpartum practices often conflicted with the structures and recommendations of the Western biomedical system, were regarded by second-generation and more established immigrants as stressful, and were perceived by a quarter of their study participants as a barrier to seeing their healthcare provider. Edna's account also illustrates how her family's concerns for the health for her and her child were outweighed by their fear of the health system's implicit authority, an issue which will be revisited in Chapter 7.

Stomach binding was another traditional Somalian postpartum recovery treatment that Edna struggled with and abandoned:

> "After a birth my mother's family practices, especially where she comes from, they bind the stomach. And I remember that Mom said then, 'You have to do it, or else you'll get a big stomach. It will never go back in, you have to do it.' And I remember that she bound it, but it hurt so much and was so hard that I just took it off. So that was hard to carry out."[27]

Kim also rejected a similar treatment that involved lying down with a hot water bottle on her stomach, as her mother recalled:

> "I said, after you've given birth, then you lie there. And it isn't hard, but she wouldn't do it. I said, it helps to press the blood into your stomach and out. A lot, it helps. And when you're done with birth, then you don't have a big stomach. (…) When I come to a woman, the Vietnamese women in Norway, and I help them, and do it for them, *they* did it, but [to Kim] you didn't want to do it!"[28] [Kim's mother, originally from Vietnam]

Kim and her mother, who participated in a dyad interview together, provide an interesting case study on the intergenerational transmission of, and negotiations around, postpartum care knowledge and behaviors. Kim's mother had migrated to Norway as a refugee from Vietnam, where she had been well-educated and given birth to her elder children. In Norway, where her younger children were born, she was active in her community, and described herself as more

open-minded than other immigrant parents from Vietnam because of her education and willingness to learn. She expressed sadness and frustration, albeit in addition to acceptance, regarding the numerous ways her daughter declined her care and advice postpartum.

> "…I thought I would come to her and be here, and take care of her…help her as much as I can. (…) Then she doesn't have to do so much when she has a baby, right? And in Vietnam, there we have to have people to help the woman who has a baby. Whereas here she wants to do it herself! And she doesn't want to have Mom at home with her. (…) So I was a little sad in the beginning. And I didn't get to be as near to her as I wanted. To get to come and help and do the things when she is poorly and not strong enough, when she's just had a child. (…) But I tend to listen to her. So I just say what I think is good for her and [resigned tone] 'Okay', but not do it."[29]

The two central points of disagreement were Kim's rejection of her mother's proposal to provide live-in postpartum care, and ambivalence towards Vietnamese remedies, such applying pressure and heat to her abdomen, taking a steam bath infused with lemongrass and citrus peels, and use of herbal medicines:

> Kim's mom: "What's most different is that in Vietnam we have like, spices, vegetables that can be used…[asks Kim to translate from Vietnamese]"
>
> Kim: "Medicinal herbs? Turmeric and things like that."
>
> Kim's mom: Yeah, like that. Ginger, different things. We use a lot of that. And I can't force her to do it [laughs]…One time, the child coughed a lot, when I came here I had to do something. (…) I steamed a kind of onion. And I had rock sugar (…) And when she drank it, then I saw that she was better at once yeah, but…"
>
> [Kim makes an irritated face; we all laugh]
>
> Researcher: "She doesn't trust it?"
>
> Kim's mother: "She doesn't trust it. But I see that I must do it."[30]

Their opposing attitudes towards Western biomedicine were also illustrated by Kim's criticizing her mother's expressed ambivalence towards Western medicine and preference for herbal remedies and prayer:

> Kim's mother: "I am also the type who self-medicates/treats myself when I - "
>
> Kim: "Not good, Mom."
>
> Kim's mother: "When I'm sick, I treat myself. (…) I'm the type that doesn't like going to the doctor so much…taking so much medicine. But if I'm sick and tired,

> then I rest (…) I pray to God. And if…I must go to the doctor, then the doctor says something, then I listen to the doctor."[31]

Kim's mother lamented that both Kim and her daughter-in-law insisted on doing things themselves postpartum instead of resting, and attributed Kim's current ailments to her failure to recognize the importance of accepting help to postpartum recovery:

> Kim's mother: "In Vietnam we have it in our head that we need help now [in the postpartum period]. Just a month. Because we need to be stronger after that. After one month then we can do a lot of things. But the first month, then we can get help. If we have people to help us, we have to accept it."
>
> Kim: "I should have listened to you, Mom."
>
> Kim's mother: "Yes. Now I see that she [Kim] isn't doing well in her shoulders and arm, it seems, a long time, it doesn't seem good. (…) Also I remember when I was in Vietnam, the eyes got a bit painful, or difficult, when we come into the sun too early, or we can get sick, cold, and freeze if we're without…enough warm clothes after the birth. That is very important in Vietnam. We have a lot of wind, wind that makes it easy for you to get sick."[32]

For her part, Kim admitted in retrospect the merit of the traditional ethos of postpartum rest and recovery her mother had tried to facilitate, and reflected that it made her recognize the value of certain Vietnamese customs after having struggled fiercely against them in her youth:

> "I've been used to doing what I want for a long time; I moved out when I was 14 because I disagreed [with my parents] on many different things. But I don't know, after I became a mother, then I thought, okay, there are many Vietnamese things that are very good. And that we can learn. We Norwegians, in a way."[33]

Intergenerational conflict between traditional versus western biomedicine has also been noted outside of a migration/acculturation context, as studies from Jordan and China highlight the similar struggles of new parents to reconcile the advice of their parents and in-laws with modern neonatal health practices (Mrayan et al., 2016; Xiao & Loke, 2021). While in the Jordanian and Chinese studies, intergenerational conflicts were framed in terms of modernity vs. tradition, and wisdom and experience vs. scientific knowledge, in this study, the second-generation mothers and their families often regarded these intergenerational differences through the lenses of migration and minority status, with perceived implications for their belonging as Norwegians and members of their families' ethnic and cultural communities. This is also illustrated by how Kim's mother frames her acceptance of Kim's differences in opinion: "I gave birth to her in

Norway, so I know she only grew up in Norway, not in Vietnam. So therefore it isn't easy to get her to listen to what I think."[34]

Similarly, Jina's explanation of why she, herself a healthcare professional, decided to embrace her mother's advice concerning postpartum rather than solely relying on the Norwegian medical guidelines, is grounded in the suggestion that guidelines aimed at the general, majority population may not be ideal for her individual circumstances:

> Researcher: "So you followed more what she [your mother] recommended than what was in the healthcare guidelines?"
>
> Jina: "Yeah, I think it was more because… she had said to me after the birth that I shouldn't go out. That our bodies are not the same as the body of a native, or ethnic Norwegian. […] They're kind of equipped to tolerate strong wind and like the cold, etc. And that time I said… [dismissively], "Yeah, yeah, it's not necessary, it's fine." So I was outside a week or two after the birth. But then […] I regretted it a little, I actually ought to have listened to her, because I felt really, really bad after that afterwards, you know? And then she was like, 'Mama said so, what did I say?' […] After that, because I didn't listen to her the first time, then I thought like, "Ok, but now, next time when she tells me, gives me advice about things, then I ought to listen more to her than what the national guidelines say." Because those don't apply individually, they apply generally, right? And when I listened to her, then I felt that my body became more quickly healed."[35]

Many of the women described reevaluating their preconceptions towards their mothers' practices, which they had initially written off, upon discovering they were effective, and sometimes even affirmed by biomedical authority in Norway, and gaining renewed respect for their family's traditional knowledge:

> "When I read…like this Norwegian stuff written by these doctors that recommended you to put pressure on [your stomach], I thought like, okay what my mother actually says, that comes from her mother again, and comes from, her community of women, from her culture, it is basically in line with what researchers say today, that you should do as well. So I was really happy with that, you know, it's like wow, I got much more respect for the Vietnamese, you know, culture, after having given birth to my children. I just think I valued it much, much more." [Kim]
>
> "…these are like these old wives' tales, but they work! (…) In the beginning I wouldn't believe it cause obviously I'm not as traditional, and she still believes in the natural postpartum methods but I have to say they work! And if anything, they don't harm you in any way. They're very comforting. Like having a bowl of broth when you're feeling like shit, it's really nice. So even if it's psychological it helps.

> (…) I feel like I would do the same with her [my daughter] one day…even if I don't believe in it in the medical sense but I do think there's some wisdom in these traditional methods." [Tania]

The perspectives and attitudes expressed by the second-generation mothers in this study towards their families' postpartum care practices provide rich context with which to explore selective and dissonant acculturation, as many of the participants characterized themselves as skeptical of the validity of many of the components of traditional postnatal care, but also praised the ethos of support, care, and reverence for the vulnerabilities of birth and postpartum these practices represented. Consistent with the selective acculturation framework, participants positively appraised many aspects of the postpartum care and support and care they were able to access by maintaining openness towards their parents' traditional practices, which can be interpreted as a form of ethnic capital (Friberg, 2019). That many participants also expressed regret at dismissing or rejecting aspects of their parents' advice also illustrates the potential losses incurred by dissonant acculturation. It is worth considering whether disillusionment with the health system produced a more positive appraisal of the support resources and "ethnic capital" offered by the participant's families, as well as examining the conflicts and contradictions presented by the roles of family and the health system in the postpartum period, which I will explore in more depth in the next chapter.

Chapter 6: Domains of social support in postpartum care:

> "There isn't one person who fills all the areas. In any case, I remember my husband was the one who was most valuable when it came to the emotional support. Then of course there's the kind of, everyday support, then I would say that it was my in-laws, and my siblings were a very good support. Since, as I said, they cleaned, they took care of everything. And that is a good support."[36] [Edna]

The interviews revealed how new mothers relied on different individuals in their networks to fulfill different roles across the four domains of social support (instrumental, informational, emotional, and appraisal). Support from the women's mothers was predominantly instrumental; support from partners was more commonly distributed across the instrumental, emotional, and appraisal support domains; and support from friends or peers was predominantly characterized as appraisal. Healthcare personnel were most impactful in the domains of informational and appraisal support. Other commonly mentioned sources of social support were siblings, in-laws, mothers' support groups, and the internet and social media. In some cases, the participants perceived that the members of their social networks complemented each other well; in other cases, they produced or compounded confusion and tension. Informational support was the most common site for ambivalence, unmet needs, and conflicting input. An individual could simultaneously provide support that was perceived by the new mother as highly valuable in one domain, while providing counterproductive or stressful support in another.

The aim of this chapter is to apply the social support framework to the participants' postpartum care experiences, specifically by mapping their interactions with the different care providers and members of their social support network according to the four categories of social support. This analysis draws upon the key conceptualizations of how social support is operationalized, which assert the importance of alignment between desired and received social support (Sampson et al., 2015. Lincoln's (2000) review of social support and illness literature identified that two different types of supportive configurations are believed to induce stress: "(1) when the patient (or individual) perceives the wrong person as having provided a particular type of support and (2) when the patient (or individual) feels that although the correct person has provided the support, they have not done so in a manner perceived as helpful" (Ibid, p. 5). The existing knowledge base and the discussion of findings in Chapter 4 and 5 suggest that second-generation mothers may be particularly vulnerable to such mismatches between desired and received social support

due to prominent roles that both the health system and family networks play in the postpartum period, as well as the ambivalence of their relationships and affinity to both institutions and their respective normative expectations.

6.1 Instrumental support

Household assistance during times of illness or crisis, including the postpartum period, was once widely available to women in Norway in the form of a national *husmorvikar* ("temporary housewife") service, which was established in the postwar years but dismantled in 1980 on the basis of increased female workforce participation and access to public childcare and paternity leave (Børstad, 2014). Today, Norway's advanced welfare state (Hedlund & Landstad, 2012) has replaced many of the social care functions once filled by local community and family networks, but does not address the need for instrumental support, that is, "tangible assistance such as practical help with daily living" (Evans et al., 2012, p. 406), in the postpartum period: in fact, it was only in 2022 that changes were made to paid parental leave regulations to grant fathers and partners the right to draw upon up to two weeks of their parental leave allowance in the time around the birth, concurrently with the mother's leave, enabling partners to be available at home to provide instrumental support (NAV, 2023; Prop. 15 L (2021–2022), 2021).

The continued need for instrumental support postpartum is evidenced by existing findings that "birthing individuals expect instrumental or practical support (i.e., help with functional tasks) from partners and family members, believing that this type of support is critical to their postpartum physical and emotional recovery" (White et al., 2023, p. 532), but do not receive it. While this gap can be observed in many high-income, Western countries, models of care that acknowledge this need can be found in, for example, the Netherlands, where postnatal care benefits for new mothers include up to 10 days of in-home care including practical household assistance, such as shopping, cleaning, and meal preparation (Van Teijlingen, 1990) as well as the emergence of postpartum doulas in both the United States and Norway, whose roles typically include instrumental support among other forms of non-medical support (Greenberg, 2018; Norsk Doulaforening, 2022).

6.1.1 Mothers and kin

Instrumental support was the most prominent type of social support new mothers described receiving from their informal support network, and their mothers and partners were the main sources. Family members often regarded it as their duty to assume an instrumental support role for the new mother for a culturally prescribed period after the birth:

> "…from what I understand, like my mom didn't say it, but that's kind of...her responsibility is at least until one month, she takes care, and if she doesn't do that it's like ,'shame on you', and then you're a bad mother if you don't do that for your daughters." [Kim]

> "It should be said, (…) it is intense, it is, the first two months of the child's life, and then the families disappear. After that, then you see almost nobody. They all go on their way, everyone does what they have to do. (…) Suddenly there's no one anymore, and then you are just left to yourself and your things, and you have to figure it out yourself. (…) It was, right at that point, a relief, just then and there when they disappeared, but it was a very strange feeling that suddenly from being there 'in my face' all the time to nothing, it was very, very peculiar."[37] [Edna]

Although Edna expressed appreciation for the instrumental support she received from a large family network, her "relief" at their departure highlights her regard of their involvement as a mixed blessing, due to the constant presence of family members in her home and the unwanted advice and scrutiny it entailed. When she had her second child, she explained that some of her family's attention was redirected to her elder child, which allowed her to focus on the new baby and made the intensity of their support more tolerable:

> "…when I was going to have child number two, and was postpartum (…) their roles of helping me were much more 'appreciated', because then I didn't need to take care of my [first child] (…) They helped him with lunch bags, they did school drop-off and pick-up, I didn't have do all of that for a super long time. So I could just focus on being a mom again, I was almost like a first-time mom again, you know. So it's a bit different, I think, when you have more children, to have, to come from a culture where, in a way, the norm is that they almost move in with you. It helps a lot when you have other tasks you have to do, but when it's your first child, I think it's harder."[38] [Edna]

For many of the women, their family's provision of support was highly gendered, with mothers and sisters taking a prominent place in their accounts of support across all the domains. Within the instrumental support domain there was some, but markedly less, mention of support from fathers and male relatives, and typically this was limited to tasks outside of the home:

> "[My mom] would clean the kitchen...she's super like that. (…) Her love language is like doing service for other people. So she really helped. Just the food part it was so helpful cause you just can't cook, it's so chaotic in the first few weeks. (…)

> My dad would just be like I can drive you to your appointments because we didn't have a car at the time." [Tania]

> "The men, yeah, they went and shopped or did errands outside, but normally it was just the ladies, as in the women and the girls in the family who help."[39] [Edna]

This pattern also reflected the gender roles many of the women observed of their parents' relationships, wherein their mothers were primarily responsible for domestic labor and childcare, even when they were also employed outside the home. Many of the women also speculated that the ardent support they received from their mothers and female kin was in part due to low expectations – based on cultural norms and experience – of paternal involvement in the postpartum period:

> "I think they [my family and in-laws] were very surprised that he [my husband] was so helpful. (…) So I think maybe (…) both my family and his family expected that I was going to ask for more help. And were very surprised that we managed without, just did it. Because we [Somali women] help each other, in a way, because that [paternal infant care] really isn't so common."[40] [Edna]

> "Women, they tend to give care to others, but when they have a baby, they need care from others. We [Vietnamese] understand that."[41] [Kim's mother]

A few of the women noted that their mothers, despite carrying out traditional care practices for their daughters, had given birth as first-generation migrants in Norway with neither the help of their husbands, due to traditional gender roles, nor of their families, due to migration:

> "[My mom] didn't have any support system in Norway. (…) I can't even imagine how hard her *barselperiode* [postpartum period] must have been. (…) She had no one, oh my god. I have no idea. And my father is not like, I don't think he knew what he was doing either [laughs]. It's not that he's a mean person, it's just not expected for the man to be that way, y'know. So the woman just does everything, and she [my mom] probably just did everything herself, poor thing, yeah. [Clicks her tongue sadly] She did. And I guess that's why she overcompensates with me. Cause she's like, 'Oh my god, let me give my daughter what I didn't have.'" [Tania]

The loss of social networks is a common, isolating effect of migration (Bains et al., 2021; Kay, 2022; Mrayan et al., 2016), meaning that many of the participants' mothers performed postnatal care for their daughters they themselves were deprived of as an effect of migration.

6.1.2 Partners

All of the women were married, and most described their relationships as more equal compared to their parents' generation, a reflection of generational shift in gender-role attitudes between first- and second-generation immigrants (Kitterød & Nadim, 2020) that is underscored by most of the participants' characterizations of their husbands as willing and valuable sources of instrumental support:

> "[My husband] was home the first month. And I remember that, being a really nice time even though I was in horrible shape. (…) I don't think I changed like one diaper during the first entire month. [laughs] And he did everything. And he was really, really nice. (…) I told him like, 'This breastfeeding thing, like I can't, I'm so concentrated on this baby being attached properly to the breast and all that. Can you keep track on every time I breastfeed at least for the first month while you're home? Can you just...whether it's the right or the left boob [laughs] and how many minutes and God knows what? Because my head doesn't function.' So he did. (…) I think it naturally came, how we shared the things because I couldn't move. (…) In general, my husband and I, we are very equal, in many ways." [Kim]

> "My husband helped too. Mom was there the first days, so we could relax a bit. But then it was my husband who took the rest."[42] [Ada]

> "[My husband and I] talked over, that we have to take turns sleeping, for example, in the beginning. (…) And then he said, 'Yes, of course.' And he works from home, which makes it so he has time for it. And so he said, 'I will take all the diapers. Just rest and think of yourself and like, just don't think about us. We'll sort out the rest.' So that's how it was."[43] [Jina]

The majority of the participants' husbands were either able to take time off from work or to work from home and be physically present in the postpartum period. These participants positively appraised their partners' support and reflected that their postpartum experiences would have been much more challenging if their partners had been away at work. Partner support has been shown to have a mediating effect on postpartum depression and social inequality stressors among both first- and second-generation immigrant women (Nakamura et al., 2020).

There was a wide array of cultural diversity among the partners, but most of them also had a migration background and were either also children of immigrants or had migrated themselves. This is consistent with the statistic that 80 percent of adult children of immigrants in Norway choose a spouse with migration background (Amundsen, 2019). Half of the couples had a shared

cultural background: one husband was a Norwegian-born child of immigrants, another had immigrated as a child with his family, and one was a recent adult immigrant. One husband was a Norwegian-born child of immigrants from a different non-Western country. Two of the husbands were European: one ethnically Norwegian and the other from a different Western European country. Most of women characterized the relationship between their parents and their husbands as generally positive, and perceived that their husbands were welcoming and appreciative of the practical support from relatives. However, some of the women also noted that that involvement in the postpartum period of individuals outside the nuclear family was often a departure from the dominant norms from a Norwegian majority perspective, which was reflected in interactions with their husbands, in-laws, friends, and health personnel.

Selma, for example, recalled that her in-laws, who are ethnically Norwegian, visited after the birth primarily to see the baby and bring presents, but offered no instrumental help even though she had had postpartum hemorrhage, a dangerous complication. This interaction, and what she perceived as her husband's complicity in it, led to conflict between them, because acting as a host and treating his parents as guests directly contradicted Selma's expectation that family should assume a helping role to new parents in the postpartum period:

> "[My parents-in-law] didn't bring anything with them, they didn't cook, like nothing, they just brought presents (…) which is very nice. But we didn't get any help and *we* were actually hosting *them*, like making *them* food [emphasis added]. (…) and we had arguments about this, me and my husband. I was telling him, 'You were cleaning the house before they came, what the hell? You were keeping up appearances with them, they're supposed to be here to help us. And they were just guests.'"

Kim made a related, contrasting observation, reflecting that the unspoken understanding in the Vietnamese community that a postpartum mother was the object of care and nurturing, and emphatically not a hostess, liberated her from any pressure to make herself or her home presentable during visits from her Vietnamese friends and family compared to non-Vietnamese visitors, whose expectations seemed more ambiguous. For Selma, while her mother's attitude exemplified this understanding, the attitude of her parents-in-law typified what she saw as the "lack of a village" in Norway and the expectation of a nuclear family's self-sufficiency even in its most fragile stage. It was only by exposing the extent of her suffering that she shifted this attitude:

> "…my mum came over with home cooked Syrian meals once a week for two months. (…) we said this to my mum-in-law, and she was like 'Oh?'…and I remember it to be quite a judgmental [and/or] surprised 'Oh?' because right after that she would say (…) they had to 'manage on their own' ('vi måtte klare oss sjøl') - she said that phrase several times during the first few months postpartum. Even if her own mother was living close to her, they still had to manage on their own. If that's true - then I find that extremely tragic. My mum cooked for us with pleasure. It was her greatest joy to help us out and help me recover (…). My mother-in-law came over twice to help out with cleaning. She was of great help then but (…) I'm convinced that had I not cried of pain and exhaustion she wouldn't have helped out. Not because she's a mean person but because 'in their days they had to manage on their own.'" [Selma, follow-up email]

For Edna, the expectations of health personnel – that her husband be equally involved and competent as a parent, and seemed to her unaware of how heavily involved their families were in her pregnancy, birth, and postpartum – led Edna's husband to take on a greater share of parental responsibility beyond the prevailing gendered role expectations of fathers within their Somali community:

> Researcher: How did you form the expectation of what kind of role he [your husband] was going to have when the baby came?
>
> Edna: I think we kind of did that through the municipal health clinic, that I felt they had an expectation that this here was something we had to do together (…). I think that they expected that he should know just as much about the baby as I knew (…). Then he couldn't sit on his bum, and he had to do those things too in order to be more involved. So I think maybe the expectations came from there…
>
> If he hadn't felt that 'they expected from me that I kind of had to contribute here', then it's not certain that we would have (…) managed to break the cultural barrier that the man does not help.[44]

Although Edna felt that health personnel played a positive role in facilitating instrumental support from her husband, several of the other women noted that the health system presented an impediment to their partners' practical support when they were not permitted to stay at the hospital together. This echoes previous findings that such restrictions can motivate mothers to discharge themselves early (Aune et al., 2021; Vik et al., 2023) and promote perceptions that health personnel and hospital rules "undervalue" (McLeish et al., 2021, p. 457) the postpartum role of partners. The potential for the different care configurations to undermine one another's capacity for support is also illustrated by Edna's reflection on how her husband was impeded from claiming a more equal parenting role early on, because the intensity of the instrumental

support from their families in the postpartum period did not leave much room for an "involved father":

> "I feel possibly that…the family's role makes it so that he [my husband] gets a bit forced to the side. I thought in retrospect that was possible. I don't think he felt useful before the baby was big enough that they [the relatives] stopped coming. Then he began to fill the role that they'd had back, to take care of the baby, change the baby, relieve me when the baby cried, then he began to take his role back. But the first weeks, he…he was scarcely allowed to cuddle with his own baby. I think he was just a little squeezed out, you could say."[45] [Edna]

Participants' experiences with negotiating the gender role norms and assumptions that persist in both their families' cultures of origin and the majority Norwegian society, as well as the impact of these norms on their access to partner support, are important themes that will be revisited at greater depth in Chapter 7.

6.2 Informational support

Seeking out, applying, and appraising information about postpartum recovery, breastfeeding, and infant care is often a central yet exhaustive and time-consuming aspect of the postpartum period (Aston et al., 2018; Henshaw et al., 2018; McLeish et al., 2020; Tveit & Söderhamn, 2015). Evans et al. (2012) defines informational support as "advice giving, information sharing, and personal knowledge development" (p. 406). New parents are often overwhelmed by the volume and inconsistency of informational support regarding childcare, but report gaps in information on their own physical and mental adjustment (Henshaw et al., 2018). Albanese et al. (2021) assert that health providers' focus on infant needs and high-risk maternal health conditions, versus new mothers' focus on psychosocial needs and daily functioning concerns, represents a disconnect between provider and patient expectations, priorities, and conception of healthcare needs in the postpartum period. Consensus on the optimal way to deliver parental education and information support is lacking, but evidence suggests that information provided in the early postnatal period is poorly retained by new parents. In addition, Norwegian guidelines emphasize the importance of individualized guidance and education (Albanese et al., 2021, Helsedirektoratet, 2014). Participants in this study often regarded healthcare workers as the most trustworthy or authoritative sources when navigating inconsistent or conflicting advice and, as discussed in Chapter 5, were sometimes skeptical or dismissive of advice disseminated by their families.

Inaccessibility or inconsistency of information from healthcare workers, however, also prompted them to turn to alternative sources, especially on the internet and social media platforms.

6.1.1 Navigating conflicting information

Many of the women in the study expressed a desire to ground their parenting choices in "evidence-based", "scientific" knowledge from medical, psychological, and child development professionals, in contrast to intuition, common sense, or tradition, which is how they often characterized their parents' attitudes and advice. This tension can be seen as a "negotiation" between the discourses of "intuitive" mothering and "medicalized" mothering: intuitive mothering discourse assumes that mothers "should be able to naturally take care of their baby" based on instinct, while medicalized mothering positions mothers as "unknowledgeable and in need of expert information and guidance from health care professionals to solve or help mitigate issues" (Price et al., 2018, p. 1557). For example, Kim recalled how her structured, technical approach to feeding her children conflicted with her mother's opinion that feeding small children should be flexible and intuitive:

> "[My mom] doesn't understand this kind of rigidity when it comes to eating hours. (…) She thought I was completely fucked up when I was tracking when I was breastfeeding. She thought that was really OCD. [laughs] No, she was just like, 'What are you doing that for? Just give her [the baby] food when she's hungry, don't be so square.' (…) I think the Vietnamese way of thinking is, is just, when children are small (…) it should be extremely flexible, and then you can get more rigid with time, by age. But for me, who's kind of a control freak, it was kind of nice to have certain hours." [Kim]

Price et al. (2018) assert that both medicalized and intuitive mothering discourses can hurt maternal confidence and contribute to new mothers feeling like "bad mothers". This can be demonstrated by Tania's stated annoyance with her mother, whose insistence that she should supplement with formula because her baby was crying can be seen as characteristic of intuitive mothering discourse, while Tania's approach of seeking confirmation from normal growth and development charts is an example of "medicalized mothering discourse":

> "…I've confirmed from everywhere, babies cry even if they're full, but my mom would keep telling me, your milk is too thin, you need to [supplement] - you need to also give her some Nan [formula], right, and I was like, 'No, Mama it's fine, I can give her milk, I know she's fine.' Cause like, what are the signs that she's fine: she's growing, her weight is going up, she's doing all those things she's supposed

> to do. She was perfect, her chart was over average at that point. So I was like, 'This is fine, my milk is fine. I don't need to supplement.' Because she kind of pushed me and she's like, 'She's crying because she's like hungry, she's still hungry, your milk is thin.' I was like 'Mama, stop saying that!' That was the only annoying thing my mom did. I know it came from a place of like, wanting her [the baby's] best. And also because in our time, when she gave birth to us, it was so normal with formula for some reason." [Tania]

Feeding was a topic of heated disagreement between most of the women and their families, most notably when it came to supplementing versus exclusive breastfeeding, which many of the women pursued in accordance with Norwegian public health recommendations:

> "99 percent of Somali woman and grandparents and moms, they believe that breastfeeding, just breastfeeding by itself, it's not enough. (…) Everyone around me, my in-laws, aunts, everyone commented that my baby was so small. 'Why are you not giving him extra food?' And I got told that I was starving him, on purpose, because I was only listening to Norwegian authorities, they said. So there was a lot of pressure around me to follow the same traditions that we had in Somalia."[46] [Edna]

Both Tania and Edna, who were effusive in their appreciation of the practical support their families provided, illustrate how it was simultaneously frustrating and distressing to be on the receiving end of persistent entreaties from their families to supplement with formula, and to be met with accusations of harming and malnourishing their babies when heeding the authority of healthcare workers over their families' authority. Edna reflected on how having to navigate conflicting information between these two powerful sources hurt her self-confidence as new mother:

> "I would almost say that their comments and everything there made it that I got less self-confidence. I felt less, I almost felt like a bad mother, because they were never satisfied with the things I did. Because I think probably that I tried to take the advice I got at the health clinic, that I probably took quite seriously. Meanwhile they think that I should do that [which they recommend], and not listen to the nurse…I often felt like a bad mother when I was in contact particularly with my in-laws, yeah, and their like 'bunch', you know? So no, then and there it was neither, it was certainly not a strength, (…) but I think the reason was probably the conflicting information I got from the health clinic, and what they tried to convey to me, it doesn't go together, in a way (…) and I felt that I often was just, 'Ok, who should I listen to?'"[47] [Edna]

Some of the other participants, however, viewed their parents' advice as helpful even when it deviated from information they had received elsewhere. Jina noted that lack of consensus among

mainstream Norwegian sources on certain issues, such as the risks of alcohol consumption while breastfeeding, led her to default to her parents' advice, which was more unequivocal:

> "I did really want to have like a little sip [of wine]…in my *barselgruppe* [postpartum mothers' group], for example, so there was a mother who had a glass of wine, I thought that sounded really great, actually. But then when I said to my mother though, and my father, then it was, 'No, you shouldn't do that. It goes over into the breastmilk, no.' So then I didn't do it."[48] [Jina]

Ada highlighted that she experienced her mother's informational support as helpful and reassuring, and interpreted her mother's input as "tips" rather than criticisms, even when they diverged with her own opinions, because her mother seemed to dispense advice according to Ada's expressed needs, and to accept Ada's decisions without pressure or negativity:

> "Mom has lived here [in Norway] quite a while. She has had three children who are born here, so she has been in the same health clinic too, you know. So she knows a bit how it is, but she can still go a bit back and think, 'Yeah it might help, for example if she [the baby] has gas, then it can help to do such and such. We've done that before.' But (…) she has stood back when I've said, 'No, I'm not doing that.' So she hasn't nagged. (…) She doesn't comment negatively, for example, if there's something I say. I see that she tries to help by giving, for example, tips about what I talk about, or if there's something I ask her. 'I have experienced that and that and that.' So she can really be very helpful, and it reassures me to talk with her."[49] [Ada]

Ada's characterization of her mother's informational support role supports claims that effective social support is responsive to the receiver's individualized needs (Helsedirektoratet, 2014b), and respectful of the receiver's autonomy (Floyd & Ray, 2016). It also aligns with Xiao and Loke's (2022) model for intergenerational co-parenting in the postpartum period which highlights the importance of role clarity, with grandparents respecting generational boundaries by not controlling or instructing the mother, respecting and learning from the mother's parenting knowledge in the event of disagreement, and providing advice and collaborative problem-solving when the mother had "no idea" how to handle a situation.

6.1.2 Self-help

As discussed in Chapter 4, many of the participants were dissatisfied with the amount and quality of guidance they received from health personnel in both the early and later postpartum period, especially around breastfeeding. Many of the participants reported struggling with a delay in

their milk production, or with getting adequate supply, and were frustrated that health personnel had not helped them to understand and address the underlying cause:

> "…I got a blood transfusion. And [what] kind of nobody had thought about, was when you lose a lot of blood, then eventually (…) there will be a period where the milk becomes a little less than if you had not lost a lot of blood."[50] [Edna]

> "I just remember being like, 'Um, how do I get milk out? What do I do?' And [the nurse] just brought this machine, and she gave it to me like (laughs), 'Here you go', and I'm like (laughs), 'I don't know how…' (…) I didn't really know how to do it. And she just put it on me, I kept trying, there was nothing coming out and that was like my introduction to breastfeeding." [Tania]

> "Almost none of the advice I received was about increasing my milk production. And when you have postpartum hemorrhage, and that's what I learned in the aftermath, that the first priority should be increasing your milk. And there's several ways of doing that, different ways you have to do that simultaneously. And one of the things is rest. (…) Just maybe that one nurse was like, 'You need to rest.' But I didn't understand, she didn't tell me because you lost a lot of blood. (…) So like the importance of sleep I didn't really know about this until many weeks [later]. And also the importance of eating a lot of calories, I didn't know about this at all, [that] women who struggle with their milk production, postpartum hemorrhage or not, they need a lot of calories. They also need a lot of rest, I didn't know anything about that." [Selma]

For Tania and Selma, frustration with the lack of guidance was further intensified by incidents at the maternity ward in which their newborns were formula-fed by nurses who did not inform or seek the mothers out to attempt breastfeeding first, in contravention of clearly articulated intentions and even an established plan to breastfeed at least partially. Their experiences closely mirror findings from Vik et al.'s (2023) study of early breastfeeding experiences in Norway during the COVID-19 pandemic, which reported that women felt forgotten and were "advised to watch videos or use the internet for breastfeeding support" (Ibid, p. 7), and perceived that healthcare providers were "stressed or heavy-handed when ask[ed] for breastfeeding support [or] fed the baby with formula without information and consent" (Ibid). Both Tania and Selma felt strongly that the absence of holistic guidance on helping them to breastfeed and on increasing their milk production, as well as the hastiness of health personnel in switching to formula, derailed their earnest breastfeeding efforts, and they continued to struggle with breastfeeding after returning home.

In contrast, Jina, whose breastfeeding journey also included challenges with milk production, can be seen to illustrate the positive impact of a longer stay at the postpartum hotel, with more support to practice breastfeeding and increase her production:

> "Because I struggled a lot with breastfeeding and…I had not actually thought anything about it, to be completely honest, about breastfeeding. (…) The midwife said that I could stay another week, so we stayed there quite long actually (…) and then I like got to train a little to breastfeed, actually. So that was actually what I got the most practice on.
>
> [My milk production] did get better, but I had to work hard for it. (…) I had to pump. Pump, and…eat well, and recover after the birth.[51]

Vik et al.'s (2023) study noted that many mothers expressed a desire to stay longer at the hospital to secure breastfeeding, while others voluntarily checked out early from the hospital due to lack of support, and highlighted how online self-directed resources were often used as a substitute for hands-on guidance from health personnel. This theme of online "self-help" was identified in many of the participants' descriptions of accessing postpartum informational support:

> "My personality is the kind where, if I don't know something, I'll try to find out. (…) I was Googling a lot. I feel like every new parent does Google a lot. You Google the shit out of everything. But I would try to use like reliable sources, I had like gathered a book[mark] list of *Ammehjelpen*, of (…) all of those like official Norwegian health information places. And yeah...I feel like it helped, it worked, but there was a lot of like me recollecting information. Me just…y'know, helping myself." [Tania]
>
> "That period where I struggled with breastfeeding and stuff, then I was online quite a bit, yes. And there I found a kind of breastfeeding community, quite simply, online, that was really helpful. I could listen, read various tips and tricks and the like."[52] [Edna]

Many of the mothers turned to other mothers in their social networks, the private healthcare market, and the internet and social media for help and advice, consistent with extensive documentation of how the internet and social media play an important role in the women's access to informational support (Evans et al., 2012; Price et al., 2018). These efforts to obtain informational support, I argue, can be seen in the context of their experiences struggling to access adequate care from under-resourced and understaffed maternity wards and public health services, as discussed in Chapter 4, and indeed, as a product of national policy. For at least two decades, the Norwegian public health authorities have embraced a strategy of shifting responsibility for health promotion from the state to voluntary organizations that will promote

individuals' ability to address their own needs, citing the welfare state principle of "help to self-help" (Hedlund & Landstad, 2012; Helsedirektoratet, 2014a). The Norwegian Directorate of Health's 2014 national plan for self-organized self-help had the stated aim of addressing not only the unmet need for coordinated services and disease-prevention in the health services, but also the challenges presented by "demographic development and change in the burden of disease" (Helsedirektoratet, 2014a, p. 10) that "may threaten society's economic sustainability" (Ibid). In their analysis of the construction of self-help in Norwegian health policy, Hedlund & Landstand (2012) assert that "public health authorities are outsourcing to the third sector what was formally [*sic*] an important part of official health policy" (p. 73) by presenting "an individual approach to health problems…as an empowerment ideology" (Ibid).

Ammehjelpen (Breastfeeding Help), a non-profit organization that provides free breastfeeding guidance by phone, email, and social media via volunteers with lived experience of breastfeeding, can be seen as an example of this shift to the "third sector". Ammehjelpen was mentioned by all the participants in this study, who were either referred by health personnel to Ammehjelpen's website, which houses an abundance of breastfeeding resources, or discovered it themselves when hospital or health clinic personnel were insufficiently responsive to their breastfeeding challenges:

> "…I remember that there was especially the website called *Ammehjelpen*, and that I was told at the hospital, if there was anything I wondered about, then I could also look in there. So I thought that then it sounded very "legit", in a way. (…) And I knew that it was run by a group that consisted of both professionals and women who had themselves gone through the problems they help other women with. So I felt that I could trust them, absolutely."[53] [Jina]

> "*Ammehjelpen* was really helpful as well. Especially when I had this overproduction, this interval breastfeeding and all that. It really, really helped, so that was good. Because I didn't feel like I got much help from the *helsestasjon* [municipal health clinic]". [Kim]

> "…that was also a funny thing, postpartum nobody told me about *Ammehjelpen*. Actually I think the last day [at the hospital], a nurse told me like, 'You can read on their website' and I was like 'Read?' [in a tone of disbelief] Like... I'm just like...but I don't think she told me you can contact them, so I didn't know that you can actually contact them." [Selma]

The Norwegian health system has been criticized by advocates for using Ammehjelpen, which is funded by private donations and a 1.5 million kroner annual state budget grant, as a band-aid to

avoid investing in sufficient capacity and competency in the public health sector for individualized guidance (Hansen, 2022; Holø, 2022; Mortensen, 2022; Tjeldflåt, 2022). Mortensen (2022) asserts an increasing reliance on Ammehjelpen, which "receives approximately 36,000 inquiries from women every year, the questions becoming more numerous and more complex, [and] has become such an incorporated institution that it is taken for granted, including among health personnel" (p. 86, my translation).

"Mother's groups" are another common source of support information and information exchange that can be seen as an example of "help to self-help". Expectant mothers are typically invited to a *barselgruppe* ("maternity group") or *termingruppe* ("due date group") by staff at the municipal health clinic, which is then expected to govern and coordinate itself. Self-initiated *termingrupper* can also be found online. For example, Tania cited a Facebook/Snapchat group she joined online as a primary source of informational support:

> "I was pregnant during Covid and we didn't have any *barselgruppe* in our health station. So I met a bunch of like, women on Facebook. And we made a mini-Snapchat group just like us, Oslo girls who were pregnant with our first kid. (…) That's also been a source of my information. (…) We talk all the time, just about random things, either send a video of our kid, or talk about, 'Oh I gave her this food, is this okay? What do you do when they have eczema? What do you do?' 16 different babies, 16 different experiences, we have so much to learn from each other." [Tania]

Positioning "self-help" as an alternative to individualized support may also fail to consider how it may compound conflicts within an existing network of care and reproduce inequities. The contradictions produced by the "help to self-help" strategy are highlighted in Selma's experience of attempting to advocate for herself and critique the health system's lack of guidance, and being met with patronizing comments from her public health nurse, who suggested that it was Selma's high level of academic and professional achievement that drove her demand for better information support:

> "The first *helsesykepleier* that I had, his [the baby's] nurse, has come with some weird comments to me, that made me feel like that, is this, how do you call this in English, 'low expectations racism'? (…) I told her like, 'I'm not happy with the way you helped us. I didn't feel like it was professional at all...and I had to do a lot of research on my own, and read on *Ammehjelpen's* website, and to read like on the internet how to increase my milk production, and you didn't tell me about this lactation consultant before he [the baby] was three weeks old. You should've told me before.' (…)

> The first time after he was born, she was like, 'It seems like you have a very academic approach to breastfeeding.' Also, weird comment, but I didn't know how to interpret it, so I didn't think so much about it. But then the *third* time, when I was at the *helsestasjon* [clinic] complaining to her and then she was saying like, [disingenuous tone] 'You have a [graduate degree] right, maybe that's why you're so interested in doing research on breastfeeding.' She was like…you have this fixation on this, what the hell?"

Selma described how the nurse's repeated impertinent references to her educational background, combined with her observations that she only saw women of color bottle-feeding at the health clinic, fueled her suspicion that health personnel were neglecting to support women of color with breastfeeding due to "low expectations" stereotyping. Her suspicions have a valid foundation: previous research has documented implicit racial bias and discrimination behavior among Norwegian health personnel (Alnæs-Katjavivi, 2021) and a study from England revealed that stereotypes of migrant women as too submissive to family pressure to formula-feed discouraged maternity care professionals from supporting migrant women to breastfeed (McFadden et al., 2013).

6.3 Emotional support

Emotional support is critical to well-being in the postpartum period, when women are at increased risk of depression and other forms of psychological distress and therefore in higher need of "concern, affection, comforting, and encouragement" (Evans et al., 2012, p. 406). As demonstrated earlier in this chapter, members of a new mothers' social network may provide valuable support in one domain but not another, or their support, when at odds with the recipient's desires, may itself become a stressor. Most of the participants in this study perceived that their families had less competency for providing emotional support, and identified partners and friends as more valuable in this domain. The power of postpartum emotional support is demonstrated by findings that a poor relationship with one's mother and perceived inadequate emotional support from one's partner correlate with postnatal depression (Stuchbery et al., 1998); that emotional support from their partners had the highest effect on buffering new mothers' postpartum stress (Sampson et al., 2015); and that emotional support has a protective effect against postpartum depression, anxiety, and impaired infant bonding for mothers who lack practical support (White et al., 2023). For the purposes of this analysis, emotional support was

interpreted as encompassing the supportive behaviors of listening and talking with the new mother in ways that convey empathy and facilitate her sense of being seen, understood, and accepted (Drageset, 2021; Xiao & Loke, 2022).

Several of the participants reported overwhelming feelings of loneliness postpartum. For Edna, this feeling was especially disconcerting because it persisted even though she was usually surrounded by family in the postpartum period, and seldom physically alone:

> "Yeah, [the loneliness] is the worst part of postpartum. I would say that actually it's singlehandedly the worst feeling. Even worse than the [physical] pains. (…) It came as a surprise to me. And then you just think, 'Am I imagining it myself? Why do I feel this? Why is it like this for me? My family is at home with me, everyone is at home with me,' but nevertheless you feel that you are completely on your own in being a new mother."[54] [Edna]

Edna reflected that the physical pain of postpartum was in some ways more bearable because she expected it, whereas the counterintuitive nature of her loneliness only heightened her distress. She observed that this went unacknowledged by her family, who appeared to her chiefly preoccupied with fulfilling their culturally prescribed support roles and therefore not very attuned to Edna's needs "as an individual":

> "…surprisingly enough, then I would say that as an individual you are a bit…ignored in a way, so it is very difficult to explain, but you get a little kind of…you get kind of overlooked. Because the families, […] I mean both my family and my in-laws, they are so occupied with everything kinda, everything that has to be done, and everything that you have to do correctly, that it's kind of like there isn't anybody that is necessarily focused on you as a person, who asks how it's actually going, like how you are. So that was indeed lacking."[55] [Edna]

This characterization of family as being intensely occupied with instrumental and informational support yet absent when it came to emotional support was also echoed by Tania's observations of how her mother fulfilled her role, as more caregiver than confidante:

> "My mom, she would keep asking, 'How's your scar, is it healing?', (…) she'd call, she'd be like, 'Don't pick up tough things, don't do this, don't do that, I can do it, tell me, I can do it.' She helped in like the practical ways. But emotionally I don't really...also like, my mom was raised without a mom (…) and she was always the caretaker in her family. So I feel like she's not really...in touch, like with the emotional um...what do I call it? Support that one may need. She's very helpful, very practical, she'll cook for you, she'll do all these sweet-ass things, but that emotional, 'How are you doing? Do you need a hug?' (laughs) That's not really there. And I think that's because she was always the caretaker, that's just the

> role she's had her entire life (…) That's just like an impact of her childhood." [Tania]

Tania perceived that her mother did not have strong fluency in emotional support due to a difficult childhood. Ada also recalled that even though her family did not treat her experience of postpartum depression as taboo, and even encouraged her to seek professional help, she still perceived that her mother had difficulties fully understanding what she was going through, despite being a valued source of positive support and reassurance in other domains:

> "Mom, she didn't completely understand right in the start, as I said. She would say like 'Yeah, you shouldn't have more children, you know. One is enough.' That was a little difficult for me to think because I do actually wish for more children, even though I think it's hard with the first one (laughs). So that could kind of be a bit hard to get past. But I felt that I had to mention several times, 'I'm struggling mentally, don't come, like, don't stress me so much."[56] [Ada]

By contrast however, Kim included her mother, whom she described as "sensitive and caring" and attuned to the emotional challenges and needs of new motherhood, among the individuals she regarded as emotionally supportive. They discussed postpartum depression frankly in their joint interview, during which her mother emphasized the importance of an emotionally supportive network with whom one could share one's feelings in preventing postpartum depression and anxiety, but also acknowledged that she or others in her generational position might not be best suited to fulfill those needs:

> "A new mom needs attention and help. And I think everyone needs that. So we have to take care of her feelings in such a way that [she] doesn't become depressed, get postpartum depression, alone with worries for the child and things. Need to air it out. If they have a group to talk together with, that's good, yeah. If they think the other generation doesn't understand them, [laughs] then they need understanding between the same generation."[57] [Kim's mother]

Kim emphasized the importance of peer groups as sources for emotional support, highlighting how having a group of friends who were also parents provided an outlet in which they could openly share their experiences and struggles with one another:

> "I talked *a lot* [laughter] to my mom and my sister and my husband and my friends who had given birth before. (…) With my first child I was really lucky because some of my very, very good childhood friends were expecting their second baby at the same time. So then we could talk through it and we were really, really open about it. So we would talk about our birth experiences, and we'd re-talk about it…I would re-tell what happened, and also [talk about] all these physical issues." [Kim]

While most of the women identified their partners as important sources for emotional support, many also perceived that their husbands' ability to relate to their experiences of motherhood and recovering from the postpartum period was limited, and thus limited their ability to provide genuine empathy and effective emotional support. These women remarked that their relationships with other women who had given birth was more valuable in this regard:

> "…there are also a lot of things that a man cannot understand in the same way, you know, as a mother who has already had children, understands it in a very different way. Like when my sister came (…), she knew how painful it was, how exhausting it was, how tired I was, she knew how it was to have a body full of hormones. She knew it in a way I think men cannot, having the same body. They don't get it in the same way. They are not the ones who have experienced birth."[58] [Kim]

> "For me, [emotional support] was talking with girlfriends who had also given birth. Good girlfriends who knew exactly what I had gone through, which they had also gone through. Which perhaps the husband or the fathers didn't understand. Simply because they hadn't gone through a birth. So it helped me a lot. Because I remember that I talked to one…when I was visiting her she said that having a child, 'It really…tests the relationship, between me and my guy, me and my husband.' And then I said, 'Yeah, I actually notice that too.' But again that's because there's another occupant here. [laughs] It's not because there's like something wrong with me and my husband."[59] [Jina]

Jina's observation that the postpartum period can strain the relationship between parents underscores findings from earlier studies in Norway and Finland that new parents commonly describe changes to their relationship as an unexpected and overlooked aspect of postpartum, and desire guidance and support from health personnel in this area (Høgmo et al., 2023; Oommen et al., 2011). The potential value of such guidance is reinforced by evidence that poor partner support is a key risk factor for depression (Eberhard-Gran et al., 2002), and by evidence that "increased level of emotional support at the time of childbirth by the biological father has cumulative effects so that even years after the child is born, support has an ameliorative effect on [maternal] mental distress" (Meadows 2011 in Sampson et al., 2015, p. 4). Selma's reflection on the tensions between her and her husband in the postpartum period provides multifaceted insight into the challenges of accessing emotional support:

> "It has taken him awhile to realize, like...things are really hard for me. They've been really hard, mentally and emotionally, and everything. And that I'm doing a lot of work at home also, a lot of household work and stuff, that I'm experiencing things like the workload's very uneven. But he doesn't experience it in the same way. (…) And I was at the brink of divorcing him at some point, actually,

> because, it wasn't just about the unevenness of the workload, but it was also just me feeling lonely with the whole postpartum experience. Not that he hasn't been supportive in any way, he has been, but it was sort of....it was, I wouldn't say conditional support, but limited in a way. (…) He *did* comfort me, many, many times. But also at some point he showed very clearly that he was...fed up, bored of...you know, this whole postpartum, breastfeeding grief thing." [Selma]

That Selma's emotional distress and discontent with her husband's emotional and practical support were so severe that she seriously considered ending their marriage illustrates how imperative partner emotional support is for the postpartum period, and the complexity of new mothers' emotional support needs. Not only may sources of support in other domains, including partners, mothers, and health personnel, be less effective in the emotional support domain, but they may in fact heighten emotional distress by presenting conflicting information, or falling short of new mothers' expectations and needs.

6.4 Appraisal support

There is some ambiguity in the existing literature when it comes to defining appraisal support, also frequently referred to as affirmational support, as some social support models conceptualize appraisal support as an aspect of informational support (Oommen et al., 2011; Salonen et al., 2014), and others include it in their definition of emotional support (Dennis & Ross, 2006). The definition of affirmational support used in this analysis is "the communication of information to enable positive self-evaluation, specifically the rightness of what the recipient has done or said" (McLeish et al., 2021, p. 452); in some social support literature this is also described as "esteem" or "appraisal" support (Leahy Warren, 2005; Xiao & Loke, 2021). In a postpartum context, the definition of appraisal support can be further refined to refer to new mothers' "need to understand what was normal for babies and to have their own performance as a new mother affirmed" (McLeish et al., 2020, p. 5), and a strong correlation between appraisal support and maternal confidence has been observed in earlier work (Leahy Warren, 2005). The experiences of the participants in this study, namely the distress and loss of confidence brought on by the need to reconcile competing sources of authoritative information, also validate appraisal support's status and function as a distinct domain of social support for this population and context.

In McLeish et al.'s (2021) research, mothers in England emphasized the "importance of being reassured by midwives or health visitors that they were doing things 'correctly'" (p. 454) and perceived their positive appraisal as more meaningful because they regarded health professionals as more objective than friends and family, whose positive feedback could be personally motivated. Praise and positive feedback, particularly when it came to the baby's growth, was often interpreted by new mothers as positive reflection on their parenting (McLeish et al. 2021). Health personnel were also identified as an important source of appraisal support by the women in this study, but in their case this appraisal was meaningful because it helped women to reconcile the information support received from family members and others outside the health system.

As mentioned earlier in this chapter, several of the women found themselves in disagreement with family members about whether to give their babies anything in addition to breastmilk. Edna, whose family members' belief that her baby was underweight and needed to be fed formula led them to accuse her of "starving" him by adhering to exclusive breastfeeding, recalled how helpful it was to be reassured by the nurse that "there was nothing wrong" with her son by demonstrating that he was meeting normal growth metrics:

> "…I approached the public health nurse myself with the thought that everyone pointed at my baby as being so thin. And that time I remember I got good support from her, when she said, 'You know what, no, now I will show you here, your baby follows the curve, it follows the right curve. Weight, age, height, everything fits here." And then I was reassured in a way. (…) It helped a lot. I remember how scared I was that I didn't…I thought maybe that my baby wasn't doing so well, so when she showed me, like that she actually said, 'No, you have to see, age, weight, all of that, objectively, there is nothing wrong with your child.' Yes, that helps.'"[60] [Edna]

Tania had a similar experience, in which her mother interpreted her baby's crying as indicative of malnourishment and implored her to supplement with formula, but confirmation from health personnel that the baby's crying was "normal", and that she was meeting growth targets, affirmed Tania's own interpretation of her baby's "signs" and empowered her to set her mother's advice aside:

> "I tried giving her [my baby] Nan [formula] and she didn't take it. So I took it as a sign, I was like, 'She's fine, she doesn't even want it!' She's not hungry enough to want it. And her weight and everything was fine. I asked my midwife, I would

> always consult someone over there [in the maternity and child health clinic], and they'd be like 'She's fine. She's gonna cry, she's a baby, she'll cry anyways'."

Participants also drew upon appraisal support from other members of their informal social networks who reinforced their decision-making and encouraged them to resist unwanted input. Sampson et al., (2015) notes how having "a partner that agrees with the mothering choices and affirms that she is a good mother" (p. 4) and demonstrates respect for her rules, routines, and parenting choices, contributes to decreased parenting stress and depressive symptoms. This type of affirmative partner support is exemplified by Tania's experience of how her husband's faith in her instincts and respect for her judgment as a mother helped them to confront or deflect external input as a "team":

> "Even my sisters-in-law and my mom were like, 'Just supplement', and I kind of had to navigate my own way through it, to just be like, 'I wanna breastfeed, I wanna solely breastfeed.' And he [my husband] was just like, 'Whatever you want', he was just super supportive, and 'Whatever you feel is right, we'll just do that cause like you're the mom, you should get first right on that part' so it was like super easy navigating it at home with us." [Tania]

Edna reported that her husband also supported her by encouraging her to ignore the chorus of opinions she was receiving from their families, but also noted that his place as a man outside of the women's sphere of postpartum and childcare diluted the strength of his affirmational support to counter the authority of Edna's female relatives:

> "[My husband] supported me, I will say that he supported me, but…our culture is probably very much like, women-dominated (…). So he tried as much as he could, but then even though he said that I don't have to listen to it, or think about what they say, it was not so simple, I did [listen], it affected me anyway."[61] [Edna]

For Ada it was her older sister who, likeminded in her attitude towards adherence to health guidelines, encouraged Ada to stick to her decisions and desires as a mother over other family members' conflicting opinions:

> "[My sister] is a bit more like, rules must be followed. So she has been very helpful in that sense. She's said, like, 'Yes, if that's how it is, then that's how it has to be. You have to say no to people. Don't let them pester you,'…She has helped in that sense."[62] [Ada]

Shared values and lived experiences are particularly pertinent to perceptions of affirmational support for postpartum women, as obtaining confirmation of their experiences and emotions as

"normal" is often critical to new mothers' sense of self-efficacy and well-being (Alstveit et al., 2010; McLeish et al., 2020).

> "It was mostly friends [that I talked to]. Especially his [my husband's] friends, actually. And a lot of them were like, 'Yeah the system is messed up, the system is messed up.' And I was really happy that I wasn't the only one, like who struggled with breastfeeding. Not that I would want this on anybody else, of course. But it was nice to know that I wasn't crazy or weak or bad or anything." [Selma]

Edna explained how the acknowledgement and affirmation she craved was elusive due to the lack of individuals in her social circle who shared her lived experience as a young mother attempting to reconcile the differences between the Norwegian health system and Somali traditions and norms:

> "When you have such a small child (…) you don't go out, you don't do so much, you don't meet many people, so…you are very isolated and would like that those around you, kinda give you that acknowledgement, yeah. (…) The problem was just that I was the only one in my social circle who had children (…), because we were very young, you know, so…my Norwegian girlfriends, they had no idea what I was going through, and my Somali girlfriends, they were just, for them it was just what they are used to from their home, right, so you for them was, yeah, just how it was, there was no discussion, in a way."[63] [Edna]

Promoting mutual support and affirmation through shared lived experience is often the purpose of peer support interventions like the "mothers' groups" (*barselgrupper*) organized by municipal maternity and child health clinics. However, because the program is not very standardized, with start-up time and content varying by clinic even across the municipality of Oslo, and leaves mothers to continue meeting "at their own initiative" (Oslo kommune, 2015), experiences and participation are then largely dependent on the group's individual dynamics, and this is reflected in the mixture of participants' perception of the value of the mothers' groups.

Selma described how she initially approached her *barselgruppe* on the defensive because she had been unsuccessful with breastfeeding and feared being judged for formula-feeding. However, in her group she met other mothers who also struggled with breastfeeding and even appealed to her for guidance on bottle-feeding, an experience that helped to bolster her self-worth:

> "Actually…the women in the *barselgruppe* were so nice. They were like, '[Selma,] I'm struggling giving my son the bottle, do you have any advice?' or, 'How did you manage to give him the bottle?' Survival! Like, he needed food, I didn't have it, so…[laughs]. But it was nice that they were sort of treating me like

> an expert, you know, so I felt like I had some value. Not that, not that formula feeding moms don't have value, of course I don't agree on that statement, but I felt like *I* had no value. And so it was nice that they treated me that way." [Selma]

Tania, who did not have access to a formal *barselgruppe* due to the pandemic, formed a close and lasting bond with a group she found through Facebook, and attributed their successful dynamic to their similarities in age, values, and commitment to a judgment-free space:

> "There's never been any conflict, any judging. Like some of us for example supplemented, some of us breastfed, some of us did this differently, some of us used natural diapers as opposed to these diapers. (…) We're all very accepting of the fact, 'You do you, do what works for you.' (…) Our age brackets are quite similar. We're probably brought up in the same way, maybe, or I don't know. But something makes us just click, I guess. (…) We've had these talks where we've been like, okay you see on Facebook there's so much 'mom-shaming' on different groups. So we made this group cause we were like, 'Okay no one's gonna mom-shame in this group. We need to be very nonjudgmental.'" [Tania]

Earlier research has touched upon the theme of fear of judgment within postpartum mothers' groups, noting heightened sensitivity to implied criticism amongst new mothers and pressure to perform good motherhood, and that dis-affirming encounters with other mothers were demoralizing and isolating (Alstveit et al., 2010; McLeish et al., 2021). These factors explain an aversion to situations involving direct or implicit comparison to other mothers. Several of the participants in this study described feeling deterred from participating in the *barselgrupper* by their perceived differences to the other women in the group, whether age, culture, or life situation. This finding supports and enhances previous research that have suggested mothers' group participants experienced bonding to be easier with mothers with similar backgrounds, and that "women in more marginalized positions…felt judged or stigmatized in postpartum community groups" (Price et al., 2018, p. 1554). Although a "sense of belonging" is commonly framed as a product of emotional support, the findings from the current study strongly imply that it is conditional for effective appraisal support.

For Ada, who described making a solid attempt to participate in the *barselgruppe* despite low attendance among the group, participation added little value when she already had pregnant with similar cultural backgrounds and family situations, whilst the rest of her *barselgruppe* were all ethnically Norwegian:

> "I think I was with them [the *barselgruppe*] maybe for two months. Once a week. But there weren't so many, we were maybe three, four people at a time. (…) But

> then, as I said, I had some friends who I was pregnant together with. It was a little like we had a *barselgruppe* together. So I stopped going to the *barselgruppe* we had in the health clinic. (…) I had my own friend group, who were much better and nicer to be together with…yeah, it was much easier to talk with them, to put it that way. They are all Turkish, everybody. So they understand a bit more how it is. (…)
>
> They are married to Turkish men too. There is a lot of difference between (…) Turkish and those who are born and raised here. And our husbands come from the same village too, so…the culture is very similar. So you kind of get to exchange a bit of information about how they are doing at home, and like if they get help, or the in-laws, for example. (…) So we have a lot of the same things in common, it is much easier (…) to talk with them and discuss, and see that a lot is the same, and also very reassuring…"[64] [Ada]

Ada's account underscores how certain aspects of her postpartum experience were informed by the circumstances of her cultural background, and her husband's background, and therefore created a need for more multi-dimensional affirmational support which only her similarly situated friends were positioned to provide. Edna's experience similarly highlights the barriers to affirmational support and belonging erected by significant perceived differences in cultural norms around the postpartum period:

> "I was only there one time. (…) It really was very different. That mothers' group only consisted of Norwegian women, you know? And we had such completely different experiences of postpartum, that I didn't find anything we had in common, so I stopped. First of all, they were a lot older than me. (…) Everyone kind of talked about how tired they were (…), complained that they slept too little, they had so little help. No, I have to say that I was in fact fortunate there, right? I had a lot of help, that wasn't something that (…), I also felt that I couldn't relate to the issues they came with. And I dared not come with my own issues, because I thought they were just…like, very strange, in a way. I had very different issues that I felt that I could not present to the group. And so I kind of just chose to shut up."[65] [Edna]

Edna reflected that, far from normalizing her postpartum experiences, her participation in the *barselgruppe* and perception that none of the other woman could relate to her difficulties, made her feel like an outsider:

> "…for us Somalis, pregnancy and childbirth, it's a very, like, family affair. But in the mother's groups, it was very clear that…pregnancy, birth, and children, it was just, in a way, nuclear family and not extended family. And it was so far from my perspective that (…) I didn't feel at home there and didn't have anything in common with them." [Edna]

Even Kim, who was an enthusiastic participant in her mother's group, noted that although she did not view it as a hindrance to her connection with predominantly ethnically Norwegian group, her mother's support did set her apart:

> "I kind of identify as Norwegian, so the only thing that was kind of different for me compared to the other ladies, was just like, my mom was so, so, so helpful with all the food and all the stuff. So they were just very jealous [laughter], the rest of the group. I just felt really, really lucky. 'Yeah, my mom, she cooks!'" [Kim]

Ethnic and cultural differences were not the only reasons given for ambivalence or disengagement with the mother's groups. Age and parity were also a factor, as many of the women reported struggling to find common ground with older, second- or third-time mothers. Mothers who did find their way to a sufficiently affirmational postpartum support group, whether through the maternity and child health center or on their own, felt that being "just new moms" contributed positively to group dynamics. However, Kim also remarked on the homogeneity and the conspicuous absence of women of color in the mother's groups she observed in her neighborhood:

> "…this *barselgruppe* thing, that's good! I think they should encourage people, I notice that it's mostly Norwegians even though we live in a really diverse neighborhood. I think that's sad. But maybe they have other groups and other people and all that. The people who have the other backgrounds, they tend to maybe connect more with their families than with unknown people at the *helsestasjon*, but I think they should try to encourage those people to participate in that, cause I think that would be really, really valuable." [Kim]

Concern over low participation of women with minority and immigrant backgrounds in Oslo's *barselgrupper* has also occasionally been raised in the media (Bakken, 2010; Mena, 2022). In 2020, the *Norsk Kvinners Sanitetsforening* (Norwegian Women's Public Health Association) established a program aimed at addressing low participation, "*barseltreff på tvers*" ("maternity meetings across"). However, its focus is on first-generation immigrant women whose *barselgruppe* participation is impeded by lack of shared language, rather than lack of shared experience or belonging, as many of the women in this study reported.

Mapping out second-generation immigrant women's experiences with postpartum care and support against the four domains of social support confirms the importance of each domain to women's postpartum recovery, self-confidence as a mother, and emotional well-being. However,

the women often experienced that their expectations and desires for support from individuals in their support network did not align with the individual's anticipated role or capacity for support in the desired support domain. This dissonance could be distressing: "Where the aspect of support received does not match the aspect of support desired, it may be ineffective or may increase rather than diminish stress" (McLeish et al., 2021, p. 452). Many of the women in this study had good access to instrumental support from their partners and families, but had more difficulties accessing adequate emotional and affirmational support. The women's mothers and female kin often saw their support roles as practical and informational, whereas the support they most desired from those sources was practical and affirmational. Unwanted informational support had the power to damage new mothers' self-confidence and emotional well-being, or contribute added stress due to the need to reconcile competing advice. Reliance on extended family or a broader social network for practical support conflicted with dominant cultural norms in Norway of nuclear family self-sufficiency, while male partners' assumption of equal parenting and practical support roles sometimes challenged families' female-led mechanisms for postpartum support. The mothers privileged and sought out health personnel's expertise and authority in the domains of informational and appraisal support, consistent with previous research (Leahy-Warren, 2005); an added dimension of health personnel's expertise was as a buffer against unwanted advice and criticism from other sources, which threatened their self-confidence. Their unique position in relation to both the dominant Norwegian culture and their family's culture made appraisal support more critical, but postpartum mothers' groups formed by the maternity and child health centers did not fully meet their need for information exchange and confirmation from relatable similarly situated peers. Securing the social support necessary across all four domains for recovery and transition to motherhood, while avoiding threats to emotional well-being, could therefore be a complex and contentious process.

Chapter 7: Negotiating support and intergenerational relations

Evident throughout most of the participants' discussions of their experiences with postpartum support and transition to parenthood was the theme of negotiating parental authority, support, and their parenting approach on their own terms and according to their own needs and values. Smette & Aarset (2023) describe how the transition to parenthood for children of immigrants often entails a renegotiation of intergenerational power relations that reshapes "relationships between parents and children, grandparents and grandchildren, and between the first and second generation" (Ibid, p. 2) as well as broader intergenerational changes in terms of gender relations and family formation that demand "renegotiations of relations, emotions, and obligations between family members" (Ibid). This chapter explores how these renegotiations of power and relationships unfold during the postpartum period.

Although the women I interviewed received substantial social support from their families, none of them had planned for or negotiated the roles of their support network before the birth. In fact, many of the participants described themselves as passive or reluctant when it came to help-seeking, and credited the initiative and tenacity of their extended family and community:

> "I understand that a lot of Norwegians feel really lonely after giving birth, because it's not so common to ask for help. I didn't ask either, but my mom came in! [laughter]" [Kim]
>
> "I don't really ask anyone for help. I don't even ask my parents, my parents just do things themselves [laughter], they're like those pushy parents, like, 'Do you want help? We'll help you!'" [Tania]
>
> "With my mom it was this about the food and stuff. It was more her idea I guess, and I didn't say no to that, of course. (…) No, I think I don't think I was very expressive." [Selma]

Across the board, it was the women's families who took the lead and set the parameters for where, when, and how they would provide support, while the women themselves did relatively little to articulate their needs in advance. Some of the women had seen their mothers fulfill the same role after other births in the family, were therefore broadly aware of their families' norms for postpartum support and did not need to explicitly solicit it.

Edna recollected how her familial support network mobilized themselves, and could not even be deterred by the barriers presented by the healthcare system, such as visiting restrictions:

> "What happened after I had the baby was that they [my extended family and in-laws], (…) I had to just tell them it wasn't possible…to visit the maternity ward, but that didn't stop them, because they came, and were down in the canteen. Everyone, they gathered there, they were there practically all three days. (…) Then we came home, and then they were already at home, and made food, and took care of things and just waited for (…) us to come home with the baby. And then the visits start. Because then everybody and kind of, anybody, comes to visit. It doesn't matter whether you know them well, as long as they know your parents well, then they come, to like deliver gifts and see the baby and stuff. So we had visits practically, almost daily."[66] [Edna]

The chief benefit in the support network "mobilizing itself" was that these new mothers received help without needing to ask for it, that prioritizing their own health after childbirth was expected, and that they did not even need to expend the mental energy to plan or coordinate this support. In other words, the practice normalized their need for support and care. The downside was that for many women, the care provided was often delivered according to culturally prescribed roles and assumed needs rather than their individualized wants or needs and therefore sometimes clashed with women's desires and values as new mothers or encroached on their parental authority or personal space. Research on social support across a wide range of disciplines and populations has linked mismatches between desired and received social support, as well as negative social support interactions, to poor mental health (Boutin-Foster, 2005; Floyd & Ray, 2016; Lincoln, 2000; Mrayan et al., 2016; Xiao & Loke, 2022). Managing these disconnects created stress and demanded the new mothers' emotional labor during an already emotionally and mentally challenging time.

7.1 Parental authority in the second-generation

Dealing with unwanted advice or conflicting information on postpartum recovery, feeding, or childcare from their support network, especially from extended family members, was a common cause of ambivalence in the participants' experiences of postpartum support, as discussed in Chapter 6. The women responded to unwanted informational support in a variety of ways, but all of them demonstrated attempts to exercise autonomy and authority as new parents, whether directly or indirectly.

Some of the women described that they interpreted their mothers' advice as suggestions and were comfortable setting clear boundaries to protect their own wishes while retaining support that was on their terms. The clearest example of this is Kim's resolve that her mother's postpartum visits would be limited to the daytime and not overnight:

> "[My mom] felt that as a responsibility, kind of according to her customs. But I was more like, 'No, Mom it's okay, you can come during the day.' (…) I'm quite good at settings boundaries with my parents, I don't have any issues with that! So no, I'm quite frank and sometimes my mom, she'll be a bit upset with it, but she's like, 'Okay you're Norwegian'. (…) I guess she was a bit sad (…) that she couldn't stay here overnight and all that. It was like, 'Mommy, I haven't lived with you for ages, like why should I do it now? Like come on, you can come, but you don't need to spend the night, it's okay.' But no, I didn't have any issues with that. I just told her to come not so often so that was fine." [Kim]

In their dyad interview, Kim's mother described being upset due to both her diminished ability to fulfill her postpartum role and help Kim around the clock, and the inconvenience of commuting to and from Kim's home, but conveyed that she ultimately understood and respected Kim's wishes.

For the other women that I interviewed, setting boundaries could bear more negative consequences. Tania and her husband, both children of immigrants from Pakistan, decided to forego an Islamic custom of shaving their newborn's head. Although this went against the grandparents' wishes on both sides, Tania's parents accepted the decision with good humor, while her mother-in-law cut off contact for a month. These differences and previous conflicts discouraged Tania from seeking her mother-in-law's help because she felt it was potentially conditional upon conforming with her expectations:

> "…there's been periods where I've been sick and she [my mother-in-law] would show up and also cook, or, clean or whatever, help us out. And I was like, 'Okay great, thank you that's really nice of you.' But if I would actively seek help? No, I wouldn't. Cause I don't want their opinions. (laughter). Because I do feel like it could come with conditions.
>
> [With my husband's family] it's like, 'If you don't do what I say, we won't talk to you', or like, there's always some kind of negative consequence. And so he [my husband] has to like, all the time, take distance from people." [Tania]

For some of the other women, unsolicited advice was perceived as critical and coercive, emotionally fraught, and was something the women actively avoided, especially from sources

they felt lacked their shared values or priorities. For example, Selma described having a "complicated" relationship with her mother, and even though she appreciated her mother's generous practical support, her perception that her mother did not sufficiently respect her wishes as a parent led her to forego potentially supportive situations in order to avoid stress and conflict:

> "Actually I rarely visit her [my mother] because (sighs) I don't feel like I get that same kind of help that I would get like with them [my in-laws], and also there's always this bickering. And having to like, assert my authority all the time, which I don't need to do with them [my in-laws], or rarely need to do with them. So it's better for her to come here, but it's also a lot of work. (…) I need to do all the like, household work, you know, instead of being able to relax. I'm just like, stressing around all the time." [Selma]

This kind of avoidance could arise even when supportive individuals were not otherwise characterized as critical and coercive. For example, Tania generally described her mother as supportive and not inclined to exerting pressure on her but was annoyed by her mother's insistence that her baby was not sufficiently nourished by breastmilk alone and should be fed formula. While her mother and sisters-in-law provided valuable practical and informational support to her in other ways, when it came to breastfeeding, Tania relied solely on guidance from her midwife from the health center and consciously chose not to ask her family members for advice on breastfeeding because she did not want to subject herself to their divergent opinions:

> "…I didn't really take advice on breastfeeding [from] anyone because I do know everyone had like different opinions. Because all of my sisters-in-law supplemented, and my mom was like, '[The baby's] still hungry, give her more', so I knew 'Ok, that's not the place to ask'. …One thing we were really keen about from the beginning was that it's our kid, we wanna do things our way, so let's just not ask everyone for their advice either cause we really don't want it! We wanna figure this out ourselves." [Tania]

Reconciling conflicting advice about breastfeeding versus formula-feeding or supplementing breastmilk with formula was also a struggle for Edna, who related that she was upset by her relations' insistence that her baby was "too thin" and should be fed formula. She described how she grew so weary of defending her decisions that she ultimately resorted to pretending to take their advice even as she continued following health personnel guidance to breastfeed exclusively:

> "I also learned to not answer completely everything they want, that I just had to say 'Yes, it's fine, I've done it.' And if they say, 'Have you given the baby formula?', then I say, 'Yes, I've done it.' To kinda stop, to be spared the kind of 'berating', the like 'Why aren't you doing it?'. Yeah, just, 'No, you know what, I've done it, I've done it, I've done it, yes.' So there comes a time when you are

> tired of arguing all the time, and all the time trying to convince them, so you just say, yeah, "No, I've done it, I've done it."[67] [Edna]

New mothers' parental authority in relation to their social network is often shaped by cultural norms that define family structure and roles, as well as the parameters and terms for negotiation between family members (Xiao & Loke, 2022). Selma described feeling incapable of facilitating and navigating the kind of grandmother role that would be normal for her mother to occupy in Syria, in a Norwegian context, especially due to the nature of their relationship:

> "In the Middle East, they have a very big role, grandmothers. They take up a lot of space and in a good way, I guess. They sort of become the second mom to the child. But that's not how it is in Norway. And I would say maybe I'm more Norwegian in a sense. But also I'm very protective of him (my son), and I have a complicated relationship with her (my mom), which makes it hard for me to trust her with my baby, in a sense. And so maybe...she does want to take up a bigger space, a bigger role, be like, a grandma-grandma. […] I feel like a bit sad that it's not like this, but then I don't know how to do it differently cause I'm not Syrian, you know." [Selma]

Edna described how within the normative Somalian family structure, her in-laws held a great deal of authority when it came to the care and upbringing of her children, engendering a sense of collective ownership over her child that, while sometimes manifested as supportive, also made it difficult for her to enforce her own parental authority to set boundaries and implement guidance from health personnel:

> "The in-laws have a lot more, (…) they come into play with force after the birth. Because they have a lot they would say about how the baby should eat, when the baby should eat, the baby's name…they feel that they have a lot they should say. (…) At least in my culture it's more like that."[68]

> "It was absolutely challenging, because I was kind of scared, you know. (…) There was at that time, I believe, one type of flu or another going around, and at the time the nurse said that it was very important that not everyone can cuddle with the baby, the baby should lie with you, and setting that kind of boundary was very, very difficult. I had my baby close to me all the time, yes, so it was hard those times, because 'everybody must hold, everybody must hold, everybody must hold' and (…) you feel that they own the baby with you, that it isn't just your child, but that it's everyone's baby. And then it was a bit nice, just in the times when like the baby cried all the time, and you were so tired, that then you suddenly had someone who could walk with the baby for you, that you didn't need to exhaust yourself. So it was both, absolutely both."[69]

Ada also had to navigate the delicate task of asserting parental authority to her in-laws, who lived in Turkey, and with whom she and her husband stayed while visiting. Though her

mother and mother-in-law had both encouraged her to supplement nursing with other food, she had an easier time deflecting her mother's advice, while she tried to enlist her husband to intervene in her mother-in-law's case:

> "My mother-in-law is a little more like, tradition and culture: 'We can do this, we can do that.' It has been a little hard for me to say no to her, instead of saying it to my mom. With my mom I can just talk how I want. But with my mother-in-law, then it's a little harder. I think, if I say something wrong now then she may get upset, or she may think it's disrespectful, you know? So I always had to tell my husband, 'Can't you tell your mother that she has to relax a bit?', for example. That we don't do that with the baby. We don't give her food, you know. We breastfeed, we only breastfeed, nothing more. I had to warn her a few times. I think she didn't receive it as well as my mom did. I feel that."[70] [Ada]

Another approach women used to compensate for insufficient authority in their relationships with family members was appropriating the authority of healthcare personnel to avoid or quiet dissenting opinions. Tania described taking advantage of her mother's faith in doctors to convince her to change her feeding practices:

> Tania: "[My mother's attitude is] like, 'They're doctors, they know best'… If I tell her that the doctor said that, she'll be more (laughs)...she'll trust it more. For example, I had to like make my mom stop giving her [the baby] so much fruit. She was eating so much fruit. So I told her that the doctor told me that…she's having diarrhea because of like so much fruit, and then my mom was like, "Oh okay, I won't give her fruit anymore." (laughs).
>
> Researcher: "But you just made it up?" (laughs)
>
> Tania: "I made it up! Cause I know it works! If I say, 'Mamma don't give her fruit, okay?' it won't work. (laughs). She'll just say I don't know. In that sense she's very trusting of the doctors." [Tania, Pakistani background]

Tania's white lie to her mother points to the expediency and efficacy of packaging her wishes in the "borrowed" authority of someone her mother would accept and respect without question – a doctor – than to convince her mother to respect Tania's authority and knowledge as a new mother alone. Conversely, Tania admitted that when doctors affirmed her mother's advice, she kept this to herself in what could be seen as a strategy to maintain her own parental authority:

> "Some of the things that my mom has like said to me, those are things that the doctor has like at one point confirmed, and I would be like oh my god, my mom...but then I never go and tell her this, because...then she'll just get that confirmation that she needs!" [Tania]

The convenience and efficacy of health personnel authority was something Edna also remarked upon, when the numerous members of her family and in-laws who had been with her in the labor and delivery ward were prevented by hospital staff from following her into the maternity ward, to her relief:

> "It was a great comfort…because at the maternity ward, I suddenly didn't have any choice there. It wasn't I who said no…. there was someone [from the hospital] who said, 'No, you can't come. It's just these three here, mom, dad, and the child who are coming in. Everyone else must leave.' That, I remember, and it was kind of strange. I thought that, now surely they [my extended family] are going to be mad. There wasn't anything I could say, it wasn't anything dad said…..It was what *they* [the hospital staff] said. That I remember thinking, 'How wonderful that was.'" [71] [Edna]

The desire for space and autonomy as a nuclear family, and the importance of setting boundaries to safeguard this, is often a key priority for second-generation parents (Smette & Aarset, 2023), as Ada highlights here, even where their families' involvement is regarded as a positive asset:

> Interviewer: "Was there anything that you, for example, wished that maybe the health professionals would have said directly to your mother, or to your husband, which was important at that time?"
>
> Ada: "No, I think that they don't need to bring Mom in so much. I'm a bit, I think a bit that…it should be [our own] family, you know. Okay, I am really fond of Mom, I am, I do try to involve her a lot. But nevertheless when it comes to certain things, then I think that we can make decisions within our own family. So I think that Mom doesn't need to get so much information. (…) She doesn't need to know so much. But my husband, I think that he ought to know everything I know about. And they [health personnel] have indeed been very helpful. (…) But I think it is important too, since he has to know how I am doing, or how the baby is doing."[72]

The importance of maintaining parental authority has been previously discussed in research on social support. Although research on the negative effects of social support is relatively limited compared to the volume of research on its benefits, prior research on health and social support has conceptualized social support as a "double-edged-sword" in which "positive and problematic support from social networks as two different domains… can coexist" (Boutin-Foster, 2005, p. 2), and "efforts to provide social support can alleviate stress and can also augment stress," (Ibid.). Some forms of informational support can in fact amount to social control (Ibid). This supports findings that intrusive or unwanted advice and support in the postpartum period can be

experienced as a loss of control for mothers, which in turn negatively impacts self-esteem (Mrayan et al., 2016).

One proposed model that conceptualizes the interactions between negative and positive social support asserts that negative encounters are "more salient than positive interactions" (Lincoln 2000, p. 241) and therefore have the power to amplify stress and depression, and harm psychological well-being in ways that may not be sufficiently buffered by positive social support (Ibid.). Managing social support that "constrained respondents' abilities to make their own decisions and operate freely" can be perceived as burdensome, especially for recipients who were already coping with trauma or other forms of emotional distress (Floyd & Ray 2016, p. 12-14). A systematic review and concept analysis of intergenerational co-parenting in the postpartum period presents substantial evidence from a broad array of cultural contexts of the importance of establishing boundaries for grandparents to respect parents' parental authority, and that "a conflicting intergenerational co-parenting relationship can exacerbate depressive symptoms in the mother" (Xiao & Loke 2022, p. 20). Given this knowledge, it is not surprising that the mothers in this study used both direct and indirect means of protecting their parental authority in the postpartum period.

7.2 Parent-child relationships

The participants' earnest interest in their children's emotional well-being, aspirations for an emotionally healthy parent-child relationship, and dedication to chosen parenting approaches in support of these goals, are motivations that offer important insight into their motivations and strategies for negotiating their parental authority and the social support offered by family members. Aarset et al. (2021) found that the parenting approaches of second-generation immigrant parents in Norway often center around "being part of a generation of involved parents with emotionally close relationships with their children" (Ibid., p. 89) and distancing themselves from an "immigrant parenting" approach often "presented as obsolete with authoritarian and patriarchal forms of parent-child relationships" (Ibid.), in contrast with a "Norwegian (or Nordic) parenting public discourse" (Ibid.) that is generally presented as both timeless and modern. The interviews showed that new mothers were highly preoccupied with embodying a parenting approach centered on emotional well-being and attachment from a very early stage:

> Researcher: Have you and your husband had any discussions about what kind of upbringing he [your son] will have?
>
> Jina: Yes, we talked about it a lot before we even became pregnant. 'How should it be? How do we wish to be? What is it both of us have to work on?' We also talked about it while I was pregnant. Watched a lot of those kinds of programs, discussion programs, debates and things like that, and talked together. What we want to avoid was being like, strict immigrant parents, like first-generation immigrants. Who came to the country with nothing, right, and worked from the bottom up. (…) We aren't in the same situation as the first-generation as immigrants, so not knowing, not being informed, that's not a thing that applies to us, me and my husband, because then we are second-generation. So we've said that we're becoming almost, rather the same as everyone else here in the country. [We] try to (…) child-rear by socializing and…maybe don't, like, scold. 'Gentle parenting?' That is the direction we wish to go. Not like, 'That's so expensive, you have to listen to me, I am the parent.'[73]

Many of the participants' explanation of their parenting philosophies echo Gilliam (2022)'s observations that the "habitus" or norms and practices of second-generation parents in Denmark is significantly constructed by their experiences as "inside-outsiders" in Danish institutions (p. 9), and that their adoption of dominant Danish parenting norms comprise both a "strategic" adaptation to avoid stigma, but also internalized and meaningful aspirations for children's social lives and emotional well-being: "[Second-generation parents'] experiences of their parents' shortcomings, and their wish to do things differently and be attentive to their children's needs and feelings thus also seem to be founded in their own embodied memories of feeling regret, shame, and frustration" (Gilliam 2022, p.10) and experiences of "the consequences of their parents' non-compliance with the forms of parenting that were practiced and idealised around them" (Ibid.). Like Gilliam's informants, the mothers in this study demonstrated a heightened concern for their children's emotional-being informed by their own, more hierarchical upbringings:

> "[My parents] are great parents, they're very loving, but I also try to work with the "pedagogical" with [the baby] but they weren't really like that, I guess. The same goes with his [my husband's parents] - it's just a thing from that generation, they were different in their parenting style. More like 'Just do this, this, this', right, and that's it. (…) Like how the older generation will often term us as 'sensitive' (laughter)...[and that] we're raising a bunch of...losers (laughter). But I feel like it's nice that we're trying to raise kids that are also emotionally aware and healthy and ready and y'know, all those things." [Tania]

> "In Norway, you have a democratic tradition, right? A non-authoritarian tradition. Yeah, where there is equality. And where you listen, and where you talk to someone and try to keep a dialog open. And not misuse power. And that there I think is very important (…). So I think that's what you need to have [in parent-child relationships]. I think that's difficult, you know, for Asian parents."[74] [Kim]

As mentioned in Chapter 5, both Tania and Kim described how their positive experiences with their families' traditional postpartum care practices strengthened their appreciation of the supportive aspects of their families' cultural traditions. Their expressed desire to "pass on" these practices to their daughters, or assertion that they should be adopted into Norwegian societal norms, is evocative of segmented assimilation, the partial retention of identity linked to the parent's home country. When it came to their own parenting approaches, however, many of the participants appeared determined to preserve their parental authority as a means of protecting their children and themselves from what they perceived as the harmful cultural aspects, attitudes, or parenting behaviors of the first-generation immigrant community, an impulse more reminiscent of dissonant acculturation:

> "External noise (…) might like, of course, could it ruin a day for us? Yeah sure. But it doesn't impact our parenting, I don't think so. That's something we've been very, like…we don't want any kind of generational shit to impact our kids. Especially like, girls in our culture, can be like…on the receiving end of the shittiest of the shit. (laughter) So I really wanted to make sure that that's not the case with my kid. Or me, for that matter! I try to protect myself as much as I can from it. I'm very firm on the fact that okay, those are your beliefs, they're not my beliefs, and that's it. I'm not gonna do things just to make you happy or like, be better or be nice to me. It doesn't work that way." [Tania]

The participants' reflections also reveal a deep motivation and sense of responsibility as second-generation parents to interrupt the generational transmission of harmful, authoritarian parenting practices:

> "My husband is more like, he has to try to break out of that, 'You have to listen to me, I know best' and such, but he isn't actually like that. He told me that when he was young, he was beaten at home. So that is something he promised himself, that he will never be like his father (…) and be so aggressive. So he is not an aggressive guy at all. He is very, very calm and patient. I see that very much now, in him."[75] [Jina]

> "I really try to not be this authoritarian parent. But I find it kind of hard because, because there's part of me who grew up with it and part of me that didn't. So obviously if you don't really think about it consciously, I think you unconsciously will bring on what you received yourself." [Kim]

Gilliam (2022) argues that it is precisely this preoccupation with the risk of reproducing their parents' attitudes and behaviors, and the "worries, alertness, and readiness" (Ibid., p. 13) to carve out "a safe insider space for their children" (Ibid.) and avoid "the stigma and negative influence of both minority and majority communities" (Ibid.), that differentiates second-generation immigrant parents from their majority peers. This perspective provides more insight into the various forms of renegotiation that second-generation mothers undertake in the postpartum period, but also the perceived stakes of safeguarding their parental authority – on their own, and their children's emotional well-being.

7.3 Partner support

As discussed in Chapter 6, the majority of the women interviewed for this study described the division of parenting responsibilities between themselves and their partners (all of whom were male) as being more equal than that of their parents, who had adhered to more traditional gender roles wherein mothers had greater responsibility for childcare and domestic labor:

> "Because we [my husband and I] both work, we both do things at home, it's just an understood thing. And I think that's something that's different about our generation. All of us, or at least the people I know, we all do things equally, most of us, whereas in our parents' generation it was more traditional, where the man would work and the woman would like...it's not like that with us, luckily." [Tania]

This intergenerational shift corresponds with existing data analysis findings that second-generation immigrants in Norway share similar attitudes and practices about gender-egalitarian work-family attitudes with the general population (Kitterød & Nadim, 2020; Nadim, 2014), and all of the women characterized their partners as being involved parents and important sources of support in the postpartum period. Nevertheless, when asked to appraise their partners' competency and preparedness for the postpartum period, many of the women discussed needing to instruct, groom, and manage their partners in parenting or infant care skills:

> "…it was I who instructed him [my husband] again. I said, 'You do this, you have to do it this way and this way.' He was…involved himself enough times that he eventually understood himself how to change diapers, comfort the baby and the like. But oh yes, then it was on me to teach it to him. Instead of the two of us learning together."[76] [Edna]

Even though Edna and her partner, who had both immigrated with their families as children, were encouraged by health personnel to adopt a more equal approach to parenting than was

normative in their Somali community, she conveyed that she still experienced that it was her role as the primary caregiver to cultivate her partner's competency as a parent and source of support. This expectation was reinforced by their families, in whom Edna perceived a double standard for mothers and fathers:

> "I think they [my family] were very surprised that he [my husband] was so helpful. He did get a lot of praise for the things he did. While if it was expected of me, then he got a lot of praise."[77] [Edna]

This dynamic was also highlighted by Ada, who felt that although she (born and raised in Norway to Turkish parents) and her husband (born and raised in Turkey and a recent migrant to Norway) had discussed their expectations for their roles and responsibilities for the postpartum period extensively during her pregnancy and agreed to be equal parents, this was challenging in practice because Ada felt he lacked sufficient competency when it came to childcare and childrearing. She conscientiously sought out information about child development to inform her parenting and childcare decisions, but sometimes encountered resistance from her husband on her "research-informed" approach:

> Researcher: Do you think that he [your husband] had enough, for example, knowledge or competence?
>
> Ada: No. (very directly) I don't. Just to put it bluntly. As I said, I have read a lot about raising her, and what is dangerous, what she can do, what she can eat and what she can't eat. Both from the start and along the way. How she should sleep for example. I have really been reading, did research. I have been on Facebook groups, for example, and read a lot on Instagram and bit of things like that. (…) But he has been the opposite. He has even said, 'No, I don't believe in what you're reading.' He has always been, 'Yeah, but that's like, research, it can be changed the day after, you know?" He has kind of been the opposite.
>
> Researcher: But did he take his own initiative to convince you of the opposite?
>
> Ada: No…he was actually saying that, 'Yeah, well my parents have raised me in such a way, so surely it's fine.' But I was like, 'Yeah, no, that was in the old days, and it wasn't okay in those days either. You might have been a different person if your parents had done things differently, for example.' But I had to kind of have a couple conversations in order to convince him so that ultimately he said okay.
>
> Researcher: And was that hard for you to have to –
>
> Ada: Yes, it actually was, because I was already struggling. And so trying to convince him and kinda see that he doesn't believe what I'm saying has been kinda difficult, it was.[78]

Because she had difficulties with breastfeeding and experienced postpartum depression, reconciling their differing parenting beliefs was an added emotional burden for Ada, who noted that despite their shared Turkish family backgrounds, the postpartum period highlighted the differences of their upbringings in forming gender role expectations. She described how even though she felt she performed significantly more of the childcare, her husband humorously boasted to his family that it was he who always took care of their daughter, exposing Ada to her mother-in-law's disapproval:

> "My mother-in-law said, 'It is always him who's taking care of her down there [in Norway], isn't it?' Then she like, began defending her son right away. So I have kind of experienced a couple of those kinds of episodes, yes. But then I told her, 'But he doesn't.' (…) We figured out that it was him, he joked around a little too much, and said, 'Yes, I take care of her all the time.' (…) But nevertheless she is quick to feel sorry for her son. (…) 'He has to rest. He can't take care of her all the time.'"[79]

Although Ada reported strong Turkish cultural influences in her own upbringing and family life, she described an acute consciousness of the cultural differences she had with her husband and his family. Though she appreciated her husband's challenging his family's gender role expectations to be a more involved father, she still found navigating these differences to be difficult, often sought support and advice from friends with similar marriage situations, and felt that she was still left with the primary responsibility for their daughter:

> "[My mother-in-law] thinks he has to help, but I have to have the main responsibility, and he has to help. (…) But luckily he doesn't agree (…) he says, 'Yes, well it is just as much my child as it is yours. So I also have to do something.' But nevertheless then I feel that I have the main responsibility. (…) What can be totally difficult for me, is that my husband, he wasn't raised here. I can easily see the difference. I feel the difference. (…) But I feel that he is beginning to get used to it, but (…) there is not a lot of equality when it comes to raising children in Turkey. It is changing a lot now, but my husband comes from a village, and in the village…things don't go as quickly. (…) Luckily my husband isn't so…not there, in a way. He thinks and helps a lot when it comes to raising her [our daughter]."[80]

In addition, Ada also often had to interpret for her husband during her maternity care appointments as he was still learning the Norwegian language. Even though the care guidelines in Norway place strong emphasis on including the partner in maternity care, and patients are legally entitled to professional translators (Helsedirektoratet, 2014b), interpretation services were not offered and it was Ada, the patient herself, who had to be her husband's interpreter and the

gatekeeper of information from health personnel, as well as his cultural broker and educator when it came to parenting practices. His migration background, for both structural and cultural reasons, therefore played a significant role in shaping her postpartum experience and role as their daughter's primary caregiver even though they wanted a more gender-equal partnership.

It is essential to underscore, however, that normative assumptions of mothers as primary caregivers persist and remain relevant to postpartum care experiences even in Norway's overall population. Previous studies of postpartum care in the Nordic countries have highlighted that healthcare providers often insufficiently include male partners, who perceived the maternity care environment as a "women's world" and felt therefore sidelined as parents (Feenstra et al., 2018; Høgmo et al., 2021; Persson et al., 2012; Solberg et al., 2021). Barimani's (2017) research in Sweden also found that lack of role clarity was common for partners and role conflicts were a pervasive theme for couples' transition to parenthood. Though this dynamic may be heightened or more multifaceted amongst parents with migration backgrounds who are simultaneously navigating gender role evolution across multiple social contexts, it is still pervasive amongst Norwegian majority parents, as Selma demonstrates, speaking on her ethnically Norwegian husband and the broader Norwegian society:

> "There's a lot of grooming here. (…) Teaching him [my husband] how to like, do this and do that with the baby. (…) I wish there was a course that talks about the partner's or the husband's role *postpartum*. Like, husbands should do the diaper changes, they should do the bottles, they should do the household, they should do the cooking, they should do all of this. And the woman shouldn't have to tell them what to do. But...that's what I had to do. Because he didn't know, I had to tell him. And I don't think it's a personality thing. Maybe partially, maybe it is. But when I talk to other friends, they say like they had to do the same. They had to nag on their husbands. And I think there's a lack of awareness. There's a lot of talk out there that the partner is crucial during birth. But there's not so much talk about how crucial and important and invaluable his role is postpartum, you know? (…) It's not like this proper discourse around it, that husbands should really do most of the work while the mom recovers and breastfeeds or whatever, or pumps, yeah? So...my impression is that a lot of women, they have to groom their husbands, they have to teach them everything, instruct them, and yeah, basically be managers right after giving birth, and it's too much." [Selma]

Selma observed that while many of the prenatal education courses offered by the municipal health clinic were aimed at and encouraged the participation of both partners, this was not the case for the only course that covered postpartum concerns, which was on breastfeeding, and

noted the "lack of awareness" and resources to prepare male partners for their postnatal role added an additional burden of educating and "grooming" their partners at an already-demanding time. She did note that while her in-laws did not offer much practical support, they supported her indirectly by urging her husband to take more responsibility at home. This contrasts with some of the other participants' in-laws, or indeed Selma's own mother, who affirmed the lower expectations for fathers, and even enabled it through their support:

> "[My husband's] parents are very much on my side (laughs). Like, (scolding voice) 'If he doesn't do good enough, you tell us, and we'll tell him.' (laughs) Or like, (scoff), they call his name, 'Oh, [husband's name] come on, get up, take this, come on, lalala.' So they boss him around, I like that. That's nice. So in that way they also help me. You know, they take some of that load off of me.
>
> …my mom really adores him. So she's mostly on his side. So when I was telling her, (sighs) he doesn't cook, like he doesn't, she's like, 'I'll cook! [He can] just relax with you.' (laughs) So of course...it was invaluable that she cooked, because he would have never." [Selma]

Two of the women who expressed satisfaction with their partners' preparedness believed it was enhanced by experience from family: Jina's husband had taken care of much-younger siblings, while Kim's older sister had specifically advised her to ensure her husband learned about breastfeeding in advance:

> "I knew from my sister's experience. Because she said, you should read up a little bit about breastfeeding before you get the baby, both of you, so that he [my husband] would know how to support me and he would know what to do. But basically he did what he was supposed to do in terms of carrying and taking care of the baby and changing the diaper, doing all that kind of practical things. Take her for a stroll if I needed a rest and things like that." [Kim]

Tania also described her husband as being proactive in developing his own competency as a parent rather than looking to her for guidance, even though coronavirus pandemic measures had excluded him from prenatal appointments and early postpartum days in the maternity ward, and recalled how he was forced to work things out on his own because she was too exhausted to teach him:

> "I was exhausted, I couldn't even be a cute loving mom in the beginning. I was kind of like, 'Get her [the baby] off of me, I'm so tired, I'm so exhausted'. And [my husband] would just be up all night, cradling her, taking care of her. And I remember he had never changed a diaper in his life, and this one night he was like, 'Tania, can you change her diaper? Can you change her diaper?' (laughs) He's never changed a diaper, right? And I was like, 'No! Leave me alone!' And he

> just went in there, he just figured it out, and he was like, "I didn't know how to put it on! I didn't know what to wipe!" …so it was a huge learning curve for him as well, where he was just thrown into it. He didn't know anything. (…) Whatever I would learn from someone, like if I talked to a doctor or whatever, I would convey to him. But even he, he was very good at like...just figuring things out as well. I didn't really feel like I had to spoon-feed him. He knew. We were figuring it out together, how does this baby work. We were just doing it together, for sure. It's very like 50/50. And at times I feel like I've learnt from him, than he has of me, even though I am the mother. [Tania]

In addition to mastering the skills of parenthood and infant care, attending to their physical and emotional well-being and recovery from childbirth, negotiating support from their social network, new mothers also often find themselves charged with cultivating their partners' emergent parenthood as well as their own. Although gender equality is idealized in Norway, entrenched institutional and social barriers persist, making full equality elusive for many families, and often positioning mothers as the default parent. The experiences of the participants in this study corresponded with earlier findings of the Norwegian health system's poor incorporation of fathers in maternity care (Høgmo et al., 2021, 2023; Solberg et al., 2021), but also share similarities with studies on postpartum social support in Jordan and China (Mrayan et al., 2016; Xiao & Loke, 2021) which note that traditional forms of family support can also reinforce the attitude that fathers are redundant or irrelevant to the postpartum period, discouraging them from taking a more active role or becoming a barrier to the development of their parental competency.

Chapter 8: Challenges to emotional well-being in the postpartum period:

Previous research has found both higher prevalence of postpartum depression symptoms and barriers to seeking mental health care among ethnic minorities and women with immigrant backgrounds (Nakamura et al., 2020; Zlotnick et al., 2023). Lyberg et al. (2011) also found that among migrant women in Norway, grief, loss, and previous traumatic events frequently rose to the surface during pregnancy, birth, and/or postpartum, manifesting in both depressive and physical symptoms. There has been an increase in research on the relative mental health vulnerability of children of immigrants in Norway and other Western countries in comparison to their parents' generation and native-born population, but existing studies are often focused on adolescents rather than adults, and have produced ambiguous and contrasting findings (Abdulhamed et al., 2022; Ekeberg & Abebe, 2021; Kim et al., 2018; Mood et al., 2017). Research from Denmark has identified increased risk of perinatal mental disorder in both first- and second-generation immigrant women, and equal risk of postnatal mental disorder, in comparison to the native Danish population (Munk-Olsen et al., 2010), while results from a French longitudinal study showed higher levels of postpartum mental health difficulties among first-, but not second-generation women (El-Khoury et al., 2018). Postpartum socio-emotional well-being among the second-generation is therefore an area with highly relevant implications that is still poorly understood.

Previous research in Norway identified postpartum emotional stressors among first-generation women that stemmed from traumatic memories, such as from experiences of war or female circumcision, but also lack of social network, and yearning for one's female relatives (Lyberg et al., 2011). Studies suggest that emotional stressors among second-generation women both overlap with and are distinct from those experienced by the first-generation. Wandel et al. (2016) note in their research on mothers of Somali background in Norway that participants who had grown up in Norway with immigrant parents "perceived life in Norway as stressful and lamented the lack of a support system…in contrast with the tradition in Somalia, where family and friends were present to support the mother as she breastfed and bonded with her new born infant" (Ibid: 491), suggesting that "insecurity and anxiety" due to "being a mother in a foreign environment" was also present among children of immigrants as well as immigrants themselves (Ibid). Mamisachvili et al. (2013) compared first- and second-generation mothers in Canada and found

that the second-generation mothers internalized "the expectation that they should be able to manage motherhood without support […] contributing to mood problems for all second-generation participants...[who] felt guilty because they could not achieve the standard societal image of the self-reliant, independent mother" (Ibid, p. 166-167).

This chapter will discuss the factors that negatively influenced participants' emotional well-being in the postpartum period, specifically the impacts of their experiences with giving birth and breastfeeding, factors which have shown to increase their vulnerability to postpartum mood disorders. It will also discuss experiences and interactions with informal and formal support providers that contributed to the new mothers' loneliness and of not being seen or heard.

It is important to note that psychological health status was not designed to be a central focus of this study and the interviews did not include any direct inquiries or assessments about postpartum depression or other mood disorders. However, since postpartum emotional well-being and access to emotional support were relevant to the research topic, some of the participants referred to their mental health within those contexts. Any assertions related to whether participants did or did not have postpartum depression is based on their own disclosures or assessments and not externally validated. Although a couple of the participants did report receiving care from mental health professionals, it is also worth noting that concepts and language from psychology have increasingly entered mainstream, lay discourse around health and well-being, making it sometimes unclear to what degree the participants' statements were informed by professional judgment or their own self-assessment.

8.1 Breastfeeding

> "The most difficult thing that I ever managed to do in my entire life was breastfeed my children, honestly. It's so difficult, technical, painful, and I don't know what. And I remember thinking, how did people do it? It looks so easy! I'm supposed to be able to do this without any fuss and it's so painful." [Kim]

The challenges and pressures related to breastfeeding have been consistently shown to have a powerfully negative impact on the mental health of mothers in the postpartum period. The presentation of breastfeeding as "natural", "normal", "intuitive", and expected by both health professionals and society at large contribute to women judging themselves as failures when confronted with difficulties and negative experiences with breastfeeding (Barimani et al., 2017,

p. 540). This problem is particularly acute in Norway, where exclusive breastfeeding has been heavily promoted a public health goal and thus become heavily normalized. Breastfeeding rates at six months of age in Norway were measured to be among the highest in Europe prior to the COVID-19 pandemic: "Breastfeeding is promoted in a national action plan launched in 2017 for a healthier diet and national surveys published in 2020 showed that 78% of babies in Norway were breastfed at 6 months and 48% at 12 months" (Vik et al., 2023, p. 2). As I have discussed in Chapters 4 and 6, this eagerness to promote breastfeeding at the policy-level is not reflected in government provision for, and mothers' access to, resources and professional competency for sufficient breastfeeding guidance and support, and the health system has increasingly come to rely on third-sector, voluntary entities (i.e., Ammehjelpen). Indeed, more recent statistics suggest a worrying declining trend showing that significant decreases in exclusive breastfeeding at discharge recorded during the COVID-19 pandemic and attributed to early discharge rates and diminished access to health personnel support and guidance, have not recovered in succeeding years even after pandemic restrictions were lifted (Vik et al., 2023, p. 8).

The push for and normalization of breastfeeding in Norway, both socially as well as by the health system, made all of the women I interviewed intensely motivated – or perhaps pressured – to breastfeed, only to have their expectations shattered by a reality that was often far more challenging, intensely painful, and all-consuming than the idealized representation of breastfeeding that they had imagined before giving birth. The quote from Kim, above, illustrates how the experience of struggling with breastfeeding and reconciling its dissonance with a heavily normalized representation of breastfeeding in Norway as easy, "natural", and ubiquitous, was a significant challenge for many women to overcome. This echoes Razurel et al. (2011) who suggest that women perceive breastfeeding negatively due to the differences between the problems they encounter and "information given during prenatal education where the future difficulties of breast feeding are often concealed" (Razurel et al., 2011, p. 240).

Selma's account of the breastfeeding discourse promulgated throughout her prenatal care illustrates how deeply entrenched assumptions and expectations around breastfeeding are at the *helsestasjon*, and how the focus on normal birth and breastfeeding left little space for preparation and acceptance of mothers who were unable or unwilling to breastfeed.

> "…I didn't know breastfeeding would be such a big deal until I got my baby. (…) I feel like breastfeeding is such a big deal in Norway, and they make it into a big deal, because that's almost the only thing they were talking about in the *helsestasjon*. 'Are you gonna breastfeed? Do you have plans for breastfeeding?' And they gave us (…) a course on breastfeeding and never, not a single time during this one-and-a-half-hour course, plus dialog after the course, did they mention that some women, maybe might not manage to breastfeed, because of c-section, postpartum hemorrhage, whatever, or genes, maybe they might not have milk. So like you get this expectation that its completely normal, and expected of you, and natural to breastfeed, you know?" [Selma]

Encountering persistent difficulties with breastfeeding was often a profound emotional stressor, as Tania related:

> "[Struggling with breastfeeding] would make me like kind of cry, like I was really upset because [my baby] would keep crying. I know it's normal, babies are supposed to cry, but it just seemed like she was hungry and I wasn't really able to give her any milk. And I was like, 'Shit, why isn't my production coming in?'" [Tania]

Some of the women more explicitly connected their difficulties with mental well-being in the postpartum period to their struggles with breastfeeding, albeit in somewhat different ways. For Ada, who reported having experienced postpartum depression, the constant demands of breastfeeding made her feel restricted and housebound, and she recalled envying the freedom she perceived others enjoying:

> "The breastfeeding was the most difficult. I feel it was maybe one of the things that most made it that I got postpartum depression, I think. (…) I thought a lot that I couldn't go out, because [the baby] was hungry, you know? At that time, it wasn't so easy to nurse her outside. Back then I could sit and nurse a very long time. I couldn't take it, you know? (…) I'd think a lot, "OK, my husband, for example, he went to school. I thought ok, he can just go to school. He can just go out. I have to sit here and take care of her. Everyone can do what they want. I have to sit at home and not do anything else, you know?" Now it sounds very strange for me to think that way, but at that time I would just think like that, you know. So that, I think, was very difficult. As soon as I went on Instagram for example, and saw someone was out for example, and sitting and drinking coffee together. Then I thought that they can just go out as they want. I have to sit here, nurse her all the time. (…) It felt like I nursed her the whole day. I thought that was really hard."[81] [Ada]

While social visits had the potential to ease the isolation brought on by the physical restrictions associated with the postpartum period, they could also present their own dilemmas when it came to navigating privacy and social norms around breastfeeding. Schmied et al.'s (2012)

meta-ethnographic study of breastfeeding experiences among migrant women found that they sometimes elected to formula-feed due to discomfort with breastfeeding in front of others. Ada, for example, recalled that she initially isolated herself to nurse out of respect for perceived taboos and Turkish cultural norms, despite coping with intense feelings of isolation and yearning for company in the postpartum period:

> "I felt a lot better when somebody came by. A different face. In the start, when my family came, when I was going to nurse [the baby], Dad was with us. At that point I thought I couldn't breastfeed next to him. So I went to the bedroom, but it took a very long time. I thought it was very boring to sit alone in the room, like breastfeeding. And in the end, I said, 'You know what, I'm just going to go in and nurse. It's my father, it's fine.' It isn't that I didn't want to nurse next to him, but it's like, respect and culture, you know, that I'm not respectable. He never cares about it, actually. […] So I sat together with him eventually and nursed. And do that still."[82] [Ada]

Ada also had to navigate privacy and breastfeeding during an extended visit to her in-laws in Turkey, where she recalled her attempts to retreat from the family social space to breastfeed with privacy and peace and quiet were met with discontent from her mother-in-law:

> "It was a bit harder down there [in Turkey], living together with [my in-laws], you know. It took a long time to breastfeed. I didn't want to breastfeed next to them. I went to our room and nursed there. (…) So I was inside our room a lot. I'm breastfeeding, that already took a long time, and she would sleep while we nursed. So it happened that I was in the room a lot, and then I heard [my mother-in-law] say a lot, 'Why is she in the room? Why doesn't she come out? I want to see my grandchild' and that kind of thing. I think it became a bit too much, that trip. Or a bit too long."[83]

Although all the participants normally lived in nuclear-family households, having foreign extended family or in-laws meant that a few of them temporarily experienced intergenerational living during extended visits in the early months after giving birth:

> "I was like three or four months postpartum when his mom and brother came to live with us. I think that was a bit too much for me, because I had to breastfeed like all day. […] I couldn't just whip out my boobs, so I had to always go in [to the bedroom]. […] It's hard living with other people when you're going through postpartum. And I think no one understands that because, for example in Pakistan, it's so normal that you just live with your entire in-laws. [...] [Postpartum] is very challenging and you really need your privacy and space, it's so important because you need to figure so many things out. Like I could have never figured out breastfeeding if I wasn't allowed to just literally sit here naked and just like figure it out. What do you do when you have so many people around you right? […] So I

> think that was kind of challenging, having someone live here while I was breastfeeding. For sure." [Tania]

Tania also reflected on the importance of privacy and space in the postpartum period and described how temporarily sharing her home with her in-laws impeded her freedom to breastfeed and felt this consideration went unrecognized because intergenerational households are so normalized in Pakistan. This dilemma could also have been heightened due to the mothers' adoption of exclusive breastfeeding rather than supplementing or formula-feeding, which was more normalized amongst the women's families and might allow more flexibility to feed the baby in shared social spaces. Wandel et al.'s (2016) study on breastfeeding attitudes among Somali-Norwegian mothers notes that Islamic modesty norms could made breastfeeding a challenge, and make formula-feeding a more practical option. Whether due to cultural taboo or personal discomfort, the presence of visitors, combined with the demands of breastfeeding, could increase, rather than ameliorate new mothers' isolation in the postpartum period.

In Selma's case, it was the immense struggle to establish breastfeeding, and then ultimately coming to terms with bottle-feeding her baby, that took a great toll on her postpartum mental well-being. She described how her postpartum experience clashed with her expectations and shattered her confidence that she had been prepared to meet the challenge of breastfeeding:

> "[The postpartum hospital stay] wasn't like this 'rosy thing' I had in mind, that we would be together in the family room. And you know, I've heard breastfeeding is tough, but I thought that, I read about this, I've attended a course, you know like...not like it wouldn't be challenging but I felt that, how do you say, *utrustet,* like I was armed in a sense. I had the tools. I felt a bit confident about the whole thing, you know. And so everything was like a slap in the face (laughs), a huge slap in the face. It was totally not what I expected." [Selma]

While all the women who participated in this study described feeling extremely motivated to exclusively breastfeed, in line with dominant Norwegian infant feeding norms, Selma related how her persistent difficulties with supply, including numerous attempts to obtain breastfeeding guidance from both public and private healthcare workers, did not culminate in success and resulted in breastfeeding grief. The lasting emotional impact of this was evident throughout her interview, where she became tearful in multiple instances recounting her breastfeeding experience, and feeling of being failed by the healthcare system:

> "I was berating myself, many months, thinking I should've listened better, I should've remembered better, I should know better. But (…) I'm finally at a place

> where I'm like, no, it's them. Like, they're the professionals. They should have taken better care of me. And there's a system here that has failed me. (…) I think mostly now I feel regret and guilt over having obsessed so much about the breastfeeding (…) because I felt like I stressed him (the baby) out as well, and I stressed out my husband, and I stressed myself out, instead of just like, accepting and enjoying those first few weeks and months you know? I did give up after three, four weeks. But the disappointment, the rage, the sadness, was really eating me up, for, I would say, two and a half, three months." [Selma]

The profound impact of successful breastfeeding on mothers' emotional well-being and sense of self-efficacy as a mother has been well-documented in previous research (Eberhard-Gran et al., 2002; Hjälmhult & Lomborg, 2012). Razurel et al.'s (2011) qualitative study on stress and social support in the postpartum period identified breastfeeding as "the major stressful event" in the at-home postpartum period and observed that "a strong idealization of breastfeeding" contributed to it becoming perceived by new mothers as a high-stakes "indicator of a 'good mother" (Ibid, p. 240). A study on the experiences of mothers in Norway who were not breastfeeding reported that many experienced pressure, shame, guilt, and disempowerment with deciding to formula-feed (Hvatum & Glavin, 2017). These themes resonate in Selma's characterization of how the drive to achieve breastfeeding became all-consuming for her:

> "I was so adamant on getting the breastfeeding right, like everything was about that in the end. I don't know, I was just obsessed, probably because I was talking to like friends about this on the phone and everything, and everybody was like, 'Yeah it's hard, but it took me three months and then everything was easier after three months, so don't give up.' So like, everybody was hammering this idea into me that it only takes effort and if you just stick it out, it'll work out. So I felt like if I don't stick it out, then I've given up and then I'm a failure, I wasn't tough enough, like everybody would say, 'I was stubborn, I was stubborn, that's why I didn't give up.' So I was like, okay stubbornness is a good thing, maybe and I'm not stubborn so I'm not a good - I don't know. […] It became my whole identity all of a sudden. And it wasn't something I gave even two cents about, before birth, you know? Then after birth it was just like everything to me." [Selma]

This discourse which Selma observes fueling her "obsession", of breastfeeding as a "fight" for mothers to win through endurance, is common in the literature (Börjesson et al., 2004, p. 591) and also came up in other interviews in this study. Selma's reflection that breastfeeding became wrapped up in her "whole identity" aligns with assertions that "breastfeeding represents a fundamental cultural value in Norway" (Hvatum & Glavin, 2017, p. 3144). This entanglement of breastfeeding and identity became even more intensified, Selma reflected, by her own

consciousness of being a visible minority woman and what can be seen as internalized stigmatization and stereotyping of immigrant women of color as unmotivated or disinclined to breastfeed, which further intensified the pressure and emotional distress she experienced around breastfeeding:

> "I was having this inner racist dialogue inside of me. […] I was like, I wanna be like those middle-class white women breastfeeding, I don't want to be like those other women in Groruddalen [section of Oslo with a high density of inhabitants with migration background], other immigrant women...I don't want to be seen as one of those. So I started having all of these...yeah racist thoughts in my mind, that I don't want to be associated with 'these kind' of women. So it became this whole like, 'breastfeeding is a Norwegian thing.' And not breastfeeding is not a 'Norwegian' thing, and it's the 'lazy' kind of thing. So yeah, I was, like, sort of recreating this stereotype that immigrants are lazy, sort of, you know it wasn't on purpose but when I reflect on it now, that's what I was doing, in a sense, yeah? And I was like, those are – "I'm like the good immigrant, I'm a Norwegian immigrant, I breastfeed." Of course, that doesn't make any sense, that's just my inner racist talking. […] I was embarrassed…and a bit ashamed. But not to the extent that I was like, too afraid of giving him the bottle in public, but I was all the time thinking, 'What would they think of me? Would they see an immigrant woman giving the bottle? Would someone think that?'"

Selma's reflection is echoed in Hvatum & Glavin's (2017) study, which discusses the hegemonic nature of breastfeeding in Norway, reporting pressure to breastfeed coming from both social networks and health personnel. They report that many women in their study perceive that to breastfeed was "to adapt to Norwegian culture" (Hvatum & Glavin 2017, p. 3148) while to formula-feed was to break an implicit rule and face alienation and stigma: "The mothers felt disgraced and felt that they were set apart. They felt as though they were seen as part of a stereotyped group. The negative attitudes and prejudice from people around them and the healthcare workers made them feel abnormal" (Ibid, p. 3149). What differentiates Selma's experience is that her anxiety around bottle-feeding is related not only to her fear of being viewed as a bad mother, but also to internalized racism and desire to be viewed as a "good", "Norwegian" immigrant.

This internalized idealization of dominant parenting practices, and the risk of "misinterpellation" (being mistaken for a first-generation immigrant and rejected by the dominant society) is discussed in Gilliam's (2022) research on second-generation minority Danish parents, which describes an "ambivalent" relationship between second-generation parents and contemporary

first-generation parents due to the awareness of second-generation parents that "their belonging is fragile, their inclusion conditional, and that they can always be mis-interpellated and excluded" (Gilliam, 2022, p. 11). Gilliam asserts that threat of mis-interpellation and fragility of her participants' 'Danish' belonging feeds pressure to perform 'good', 'Danish' parenting. Research in Norway echoes this, finding that despite greater confidence navigating majority social institutions, second-generation parents "may overperform good parenting…to manage the stigma attached to the 'bad immigrant parent'" (Handulle, 2022 in Smette & Aarset 2023, p. 2).

Echoing this intergenerational dissonance, Selma, like many of the other participants in this study, perceived that her family members did not understand the implicit stakes of not breastfeeding as a visible minority woman in Norway:

> "My family was mostly like, 'Why are you so obsessed with breastfeeding? Just give him the bottle.' (laughs) […] It wasn't like they weren't supporting me in my breastfeeding journey, but they maybe didn't understand how serious it was for me, I guess." [Selma]

Their advice to supplement or formula-feed therefore did little to assuage the new mothers' fears of not fulfilling the dominant expectation in Norway that "good mothers" breastfeed, and in some cases, as discussed in Chapters 6 and 7, only served to subject the mothers to yet another – contradictory – stream of implicit criticism.

8.2 Processing birth experiences and trauma

Several of the participants in this study reported dwelling upon, scrutinizing, and processing their birth experiences as a significant preoccupation during their postpartum period. Previous research has not only identified negative birth experience as a key risk factor for postpartum depression but attributed it to "deeper and long-lasting depression [as] part of an important grieving process during which the person must attempt to work through and reinterpret their birth experience in order to make some kind of sense out of it" (Davis-Floyd 2022, p. 52). This association has also been corroborated locally with data from the Akershus Birth Cohort which also found a significant association between negative birth experience and postpartum depression (Rosseland et al. 2020).

The postpartum reinterpretation process Davis-Floyd describes is exemplified by Jina's experience. Jina expressed that that while she had hoped for an intervention-free birth, ideally at

home or in a midwife-led birthing center, her 48-hour labor ended up including multiple successive interventions culminating in an acute intervention at the final delivery stage for which she felt inadequately informed by health personnel. She described spending months dwelling upon and coming to terms how the birth had unfolded:

> "I thought about it a good time after though, two or three months after, in order to in a way, accept, or kind of understand, that they are just human, everyone. They surely did try their best for me and for the baby though. (…) But then it went how it went, you know. (…) But the last hour of the birth did go really fast, so that's what made me think for a long time (…) what happened there. I have indeed reconciled with myself, I have kind of accepted it, and thought that this was just something that had to happen. If not, it could have been much worse, I think.[84]

Jina pointedly did not frame her thoughts as depression, which she defined in terms of detachment from or risk of harming one's child, and her language suggests a normalizing interpretation of both her birth experience and her emotional response to it, despite describing it as tough and long-lasting:

> "I think it's a time everybody thinks about, but it wasn't depression, where I thought like, 'I have to take space from my child', that I would think that I was going to do something that hurts my child, or that I had to distance myself from my child because I felt that I kind of lost sensitivity, contact with my child. It wasn't like that, fortunately. It was much more how the birth itself was. Was there anything that could have been done differently? Because I am like that, kind of a perfectionist at things. But I have now realized that we are all human, and human error can happen, and the most important was that my child didn't die, or became sick, like properly sick. I am still getting over it. It's been kind of up and down. But it was really tough."[85]

Jina was interviewed about six months postpartum and characterized her birth experience as something she was "still getting over". However even the participants who had given birth several years prior to the interview spoke of flashbacks and negative memories related to their birth experience:

> "I can still feel it, if I do this yoga breath that I did in order to just survive all these contractions, sometimes if I do that kind of deep breath again...it's just...I get back there. It's not nice." [Kim]

> "I was just very unprepared for how it could affect me mentally […], specifically to lie in the same position that you have to be in. […] When you are circumcised there are many who hold you, in order to hold you in place. And in a birth context it happens that there comes a moment where people […] hold you, but not to hold you against your will, more to support, right? Because you have to push in a

> specific way, so then they hold you. And that can kind of create 'flashbacks'. (…) I do have to say a lot of the memories came back much more clearly after the birth than before the birth. That is probably what was most unpleasant."[86] [Edna]

Edna's experience echoes findings from Lyberg et al. (2011) in which midwives reported that migrant women's traumatic memories of war and circumcision could manifest as physical symptoms and flashbacks during labor and contribute to perception of the birthing experience as abusive. Edna's observation that her memories of circumcision were intensified after the birth is also noteworthy and highlights the layered, potentially cumulative nature and longer-term implications of birth-related trauma.

Selma, meanwhile, described an anxiousness after coming home from the hospital that was so intense and persistent that she was unable to rest or negotiate offers of help from family and friends. She attributed this to negative experiences in the hospital with postpartum hemorrhage and with an incident where a nurse went against Selma's wishes and feeding plan by formula-feeding her baby instead of waking Selma up to nurse:

> "I still struggle with actually giving myself time to rest, but the first few months I would say it was trauma from the nurse. Because when she took him and fed him three bottles against my wish, I was sleeping, I was resting. And when [crying] I was done giving birth, I was resting, I was under anesthesia, so […] I felt like I could never rest or relax. I couldn't like, trust that everything would be okay. And for maybe two, three months, I would often wake up with a cold sweat, and like a hammering heart […] I would wake up every 10 minutes and be like so frantic, and I would always think that I was away from him for four hours, but it was also like 10 minutes, 15 minutes, 20 minutes. So even though people were helping me, I wasn't resting, which was important."

Selma's struggle to rest and accept offers of support aligns with research on negotiating unwanted support. Floyd and Ray (2016, p. 14) assert that "[support] receivers who are already traumatized or grieved may easily see such gestures as burdensome, presumptuous, or overbearing" and that unwanted support can contribute to "additional stress beyond what they are already managing, which has implications for their mental and physical health as well as for their relationships with providers" (Ibid., p. 14). Some research has also suggested that previous traumatic experiences and interpersonal traumas often resurface during the postpartum period (Rydberg, 2023). Selma's reflection about how the tensions in her relationship to her mother were "heightened" in the postpartum period, influencing her emotional response to her mother's

help, corresponds with both these phenomena and illustrates the wider emotional consequences of when women experience that their wishes are disregarded and their trust betrayed by care providers:

> "I was so overprotective of [the baby] […] because I have like a history with my mom […] after I became a mom, I guess I was a bit like, very on guard against my mom. […] We don't have a bad relationship, but we have a complicated relationship. And I think […] the anxiety about our relationship, was sort of heightened after I became a mom myself. So this coupled with like the trauma from the *barselavdeling* [postpartum ward] made it really hard for me to like, trust her with my baby […], I was like a hawk over her all the time. When she was holding him, I […] had two eyes on the back of my head, always watchful, always anxious. And it wasn't her fault, it was just me."

Selma and Ada both sought psychological care in the postpartum period, but both were ambivalent about the efficacy of the providers they were given in the public health system, and described desiring constructive, concrete help rather than just a listening ear. Selma eventually engaged a private therapist with expertise in postpartum and breastfeeding grief, which she framed as an investment in "high quality care" for her son's sake as well as her own:

> "I was on the edge, all the time. […] I had a short fuse. I was tense all the time, stressed out, burnt out, and I was like, 'This is not good for him [the baby], and I'm not going to be a mom for just one year, I'm going to be a mom forever (laughs) so I need to […] take this seriously.' And...I wouldn't say that I have postpartum depression. Maybe I did the first few weeks, I was like crying all the time, every day, a lot…but it gradually became better. And I'm also a person who struggled with depression before. So I know the signs for depression. And I had pregnancy depression, during the first trimester, and the *helsestasjon* knew about this. So I was prepared that hormones were gonna fuck me up postpartum."

Selma's and several other participants' willingness to discuss their postpartum mental health, as well as a few of the participants' characterization of their family members as conscientious of and supportive around postpartum depression contrasts with the common generalized narrative of mental health stigma amongst immigrant and minority communities. Having said that, the fact that so many of the women openly conveyed significant, long-lasting emotional difficulties during postpartum yet were hesitant or unsure about the label of postpartum depression, may reflect enduring societal stigma against postpartum depression, but could also be explained by the lack of clarity around the conceptualization of postpartum depressive symptoms. Abrams, Dornig, and Curran's (2009) study on service use and help-seeking attitudes among low-income

ethnic minority women in the U.S. with postpartum depressive symptoms found that, while women often expected cultural stigma, they also often encountered supportive and nonjudgmental responses from family members, including encouragement to seek help from doctors or mental health providers, and reassurance that stress and negative emotions were a normal part of new motherhood. However, this 'normalization' often contributed to women's tendencies to minimize their symptoms and ambivalence about providers' medicalized, and especially pharmacological, approach to postpartum depression (Abrams, Dornig, and Curran, 2009). Ambiguity in how postpartum depression is defined, including "that [postpartum depression] may have become an oversimplified term used to cover a broad spectrum of experiences occurring during the postpartum period, ranging from baby blues to psychoses" (Mamisachvili et al. 2013, p. 163) may contribute to obscure recognition of its symptoms and differentiate between "a normal condition and depression" (Oslo University Hospital 2023).

8.3 "Being seen and heard"

> "Once you give birth it's all about the baby. It's not about the mom and her well-being or wishes, or ambitions, or whatever." [Selma]

Many of the participants reported feeling that their needs were overlooked and overshadowed by the baby's needs during the postpartum period, especially by health personnel and the health system, a finding has also been reported in earlier research (Henshaw et al., 2018).

> "I kind of feel, the health clinics, it was…when you were done with the pregnancy, then there was actually no one who saw you. Then it was kind of, focus on the baby growing, if the baby ate, sleeping routines, feeding routines, vaccinations and the like. So there wasn't actually anyone who like, necessarily asked […] about how I was doing."[87] [Edna]

> "[During the home visit] the midwife I was assigned by the municipality (…) asked how it was going with me and like, my body, and then I mentioned a bit more with my worries surrounding what's going on with my body. Bleeding (…) and that kind of thing. And then she said, 'Yeah, I'm sure it'll be fine, yes, yes, it's fine.' Then she was also very interested to see the child, I kind of felt like that took up the most space there with the stuff with the baby, though I do understand."[88] [Jina]

The theme of gratitude came up frequently in the interviews, and many of the women recalled encounters with support providers who told them they were "lucky" and tried to encourage them

to feel grateful rather than unhappy with their perinatal or postnatal experiences. For example, both Ada, who was struggling with postpartum depression, and Kim, who suffered from painful overproduction of milk, recalled being met by dismissive attitudes and lack of empathy from support providers:

> "The times I mentioned that she [the baby] was so difficult and things like that, then she [my mother] said, 'Yes but she is the loveliest baby we've ever seen, you don't know how the others are, they have very sick children, and they cry all the time and don't sleep at night.' She always said that I was lucky and must be grateful, but then I felt that she didn't completely understand what I was going through. It's kind of been that she has been both very helpful and sometimes the opposite."[89] [Ada]

> "…because [of] the pump, basically I got overproduction. So I had so much milk and I remember (…) every single time I was breastfeeding her I felt like it was so painful. And she had more than enough milk, it was running like crazy, like I would walk [through the apartment], and it would just drip milk all the way. [laughter] […] Every time I went to the *helsestasjon* or I called people they were just like, 'Yeah but you're lucky you've got lots of milk!' and I'm just like 'Yeah, I'm not so lucky, it hurts like hell.'" [Kim]

Such encounters were often interpreted as minimizing or silencing the women's difficulties and seemed to increase their sense of alienation. Edna recalled how cultural expectations to be "happy" and "grateful" hindered her from expressing her true feelings and desire for respite from the company of her family and in-laws in the postpartum period:

> "You get a little forgotten, I think. (…) You're not supposed to have problems, now you're supposed to be in a period where you're just supposed to be happy, you know? (…) And not cry, not be sad, you've had a healthy little baby, you have a lot to be thankful for, so the expectation that you're just supposed to be thankful was great. Yeah, they only expected gratitude and nothing else. And therefore it's also very difficult to complain, or to say no, 'Can't you all go home early or not come today?'"[90] [Edna]

Edna also highlighted how, contrary to the assertion that social support is protective against postpartum depression, the configurations of postnatal care and support enacted by her family and community could in fact obscure the effects of postpartum depression by failing to center the woman's individual needs:

> "I think it was maybe a bit embarrassing to feel that feeling [of being lonely and down] when you have, [a] "full house" (…) so I said nothing to anyone. But I did understand eventually that it was completely normal, and I think there are many who have it so. For example, I have a [female relative] who told me that what she thought was very strange was that when she had her first child, while I kind of just

> wanted to hold the baby, and I didn't want that they [my relatives] would take [him], but for her, she felt nothing. She was indifferent and said that she didn't care. Today, I understand (…) that the experience she had (…) of feeling that you don't have any connection with the baby is indeed very typical for postpartum depression. But she didn't realize it, and there was no one who said it back then (…) because there is no one who thinks it is strange that everyone else is holding the baby, because that's how it was, everyone holding the baby except her. (…) And then one can just think that she is just following the rules and the culture and not complaining, while she was really struggling."[91] [Edna]

In Norway, new mothers are recommended to be given the opportunity to discuss their birth experience with the midwife or obstetrician who attended their delivery, with research conducted by the Norwegian Public Health Institute finding that women who participated in these conversations were more likely to describe their patient experience as positive (Sjetne & Iversen, 2023). The two women in this study who mentioned participating in this conversation spoke of it with some ambivalence, on the one hand highlighting the catharsis and personal significance of voicing their experiences and holding health personnel accountable, but on the other hand expressing some skepticism about genuinely being heard:

> "It was important for me to talk to the hospital about my experience because I needed to place that responsibility with them and just say that this is not okay. And having done my part of it, for women afterwards, but you see that now it doesn't really help." [Kim]

Selma also noted how the discourse of gratitude was also invoked in her conversation with her obstetrician about her birth experience, which had culminated in a vacuum-assisted delivery and postpartum hemorrhage:

> "On the one hand, [the doctor] was like telling me that this was a necessary procedure, 'If you were giving birth in a poor country you would have died, your baby would have died.' But on the other hand, her telling me that was like, I have to be grateful. I should be grateful. It sort of traumatized me even more, because I felt like I have no say. […] I'm not entitled to have any feelings of disappointment or anything, I just have to be grateful. And of course I have to be grateful because of course she's right. If I were giving birth in Syria or Afghanistan, I would have probably died, he [the baby] would have probably died. I don't want to be this spoiled brat. Of course I am grateful, but that the same time I felt like I couldn't have, there was no room for any feelings." [Selma]

While Selma described some aspects of the after-birth consultation as comforting, her sense of feeling silenced and disempowered by this interaction, with its indirect reference to her migration background, suggests that a migration perspective may influence

women's expectations of or willingness to critique the Norwegian health system. This is discussed in Bains et al. (2012), which theorizes that recently-arrived migrant women's satisfaction with Norwegian maternity care was not necessarily an indicator of actual quality of care, but was related to low expectations, which could be influenced by their health literacy, cultural context, and previous experience with healthcare in other countries.

Tania's observation about how her exposure to birthing conditions outside of Norway tempered her willingness to complain about negative aspects of her birth and postpartum experiences indicates that the influence of migration perspective on reported satisfaction can also be relevant for subsequent generations of women with migration background:

> "There's women who have given birth displaced in other countries, like it could be so much worse. That's also part of why how I've always been like, my postpartum was fine, it's been great. Maybe for someone who's super privileged in Norway and doesn't really know how it's like other places, they would have thought it was terrible, but for me who's seen so much else, and been so many other places, (…) I think because of that I was just not that complaining of my situation.
>
> I do feel like it's a pain going through the system. It's just like when you have supposedly the best healthcare in the world, it should be better than this I feel. But I can't complain because (…) I've lived in the UK, it's so shit. And then I've lived in Pakistan, there's no healthcare there. So when I compare it, I'm like, wow Norway's amazing. It is, in comparison, it's great." [Tania]

However, Tania's reflection also points to a conflicting perception, which several of the participants articulated, that accessing adequate maternity care required "fighting" and "nagging" despite Norway's position as wealthy welfare state:

> "It's unbelievable! And this, in Norway. [My husband] was just outraged. I remember him calling his friends [in his home country] - like 'It's the richest country in the world and they don't receive women in labor! They don't accept them! Can you believe it? I had to fight in order for us to get in! And to stay! What the hell is this?'" [Kim]
>
> "We have this, it's a welfare state. All of our taxes go there. High taxes! (…)
>
> But here in Norway it's like, you have to nag, and nag, and nag. Because I've spoken to many friends later, and they were like 'No I nagged and I nagged, I nagged and I got the help I needed in the end.' And I felt like 'Oh my god, I didn't

> nag enough.' So again I was blaming myself, I didn't nag enough. But now I'm like, why do I even have to nag?" [Selma]

That current health system conditions demand fierce, tenacious self-advocacy from new mothers in order to access individualized care, is alarming given the importance of individualized, person- and family-centered maternity and postpartum care to long-term health outcomes (Sudhinaraset et al., 2021), the value that new mothers place on "feeling seen" by healthcare providers (Wandel et al., 2016), and the tendency for new mothers to feel discouraged from seeking professional guidance by encounters in which health personnel fail to adapt care to their individual circumstances (Frederiksen et al., 2021). Moreover, the Norwegian national guidelines for postnatal care recommend support and guidance adapted to individual needs and circumstances over generalized guidance and education (Helsedirektoratet, 2014b). This demand for self-advocacy, combined with the health system's increasing reliance on "self-help" and third-sector resources, as discussed in Chapter 6, constitutes a barrier to individualized care that is further heightened by the structural and workforce challenges in the healthcare system that impede postpartum continuity of care: "a lack of continuity of care and enough time to build relationships may lead to the impression of the midwifery service being there purely for medical control purposes rather than meeting the woman's emotional and psycho-social needs" (Aune et al., 2021, p. 10). As access to quality care becomes contingent on an individual's capacity to self-advocate, which may be mediated by cultural norms and relative societal privilege, future policy and research should examine if these conditions are in fact reproducing systemic inequities in healthcare access and outcomes.

Conclusion

For many of my participants, the postpartum period was the site of intense, concurrent negotiations: of their relationships to their parents and to their parents' cultural values; of the health system's capacity to provide them with individualized care and guidance; of their position as ethnic minorities in Norwegian society; of the gendered expectations that shape their and their partners' roles; of enduring physical and emotional pain; and of their goals and fulfillment as new mothers.

In some cases, the mothers were able to draw upon various forms of cultural capital to derive complementary benefits from both the health system and informal care networks, mobilizing the social support they needed from the sources they desired it from, while setting boundaries to protect themselves from any negative costs of that support. In other instances, their position as visible ethnic minorities could heighten self-imposed pressure to satisfy normative Norwegian ideals of motherhood and comply with the authority of health personnel, giving rise to tension, conflict, or compounded stress when subject to pressures to adhere to authoritative knowledge within their family network. Many of the women expressed a degree of ambivalence or skepticism towards some of the traditional recovery practices encouraged by their kin, and resisted the informational support that accompanied it, but in other instances they embraced them and expressed new appreciation for the value of these cultural traditions. Ultimately, most of the women sought to negotiate a balance between retaining the aspects of a traditional postpartum care regime which they experienced as positive – the company and care of their families and kin, freedom to focus on their recovery and their baby – and aspects that they experienced as negative and stressful, such as unsolicited advice, criticism, and lack of privacy.

New mothers are often grateful for the instrumental support that traditional postpartum care offers, but also skeptical or ambivalent about their parents' use of folk medicine or infant care practices, and look instead to health personnel for authoritative knowledge, especially on breastfeeding. When healthcare providers are able to provide individualized guidance and continuity of care, they become a source of trust and reassurance, and have the power to provide appraisal support that increases new mothers' confidence and buffers criticism or conflicting advice from families. However, the prevailing challenges of staffing shortages and maternity

ward capacity have meant that patients are increasingly left on their own postpartum at a time in which their physical and psychological vulnerability can impair their capacity to engage in the self-help or self-advocacy necessary to access adequate care. While fathers may aspire to equal parenthood responsibility and to be a source of support for the mothers, their societal roles are still in flux and in both majority Norwegian and migrant cultural contexts, systems or configurations of care are not always structured to give fathers a place in the traditionally "women's world" of maternity and postpartum, which may thereby limit their supportive value to new mothers, place the onus of facilitating paternal competency on the postpartum mother, or undermine the couple's goals for fulfillment of their parenting roles.

Both demographic and health system trends in Norway suggest a need to look beyond the postpartum period as a solely maternal, or indeed nuclear family affair. In neighboring Sweden, recent changes were made to parental leave policy to double, from 30 to 60, the number of days in which parents can concurrently take paid leave, and even allow parents to transfer up to 90 days of their paid leave allowance to a close relative, enabling greater flexibility in childcare arrangements (Socialdepartementet, 2023), highlighting the increasing importance of partner and family support after birth. The current challenges in Norway's maternity care system represent an increasing burden on new mothers – challenges that may be tempting for policymakers to presume can or should be absorbed by partner and informal social networks, and other forms of "self-help". The findings in this study point to both potential advantages and disadvantages of such an approach, even where such informal networks are available and eager to fill a central postpartum support role. Intergenerational differences, though often heightened by co-occurring factors related to migration, such as dissonant acculturation, are also pertinent to the general population. Both policymakers and the professionals who work with expectant or new parents should be aware of the pitfalls in conceiving social support as unilaterally positive and a therefore expedient substitute for individualized professional guidance and care. The findings in this study suggest an unmet need for health or social care professionals to take a more active role in encouraging postpartum help-seeking by ensuring that expectant parents form realistic expectations of the postpartum period, especially around breastfeeding, and to mobilize and manage supportive networks, even – or even especially – among women for whom informal postpartum care configurations may already exist as a cultural norm.

In negotiating support during a psychologically vulnerable period, new mothers may face dilemmas in balancing their varied support needs, as well as the well-being of their baby, with emotional stressors that support sources can encompass – either forgoing needed support to avoid negative interactions or threat to their parental authority and confidence, or enduring poor emotional well-being to avoid jeopardizing the relationships that confer needed social support. Those who provide care to women with immigrant backgrounds should be aware that many may have ambivalent or complex relationships with their families and families' cultural traditions, potentially complicating their experience of support in the postpartum period. Providers should also be aware that difficulties finding a sense of belonging or validation within mothers' groups (*barselgrupper*) may pose a barrier to participation and access to the informational and appraisal support that peer support interventions typically facilitate, and more research is needed to identify ways to improve the accessibility of such programs to mothers with migration and ethnic minority backgrounds.

It is also important to note that many immigrant families lack significant family networks in Norway, and this often remains substantially true even for women of the second generation. While their experiences were the central focus of this study, the perspectives that were provided suggest that the labor of carrying out traditional, culturally prescribed postpartum care can also entail a significant burden for their first-generation mothers. This consideration is especially important given that the postpartum care regimes they attempt to reproduce for their daughters are often conceived as a shared responsibility that is distributed across a broader network of female kin, which they themselves may have lost due to migration. A few of the participants in this study expressed concern about the burden of their mothers' extensive caregiving efforts, and many of their accounts created an impression that the first-generation mothers often bore the responsibilities of maintaining, transmitting, and implementing the care traditions and knowledge of postpartum alone for their daughters and daughters-in-law. Their experiences and perspectives as providers would be valuable to explore and could further yield valuable information concerning both their daughters', and their own well-being.

References

Aarset, M. F. (Director). (n.d.). *Foreldreskap og tilhørighet i «andregenerasjon»*. Retrieved October 24, 2023, from https://film.oslomet.no/foreldreskap-og-tilhorighet-i

Aarset, M. F., Smette, I., & Rosten, M. G. (2021). Thinking through generation. In A. Falch-Eriksen, M. Takle, & B. Slagsvold (Eds.), *Generational Tensions and Solidarity Within Advanced Welfare States* (1st ed., pp. 79–95). Routledge. https://doi.org/10.4324/9781003129592-7

Abdulhamed, R., Lonka, K., Hietajärvi, L., Ikonen, R., & Klemetti, R. (2022). Anxiety and depression symptoms and their association with discrimination and a lack of social support among first- and second-generation immigrant adolescents. *International Journal of Intercultural Relations*, *87*, 193–205. https://doi.org/10.1016/j.ijintrel.2022.03.001

Abrams, L. S., Dornig, K., & Curran, L. (2009). Barriers to Service Use for Postpartum Depression Symptoms Among Low-Income Ethnic Minority Mothers in the United States. *Qualitative Health Research*, *19*(4), 535–551. https://doi.org/10.1177/1049732309332794

Albanese, A. M., Geller, P. A., Sikes, C. A., & Barkin, J. L. (2021). The Importance of Patient-Centered Research in the Promotion of Postpartum Mental Health. *Frontiers in Psychiatry*, *12*, 720106. https://doi.org/10.3389/fpsyt.2021.720106

Almeida, L. M., Casanova, C., Caldas, J., Ayres-de-Campos, D., & Dias, S. (2014). Migrant Women's Perceptions of Healthcare During Pregnancy and Early Motherhood: Addressing the Social Determinants of Health. *Journal of Immigrant and Minority Health*, *16*(4), 719–723. https://doi.org/10.1007/s10903-013-9834-4

Alnæs-Katjavivi, P. (2021). Ubevisste holdninger hos leger. *Tidsskrift for Den norske legeforening*. https://doi.org/10.4045/tidsskr.21.0048

Alstveit, M., Severinsson, E., & Karlsen, B. (2010). Obtaining confirmation through social relationships: Norwegian first-time mothers' experiences while on maternity leave. *Nursing & Health Sciences*, *12*(1), 113–118. https://doi.org/10.1111/j.1442-2018.2009.00508.x

Ammehjelpen. (2023, August 1). *Hvordan skrive barselplan?* Ammehjelpen. https://ammehjelpen.no/barselplan/

Amundsen, B. (2019, July 5). *Slik går det med innvandrerbarna*. https://www.forskning.no/innvandring-utdanning/slik-gar-det-med-innvandrerbarna/1355870

Andersen, B. (2023a, December 8). *Fødselsdepresjon: Etterlyser bedre omsorg til nybakte mødre som sliter*. NRK. https://www.nrk.no/nordland/fodselsdepresjon_-etterlyser-bedre-omsorg-til-nybakte-modre-som-sliter-1.16631109

Andersen, B. (2023b, December 18). *Fødselsdepresjon: I Mosjøen og Orkdal får mor ha med babyen når hun legges inn: – Et unikt tilbud*. NRK. https://www.nrk.no/nordland/fodselsdepresjon_-i-mosjoen-og-orkdal-far-mor-ha-med-babyen-nar-hun-legges-inn_-_-et-unikt-tilbud-1.16665429

Andresen, F. (2021, September 8). - *Ekstremt dramatisk*. dagbladet.no. https://www.dagbladet.no/nyheter/ekstremt-dramatisk/74197253

Aston, M., Etowa, J., Price, S., Vukic, A., Hart, C., MacLeod, E., & Randel, P. (2016). Public Health Nurses and Mothers Challenge and Shift the Meaning of Health Outcomes. *Global Qualitative Nursing Research*, *3*, 2333393616632126. https://doi.org/10.1177/2333393616632126

Aston, M., Price, S., Etowa, J., Vukic, A., Young, L., Hart, C., MacLeod, E., & Randel, P. (2014). Universal and targeted early home visiting: Perspectives of public health nurses, managers and mothers. *Nursing Reports*, *4*. https://doi.org/10.4081/nursrep.2014.3290

Aston, M., Price, S., Monaghan, J., Sim, M., Hunter, A., & Little, V. (2018). Navigating and negotiating information and support: Experiences of first-time mothers. *Journal of Clinical Nursing*, *27*(3–4), 640–649. https://doi.org/10.1111/jocn.13970

Aune, I., Tysland, T., & Vollheim, S. A. (2021). Norwegian midwives' experiences of relational continuity of midwifery care in the primary healthcare service: A qualitative descriptive study. *Nordic Journal of Nursing Research*, *41*(1), 5–13. https://doi.org/10.1177/2057158520973202

Aune, I., Voldhagen, H., Welve, I., & Dahlberg, U. (2021). Early discharge from hospital after birth: How Norwegian parents experience postnatal home visits by midwives – A qualitative study. *Sexual & Reproductive Healthcare*, *30*, 100672. https://doi.org/10.1016/j.srhc.2021.100672

Bains, S., Sundby, J., Lindskog, B. V., Vangen, S., Diep, L. M., Owe, K. M., & Sorbye, I. K. (2021). Satisfaction with maternity care among recent migrants: An interview questionnaire-based study. *BMJ Open*, *11*(7), e048077. https://doi.org/10.1136/bmjopen-2020-048077

Bakken, A. (2010, November 29). *Blendahvite barselgrupper*. https://www.aftenposten.no/norge/i/mB36p/blendahvite-barselgrupper

Bakken, J. D. (2023, January 30). *Jordmødre på Ullevål rekker ikke gå på do eller spise på jobb: – Det er hverdagen*. NRK. https://www.nrk.no/osloogviken/jordmodre-pa-ulleval-rekker-ikke-a-ga-pa-do-eller-spise-pa-jobb_-_-det-er-hverdagen-1.16267875

Bakken, K. S., Skjeldal, O. H., & Stray-Pedersen, B. (2017). Obstetric Outcomes of First- and Second-Generation Pakistani Immigrants: A Comparison Study at a Low-Risk Maternity Ward in Norway. *Journal of Immigrant and Minority Health*, *19*(1), 33–40. https://doi.org/10.1007/s10903-015-0329-3

Balke, I. (2018, January 27). *Helsesøster på hjemmebesøk*. https://sykepleien.no/meninger/innspill/2017/12/helsesoster-pa-hjemmebesok

Barimani, M., Oxelmark, L., Johansson, S.-E., & Hylander, I. (2015). Support and continuity during the first 2 weeks postpartum. *Scandinavian Journal of Caring Sciences*, *29*(3), 409–417. https://doi.org/10.1111/scs.12144

Barimani, M., & Vikström, A. (2015). Successful early postpartum support linked to management, informational, and relational continuity. *Midwifery*, *31*(8), 811–817. https://doi.org/10.1016/j.midw.2015.04.009

Barimani, M., Vikström, A., Rosander, M., Forslund Frykedal, K., & Berlin, A. (2017a). Facilitating and inhibiting factors in transition to parenthood – ways in which health professionals can support parents. *Scandinavian Journal of Caring Sciences*, *31*(3), 537–546. https://doi.org/10.1111/scs.12367

Barimani, M., Vikström, A., Rosander, M., Forslund Frykedal, K., & Berlin, A. (2017b). Facilitating and inhibiting factors in transition to parenthood – ways in which health professionals can support parents. *Scandinavian Journal of Caring Sciences*, *31*(3), 537–546. https://doi.org/10.1111/scs.12367

Behruzi, R., Hatem, M., Goulet, L., Fraser, W., & Misago, C. (2013). Understanding childbirth practices as an organizational cultural phenomenon: A conceptual framework. *BMC Pregnancy and Childbirth*, *13*(1), 205. https://doi.org/10.1186/1471-2393-13-205

Bernard, H. R. (2011). *Research methods in anthropology: Qualitative and quantitative approaches* (5th ed). AltaMira Press.

Bever, L. (2022, December 13). From heart disease to IUDs: How doctors dismiss women's pain. *Washington Post*. https://www.washingtonpost.com/wellness/interactive/2022/women-pain-gender-bias-doctors/

Börjesson, B., Paperin, C., & Lindell, M. (2004). Maternal support during the first year of infancy. *Journal of Advanced Nursing*, *45*(6), 588–594. https://doi.org/10.1046/j.1365-2648.2003.02950.x

Børstad, J. (2014, September 8). *Vil ha tilbake husmorvikaren*. NRK. https://www.nrk.no/trondelag/vil-ha-tilbake-husmorvikaren-1.11921170

Boutin-Foster, C. (2005). In spite of good intentions: Patients' perspectives on problematic social support interactions. *Health and Quality of Life Outcomes*, *3*(1), 52. https://doi.org/10.1186/1477-7525-3-52

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77–101. https://doi.org/10.1191/1478088706qp063oa

Brooks, H., Bee, P., Lovell, K., & Rogers, A. (2020). Negotiating support from relationships and resources: A longitudinal study examining the role of personal support networks in the management of severe and enduring mental health problems. *BMC Psychiatry*, *20*, 50. https://doi.org/10.1186/s12888-020-2458-z

Cavdar, D., McKeown, S., & Rose, J. (2021). Mental health outcomes of ethnic identity and acculturation among British-born children of immigrants from Turkey. *New Directions for Child and Adolescent Development*, *2021*(176), 141–161. https://doi.org/10.1002/cad.20402

Charlton, L. (2024, January 28). For New Moms in Seoul, 3 Weeks of Pampering and Sleep at a Joriwon. *The New York Times*. https://www.nytimes.com/2024/01/28/world/asia/south-korea-joriwon-postpartum-care.html

Clarke, A. E., Friese, C., & Washburn, R. (Eds.). (2015). *Situational analysis in practice: Mapping research with grounded theory*. Left Coast Press.

Crul, M., & Vermeulen, H. (2003). The Second Generation in Europe. *International Migration Review*, *37*(4), 965–986. https://doi.org/10.1111/j.1747-7379.2003.tb00166.x

Daníelsdóttir, S., & Ingudóttir, J. (2022). *The First 1000 Days in the Nordic Countries: Policy Recommendations*. Nordisk Ministerråd. https://urn.kb.se/resolve?urn=urn:nbn:se:norden:org:diva-12355

Davis-Floyd, R. (2022). *Birth as an American Rite of Passage*. Routledge. https://doi.org/10.4324/9781003001393

Dennis, C.-L., Fung, K., Grigoriadis, S., Robinson, G. E., Romans, S., & Ross, L. (2007). Traditional Postpartum Practices and Rituals: A Qualitative Systematic Review. *Women's Health*, *3*(4), 487–502. https://doi.org/10.2217/17455057.3.4.487

Dennis, C.-L., & Ross, L. (2006). Women's perceptions of partner support and conflict in the development of postpartum depressive symptoms. *Journal of Advanced Nursing*, *56*(6), 588–599. https://doi.org/10.1111/j.1365-2648.2006.04059.x

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2013). *Strategies of qualitative inquiry* (Fourth Edition). SAGE.

Depression, perceived stress, and social support among first-time Chinese mothers and fathers in the postpartum period. (n.d.). https://doi.org/10.1002/nur.20306

D'haenens, F., Van Rompaey, B., Swinnen, E., Dilles, T., & Beeckman, K. (2020). The effects of continuity of care on the health of mother and child in the postnatal period: A systematic review. *European Journal of Public Health*, *30*(4), 749–760. https://doi.org/10.1093/eurpub/ckz082

Dinesen, P. T., & Hooghe, M. (2010). When in Rome, Do as the Romans Do: The Acculturation of Generalized Trust among Immigrants in Western Europe. *International Migration Review*, *44*(3), 697–727. https://doi.org/10.1111/j.1747-7379.2010.00822.x

Drageset, J. (2021). Social Support. In G. Haugan & M. Eriksson (Eds.), *Health Promotion in Health Care – Vital Theories and Research*. Springer. http://www.ncbi.nlm.nih.gov/books/NBK585650/

Eberhard-Gran, M., Eskild*, A., Opjordsmoen, S., & Schei, B. (2000). Barselomsorg – søvn, hvile og tilfredshet. *Tidsskrift for Den norske legeforening*. https://tidsskriftet.no/2000/05/klinikk-og-forskning/barselomsorg-sovn-hvile-og-tilfredshet

Eberhard-Gran, M., Eskild, A., Tambs, K., Samuelsen, S. O., & Opjordsmoen, S. (2002). Depression in postpartum and non-postpartum women: Prevalence and risk factors. *Acta Psychiatrica Scandinavica*, *106*(6), 426–433. https://doi.org/10.1034/j.1600-0447.2002.02408.x

Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., & Eskild, A. (2010). Postnatal care: A cross-cultural and historical perspective. *Archives of Women's Mental Health*, *13*(6), 459–466. https://doi.org/10.1007/s00737-010-0175-1

Eberhard-Gran, M., Nordhagen, R., Heiberg, E., Bergsjø, P., & Eskild*, A. (2003). Barselomsorg i et tverrkulturelt og historisk perspektiv. *Tidsskrift for Den norske legeforening*. https://tidsskriftet.no/2003/12/fodselshjelp-og-barselomsorg/barselomsorg-i-et-tverrkulturelt-og-historisk-perspektiv

Eian, N., Øystein. (2023, January 18). *To til fire fødestuer stenges på OUS: – Jordmødrene erfarer et voldsomt arbeidspress*. https://sykepleien.no/2023/01/til-fire-fodestuer-stenges-pa-ous-jordmodrene-erfarer-et-voldsomt-arbeidspress

Eikemo, R., Vikström, A., Nyman, V., Jonas, W., & Barimani, M. (2023). Support during the postnatal period: Evaluating new mothers' and midwives' experiences of a new, coordinated postnatal care model in a midwifery clinic in Sweden. *Scandinavian Journal of Caring Sciences*, *37*(1), 260–270. https://doi.org/10.1111/scs.13103

Ekblad, S., & Kastrup, M. C. (2013). Current research in transcultural psychiatry in the Nordic countries. *Transcultural Psychiatry*, *50*(6), 841–857. https://doi.org/10.1177/1363461513511181

Ekeberg, K. A., & Abebe, D. S. (2021). Mental disorders among young adults of immigrant background: A nationwide register study in Norway. *Social Psychiatry and Psychiatric Epidemiology*, *56*(6), 953–962. https://doi.org/10.1007/s00127-020-01980-z

El-Khoury, F., Sutter-Dallay, A.-L., Panico, L., Charles, M.-A., Azria, E., Van der Waerden, J., & Melchior, M. (2018). Women's mental health in the perinatal period according to migrant status: The French representative ELFE birth cohort. *European Journal of Public Health*, *28*(3), 458–463. https://doi.org/10.1093/eurpub/cky008

Evans, M., Donelle, L., & Hume-Loveland, L. (2012). Social support and online postpartum depression discussion groups: A content analysis. *Patient Education and Counseling*, *87*(3), 405–410. https://doi.org/10.1016/j.pec.2011.09.011

Evjen, A. F. (2021, October 27). *Kritisk jordmormangel truer pasientsikkerheten på Sykehuset Østfold*. NRK. https://www.nrk.no/osloogviken/kritisk-jordmormangel-truer-pasientsikkerheten-pa-sykehuset-ostfold-1.15655280

FAFO. (n.d.). *Barn av innvandrere*. Retrieved January 31, 2024, from https://www.fafo.no/forskningstema/migrasjon-og-integrasjon/barn-av-innvandrere

Fahey, J. O., & Shenassa, E. (2013). Understanding and Meeting the Needs of Women in the Postpartum Period: The Perinatal Maternal Health Promotion Model. *Journal of Midwifery & Women's Health*, *58*(6), 613–621. https://doi.org/10.1111/jmwh.12139

Feenstra, M. M., Nilsson, I., & Danbjørg, D. B. (2018). "Dad – a practical guy in the shadow": Fathers' experiences of their paternal role as a father during early discharge after birth and readmission of their newborns. *Sexual & Reproductive Healthcare*, *15*, 62–68. https://doi.org/10.1016/j.srhc.2017.11.006

Floyd, K., & Ray, C. (2016). Thanks, but no thanks: Negotiating face threats when rejecting offers of unwanted social support. *Journal of Social and Personal Relationships*, *34*. https://doi.org/10.1177/0265407516673161

Føleide, A. (2023, January 17). *Norske kvinner går med uoppdagede fødselsskader i lang tid etter de har fått barn*. NRK. https://www.nrk.no/tromsogfinnmark/norske-kvinner-gar-med-uoppdagede-fodselsskader-i-lang-tid-etter-de-har-fatt-barn-1.15945521

Folkehelseinstituttet. (2023a). *Årsrapport for Medisinsk fødselsregister 2022*. https://www.fhi.no/publ/2023/arsrapport-for-medisinsk-fodselsregister-2022/

Folkehelseinstituttet. (2023b, November 30). *Samtale etter fødsel gir bedre opplevelse av oppholdet på sykehus*. Folkehelseinstituttet. https://www.fhi.no/nyheter/2023/samtale-etter-fodsel-gir-bedre-opplevelse-av-oppholdet-pa-sykehus/

Frederiksen, M. S., Schmied, V., & Overgaard, C. (2021). Supportive encounters during pregnancy and the postnatal period: An ethnographic study of care experiences of parents in a vulnerable position. *Journal of Clinical Nursing*, *30*(15–16), 2386–2398. https://doi.org/10.1111/jocn.15778

Fredriksen, E., von Soest, T., Smith, L., & Moe, V. (2019). Parenting Stress Plays a Mediating Role in the Prediction of Early Child Development from Both Parents' Perinatal Depressive Symptoms. *Journal of Abnormal Child Psychology*, *47*(1), 149–164. https://doi.org/10.1007/s10802-018-0428-4

Friberg, J. H. (2019). Does selective acculturation work? Cultural orientations, educational aspirations and school effort among children of immigrants in Norway. *Journal of Ethnic and Migration Studies*, *45*(15), 2844–2863. https://doi.org/10.1080/1369183X.2019.1602471

Friberg, J. H. (2021). Who wants to be Norwegian – who gets to be Norwegian? Identificational assimilation and non-recognition among immigrant origin youth in Norway. *Ethnic and Racial Studies*, *44*(16), 21–43. https://doi.org/10.1080/01419870.2020.1857813

Friberg, J. H., & Sterri, E. B. (n.d.). *Sosial kontroll og integrasjon | * Fafo-rapport 2023:14*. Retrieved November 28, 2023, from https://www.fafo.no/zoo-publikasjoner/fafo-rapporter/sosial-kontroll-og-integrasjon

Gao, L., Chan, S. W., & Mao, Q. (2009). Depression, perceived stress, and social support among first-time Chinese mothers and fathers in the postpartum period. *Research in Nursing & Health*, *32*(1), 50–58. https://doi.org/10.1002/nur.20306

Garon-Bissonnette, J., Bolduc, M.-È. G., Lemieux, R., & Berthelot, N. (2022). Cumulative childhood trauma and complex psychiatric symptoms in pregnant women and expecting men. *BMC Pregnancy and Childbirth*, *22*(1), 10. https://doi.org/10.1186/s12884-021-04327-x

Gilliam, L. (2022). 'This Society Has Taken Me.' Intensive Parenting and Fragile Belonging among Second-Generation Minority Danish Parents. *Genealogy*, *6*(3), Article 3. https://doi.org/10.3390/genealogy6030063

Green, J., & Thorogood, N. (2018). *Qualitative methods for health research* (4th edition). SAGE.

Greenberg, Z. (2018, October 2). If Only Everyone Had a Postpartum Doula. *The New York Times*. https://www.nytimes.com/2018/10/02/style/postpartum-doula.html

Gupta, A., Szymanski, D., & Leong, F. (2011). The "Model Minority Myth": Internalized Racialism of Positive Stereotypes as Correlates of Psychological Distress, and Attitudes Toward Help-Seeking. *Asian American Journal of Psychology*, *2*, 101–114. https://doi.org/10.1037/a0024183

Habel, C., Feeley, N., Hayton, B., Bell, L., & Zelkowitz, P. (2015). Causes of women's postpartum depression symptoms: Men's and women's perceptions. *Midwifery*, *31*(7), 728–734. https://doi.org/10.1016/j.midw.2015.03.007

Handulle, A., & Vassenden, A. (2021). 'The art of kindergarten drop off': How young Norwegian-Somali parents perform ethnicity to avoid reports to Child Welfare Services. *European Journal of Social Work*, *24*(3), 469–480. https://doi.org/10.1080/13691457.2020.1713053

Hansen, C. K. (2010, November 8). *Ammetåke*. Ammehjelpen. https://ammehjelpen.no/ammetake/

Hansen, C. K. (2022, October 20). *Hvorfor mener mødre og helsepersonell at det viktig at Ammehjelpen finnes?* Ammehjelpen. https://ammehjelpen.no/hvorfor-er-det-viktig-at-ammehjelpen-finnes2/

Harris, K. M., & Chen, P. (2023a). The acculturation gap of parent–child relationships in immigrant families: A national study. *Family Relations*, *72*(4), 1748–1772. https://doi.org/10.1111/fare.12760

Harris, K. M., & Chen, P. (2023b). The acculturation gap of parent–child relationships in immigrant families: A national study. *Family Relations*, *72*(4), 1748–1772. https://doi.org/10.1111/fare.12760

Harvey, T. A., & Buckley, L. (2009). Childbirth in China. In H. Selin & P. K. Stone (Eds.), *Childbirth across cultures: Ideas and practices of pregnancy, childbirth and the postpartum*. Springer Verlag.

Haugaard, A., Tvedte, S. L., Severinsen, M. S., & Henriksen, L. (2020). Norwegian multicultural doulas' experiences of supporting newly-arrived migrant women during pregnancy and childbirth: A qualitative study. *Sexual & Reproductive Healthcare*, *26*, 100540. https://doi.org/10.1016/j.srhc.2020.100540

Hedlund, M., & Landstad, B. (2012). The Construction of Self-Help in Norwegian Health Policy. *International Journal of Self Help and Self Care*, *6*, 65–87. https://doi.org/10.2190/SH.6.1.e

Heggen, H. (2023, May 15). *Iselin slo seg aldri til ro med at ho berre hadde fødselsplager*. NRK. https://www.nrk.no/vestland/iselin-slo-seg-aldri-til-ro-med-at-ho-berre-hadde-fodselsplager-1.16388096

Helgeson, V. S., Novak, S. A., Lepore, S. J., & Eton, D. T. (2004). Spouse Social Control Efforts: Relations to Health Behavior and Well-Being among Men with Prostate Cancer. *Journal of Social and Personal Relationships*, *21*(1), 53–68. https://doi.org/10.1177/0265407504039840

Helsedirektoratet. (2014a). *Nasjonal plan for selvorganisert selvhjelp 2014-2018* (IS-2168). Helsedirektoratet; Selvhjelp Norge.

Helsedirektoratet. (2014b). *Nytt liv og trygg barseltid for familien – Nasjonal faglig retningslinje for barselomsorgen*. https://www.helsedirektoratet.no/retningslinjer/barselomsorgen/Nytt%20liv%20og%20trygg%20barseltid%20for%20familien%20%E2%80%93%20Nasjonal%20faglig%20retningslinje%20(full versjon).pdf/_/attachment/inline/f70bcc8c-186f-41f1-b6e7-c897d968a285:24d3a455d94e52500dee479739d3acf83f7d6c16/Nytt%20liv%20og%20trygg%20barseltid%20for%20familien%20%E2%80%93%20Nasjonal%20faglig%20retningslinje%20(full versjon).pdf

Helsenorge. (2017, April 11). *Amming og morsmelk*. https://www.helsenorge.no/spedbarn/spedbarnsmat-og-amming/amming-og-morsmelk/

Helsenorge. (2019a, February 28). *Kroppen og den første tiden etter fødsel*. https://www.helsenorge.no/etter-fodsel/kroppen-og-den-forste-tiden-etter-fodsel/

Helsenorge. (2019b, October 29). *Barsel og oppfølging etter fødsel*. https://www.helsenorge.no/etter-fodsel/oppfolging-etter-hjemkomst/

Henshaw, E. J., Cooper, M. A., Jaramillo, M., Lamp, J. M., Jones, A. L., & Wood, T. L. (2018a). "Trying to Figure Out If You're Doing Things Right, and Where to Get the Info": Parents Recall Information and Support Needed During the First 6 weeks Postpartum. *Maternal and Child Health Journal*, *22*(11), 1668–1675. https://doi.org/10.1007/s10995-018-2565-3

Henshaw, E. J., Cooper, M. A., Jaramillo, M., Lamp, J. M., Jones, A. L., & Wood, T. L. (2018b). "Trying to Figure Out If You're Doing Things Right, and Where to Get the Info": Parents Recall Information and Support Needed During the First 6 weeks Postpartum. *Maternal and Child Health Journal*, *22*(11), 1668–1675. https://doi.org/10.1007/s10995-018-2565-3

Hjälmhult, E., & Lomborg, K. (2012). Managing the first period at home with a newborn: A grounded theory study of mothers' experiences. *Scandinavian Journal of Caring Sciences*, *26*(4), 654–662. https://doi.org/10.1111/j.1471-6712.2012.00974.x

Ho, M., Li, T.-C., Liao, C.-H., Su, S.-Y., & Su, S.-Y. (2015). The Association Between Behavior Restrictions in Doing-the-Month Practice and Mental Health Status Among Postpartum Women. *The Journal of Alternative and Complementary Medicine*, *21*(11), 725–731. https://doi.org/10.1089/acm.2013.0474

Hodnett, E. D. (2002). Pain and women's satisfaction with the experience of childbirth: A systematic review. *American Journal of Obstetrics and Gynecology*, *186*(5, Supplement), S160–S172. https://doi.org/10.1016/S0002-9378(02)70189-0

Høgmo, B. K., Bondas, T., & Alstveit, M. (2021). Going blindly into the women's world: A reflective lifeworld research study of fathers' expectations of and experiences with municipal postnatal healthcare services. *International Journal of Qualitative Studies on Health and Well-Being*, *16*(1), 1918887. https://doi.org/10.1080/17482631.2021.1918887

Høgmo, B. K., Bondas, T., & Alstveit, M. (2023). Parents' experiences with public health nursing during the postnatal period: A reflective lifeworld research study. *Scandinavian Journal of Caring Sciences*, *37*(2), 373–383. https://doi.org/10.1111/scs.13117

Holø, R. M. (2022, July 2). *Ammehjelpen ba om støtte – har fått inn over 2,7 millioner på ett døgn*. NRK. https://www.nrk.no/innlandet/ammehjelpen-sto-i-fare-for-a-bli-nedlagt.-na-har-de-fatt-inn-millioner-pa-spleis-1.16025234

Hung, C.-H., & Chung, H.-H. (2001). The effects of postpartum stress and social support on postpartum women's health status. *Journal of Advanced Nursing*, *36*(5), 676–684. https://doi.org/10.1046/j.1365-2648.2001.02032.x

Hvatum, I., & Glavin, K. (2017). Mothers' experience of not breastfeeding in a breastfeeding culture. *Journal of Clinical Nursing*, *26*(19–20), 3144–3155. https://doi.org/10.1111/jocn.13663

Inekwe, J. N., & Lee, E. (2022). Perceived social support on postpartum mental health: An instrumental variable analysis. *PLOS ONE*, *17*(5), e0265941. https://doi.org/10.1371/journal.pone.0265941

Ingulstad, C., Thomassen, A. L., Myr, R., Setlo, S. H., & Eian, L. (2022, March 20). Vil helseministeren lytte til barselopprøret? *TV2.No*.

Ingulstad, C., & Thomassen, A. L. T. (2023, January 20). *Sykehusfinansieringen gjør barsel ulønnsomt og usynlig*. https://www.dagensmedisin.no/debatt-og-kronikk/sykehusfinansieringen-gjor-barsel-ulonnsomt-og-usynlig/510467

Innspill fra Jordmorforbundet NSF til høring om representantsforslag om tiltak for å sikre trygge fødsel- og barseltjenester og jordmorberedskap i hele landet: Hearing before the Helse- og omsorgskomiteen, Stortinget 2020–2021 (2020) (testimony of Jordmorforbundet NSF).

Isachsen, H. B. (2022, May 5). *Flertall for hjemmebesøk av jordmor innen én uke: – Et viktig steg*. https://www.dagensmedisin.no/barn-og-unge-eldre-ikke-bruk-folkehelse-primaerhelsetjeneste/flertall-for-hjemmebesok-av-jordmor-innen-en-uke-et-viktig-steg/301891

Kalmijn, M. (2019). Contact and conflict between adult children and their parents in immigrant families: Is integration problematic for family relationships? *Journal of Ethnic and Migration Studies*, *45*(9), 1419–1438. https://doi.org/10.1080/1369183X.2018.1522245

Kaluza, S. (2018, April 13). Barselgrøten som forsvant. *Morgenbladet*, *14*. https://www.morgenbladet.no/pafyll/2018/04/13/barselgroten-som-forsvant/

Kay, M. (2022). *Norwegian midwives' perceptions of their practice and care challenges for recently-arrived migrant women* [Master thesis]. https://www.duo.uio.no/handle/10852/96344

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., Schmied, V., & Aslam, H. (2013). Benefits of psychosocial intervention and continuity of care by child and family health nurses in the pre- and postnatal period: Process evaluation. *Journal of Advanced Nursing*, *69*(8), 1850–1861. https://doi.org/10.1111/jan.12052

Kim, J., Nicodimos, S., Kushner, S. E., Rhew, I. C., McCauley, E., & Vander Stoep, A. (2018). Comparing Mental Health of US Children of Immigrants and Non-Immigrants in 4 Racial/Ethnic Groups. *Journal of School Health*, *88*(2), 167–175. https://doi.org/10.1111/josh.12586

Kimura, M., & Yamazaki, Y. (2023). "Don't Touch My Baby!": Negative Social Support Experiences During the COVID-19 Pandemic and Their Impacts on Maternal Mental Health. *Asia Pacific Journal of Public Health*. https://doi.org/10.1177/10105395231186008

Kirkeberg, M. I., Dzamarija, Minja Tea, Bratholmen, Nadine Viktoria Lunde, & Strøm, Frøydis. (2019). Norskfødte med innvandrerforeldre – hvordan går det med dem? Demografi, utdanning, arbeid og inntekt. *Statistisk sentralbyrå*, *Rapporter 2019/2021*, 124.

Kitterød, R. H., & Nadim, M. (2020). Embracing gender equality: Gender-role attitudes among second-generation immigrants in Norway. *Demographic Research*, *42*, 411–440. https://doi.org/10.4054/DemRes.2020.42.14

Klokk, I. B. (2013, December 4). *Har dette noen hensikt?* Nettavisen. https://www.nettavisen.no/12-95-3721740

Kronborg, H., Harder, I., & Hall, E. O. C. (2015). First time mothers' experiences of breastfeeding their newborn. *Sexual & Reproductive Healthcare*, *6*(2), 82–87. https://doi.org/10.1016/j.srhc.2014.08.004

Krueger, A. (2022, June 1). It Takes a Village to Care for a Baby. And, for a Lucky Few, a Luxury Hotel. *The New York Times*. https://www.nytimes.com/2022/06/01/style/postpartum-boram-postnatal-retreat.html

Lambert, H., & McKevitt, C. (2002). Anthropology in health research: From qualitative methods to multidisciplinarity. *BMJ : British Medical Journal*, *325*(7357), 210–213.

Langford, C. P. H., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: A conceptual analysis. *Journal of Advanced Nursing*, *25*(1), 95–100. https://doi.org/10.1046/j.1365-2648.1997.1997025095.x

Leahy Warren, P. (2005). First-time mothers: Social support and confidence in infant care. *Journal of Advanced Nursing*, *50*(5), 479–488. https://doi.org/10.1111/j.1365-2648.2005.03425.x

Leahy-Warren, P., McCarthy, G., & Corcoran, P. (2012). First-time mothers: Social support, maternal parental self-efficacy and postnatal depression. *Journal of Clinical Nursing*, *21*(3–4), 388–397. https://doi.org/10.1111/j.1365-2702.2011.03701.x

Leahy-Warren, P., Mulcahy, H., & Lehane, E. (2019). The development and psychometric testing of the Perinatal Infant Care Social Support (PICSS) instrument. *Journal of Psychosomatic Research*, *126*, 109813. https://doi.org/10.1016/j.jpsychores.2019.109813

Leirbakk, M. J., Magnus, J. H., Torper, J., & Zeanah, P. (2019). Look to Norway: Serving new families and infants in a multiethnic population. *Infant Mental Health Journal*, *40*(5), 659. https://doi.org/10.1002/imhj.21804

Libak, I. (2022, March 8). *En forsvarlig barselomsorg er for viktig til å holde kjeft om.* Agenda Magasin. https://agendamagasin.no/kommentarer/en-forsvarlig-barselomsorg/

Lincoln, K. D. (2000). Social Support, Negative Social Interactions, and Psychological Well-Being. *Social Service Review*, *74*(2). https://doi-org.ezproxy.uio.no/10.1086/514478

Liversage, A., & Ottosen, M. H. (2017). OUT OF TOUCH: Understanding Post-divorce Relationships between Children and Fathers in Ethnic Minority Families. *Nordic Journal of Migration Research*, *7*(1), 38–46.

Løvlie, A. L., & Madar, A. A. (2017). Postpartum Depression Among Somali Women in Norway. *Journal of Immigrant and Minority Health*, *19*(3), 638–644. https://doi.org/10.1007/s10903-016-0487-y

Ludvigsen, B. G. (2021, March 21). *Kun fire av ti fikk hjemmebesøk av jordmor etter fødsel i 2020*. NRK. https://www.nrk.no/sorlandet/kun-fire-av-ti-fikk-hjemmebesok-av-jordmor-etter-fodsel-i-2020-1.15426180

Lyberg, A., & Severinsson, E. (2010). Midwives' supervisory styles and leadership role as experienced by Norwegian mothers in the context of a fear of childbirth. *Journal of Nursing Management*, *18*(4), 391–399. https://doi.org/10.1111/j.1365-2834.2010.01083.x

Lyberg, A., Viken, B., Haruna, M., & Severinsson, E. (2012a). Diversity and challenges in the management of maternity care for migrant women. *Journal of Nursing Management*, *20*(2), 287–295. https://doi.org/10.1111/j.1365-2834.2011.01364.x

Lyberg, A., Viken, B., Haruna, M., & Severinsson, E. (2012b). Diversity and challenges in the management of maternity care for migrant women: Migrant women and maternity care. *Journal of Nursing Management*, *20*(2), 287–295. https://doi.org/10.1111/j.1365-2834.2011.01364.x

Makhijani, P. (2021, February 25). How Food Traditions Nourish New Moms. *The New York Times*. https://www.nytimes.com/2021/02/25/parenting/postpartum-food-traditions.html

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mamisachvili, L., Ardiles, P., Mancewicz, G., Thompson, S., Rabin, K., & Ross, L. E. (2013). Culture and Postpartum Mood Problems: Similarities and Differences in the Experiences of First- and Second-Generation Canadian Women. *Journal of Transcultural Nursing*, *24*(2), 162–170. https://doi.org/10.1177/1043659612472197

Manderson, L. (2003). Roasting, smoking, and dieting in response to birth: Malay confinement in cross-cultural perspective. In *The manner born: Birth rites in cross-cultural perspective* (pp. 137–159). AltaMira Press.

Mayes, R., Llewellyn, G., & McConnell, D. (2008). Active Negotiation: Mothers with Intellectual Disabilities Creating Their Social Support Networks. *Journal of Applied Research in Intellectual Disabilities*, *21*(4), 341–350. https://doi.org/10.1111/j.1468-3148.2008.00448.x

McCourt, C. (2009). Social support and childbirth. In C. Squire (Ed.), *The social context of birth* (2nd ed). Radcliffe.

McFadden, A., Renfrew, M. J., & Atkin, K. (2013). Does cultural context make a difference to women's experiences of maternity care? A qualitative study comparing the perspectives of breast-feeding women of Bangladeshi origin and health practitioners. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *16*(4), e124–e135. https://doi.org/10.1111/j.1369-7625.2012.00770.x

McLachlan, H. L., Forster, D. A., & Yelland, J. (2008). Is the organisation and structure of hospital postnatal care a barrier to quality care? Findings from a state-wide review in Victoria, Australia. *Midwifery*, *24*(3), 358–370. https://doi.org/10.1016/j.midw.2006.10.006

McLeish, J., Harvey, M., Redshaw, M., & Alderdice, F. (2020). "Reassurance that you're doing okay, or guidance if you're not": A qualitative descriptive study of pregnant first time mothers' expectations and information needs about postnatal care in England. *Midwifery*, *89*, 102813. https://doi.org/10.1016/j.midw.2020.102813

McLeish, J., Harvey, M., Redshaw, M., & Alderdice, F. (2021). A qualitative study of first time mothers' experiences of postnatal social support from health professionals in England. *Women and Birth*, *34*(5), e451–e460. https://doi.org/10.1016/j.wombi.2020.10.012

Mena, A. D. (2022, June 16). *Hvor er de brune mammaene og pappaene i Oslos barselgrupper?* https://www.aftenposten.no/meninger/kommentar/i/oWrwpg/hvor-er-de-brune-mammaene-og-pappaene-i-oslos-barselgrupper

Mercan, Y., & Selcuk, K. T. (2021). Association between postpartum depression level, social support level and breastfeeding attitude and breastfeeding self-efficacy in early postpartum women. *PLOS ONE*, *16*(4), e0249538. https://doi.org/10.1371/journal.pone.0249538

Merry, L., Villadsen, S. F., Sicard, V., & Lewis-Hibbert, N. (2020). Transnationalism and care of migrant families during pregnancy, postpartum and early-childhood: An integrative review. *BMC Health Services Research*, *20*(1), 778. https://doi.org/10.1186/s12913-020-05632-5

Midtbøen, A. H. (2014). The Invisible Second Generation? Statistical Discrimination and Immigrant Stereotypes in Employment Processes in Norway. *Journal of Ethnic and Migration Studies*, *40*(10), 1657–1675. https://doi.org/10.1080/1369183X.2013.847784

Miltenburg, A. S., Bains, S., Strøm-Roum, E. M., Vartdal, V. W., Sørbye, I. K., Alnæs-Katjavivi, P., Sundby, J., & Nyfløt, L. T. (2023). Svangerskap, fødsel og barseltid – mer enn bare overlevelse. *Tidsskrift for Den norske legeforening*. https://tidsskriftet.no/2023/10/svangerskap-fodsel-og-barseltid-mer-enn-bare-overlevelse

Ministry of Education and Research. (2020, November 2). *Early Childhood Education and Care* [Redaksjonellartikkel]. Government.No; regjeringen.no. https://www.regjeringen.no/en/topics/families-and-children/kindergarden/early-childhood-education-and-care-polic/id491283/

Molin, B., Zwedberg, S., Berger, A.-K., Sand, A., & Georgsson, S. (2024). "The ignored pain"—Experiences of encounters with healthcare from the perspective of women with pain persisting after childbirth—A qualitative study. *Sexual & Reproductive Healthcare*, *39*, 100929. https://doi.org/10.1016/j.srhc.2023.100929

Molstad, C. S., Gulbrandsen, F. B., & Steinkellner, A. (2022). Familieinnvandring og ekteskapsmønster 1990-2020. In *89 s.* Statistisk sentralbyrå. https://ssb.brage.unit.no/ssb-xmlui/handle/11250/2989632

Mood, C., Jonsson, J. O., & Låftman, S. B. (2017). The Mental Health Advantage of Immigrant-Background Youth: The Role of Family Factors. *Journal of Marriage and Family*, *79*(2), 419–436. https://doi.org/10.1111/jomf.12340

Mortensen, B. (2022). *Barselbrølet—Hvordan skape verdens beste fødselsomsorg*. Manifest.

Mrayan, L., Cornish, F., Dhungana, N., & Parfitt, B. (2016). Transition to parenthood during the transition to modernity in Jordan: New parents' views on family and healthcare support systems. *Applied Nursing Research*, *32*, 139–143. https://doi.org/10.1016/j.apnr.2016.07.002

Munk-Olsen, T., Laursen, T. M., Mendelson, T., & Pedersen, C. B. (2010). Perinatal mental disorders in native Danes and immigrant women. *Archives of Women's Mental Health*, *13*(4), 319–326. https://doi.org/10.1007/s00737-009-0131-0

Nadim, M. (2014). Reinterpreting the Relation between Motherhood and Paid Work: Second-Generation Immigrant Women in Norway. *The Sociological Review*, *62*(3), 494–511. https://doi.org/10.1111/1467-954X.12176

Nakamura, A., El-Khoury Lesueur, F., Sutter-Dallay, A.-L., Franck, J.-ève, Thierry, X., Melchior, M., & van der Waerden, J. (2020). The role of prenatal social support in social inequalities with regard to maternal postpartum depression according to migrant status. *Journal of Affective Disorders*, *272*, 465–473. https://doi.org/10.1016/j.jad.2020.04.024

NAV. (2023, September 20). *Foreldrepenger*. nav.no. https://www.nav.no/foreldrepenger

Negron, R., Martin, A., Almog, M., Balbierz, A., & Howell, E. A. (2013). Social Support During the Postpartum Period: Mothers' Views on Needs, Expectations, and Mobilization of Support. *Maternal and Child Health Journal*, *17*(4), 616–623. https://doi.org/10.1007/s10995-012-1037-4

Nguyen, V. V. T., Zheng, M. Y., Liu, S. M., Kallen, M. A., Kay, K., & Ivey, S. L. (2022). Prevalence of Traditional Asian Postpartum Practices at a Federally Qualified Health Center. *Journal of Immigrant and Minority Health*, *24*(5), 1251–1260. https://doi.org/10.1007/s10903-021-01299-0

NHI. (n.d.). *Barseltiden*. NHI.no. Retrieved October 15, 2023, from https://nhi.no/familie/graviditet/svangerskap-og-fodsel/normalt-forlop/barseltiden/

Nordahl, M. (2021, February 1). *Bør du ligge på magen etter fødselen for hjelpe livmoren til å trekke seg sammen?* https://forskning.no/barn-og-ungdom-menneskekroppen-svangerskap/bor-du-ligge-pa-magen-etter-fodselen-for-hjelpe-livmoren-til-a-trekke-seg-sammen/1804095

Norsk Doulaforening. (2022). *FAQ*. Norsk Doulaforening. https://www.norskdoulaforening.no/faq

Norske Kvinners Sanitetsforening. (n.d.). *Barseltreff på tvers*. Retrieved November 18, 2023, from https://sanitetskvinnene.no/vare-tilbud/innvandrerkvinner/barseltreff-pa-tvers

Norskfødte med innvandrerforeldre – hvordan går det med dem? - Demografi, utdanning, arbeid og inntekt. (n.d.). ssb.no. Retrieved April 3, 2022, from https://www.ssb.no/befolkning/artikler-og-publikasjoner/norskfodte-med-innvandrerforeldre-hvordan-gar-det-med-dem

Norwegian Institute of Public Health. (2022, May 23). *Flere mødre supplerer ammingen med tilskudd*. Folkehelseinstituttet. https://www.fhi.no/nyheter/2022/flere-modre-supplerer-ammingen-med-tilskudd/

Oma, L. (2022, March 3). *Pandemien tvang frem et fødselsopprør i Norge. Opprøret er ikke over.* Aftenpostem. https://www.aftenposten.no/meninger/debatt/i/z7Pl4q/opproeret-er-ikke-over-foedende-og-barselkvinner-maa-faa-bedre-oppfoelging

Oommen, H., Rantanen, A., Kaunonen, M., Tarkka, M.-T., & Salonen, A. H. (2011). Social support provided to Finnish mothers and fathers by nursing professionals in the postnatal ward. *Midwifery*, *27*(5), 754–761. https://doi.org/10.1016/j.midw.2010.06.017

Optimizing Postpartum Care, 736 Committee Opinion (2018). https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care

Oslo kommune. (2015, July 9). *Helsestasjon for barn 0-5 år—Helsestasjon og vaksine*. Oslo kommune. https://www.oslo.kommune.no/helse-og-omsorg/helsetjenester/helsestasjon-og-vaksine/helsestasjon-for-barn-0-5-ar/

OsloMet. (n.d.). *Barn av innvandrere tar høyere utdanning enn foreldrene sine*. Retrieved January 31, 2024, from https://www.oslomet.no/forskning/forskningsnyheter/innvandrere-hoyere-utdanning-enn-foreldre

Palant, A., & Himmel, W. (2019). Are there also negative effects of social support? A qualitative study of patients with inflammatory bowel disease. *BMJ Open*, *9*(1), e022642. https://doi.org/10.1136/bmjopen-2018-022642

Parents' history of childhood interpersonal trauma and postpartum depressive symptoms: The moderating role of mindfulness. (2023). *Journal of Affective Disorders*, *325*, 459–469. https://doi.org/10.1016/j.jad.2023.01.007

Peckover, S. (2002). Supporting and policing mothers: An analysis of the disciplinary practices of health visiting. *Journal of Advanced Nursing*, *38*(4), 369–377. https://doi.org/10.1046/j.1365-2648.2002.02197.x

Perrenoud, P., Chautems, C., & Kaech, C. (2022). "Whatsapping" the continuity of postpartum care in Switzerland: A socio-anthropological study. *Women and Birth*, *35*(3), e263–e274. https://doi.org/10.1016/j.wombi.2021.06.009

Persson, E. K., Fridlund, B., Kvist, L. J., & Dykes, A.-K. (2011). Mothers' sense of security in the first postnatal week: Interview study. *Journal of Advanced Nursing*, *67*(1), 105–116. https://doi.org/10.1111/j.1365-2648.2010.05485.x

Persson, E. K., Fridlund, B., Kvist, L. J., & Dykes, A.-K. (2012). Fathers' sense of security during the first postnatal week—A qualitative interview study in Sweden. *Midwifery*, *28*(5), e697–e704. https://doi.org/10.1016/j.midw.2011.08.010

Price, S. L., Aston, M., Monaghan, J., Sim, M., Tomblin Murphy, G., Etowa, J., Pickles, M., Hunter, A., & Little, V. (2018). Maternal Knowing and Social Networks: Understanding First-Time Mothers' Search for Information and Support Through Online and Offline Social Networks. *Qualitative Health Research*, *28*(10), 1552–1563. https://doi.org/10.1177/1049732317748314

Prop. 15 L (2021–2022) (2021). https://www.regjeringen.no/no/dokumenter/prop.-15-l-20212022/id2888219/

Razurel, C., Bruchon-Schweitzer, M., Dupanloup, A., Irion, O., & Epiney, M. (2011). Stressful events, social support and coping strategies of primiparous women during the postpartum period: A qualitative study. *Midwifery*, *27*(2), 237–242. https://doi.org/10.1016/j.midw.2009.06.005

Reblin, M., & Uchino, B. N. (2008). Social and emotional support and its implication for health. *Current Opinion in Psychiatry*, *21*(2), 201. https://doi.org/10.1097/YCO.0b013e3282f3ad89

Revheim, I., Balthasar, M. R., Akerkar, R. R., Stangenes, K. M., Almenning, G., Nygaard, E., Markestad, T., Øverland, S., Roelants, M., & Juliusson, P. B. (2023). Trends in the prevalence of breastfeeding up to 6 months of age using structured data from routine child healthcare visits. *Acta Paediatrica*, *112*(1), 100–105. https://doi.org/10.1111/apa.16367

Rist, T., Thomassen, A. L., & Engelsen, L. Y. (2023, March 6). *Debatt: Hvor er økonomene i fødedebatten?* Www.Dn.No. https://www.dn.no/innlegg/likestilling/fodetilbud/samfunnsokonomi/hvor-er-okonomene-i-fodedebatten/2-1-1413648

Rosseland, L. A., Reme, S. E., Simonsen, T. B., Thoresen, M., Nielsen, C. S., & Gran, M. E. (2020). Are labor pain and birth experience associated with persistent pain and postpartum depression? A prospective cohort study. *Scandinavian Journal of Pain*, *20*(3), 591–602. https://doi.org/10.1515/sjpain-2020-0025

Rostad, I. L. (2023, December 23). *For billig å føde normalt: - Blir straffet*. NRK. https://www.nrk.no/tromsogfinnmark/nedbygging-av-fodetilbud-i-norge_-jordmorforbundet-kritiserer-helseforetaksmodellen-1.16683192

Rydberg, J. (2023, October 9). *Hvem holder mor? Et nytt syn på morskapet*. https://www.landsforeningen1001dager.no/2023/10/09/hvem-holder-mor/

Sacks, E., Finlayson, K., Brizuela, V., Crossland, N., Ziegler, D., Sauvé, C., Langlois, É. V., Javadi, D., Downe, S., & Bonet, M. (2022). Factors that influence uptake of routine postnatal care: Findings on women's perspectives from a qualitative evidence synthesis. *PLoS ONE*, *17*(8), e0270264. https://doi.org/10.1371/journal.pone.0270264

Sacks, E., Finlayson, K., Brizuela, V., Crossland, N., Ziegler, D., Sauv&eacute, C., &Eacute, Langlois, tienne V., Javadi, D., Downe, S., & Bonet, M. (2022). Factors that influence uptake of routine postnatal care: Findings on women's perspectives from a qualitative evidence synthesis. *PLoS ONE*, *17*(8), e0270264–e0270264. https://doi.org/10.1371/journal.pone.0270264

Salonen, A. H., Oommen, H., & Kaunonen, M. (2014). Primiparous and multiparous mothers' perceptions of social support from nursing professionals in postnatal wards. *Midwifery*, *30*(4), 476–485. https://doi.org/10.1016/j.midw.2013.05.010

Sam, D. L. (2000). Psychological Adaptation of Adolescents With Immigrant Backgrounds. *The Journal of Social Psychology*. https://doi.org/10.1080/00224540009600442

Sampson, M., Villarreal, Y., & Padilla, Y. (2015). Association between Support and Maternal Stress at One Year Postpartum: Does Type Matter? *Social Work Research*, *39*(1), 49–59.

Say, L., & Chou, D. (2018). Maternal morbidity: Time for reflection, recognition, and action. *International Journal of Gynaecology and Obstetrics*, *141*(Suppl Suppl 1), 1–3. https://doi.org/10.1002/ijgo.12499

Schaming, C., & Wendland, J. (2023). Postnatal mental health during the COVID-19 pandemic: Impact on mothers' postnatal sense of security and on mother-to-infant bonding. *Midwifery*, *117*, 103557. https://doi.org/10.1016/j.midw.2022.103557

Schjelderup, H. C. (2019, December 5). *Urovekkende fra Riksrevisjonen om utfordringene i jordmortjenesten*. https://www.dagensmedisin.no/debatt-og-kronikk/urovekkende-fra-riksrevisjonen-om-utfordringene-i-jordmortjenesten/282727

Schmied, V., Olley, H., Burns, E., Duff, M., Dennis, C.-L., & Dahlen, H. G. (2012). Contradictions and conflict: A meta-ethnographic study of migrant women's experiences of breastfeeding in a new country. *BMC Pregnancy and Childbirth*, *12*(1), 163. https://doi.org/10.1186/1471-2393-12-163

Selin, H., & Stone, P. K. (Eds.). (2009). *Childbirth across cultures: Ideas and practices of pregnancy, childbirth and the postpartum*. Springer Verlag.

Shakeel, N., Sletner, L., Falk, R. S., Slinning, K., Martinsen, E. W., Jenum, A. K., & Eberhard-Gran, M. (2018). Prevalence of postpartum depressive symptoms in a multiethnic population and the role of ethnicity and integration. *Journal of Affective Disorders*, *241*, 49–58. https://doi.org/10.1016/j.jad.2018.07.056

Sirin, S. R., Gupta, T., Ryce, P., Katsiaficas, D., Suárez-Orozco, C., & Rogers-Sirin, L. (2013). Understanding the role of social support in trajectories of mental health symptoms for immigrant adolescents. *Journal of Applied Developmental Psychology*, *34*(5), 199–207. https://doi.org/10.1016/j.appdev.2013.04.004

Sjetne, I. S., & Iversen, H. H. (2023). Women report better experiences from maternity care after postnatal consultations: A cross sectional study. *Patient Education and Counseling*, *111*, 107690. https://doi.org/10.1016/j.pec.2023.107690

Skifjeld, A. (2022, February 3). *Meri hadde ekstreme smerter under fødselen, og seier at ho blei møtt med latter*. NRK. https://www.nrk.no/norge/meri-hadde-ekstreme-smerter-under-fodselen_-og-seier-at-ho-blei-mott-med-latter-1.15838156

Slomian, J., Emonts, P., Vigneron, L., Acconcia, A., Glowacz, F., Reginster, J. Y., Oumourgh, M., & Bruyère, O. (2017). Identifying maternal needs following childbirth: A qualitative study among mothers, fathers and professionals. *BMC Pregnancy and Childbirth*, *17*(1), 213. https://doi.org/10.1186/s12884-017-1398-1

Smette, I., & Aarset, M. F. (2023). Parenting in the second generation. The changing family figurations of descendants of Pakistani, Indian and Sri Lankan Tamil immigrants in Norway. *Ethnic and Racial Studies*, *0*(0), 1–22. https://doi.org/10.1080/01419870.2023.2232454

Smette, I., & Rosten, M. G. (2019). *Et iakttatt foreldreskap. Om å være foreldre og minoritet i Norge*. 2019. https://oda.oslomet.no/oda-xmlui/handle/20.500.12199/1305

Smith, T. B., & Silva, L. (2011). Ethnic identity and personal well-being of people of color: A meta-analysis. *Journal of Counseling Psychology*, *58*(1), 42–60. https://doi.org/10.1037/a0021528

Sneberg, C., & Stavanger, U. i. (2022, November 23). *Helsesykepleier må møte både mor, far og babyens individuelle behov i barseltiden*. https://forskning.no/helsetjenester-partner-svangerskap/helsesykepleier-ma-mote-bade-mor-far-og-babyens-individuelle-behov-i-barseltiden/2111054

Socialdepartementet. (2023, December 19). *Flera förbättringar i föräldraförsäkringen*. Regeringen och Regeringskansliet. https://www.regeringen.se/pressmeddelanden/2023/12/flera-forbattringar-i-foraldraforsakringen/

Solberg, B., Glavin, K., Berg, R. C., & Olsvold, N. (2021). *Norwegian fathers' experiences with a home visiting program*. https://doi.org/10.1111/phn.12995

Solheim, M. (2021, August 7). *Anette (30) sleit med å amme dottera si: – Eg har følt meg aleine*. NRK. https://www.nrk.no/trondelag/_world-breastfeeding-week__-anette-trudde-ikkje-at-amming-skulle-bli-eit-problem-1.15601042

Song, J.-E., Chae, H.-J., Ko, J. M., In Yang, J., & Kim, T. (2020). Effects of a maternal role adjustment program for first time mothers who use postpartum care centers (Sanhujoriwon) in South Korea: A quasi-experimental study. *BMC Pregnancy and Childbirth*, *20*(1), 227. https://doi.org/10.1186/s12884-020-02923-x

Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, *31*(3), 715–721. https://doi.org/10.1046/j.1365-2648.2000.01328.x

Squire, C. (Ed.). (2009). *The social context of birth* (2nd ed). Radcliffe.

Statistics Norway. (2003, March 28). *Norske mødre ammer mye*. ssb.no. https://www.ssb.no/helse/artikler-og-publikasjoner/norske-modre-ammer-mye

Statistics Norway. (2023, March 6). *Innvandrere og norskfødte med innvandrerforeldre*. SSB. https://www.ssb.no/befolkning/innvandrere/statistikk/innvandrere-og-norskfodte-med-innvandrerforeldre

Steinkellner, A., Krokedal, L., & Andersen, E. (2023, June 7). *Innvandrerne og deres barn – en mangfoldig gruppe*. SSB. https://www.ssb.no/befolkning/innvandrere/artikler/innvandrerne-og-deres-barn--en-mangfoldig-gruppe

Stuchbery, M., Matthey, S., & Barnett, B. (1998). Postnatal depression and social supports in Vietnamese, Arabic and Anglo-Celtic mothers. *Social Psychiatry and Psychiatric Epidemiology*, *33*(10), 483–490. https://doi.org/10.1007/s001270050083

Sudhinaraset, M., Landrian, A., Golub, G. M., Cotter, S. Y., & Afulani, P. A. (2021). Person-centered maternity care and postnatal health: Associations with maternal and newborn health outcomes. *AJOG Global Reports*, *1*(1), 100005. https://doi.org/10.1016/j.xagr.2021.100005

Thomassen, A. L. (2021a, May 30). Bemanning på barsel. *Barselopprøret*. https://barselopproret.no/fordypning/bemanning-p-barsel

Thomassen, A. L. (2021b, June 24). Barsel står i full fyr. *Dagbladet*. https://www.dagbladet.no/meninger/barsel-star-i-full-fyr/73941757

Thomassen, A. L. (2022, November 12). Jordmorkrisen på OUS: Jordmorflukt. *Barselopprøret*. https://barselopproret.no/fordypning/jordmorkrisen-pa-ous-jordmorflukt

Tjeldflåt, G. M. (2022, July 4). *«Viss staten ikkje vil ta ansvar for ammehjelp, burde dei ha skamvett nok til å betale dei som gjer jobben»*. Bergens Tidene. https://www.bt.no/i/4792ka

Tronsen, G. H. (2022, October 18). Vi har brukt de siste 30 årene på å bygge ned barselomsorgen. *adressa.no*. https://www.adressa.no/midtnorskdebatt/i/696edL/tiden-etter-foedsel-er-en-risikoperiode

Tveit, G. N. I., & Söderhamn, U. S. U. (2015). Hva gjør førstegangsmødre for å mestre barnestellet i tidlig barseltid? *Nordisk Sygeplejeforskning*, *5*(2), 151–164. https://doi.org/10.18261/ISSN1892-2686-2015-02-07

Valbø, A., Iversen, H. H., & Kristoffersen, M. (2011). Postpartum Care: Evaluation and Experience Among Care Providers and Care Receivers. *Journal of Midwifery & Women's Health*, *56*(4), 332–339. https://doi.org/10.1111/j.1542-2011.2011.00038.x

Van Teijlingen, E. R. (1990). The profession of maternity home care assistant and its significance for the Dutch midwifery profession. *International Journal of Nursing Studies*, *27*(4), 355–366. https://doi.org/10.1016/0020-7489(90)90094-Y

Vik, E. S., Kongslien, S., Nedberg, I. H., Mariani, I., Valente, E. P., Covi, B., & Lazzerini, M. (2023). Women's experiences and views on early breastfeeding during the COVID-19 pandemic in Norway: Quantitative and qualitative findings from the IMAgiNE EURO study. *International Breastfeeding Journal*, *18*(1), 15. https://doi.org/10.1186/s13006-023-00553-5

Viken, B., Lyberg, A., & Severinsson, E. (2015). Maternal Health Coping Strategies of Migrant Women in Norway. *Nursing Research and Practice*, *2015*, e878040. https://doi.org/10.1155/2015/878040

Wandel, M., Terragni, L., & Nguyen, C. (2016). Breastfeeding among Somali mothers living in Norway: Attitudes, practices and challenges. *Women and Birth*, *29*(6), 487–493. https://doi.org/10.1016/j.wombi.2016.04.006

Wang, M. L., & Jacobs, O. (2023). From Awareness to Action: Pathways to Equity in Pain Management. *Health Equity*, *7*(1), 416–418. https://doi.org/10.1089/heq.2023.0179

White, L. K., Kornfield, S. L., Himes, M. M., Forkpa, M., Waller, R., Njoroge, W. F. M., Barzilay, R., Chaiyachati, B. H., Burris, H. H., Duncan, A. F., Seidlitz, J., Parish-Morris, J., Elovitz, M. A., & Gur, R. E. (2023a). The impact of postpartum social support on postpartum mental health outcomes during the COVID-19 pandemic. *Archives of Women's Mental Health*, *26*(4), 531–541. https://doi.org/10.1007/s00737-023-01330-3

White, L. K., Kornfield, S. L., Himes, M. M., Forkpa, M., Waller, R., Njoroge, W. F. M., Barzilay, R., Chaiyachati, B. H., Burris, H. H., Duncan, A. F., Seidlitz, J., Parish-Morris, J., Elovitz, M. A., & Gur, R. E. (2023b). The impact of postpartum social support on postpartum mental health outcomes during the COVID-19 pandemic. *Archives of Women's Mental Health*, *26*(4), 531–541. https://doi.org/10.1007/s00737-023-01330-3

Wiik, K. A. (2022). First union formation among the children of immigrants: A population-wide study in Norway. *Advances in Life Course Research*, *52*, 100480. https://doi.org/10.1016/j.alcr.2022.100480

Wiik, K. A., Dommermuth, L., & Holland, J. A. (2021). Partnership transitions among the children of immigrants in Norway: The role of partner choice. *Population Studies*, *75*(1), 133–152. https://doi.org/10.1080/00324728.2020.1851749

World Health Organization. (2022). *WHO recommendations on maternal and newborn care for a positive postnatal experience*. World Health Organization. https://apps.who.int/iris/handle/10665/352658

Xiao, X., & Loke, A. Y. (2021a). Experiences of intergenerational co-parenting during the postpartum period in modern China: A qualitative exploratory study. *Nursing Inquiry*, *28*(3). https://doi.org/10.1111/nin.12403

Xiao, X., & Loke, A. Y. (2021b). The effects of co-parenting/intergenerational co-parenting interventions during the postpartum period: A systematic review. *International Journal of Nursing Studies*, *119*, 103951. https://doi.org/10.1016/j.ijnurstu.2021.103951

Xiao, X., & Loke, A. Y. (2022). Intergenerational co-parenting in the postpartum period: A concept analysis. *Midwifery*, *107*, 103275. https://doi.org/10.1016/j.midw.2022.103275

Xu, X., Song, L., Li, X., & Li, Y. (2022). The Impact of Mothers' Perceived Unsupportive Intergenerational Co-Parenting on Children's Social Competence: Evidence from China. *International Journal of Environmental Research and Public Health*, *20*(1), 427. https://doi.org/10.3390/ijerph20010427

Yanigasawa, S. (2009). Childbirth in Japan. In H. Selin & P. K. Stone (Eds.), *Childbirth across cultures: Ideas and practices of pregnancy, childbirth and the postpartum*. Springer Verlag.

Zlotnick, C., Manor-Lavon, I., & Leahy-Warren, P. (2023). Relationship between social support and postpartum depression in migrant and non-migrant first-time mothers. *Journal of Clinical Nursing*, *32*(7–8), 1316–1326. https://doi.org/10.1111/jocn.16297

Appendices

Appendix A. Individual interview guide

English:

1. The goal of the project and the interview
    - Your experiences with postpartum care and what kind of support you had or wished for to help with your recovery after birth and transition to motherhood
    - Support can be, both formal and informal, practical, emotional, knowedge, resources, or whatever had value for you.

2. Consent
    - Do you have any questions about the consent form?
    - Please try to avoid mentioning any other individuals by name.
    - You can withdraw from this study at any time, including after the interview, by contacting me.
    - Your name will be anonymised and details about you (e.g. your profession, residence, birth place, etc.) will be generalized so that you cannot be identified by others. However, you may still be able to recognize yourself.
    - The interview has tended to take around 2 hours. Please let me know if you have limited time; I can remain for as long as you desire/as much time you need.

3. Theme: From hospital to homecoming
    - Where did you receive prenatal care?
    - Who was with you during the birth?
    - Can you tell me a little about the care you received at the hospital after the birth? Did you feel prepared to go home?
    - Can you describe for me the first week after you came home?
    - Who was present with you after you came home? Do they usually live with you?
    - What were the biggest expectations and wishes you had regarding the time after the birth?
    - Did your changes and needs eventually change from what you anticipated?

4. Theme: Network and support sources
    - Who were you in contact with in the course of the first weeks after the birth?
    - Who were the most important people to you in this time?
    - Was there anyone who helped you by:
        - Taking care of you or the baby
        - Helping practically with errands/housework/cooking
        - Giving or finding information/knowledge
        - Support you emotionally

- What kind of support did you receive from the health system during the postpartum period?
    - Were you satisfied with the time, attention, and individualized care you received from health professionals?
    - Do you think that they acknowledge your individual needs and circumstances?
    - Was there any interaction between the health personnel and others in your network?
    - What made you willing or unwilling to seek out health personnel for advice or help?
- What kind of role did your partner have in the postpartum period?
    - How long have you been together?
    - What is your partner's background?
    - What expectations did you have for what they should do postpartum? Were you in agreement about what kind of role they would have after the birth, and how you would obtain support?
    - How would you describe your partner's knowledge or preparedness to take care of you and the baby?
    - Have there been any changes in your relationship after the birth?
    - What is the relationship between your partner and others in your network like?
- What was your family's role in the postpartum period?
    - Can you describe your family's background?
    - What did they do to help you to recover after the birth?
    - Does your family have any approaches or attitudes about postpartum connected to the country or community where they come from? What were your attitudes towards these?
    - Do you think they understood your needs and wishes?
    - How would you describe your interactions with your family in the postpartum period?
    - Why did you think that you could/could not trust them for support or help?
    - What is the relationship between your family and others in your network like?
- How did people assume their specific roles? Could you communicate your needs and wishes to them?
- What were other support sources that were valuable for you postpartum?
    - E.g. websites, social media, *barselgruppe*, etc.

5. Negotiation of needs and expectations
    - Was there anything that was unexpected or surprising for you about the postpartum period?
    - Can you tell me about one of the toughest or most challenging moments after you gave birth?
    - How would you describe your self-confidence as a new mother?
        - What helped you to strengthen your self-confidence and give you a sense of control?

    - What made you feel that you needed help?
- How was your relationship to those in your network before you became pregnant compared to afterwards?
- Did you feel you able to tell health personnel/others in your network about what you struggled with postpartum? Why or why not?
- Was there anything you were recommended, but declined, hesitated about, felt ambivalent about, or experienced as difficult to fulfill?
- Were there any resources or services you were aware of, or considered, but did not receive, or declined?
- What was it like for you to reject advice, resources, or services from, for example, the health system or your social network?
- Has your relationship to those in your social network changed after you gave birth?
- Do you think that your experience with postpartum corresponds with what is typical in Norway? Why/why not?

6. Conclusion/wrapping up
    - How would you advise your (hypothetical) little sister about postpartum if she were pregnant?
    - Anything else you want to add?
    - Thank you so much for the interview!
    - May I contact you with any follow-up questions?
    - Do you know any other potential participants?

Norsk:

7. Formålet til prosjektet og intervjuet
    - Dine opplevelser med barselomsorg og hva slags støtte du hadde eller ønsket deg for å hjelpe deg til å komme deg etter fødselen or blir mor
    - Støtte kan bestå av både formell og uformell, praktisk, emosjonelt, kunnskap ressurser, hva som helst hadde stor verdi for deg

8. Samtykke
    - Har du noen spørsmål om samtykkeskjemaet?
    - Prøv å unngå å nevne noen andre (ved navn)
    - Du kan trekke deg etter intervjuet ved å ta kontakt med meg
    - Navnet ditt skal anonymiseres og detaljer om deg (yrke, bosted, fødested, osv.) skal generaliseres slike at du ikke kan identifiseres av andre. Det kan imidlertid hende at du kjenne deg igjen.
    - Intervjuet pleier å ta ca. 2 timer. Si ifra om du har begrenset tid, jeg blir så lenge du vil.

9. Tema: Overgangen fra sykehuset til hjemkomst
    - Hvor fikk du svangerskapskontroll?
    - Hvem hva til stede med deg under fødselen?

- Kan du fortell meg litt om omsorgen du fikk på sykehuset etter fødselen? Følte du deg forberedt til å dra hjem?
- Kan du beskrive for meg den første uken etter du kom hjem?
- Hvem var til stede med deg etter du kom hjem? Bor de vanligvis hos deg?
- Hva var de største forventningene og ønskene du hadde til tiden etter fødselen?
- Endret følelsene og behovene dine etter hvert fra det du forventet/så for deg?

10. Tema: Nettverket og støttekilder
    - Hvem var du i kontakt med i løpet av de første ukene etter fødselen?
    - Hvem var de meste verdifulle menneskene for deg i denne tiden?
    - Var det noen som hjalp deg ved å
        - Ta vare på deg eller babyen
        - Bidra praktisk med ærende/husarbeid/matlaging
        - Gi deg eller finne info/kunnskap
        - Støtte deg emosjonelt

    - Hva slags omsorg fikk du av helsevesenet i barseltiden?
        - Var du fornøyd med tiden, oppmerksomhet og tilpasningen du fikk fra helsefagfolk?
        - Synes du at de erkjente dine enkelte behov/omstendigheter?
        - Var det noe samspill mellom helsepersonell og andre i nettverket ditt?
        - Hva gjorde deg villig eller uvillig til å søke helsepersonell til råd, hjelp, osv.?

    - Hva slags rolle hadde partneren din i barseltiden?
        - Hvor lang tid har dere vært sammen?
        - Hva er bakgrunnen til partneren din?
        - Hva var forventningene dine for hva de skulle drive med i barseltiden? Var dere enig om hva slags rolle de skulle ta etter fødselen og hvordan dere skulle skaffe dere støtte?
        - Hva var din partners kunnskap/forberedelse til å møte behovene til deg/babyen?
        - Har det vært noen endringer i forholdet ditt etter fødselen?
        - Hvordan er forholdet mellom partneren og andre i nettverket ditt?

    - Hva var rollen til familien din i barseltiden?
        - Kan du beskrive for meg bakgrunnen til familien din?
        - Hva gjorde de til å hjelpe deg til å komme deg etter fødselen?
        - Har familien din noen tilnærmingsmåter/holdninger om barseltiden knyttet til landet/samfunnet de kom fra? Hva var dine holdninger om disse?
        - Syntes du at de forsto behovene og ønskene dine?
        - Hvordan ville du beskrive deres samspill i barseltiden?
        - Hvorfor syntes du at du kunne/ikke kunne stole på dem for støtte/hjelp?
        - Hva var forholdet mellom familien og andre i nettverket ditt?

- Hva førte til at folk stilte seg for de enkelte rollene de hadde? Kunne du kommunisere behovene og ønskene dine til dem?
- Hva var andre støttekilder som hadde verdi for deg i barseltiden?
    - F.eks. nettsider, sosiale medier, barselgruppen, osv.

11. Forhandling av behov og forventninger
    - Var det noe som var uforventet/overraskende for deg i barseltiden?
    - Kan du fortelle meg om et av de tyngste eller utfordrende øyeblikkene etter du føde barna?
    - Føler du deg selvtillit som ny mor?
        - Hva hjalp deg til å styrke selvtilliten, gi deg følelsen at du har kontroll?
        - Hva gjorde du da du skjønte at du trengte hjelp?
    - Hvordan var forholdet ditt til de i nettverket ditt før du ble gravid sammenlignet til etterpå?
    - Kunne du fortelle helsepersonell/nettverket ditt om hva du slet med i barseltiden? Hvorfor/hvorfor ikke?
    - Var det noe du ble anbefalt, men avslo, nølte på, følte deg ambivalent over, opplevd som for utfordrende å fullføre?
    - Var det noen ressurser/tjenester du var bevisst eller vurderte, men fikk ikke/avslo?
    - Hvordan var det for deg å avslå råd, ressurser, tjenester, f.eks. fra enten helsevesenet eller nettverket ditt?
    - Har forholdet ditt til de i nettverket ditt endret seg etter du føde barna?
    - Synes du at din opplevelse med barseltiden tilsvarer det som er typisk i Norge?
12. Konklusjon/oppsummering
    - Hva ville du anbefale din (hypotetisk) lillesøster om barseltiden hvis hun var gravid?
    - Noe annet du har lyst til å tilføye?
    - Tusen takk for intervjuet
    - Får jeg kontakte deg å følge opp med andre spørsmål?
    - Jeg prøver å gjennomføre noen intervjuer med deltakerne sine mødre. Kunne du tenke deg å bli intervjuet sammen med din mor?
    - Kjenner du noen andre evt. deltakere?

Appendix B. Mother-daughter dyad interview guide

English:

- What is your perception of a new mother's health after she has given birth? What do you think is important for the new mother's health in the postpartum period? (i.e. what do they need in order to recover from childbirth?)
    - How did your own postpartum experience correspond with these beliefs?
    - How did your daughter's postpartum experience correspond with these beliefs?
    - How did you learn about these care practices?
    - Have they evolved over time?
- Do you think a mother has a specific role when her daughter gives birth?
    - What about other family members? Do you think they did what was needed to care for/support your daughter?
- Do you think midwives/health personnel provide enough care during the postpartum period?
    - What was your impression of health personnel during your/your daughter's postpartum recovery?
- What is your perception of a new mother's emotional well-being after she has given birth?
- Did you and your daughter have any conversations, before or after the birth, about what would be most helpful for her during postpartum?
- Was there anything you wanted to do, or that you thought your daughter should do, that she refused? How did you feel about that?
- Did you find it challenging/difficult to provide your daughter with the care and support you thought she should have?
- If you have other daughters/daughters-in-law, how did/would you do things differently to help them during their postpartum?

Norsk:

- Hva er oppfatningen din av helse til nybakte mødre etter fødselen? Hva mener du er viktig til å forsikre/styrke en nybakt morens helse I barseltida? (hva tror du at de trenger for å komme seg etter fødsel?)
    - Hvordan svarte din egen opplevelse med barseltid til dette synet?
    - Hvordan svarte opplevelsen til datteren dette synet?
    - Hvordan lærte du om disse omsorgsmetodene?
    - Har de endret seg?

- Mener du at en mor har en spesiell rolle når datteren hennes føder?
    - Hva med andre slektninger? Synes du at de gjorde det som trengs for å ta vare på/støtte datteren din?

- Mener du at jordmødre og helsepersonell leverte tilstrekkelig omsorg i barseltiden?
    - Hva var din oppfatning av helsepersonell under barseltiden til datteren din?

- Hva er ditt syn når det gjelder det emosjonelle velværet til en nybakt mor?
- Hadde du og datteren din noen samtaler, før eller etter fødselen, om hva skulle være mest nyttig eller verdifull for henne i barseltida?

- Var det noen som du ville gjøre, eller som du ville at datteren din skal gjøre, som hun nektet? Hvilke følelser og tanker hadde du om ønskene hennes?

- Opplevde du det som utfordrende eller vanskelig for deg å tilby datteren din med omsorgen og støttet du mente hun burde ha?

- Har du noen andre døtre/svigerdøtre, hvordan har du/ville du endre tilnærmingen din til å hjelpe dem i barseltida?

Appendix C. Individual consent form/information sheet

Vil du delta i forskningsprosjektet

Veikryss ved vuggen: Forhandling om barselomsorg og flerkulturell tilhørighet blant mødre i Norge som er barn av innvandrerforeldre

Crossroads at the Cradle: Postnatal Care and Multicultural Belonging among Second-Generation Immigrant Women in Norway

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske opplevelser til norskfødte/oppvokste kvinner med innvandrerforeldre og hvordan de opplever barselomsorg og støtte i tiden etter fødselen. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

This is an inquiry about participation in a research project where the main purpose is to explore second-generation immigrant women's experiences with postnatal care and support in Norway. In this letter we will give you information about the purpose of the project and what your participation will involve.

Formål | *Purpose of the project*

"Veikryss ved vuggen" er en masteroppgave som handler om nybakte mødre med innvandrerbakgrunn og deres opplevelser med å komme seg etter fødsel og overgangen til morskap i det norske samfunnet som kvinner med flerkulturell og innvandrerbakgrunn. Formålet til prosjektet er å styrke kunnskap om helse og velvære etter fødsel blant kvinner i Norge med innvandrerforeldre, og undersøke tilgang til og opplevelse av ulike støttekilder. Prosjektet ønsker også å utforske om eller hvordan kulturell- og innvandrerbakgrunn former opplevelser med barselomsorg. Et mål for prosjektet er å kunne bidra med kunnskap og informasjon rundt opplevelser rundt barselomsorg i Norge mer generelt, og knyttet til mødre med innvandrerbakgrunn spesielt.

"Crossroads at the Cradle" is Master's thesis project about new mothers' experiences of recovering from childbirth and transitioning to a motherhood role in Norwegian society as women with multicultural and immigrant backgrounds. The objective of the project is to strengthen knowledge about second-generation immigrant women's postnatal health and well-being and examine access and relationships to different sources of support. The project wishes also to explore if/how migration background shapes strengths or challenges in experiences of postnatal care, with the goal of producing knowledge that can potentially inform improvements in how postnatal care is conceived and delivered in Norway generally, as well as in connection to mothers with a migration background specifically.

Hvem er ansvarlig for forskningsprosjektet? | *Who is responsible for the research project?*
Universitetet i Oslo – Institutt for Helse og Hamfunn, Avdeling for Samfunnsmedisin og Global Helse er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta? | *Why are you being asked to participate?*
Vi inviterer opp til 15 individer å delta i prosjektet som:

- Er norskfødte eller oppvokste kvinner med innvandrerforeldre fra et ikke-vestlig land; og
- Har født og fått barseltjenester av det norske helsesystemet

Invitasjonen om deltakelse er blitt delt med ulike institusjoner som tilbyr tjenester for nybakte mødre.

Up to 15 participants will be invited to take part in this project, who:

- *are women born and/or raised in Norway with immigrant parents from a non-Western country; and*
- *have given birth and received postnatal care in Norway's public healthcare system.*

The invitation to participate was shared with different institutions that offer services for new mothers or engage in advocacy for postpartum/maternity care.

Hva innebærer det for deg å delta? | What does participation involve for you?

Hvis du velger å delta i prosjektet vil det innebære at du blir intervjuet i 1-2 timer om opplevelsene dine knyttet til barselomsorg og støtte fra både formelle og uformelle kilder, og hvordan disse opplevelsene har påvirket ditt velvære, bedring og selvtillit i overgangen til å bli mor.

Participation will involve a 1-2 hour individual interview during which you will be asked about your experiences with accessing postnatal care and support from both formal and informal sources, and how those experiences have influenced your well-being, postpartum recovery, and confidence transitioning to motherhood.

Det er frivillig å delta | *Participation is voluntary*

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Forskerne knyttet til dette prosjektet er ikke helsefagfolk. Dette prosjektet er uavhengig av helsevesenet og opplysning om deltakelsen din holdes konfidensielle, uten tilgang av helsevesenet, skal ikke påvirke behandlingen din og skal ikke deles med noen.

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

The researchers involved in this project are not healthcare providers or clinicians. This research project is independent from the Norwegian Health Services and information about your participation is confidential, cannot be accessed by any healthcare providers, will not affect your care and treatment, and will not be shared with anyone.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger |
Your personal privacy – how we will store and use your personal data

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Bare forskeren (Lucia Hsiao) og veilederne (Benedikte Lindskog and Heidi Fjeld) skal ha tilgang til personopplysningene dine.
- For å forsikre at informasjon om holdes anonymt og beskyttes fra ulovlig tilgang vil navnet ditt og kontaktinfoen din bli erstattet av en kode. Ditt navn, kontaktinfo, og de aktuelle kodene vil bli lagret adskilt fra intervjudata, utskrifter, og lydopptak. Alt datamateriale vil bli lagret på Tjenester for Sensitive Data (TSD), en kryptert database ved UiO. Lydopptakene vil bli slettet fra opptaksenheten umiddelbart etter at de er lastet opp I TSD, og videre slettet ved prosjektslutt.

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

- *Only the researcher (Lucia Hsiao) and project supervisors (Benedikte Lindskog and Heidi Fjeld) will have access to your identifiable personal data.*
- *To ensure your data remains anonymous and no unauthorized persons are able to access the personal data, and your name and contact details will be replaced with a code. Your names, contact details and respective codes will be stored separately from the interview data, transcripts, and recordings, and all data will be stored on an encrypted research database managed by the University of Oslo (TSD). All audio recordings will be destroyed after transcription.*

Identitetene til deltakerne vil være anonyme i eventuelle publikasjoner. Navn, alder, adresse, og datoen for når du fødte ditt barn vil ikke fremkomme i publikasjoner. Publisering kan inkludere opplysning om din etniske og kulturelle bakgrunn, sivilstatus, utdanning, arbeidsstatus, og husholdning. Selv om denne informasjonen gjør det mulig at du kan gjenkjenne deg selv i publikasjonen, skal det ikke være spesifikt nok til at du kan bli identifisert av andre.

The researcher will keep the participants' identities anonymous in any publications. The names, ages, addresses, and approximate delivery date of the participants or any individuals described by the participants will be anonymized or approximated. Publication may include information about your ethnic/cultural background, relationship status, education level, employment status, and household composition. This information may make you recognizable to yourself in publication but will not be specific enough to allow others to identify you.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes? |
What will happen to your personal data at the end of the research project?

Prosjektet er forventet avsluttet 31. desember. Etterpå skal lydopptak og alle personopplysninger skal ødelegges. Bare de anonymiserte utskriftene skal arkiveres.

The project is scheduled to end 31 December 2023, after which audio tapes and any identifiable personal data will be destroyed. Only the anonymized transcripts will be archived.

Dine rettigheter | *Your rights*

Så lenge du kan identifisere deg selv i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

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*

Hva gir oss rett til å behandle personopplysninger om deg? |
What gives us the right to process your personal data?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Universitetet i Oslo har Personverntjenesten vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

We will process your personal data based on your consent.

Based on an agreement with the University of Oslo, Data Protection Services has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Hvis du har spørsmål knyttet til Personverntjenesten sin vurdering av prosjektet, kan du ta kontakt med: | *If you have questions about the project, or want to exercise your rights, contact:*

- Lucia Hsiao (lucialh@uio.no), Benedikte Lindskog (b.v.lindskog@medisin.uio.no), or Heidi Fjeld (heidi.fjeld@medisin.uio.no)
- Our Data Protection Officer: personvernombudet@uio.no
- Data Protection Services, by email: (personverntjenester@sikt.no) or by telephone: +47 53 21 15 00.

Med vennlig hilsen,

Lucia Hsiao (masterstudent, UiO)
Benedikte Lindskog (Associate professor at OsloMet, main supervisor)

Heidi Fjeld (Professor at UiO, co-supervisor)

Samtykkeerklæring | *Consent form*

Jeg har mottatt og forstått informasjon om prosjektet *Veikryss ved vuggen* og har fått anledning til å stille spørsmål. Jeg samtykker til:

I have received and understood information about the project Crossroads at the Cradle and have been given the opportunity to ask questions. I give consent:

- ☐ å delta i et intervju | *to participate in an interview*
- ☐ å bli spilt inn via lydopptak under intervjuet | *to be recorded via audio during the interview*
- ☐ at avidentifiserte opplysninger om meg publiseres | *for de-identified background information about me/myself to be published*

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, *ca. 31. desember 2023.*

I give consent for my personal data to be processed until the end date of the project, approx. 31 December 2023.

(Signed by participant, date)

Appendix D. Mother-dyad consent form/information sheet

Vil du delta i forskningsprosjektet

Veikryss ved vuggen: Forhandling om barselomsorg og flerkulturell tilhørighet blant norskfødte mødre med innvandrerforeldre

Crossroads at the Cradle: Postnatal Care and Multicultural Belonging among Second-Generation Immigrant Women in Norway

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske opplevelser til norskfødte/oppvokste kvinner med innvandrerforeldre og hvordan de opplever barselomsorg og støtte i tiden etter fødselen. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

This is an inquiry about participation in a research project where the main purpose is to explore second-generation immigrant women's experiences with postnatal care and support in Norway. In this letter we will give you information about the purpose of the project and what your participation will involve.

Formål | *Purpose of the project*

"Veikryss ved vuggen" er en masteroppgave som handler om nybakte mødre med innvandrerbakgrunn og deres opplevelser med å komme seg etter fødsel og overgangen til morskap i det norske samfunn Formålet til prosjektet er å styrke kunnskap om helse og velvære etter fødsel blant norskfødte kvinner med innvandrerforeldre, og undersøke tilgang til og opplevelse av ulike støttekilder. Prosjektet ønsker også å utforske om eller hvordan kulturell- og innvandrerbakgrunn former opplevelser med barselomsorg. Et mål for prosjektet er å kunne bidra med kunnskap og informasjon rundt opplevelser rundt barselomsorg i Norge mer generelt, og knyttet til mødre med innvandrerbakgrunn spesielt.

"Crossroads at the Cradle" is Master's thesis project about new mothers' experiences of recovering from childbirth and transitioning to a motherhood role in Norwegian society as women with multicultural and immigrant backgrounds. The objective of the project is to increase knowledge about second-generation immigrant women's postnatal health and well-being, examine access and relationships to different sources of support, and explore if/how your background has shaped strengths or challenges in your experience of postnatal care, with the goal of producing knowledge that can potentially inform improvements in how postnatal care is conceived and delivered in Norway.

Hvem er ansvarlig for forskningsprosjektet? | *Who is responsible for the research project?*
Universitetet i Oslo – Institutt for Helse og Hamfunn, Avdeling for Samfunnsmedisin og Global Helse er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta? | *Why are you being asked to participate?*
Vi inviterer opp til 3 mamma-datter par å delta i prosjektet hvorav:

- Datteren er norskfødt eller oppvokste som ar født og fått barseltjenester av det norske helsesystemet og:
- Moren hennes innvandret til Norge fra et ikke-vestlig land.

Up to 3 mother-daughter pairs will be invited to take part in this project, of whom:

- *The daughter is born and/or raised in Norway and has given birth and received postnatal care in Norway's public healthcare system; and*
- *Her mother immigrated to Norway from a non-western country.*

Hva innebærer det for deg å delta? | *What does participation involve for you?*

Hvis du velger å delta i prosjektet vil det innebære at du blir intervjuet i ca 1 time sammen med datter/moren din om din oppfatning av helse og omsorg i barseltiden og hvordan det var å gi/motta støtte. Moren skal også bli spurt om hvordan sin egen opplevelse med barseltid svarer til meningene sine om barselomsorg.

Participation will involve an approximately 1 hour interview together with your daughter or mother during which you will be asked about your perception of health and care in the postnatal period and your experiences of giving or receiving postnatal support. The mother will also be asked about how her own experiences with postpartum corresponds to her opinions about postnatal care.

Det er frivillig å delta | *Participation is voluntary*

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg. Forskerne knyttet til dette prosjektet er ikke helsefagfolk. Dette prosjektet er uavhengig av helsevesenet og opplysning om deltakelsen din holdes konfidensielle, uten tilgang av helsevesenet, skal ikke påvirke behandlingen din og skal ikke deles med noen.

Participation in the project is voluntary. If you choose to participate, you can withdraw your consent at any time without giving a reason and your information will be deleted. There will be no negative consequences for you if you choose not to participate or later decide to withdraw. The researchers involved in this project are not healthcare providers or clinicians. This research project is independent from the Norwegian Health Services and information about your participation is confidential, cannot be accessed by any healthcare providers, will not affect your care and treatment, and will not be shared with anyone.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger |
Your personal privacy – how we will store and use your personal data

Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Bare forskeren (Lucia Hsiao) og veilederne (Benedikte Lindskog and Heidi Fjeld) skal ha tilgang til personopplysningene dine.
- For å forsikre at informasjon om holdes anonymt og beskyttes fra ulovlig tilgang vil navnet ditt og kontaktinfoen din bli erstattet av en kode. Ditt navn, kontaktinfo, og de aktuelle kodene vil bli lagret adskilt fra intervjudata, utskrifter, og lydopptak. Alt datamateriale vil bli lagret på Tjenester for Sensitive Data (TSD), en kryptert database ved UiO. Lydopptakene vil bli slettet fra opptaksenheten umiddelbart etter at de er lastet opp I TSD, og videre slettet ved prosjektslutt.

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

- *Only the researcher (Lucia Hsiao) and project supervisors (Benedikte Lindskog and Heidi Fjeld) will have access to your identifiable personal data.*
- *To ensure your data remains anonymous and no unauthorized persons are able to access the personal data, and your name and contact details will be replaced with a code. Your names, contact details and respective codes will be stored separately from the interview data, transcripts, and recordings, and all data will be stored on an encrypted research database managed by the University of Oslo (TSD). All audio recordings will be destroyed after transcription.*

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The researcher will keep the participants' identities anonymous in any publications. The names, ages, addresses, and approximate delivery date of the participants or any individuals described by the participants will be anonymized or approximated. Publication may include information about your ethnic/cultural background, relationship status, education level, employment status, and household composition. This information may make you recognizable to yourself in publication but will not be specific enough to allow others to identify you.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes? |
What will happen to your personal data at the end of the research project?

Prosjektet er forventet avsluttet 31. desember. Etterpå skal lydopptak og alle personopplysninger ødelegges. Bare de anonymiserte utskriftene skal arkiveres.

The project is scheduled to end 31 December 2023, after which audio tapes and any identifiable personal data will be destroyed. Only the anonymized transcripts will be archived.

Dine rettigheter | *Your rights*

Så lenge du kan identifisere deg selv i datamaterialet, har du rett til:

- innsyn i hvilke opplysninger vi behandler om deg, og å få utlevert en kopi av opplysningene
- å få rettet opplysninger om deg som er feil eller misvisende
- å få slettet personopplysninger om deg
- å sende klage til Datatilsynet om behandlingen av dine personopplysninger

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*

Hva gir oss rett til å behandle personopplysninger om deg? |
What gives us the right to process your personal data?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Universitetet i Oslo har Personverntjenesten vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

We will process your personal data based on your consent.

Based on an agreement with the University of Oslo, Data Protection Services has assessed that the processing of personal data in this project is in accordance with data protection legislation.

Hvis du har spørsmål knyttet til Personverntjenesten sin vurdering av prosjektet, kan du ta kontakt med: | *If you have questions about the project, or want to exercise your rights, contact:*

- Lucia Hsiao (lucialh@uio.no), Benedikte Lindskog (b.v.lindskog@medisin.uio.no), or Heidi Fjeld (heidi.fjeld@medisin.uio.no)
- Our Data Protection Officer
  personvernombudet@uio.no
- Data Protection Services, by email: (personverntjenester@sikt.no) or by telephone: +47 53 21 15 00.

Med vennlig hilsen,

Lucia Hsiao (masterstudent, UiO)

Benedikte Lindskog (Associate professor at OsloMet, main supervisor)
Heidi Fjeld (Professor at UiO, co-supervisor)

Samtykkeerklæring | *Consent form*

Jeg har mottatt og forstått informasjon om prosjektet *Veikryss ved vuggen* og har fått anledning til å stille spørsmål. Jeg samtykker til:

I have received and understood information about the project Crossroads at the Cradle and have been given the opportunity to ask questions. I give consent:

- ☐ å delta i et intervju | *to participate in an interview*
- ☐ å bli spilt inn via lydopptak under intervjuet | *to be recorded via audio during the interview*
- ☐ at avidentifiserte opplysninger om meg publiseres | *for de-identified background information about me/myself to be published*

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 31. desember 2023.

I give consent for my personal data to be processed until the end date of the project, approx. 31 December 2023.

(Signed by participant, date)

Appendix E. Recruitment notice

Appendix F. Translated quotes in their original Norwegian

[1] Edna: Det var veldig krevende. Veldig krevende å være så sliten etter fødsel (…) og det er alltid vondt, og så skal du på en måte "put on a brave face" og smile gjennom selskapene. Det var veldig slitsomt. Det var veldig slitsomt. Jeg skulle ønske at de kunne forstå at man ikke kan besøke noen, så kort tid etter at de har kommet hjem fra sykehuset. Men jeg følte absolutt at jeg ikke kunne si nei. Det var ikke mulig for meg å sette "boundaries" som er på en måte så imot min kultur.

[2] Edna: …jeg følte at jeg var veldig lite forberedt til den fasen etter fødsel…det var ingen som fortalte meg, 'The physical discomfort' for det første, den psykiske delen, og....konkret sånn på en måte hvor mye et spedbarn skulle kreve.

[3] Jina: [Den største utfordringen] var egentlig det å komme, det at kroppen skulle komme seg etter fødselen. Det var veldig dårlig. Og jeg har tenkt på i etterkant nå at....hvis jeg hadde sovet de 48 timene før jeg fødte. tror jeg, det hadde kommet meg litt lettere. Men de sier jo at det tar, ett til to år…før kroppen blir helt bra. Det synes jeg var tyngste. (…) Jeg følte meg skallebanka. Ja, banka. Kroppen var helt mer banka (…) når barna skulle sove, men ikke ville sove. Og jeg var kjempetrøtt da. Og det at...babyen kanskje gråte fordi han var sulten, trøtt. Ikke klare å finne roen...men samtidig som jeg måtte, ha det vondt, ikke sant. Ikke klare å hele tiden være der for babyen.

[4] Edna: …når jeg tenker tilbake til det, herregud, det er veldig rart at jeg ikke oppsøkte hjelp (…) jeg bare antok at det var sånn det var. For det var ingen som, på en måte nevnte for meg at det ikke er normalt å ha vondt hele tiden. (…) Så jeg holdt ut, jeg nevnte aldri om smertene mine, selv når jeg var på seks ukers kontroll (…) Så sa de bare, ja, hvordan går det? Så "det er greit," jeg sa bare, "Ja, det er jo vondt, det er ubehagelig, men det er liksom, ja. Så ja, men det er helt normalt." Det var liksom helt greit. Så jeg oppsøkte selv ikke noen, og jeg, for jeg antok bare at det skulle være sånn.

[5] Jina: Så jeg følte meg veldig godt ivaretatt (…) …jeg hadde veldig store smerter rett etter fødselen (…) og så sa jeg bare sånn at jeg trengte smertestillende, og da kom de med noen til, og paracet da. Det var veldig greit, så hver gang jeg trengte noe, så kom de med det til meg da.

[6] Ada: Vi fikk jo flere besøk av sykepleierne. De kom inn hele tida for a sjekke bade babyen og meg...Jeg var på sykehuset to dager, og de to dagene følte jeg at jeg ble godt tatt vare på. Jeg kunne bare ringe på hvis det var noe, og de kom med en gang å hjelpe og svarte. Og før jeg dro, så tok de en slags siste sjekk for å se om alt var i orden. Og så kom en jordmor innom og snakket litt både med meg og mannen min, og ga litt informasjon om hva som kunne forvente oss etter hvert og de var liksom sikre på at vi var...godt beredt, på en måte, til å dra hjem. (...) Jeg følte at det gikk ganske greit, slik at vi følte oss ganske klare.

[7] Jina: Jeg husker at vi gikk forbi barselavdelingen også, det var jo flere som delte rom, flere mødre med fedre (...) og det tror jeg hadde vært skikkelig stress.

[8] Ada: Vi bestilt oss et familierom. Da betaler du litt ekstra, og så kan mannen bli med og sover der sammen med meg. Hvis det er plass. Hvis det er for eksempel fullt, så måtte han dra hjem om natta. Men heldigvis kunne han bli med oss hele tida.

[9] Jina: Jeg synes de var veldig flinke med meg, i hvert fall. Jeg har ingenting å kommentere. Det eneste jeg merket var at de hadde det veldig travelt. Det var ikke bare jordmødre som var der, det var liksom studenter også, som jeg hadde til. Så det merket jeg jo.

[10] Jina: Så vi var jo veldig slitne alle sammen, så vi sov jo hele natta. Og da husker jeg at jordmødrene som var på det Barselshotellet, de på en måte lot oss være litt da. Og det var egentlig litt greit. Men egentlig, så fant vi ut da dagen etter, så skulle vi egentlig ha ammet, eller at vi skulle gitt barnet melk da. Så vi fikk litt sann...litt olmt blikk, men det gikk bra. Så var det en annen jordmor som kom og snakket med oss etterpå og sa at det går bra, så lenge det var bare er første natta og alle er jo slitne…

[11] Edna: Jeg må si at jeg er veldig overrasket over hvor lite informasjon jeg egentlig fikk på barsel. (…) Så husker jeg at jeg tok med meg babyen hjem, og så tenker du bare "Ok, hva skal jeg gjøre med dette lille barnet her?"

[12] Jina: På helsestasjonen, der er de jo mer opptatt av hvordan det er hjemme. Derfor kommer de på hjemmebesøk og snakker om de mer generelle ting. Så for eksempel, søvn, nye rutiner, forhold mellom meg og mannen, sånne ting. Mens på sykehuset var det litt sånn, amminga, av tiden etter fødselsdelen med mor, hvordan går det der, de ulike helsesjekkene, sånne ting.

[13] Ada: [Med fast jordmor] da slapp jeg å fortelle samme ting. Selv om de har det registrert, så får du et bånd. De vet du jo at siden magen din var liten, så har den blitt store, og så har du en baby. De har vært gjennom i samme, under perioden. Jeg tenker at det var greit.

[14]Jina: Det å faktisk snakke med helsesykepleier etter fødselen, det har hjulpet veldig. Det eneste er at, vi skulle jo hatt en fast person, men nå har det vært så travelt på jobben deres da, at nå har vi hatt forskjellige aller ganger. (latter) Og det gjør jo noe med at helsepersonellene eller helsesykepleieren ikke kjenner barnet, eller oss. Så da blir det liksom et nytt møte hver gang. Så det er litt sånn, det jeg har å si, som kanskje kan være litt sånn, ja, negativt kanskje. Ellers så er jeg fornøyd.

[15] Edna: …kanskje hvis jeg visste bedre med førstemann, så hadde jeg spurt om.. at helsesøster kunne komme hjem til meg, i stedet for at jeg skulle gå ut igjen så tidlig. (…)

Forsker: Var det greit for deg å ha en helsesøster hjemme hos deg?

Edna: Det var veldig rart (…) fordi da følte jeg plutselig at jeg måtte også presentere hjemmet mitt, sånn at, (…) hvor mye kunnskap jeg hadde der og da, og hvor mye utdanning jeg hadde der og da...så hadde jeg alltid en følelse av at, "Ok, hva kommer de til å si hvis de ser hjemmet mitt? Kommer de til å tenke at dette er ikke egnet for barn? Tenker de at dette er ikke bra for et spedbarn?" Så jeg følte, ja, en slags press på...å presentere en front, så at de ikke skulle få dårlig

inntrykk av meg. (...) Men selv om innerst inne, så visste jeg at det ikke er det som er avgjørende for at barnevernet skal komme inn og ta barnet mitt vekk.

[16] Edna: ...jeg gjorde ingenting annet enn å amme babyen og sitte der med babyen, for da er det alltid de som ordnet alt, de lagde mat, de ryddet huset, de passet på babyen når jeg ville ta meg en dusj. (...) Hvis babyen grein så holdte de sånn at jeg kunne sove litt lengre, for eksempel. Også får du beskjed om at du får ikke gå ut, fordi at de hadde tro på at så-så mange dager etter fødsel, du må være inne i....sånn helt tradisjonelt sett i Somalia, du er inne i 40 dager. Mens det lar seg jo ikke gjøre her, for du skal på helsestasjon, men i hvert fall den første uken, så er det så bare, da går du ikke noe sted, du må være inne liksom.

[17] Jina: Det var vel mest moren min og faren min som sa "Når du er født så må du være inne i en måned. Ikke gå ut, bare passe på kroppen din. Bare samle på energien, for.nå (...) har du døde og liksom overlevde igjen. Prøv ikke å gjøre noen ting. Hvis det er noe jeg kan gjøre, så kan du bare å si ifra til oss, om det blir matlaging, eller rydding hjemme. Ikke tenk på det, bare tenk på å bli healet da. Det eneste jeg skulle gjøre var på en mate, amme, og holde babyen.

[18] Ada: Hos tyrkiske tradisjon og kultur så er det veldig viktig de første 40 dagene. (...) Jeg har liksom alltid fått tips om å ikke frys, du må holde deg varm. Du må passe på når du går ut. Du må kle på deg ganske varmt selv om det er varmt ut det som er, ikke sant.

[19] Jina: (som moren hennes) «når du går ut og rett etter fødselen og ikke får hvilt, så blir skjelettet ditt helt porøst. Fordi vinden blåser så hardt på deg, og da blir det stivt og du får så vondt i hele kroppen. Og det varer mange, mange ar.»

[20] Edna: Under hele svangerskapet og så etter fødsel øgsa...du blir vartet opp, du blir pa en måte, 'taken care of', rett og slett. (...) Også de uttrykker den måten de tar vare pa deg ved mat. Alle kommer med mat. Det spiller ingen rolle om du ikke vil ha, eller ....alle kommer med mat. Det er liksom dems kjærlighetsspråk, mat, mat, mat.

[21] Ada: Også var det viktig for meg å spise godt, sånn at jeg hadde nok melk og var liksom, hadde nok energi til å passe på henne.

[22] Ada: Hvis det er noe jeg får lyst på så må jeg spise med en gang. Eller så slutter jeg å ha melk.

[23] Edna: …jeg tenker i min kultur (...) den største motivasjonen for dem, når de skulle fore meg med mye mat var at jeg skulle produsere mye melk for at barnet skal bli stor og det skal være synlig, synlig stor barn, ikke sant, det betyr at man da har (...) suksessfull barseltid. Og det er kanskje det de jobbet hardest for, vil jeg si...

[24] Jina: Da jeg snakket med jordmor, som jeg fikk via kommunen, så sa hun sånn, "må vi spise *næringsrik* mat da, ikke kjøtt, bare." (ler) Mens moren min var sånn, du må spise kjøtt, får mye jern, du ser ikke frisk ut i ansiktet, du er helt hvitt."

[25] Jina: Jeg var jo ute kanskje to uker senere liksom, og gikk da. Men jeg merket ganske fort etterpå at jeg skulle hørte på mamma. Fordi jeg ble veldig, veldig sliten etterpå, jeg tror jeg fikk ammegikt etterpå også. Det er sånn når du kjenner alle knoklene, at du ikke klarer å bevege på deg. (...) Jeg ble jo da hjemme da, hjemmeværende en måned, tror jeg, etter det. Når man tenker sann, når man har født liksom, så vil man vise fram babyen, gå ut, ta litt frisk luft og møte mennesker igjen ikke sant. Men...ja. Jeg blir bedre nå.

[26] Edna: Jeg måtte gå til helsestasjonen noen få dager etter fødsel. Og det er jo, ja, svigermor, for eksempel, likte det ikke, nei, ikke sant, for den gangen så var det fortsatt litt kaldt […] da mente de at det skulle ikke være bra for verken babyen eller for meg å gå ut så tidlig etter fødsel. […] Jeg måtte jo fortelle at det er sånn det er, og at jeg har time, at jeg må på en måte følge de timene jeg har fått på helsestasjonen. Og heldigvis, de er veldig sånn...som tør ikke å gjøre noe feil i systemet, så da var det bare "greit, det er greit, du får bare gå."

[27] Edna: Etter en fødsel så praktiseres familien til min mor, spesielt der hun kommer fra, at de binder magen. Og da husker jeg at mamma sa, "det må du gjøre, ellers så kommer du til å få stor mage, det kommer aldri til å gå inn igjen, du må gjøre det." Og jeg husker at hun bindet det, men det var så vondt og så utrolig vanskelig at jeg bare tok det av. Så det var vanskelig å gjennomføre."

[28] Mamma til Kim: Jeg sa at du må, etter at du har født barn, så du ligger der. Og det er ikke vanskelig, men det hun vil ikke gjøre. Jeg sier det…det hjelper å presse blod inn i magen og ut. Veldig, det hjelper. Og når du er ferdig med fødsel, så du har ikke stor magen. (…) Når jeg kommer til en kvinne, de vietnamesiske kvinner i Norge, og jeg hjelper dem, og gjør det for dem, og *de* gjorde det, men du vil ikke gjøre det!"

[29] Mamma til Kim: Når hun skal ha baby, sa jeg tenkte å komme til henne og være her og tar vare på henne og passe på, å hjelpe henne sa mye som jeg kan. (…) Det slipper hun a gjøre sa mye når hun har barn, ikke sant? Og i Vietnam så har vi, vi må ha folk å hjelpe den kvinnen som har barn. Og men her vil hun gjøre det selv! Og hun vil ikke ha mamma hjemme hos henne. (...) Så jeg var litt lei meg i begynnelse. Og jeg far ikke komme nåer henne som jeg ønsker. Å fa komme og hjelpe og gjøre tingene når hun er ille og ikke sterk nok når hun nettopp far barn. (...) Men jeg pleier a høre etter henne så jeg...bare si hva jeg synes det er bra for henne og «ok» [resigned tone] Men ikke gjøre det.

[30] Mamma til Kim: Også i Vietnam så har vi forskjellige, det er mest forskjell, det er i Vietnam har vi sånne krydder, grønnsaker, som kan brukes som...[says something in Vietnamese to daughter]

Kim: Medisinske urter? Gurkemeie og sanne ting.

Mamma til Kim: Ja, medisinske urter. Ja, sånne. Ingefær forskjeller. Vi bruker mye av det. Og det får jeg ikke tvinge henne til å gjøre. (ler) (...) Jeg husker en gang, barnet hostet så mye. Når

jeg kom hit, sa må jeg gjøre (...) jeg damper sann løk. Også har jeg rokksukker. Også når hun drikker, så ser jeg at hun er bedre med en gang. Ja, men...

[Daughter makes a face; laughter]

Forsker: [Laughs] Det stoler hun ikke på?

Mamma til Kim: Hun stoler ikke på det. Men jeg ser jeg må gjøre.

[31] Mamma til Kim: Og jeg er også den type som selvbehandler når jeg har...

Kim: Ikke bra, mamma.

Mamma til Kim: Når jeg er syk, jeg selvbehandler meg. (…) Jeg er den type som ikke liker a går til legen så mye…bruker ikke så mye medisin. Men hvis jeg er syk og jeg er sliten, så hviler jeg. (…) Så jeg ber til Gud. Og hvis jeg måtte til lege, så lege sier noen og så hører jeg på lege.

[32] Mamma til Kim: Vi har i hodet at vi trenger hjelp nå. Bare en måned. For at vi trenger å bli sterk etter det. Etter en måned så kan vi gjøre mange ting. Men de første måneden så kan vi få hjelp. Hvis vi har folk til å hjelpe oss, vi må ta imot hjelpen. (...)

Kim: Jeg skulle ha hørt på deg, mamma.

Mamma: Ja. Nå jeg ser at hun ikke har det bra i skuldre og armen, det virker etter lang stund, det virker ikke bra. (...) Også, jeg husker da jeg var i Vietnam, så øynene ble litt vonde eller vanskelig, når vi kommer ut til sol for tidlig, eller vi kan bli syk, kaldt og fryser hvis vi uten...nok varm klær etter fødsel. Det er veldig viktig i Vietnam. Vi har mye vind, vind som gjør at du er lett til å bli syk.

[33] Kim: Jeg har vært vant til å gjøre som jeg vil lenge. Jeg flyttet hjemmefra da jeg var 14 fordi jeg var veldig uenig i mange forskjellige ting. Men jeg vet ikke, etter at jeg ble mor, så tenkte jeg ok, at det er en del ting med vietnamesere som er veldig bra. Og som vi kan lære. Vi norske, på en måte.

[34] Mamma til Kim: Jeg fødte henne i Norge, så jeg vet hun vokser bare i Norge, ikke vokser fra Vietnam. Sa derfor, så det er ikke lett å få henne til å høre på (ler) hva jeg mener."

[35] Forsker: Så du fulgte mer hva hun anbefalte enn hva som står i retningslinjene?

Jina: Ja, jeg tror det var mer fordi at...hun hadde sagt til meg etter fødselen at jeg ikke skulle gå ut. At kroppen vår er ikke det samme som kroppen til en...ja innfødt norsk da. Eller etnisk norsk. (...) De er jo....på en måte utstyrt til å tåle sterk vind og liksom kulda og så videre. Så da sa jeg....(dismissively) "Ja, ja. Trenger ikke det, det går bra." Så da var jeg ute en uke eller to uker etter fødselen. Men så...det angret jeg litt på, fordi jeg burde egentlig ha hørt på henne fordi jeg ble skikkelig, skikkelig dårlig etterpå, skjønner du? Og da sa hun sånn, «Mamma sa sånn, hva var det jeg sa?» (...) Ja, siden jeg ikke hørte på den første gangen, så tenkte jeg litt sånn, "Ok,

men nå, neste gang, når hun sier, gir meg råd om ting, så burde jeg kanskje høre litt mer på henne enn på hva nasjonalretningslinjen sier." Fordi det gjelder jo ikke individuelt, det gjelder jo generelt, ikke sant? Og da jeg hørte på henne, så følte at, jeg at kroppen min ble fortere healet da.

[36] Edna: Det er ikke en person som utfyller alle områdene. Jeg husker i hvert fall mannen min var den som var mest verdifull når det kom til den emosjonelle støtten. Så er det jo da den, på en måte, hverdagslig støtten, så vil jeg jo si at det var svigerfamilie og søskene mine var en veldig god støtte. For, som sagt, de ryddet, de ordna alt. Og det er jo en god støtte.

[37] Edna: Det skal jo sies (...) det er intenst, det er de to første månedene av barnets liv, og så forsvinner familiene. Etter det, da ser du ingen nesten. Da går alle sin vei, alle gjør det de skal gjøre. Og så plutselig så er det ingen lenger, da blir du bare etterlatt til deg selv og dine ting, og du må finne ut av deg selv. (…) det var akkurat en lettelse akkurat der og da når de forsvant, men det var en veldig rar følelse at plutselig fra at de var der "in my face" hele tiden til ingenting, det var veldig, det var veldig spesielt.

[38] Edna: ...når jeg da skulle få barn nummer to, og var på barsel (…) deres rolle av å hjelpe meg var mye mer '*appreciated*', fordi altså da trengte jeg ikke å passe på [sønnen min] (…) så da hjelp de ham med matpakker, de leverte til skole, de hentet fra skole, jeg slapp å gjøre alt det der for kjempelenge. Så jeg kunne bare fokusere det å være mamma igjen, jeg var nesten som førstegangsmamma igjen, ikke sant, så det er litt annerledes, jeg tror når du har flere barn, det å ha, det å komme fra en kultur hvor på en måte normen er at de nesten flytter inn til deg, det hjelper veldig når du har andre oppgaver du må gjøre. Men når det er første barnet ditt, jeg tror det er vanskeligere.

[39] Edna: Mennene, ja, de gikk og handlet eller gjorde ærender utenfor, men som regel var det bare damene, som kvinnene og jentene i familien som hjelper til.

[40] Edna: Jeg tror de var veldig overrasket over at han var så hjelpelig. (…) Så jeg tror kanskje (…) både familien min og familien hans forventet at jeg skulle be mer hjelp. Og var veldig overrasket over at vi klarte oss uten, bare å stå. Fordi vi hjelper andre på en måte, for det er jo ikke så vanlig.

[41] Moren til Kim: Kvinner, de pleier å gi omsorg til de andre, men når de har barn, de trenger omsorg fra de andre. Vi forstår det.

[42] Ada: Mannen min hjalp også. Mamma var der de første dagene, så vi kunne slappe av litt. Men så var det jo mannen min som tok resten.

[43] Jina: Vi [mannen og jeg] snakket om at vi må bytte på å sove for eksempel, i begynnelsen, (...) og så sa han, ja, selvfølgelig. Og han har hjemmekontor, som gjør at han har tid til det. Og så sa han, jeg skal ta alle bleiene. Bare hvil og tenk på deg selv og liksom, bare ikke tenk på oss, liksom. Vi fikser resten. Så var det sånn.

[44] Forsker: Hvordan dannet dere denne forventningen av hva slags rolle han kommer til å ha da babyen kommer?

Edna: Jeg tror det gjorde vi nok gjennom på en måte helsestasjonene, at jeg følte at de hadde en forventning om at dette her var det noe som vi måtte gjøre felles, at vi måtte gjøre sammen. (....) da tror jeg at de forventet at han skulle kunne like mye om babyen som jeg kunne, og... da kunne han ikke sitte på rumpa, og måtte gjøre de tingene også for å være mer involvert. Så jeg tror kanskje at de forventningene kom derfra. (...) Hvis han ikke hadde følt at "de forventet meg at jeg må på en måte bidra med her", så er det ikke sikkert at vi hadde utført, at vi hadde klart å bryte den kulturelle barrieren at den mannen ikke skal hjelpe til.

[45] Edna: …jeg føler nok at...familiens rolle gjør at han blir litt tvunget litt ut på siden. Jeg tenkte i etterkant at det er nok. Jeg tror ikke han følte seg nyttig før babyen ble stor nok til at de sluttet å komme. Da han begynte å fylle den rollen som de hadde igjen, å passe på barnet, skifte på barnet, avlaste meg når babyen grein, da begynte han å ta tilbake sin rolle. Men de første ukene, han...det var så vidt han fikk lov til å kose med sin egen baby. Tror han var bare skviset litt ut kan du si.

[46] Edna: 99% av somaliske kvinner og besteforeldre og mammaer, de tror at amming, bare amming i seg selv, det er ikke nok. (…) alle rundt meg, svigerfamilien, tanter, alle kommenterte at babyen min var så liten, 'Hvorfor gir du ham ikke ekstra mat?' Og jeg fikk høre at jeg sultet han, med vilje, fordi jeg bare hører på norske myndigheter, sa de....så det var veldig mye press rundt meg til å følge de samme tradisjonene som vi hadde i Somalia.

[47] Edna: ..vil jeg si nesten at jeg...kommentarene dems og alt det der gjorde at jeg fikk mindre selvtillit. Jeg følte meg mindre, altså jeg følte meg nesten som dårlig mor, fordi at de var aldri fornøyde med de tingene jeg gjorde. Fordi at jeg tror nok at jeg prøvde å ta de rådene jeg fikk på helsestasjonen, jeg tok det kanskje litt vel alvor. Og så....og det ja, jeg tror på en måte, og mens de mener at jeg skal gjøre det og ikke høre på helsesøstera....jeg følte meg veldig dårlig mor ofte når jeg var i kontakt med spesielt svigerfamilien, ja, og deres på en mate, gjeng igjen, ikke sant? Så nei, der og da var det heller, det var absolutt ikke noe styrke (…) men jeg tror grunnen til at det var det er nok den konfliktende informasjonen jeg får på helsestasjonen, og den som de prøver å videreformidle meg, det går på en måte ikke sammen. Og da er det på en måte, og jeg følte at jeg ofte bare, "ok, hvem skal jeg høre på?"

[48] Jina: ...jeg hadde jo veldig lyst til å liksom ta en liten slurk [vin] (...) I barselsgruppen min for eksempel, så var det en mor da som tok seg et glass vin, og jeg syntes det hørtes veldig flott ut egentlig. Men da jeg sa det til min mor da, og faren min, så var det, "Nei, det skal du ikke gjøre. Det går over i morsmelka, nei." Da gjorde jeg ikke det da.

[49] Ada: Hun har bodd her ganske lenge, mamma. Hun har hatt tre barn som er født her, så hun har vært i samme helsestasjon hun også, ikke sant. Så hun vet litt hvordan det er, men hun kan fortsatt gå litt tilbake og tenke, "Ja det kan kanskje hjelpe for eksempel hvis hun har luft i magen,

så kan det hjelpe å gjøre sånn og sånn. Det har vi gjort før." Men (...) hun har stått tilbake når jeg har sagt 'nei, det gjør jeg ikke'. Så hun har ikke mast. (…) Hun kommenterer ikke negativt for eksempel, hvis det er noe jeg sier. Jeg ser at hun prøver å hjelpe til å gi for eksempel tips om det jeg snakker om, eller hvis det er noe jeg spør henne. 'Jeg har opplevd 'det og det og det.' Så kan hun fort være mye til hjelp, og det betrygger meg å snakke med henne.

[50] Edna: Ja, jeg fikk blodoverførsel. Og det som på en måte ingen har tenkt på er at når du mister mye blod, så vil også etter hvert melken din, det vil være en periode hvor melken blir litt mindre enn hvis du ikke hadde mistet mye blod.

[51] Jina: Fordi jeg sleit veldig med amme og...Jeg hadde egentlig ikke tenkt noe på det, for å være helt ærlig, om ammingen....Så hun ene jordmoren sa at jeg kunne bli der en uke til, så vi ble der ganske lenge egentlig da. (…) Så fikk jeg liksom trent meg litt på å amme egentlig da. Så det var egentlig det jeg fikk mest øving på (…) "[Produksjonen] blir bedre, men jeg måtte jobbe hardt for det da. (…) Jeg måtte pumpe da. Pumpe, og...spise godt og komme meg igjen etter fødselen.

[52] Edna: Den perioden hvor jeg sleit med amming og sånt, så har jeg vært en del på nett. Ja. Og der fant jeg sånn amming-community rett og slett på nett som var veldig til hjelp. Jeg kunne høre, kunne lese forskjellige tips og tricks og lignende.

[53] Jina: jeg husker at det var spesielt hjemmesiden som het Ammehjelpen, og det fikk jeg beskjed på sykehuset, at hvis det var noe jeg lurte på, så kunne jeg også se der inne. Så jeg tenkte at da høres det veldig "legit" ut på en mate. (…) Og jeg visste at det var drevet av gruppe som bestod av både fagpersoner og kvinner som selv har gått gjennom de problemene de hjelper andre kvinner med. Så jeg følte at jeg kunne stole på dem, absolutt.

[54] Edna: Ja, det er den verste av barseltiden. Jeg vil si at det faktisk er singlehandedly det verste følelsen. Til og med verre enn smertene. (…) Det kom litt overraskende på meg. Og så tenker man bare, "er det jeg som innbilder meg det? Hvorfor føler jeg det? Hvorfor er det sånn for meg? (…) Familien min er hjemme hos meg, alle er hjemme hos meg, men likevel så føler du at du står helt alene om det å være nybakt mamma.

[55] Edna: …overraskende nok, så vil jeg si at som individ så er du litt... 'ignored' på en måte, så det er veldig vanskelig å forklare, men du blir litt sånn...du blir på en måte litt oversett. For familiene, nå tar jeg for eksempel familien, og da mener jeg både min familie og svigerfamilien, de er så opptatt av at alt som på en måte skal alle skal gjøres, og alt som du må gjøre riktig, at det er liksom ikke noe som er nødvendigvis fokusert på deg som person, som spør hvordan går det egentlig med deg, hvordan har du det på en måte. Så det manglet jo.

[56] Ada: Ja…mamma hun skjønte ikke akkurat helt i starten som jeg sa. Hun kunne liksom si, 'Ja, du må ikke ha flere barn, ikke sånt. Det holder med en.' Det var litt vanskelig for meg å tenke, for jeg har jo egentlig lyst på flere barn, selv om jeg synes det er vanskelig for den første. (ler) Så det kunne liksom bli litt vanskelig å komme over i, men jeg har følt at jeg måtte nevne flere ganger. "Jeg sliter psykisk, ikke kom så mye på, liksom, ikke stress (...) meg så mye."

[57] Mamma til Kim: En ny mamma trenger å få oppmerksom og hjelp. Og jeg synes jeg alle trenger det. Så vi må ta vare på følelser hennes slik at det ikke blir deprimert, fødselsdeprimert, alene med bekymringer for barn og sånn. Trenger å lufte ut hvis de har en gruppe å snakke sammen. Det er fint. Ja. Hvis de synes andre generasjon ikke forstår dem, (ler) så trenger de forståelse mellom samme generasjon.

[58] Kim: … det er også veldig mange ting som en mann ikke kan forstå seg på samme måte, ikke sant. Som en mor som allerede har fått barn, forstår det på en veldig annerledes måte. Som når søsteren min kom, (...) hun visste hvor vondt det var, hvor slitsomt det var, hvor trøtt jeg var, hun visste hvordan det var å ha kroppen full av hormoner. Hun visste også sann, jeg tror menn ikke kan, ha samme kroppen. De skjønner ikke det på samme måte. Det er ikke de som har opplevd fødsel.

[59] Jina: For meg var det å snakke med venninner som også hadde født. Gode venninner som visste akkurat hva jeg hadde gått gjennom, som de også hadde gått gjennom. Som kanskje mannen eller fedrene ikke skjønte. Rett og slett fordi de ikke hadde gått gjennom en fødsel. Så det hjalp meg veldig. Fordi jeg husker at jeg snakket med en...da jeg var på besøk hos henne så sa hun at det var barn...er skikkelig...det setter forholdet på en prøve, mellom meg og typen da, eller meg og mannen eller noe sånt. Og så sa jeg "ja, det merker jeg også egentlig." Men igjen så er det jo fordi det er en beboer til her. (ler) Det er jo ikke fordi det er noe galt med meg og mannen på en måte."

[60] Edna: Jeg tror jeg henvendte meg selv til helsesøsteren med tanke på at alle påpekte at babyen min var så tynn. Og da husker jeg at jeg fikk god støtte av henne, da sa hun, "vet du hva, nei, nå skal jeg vise deg her, babyen din følger kurven, den følger riktig kurva, babyen din. Vekt, alder, høyde, alt passer inn her". Og da ble jeg betrygget på en måte. (…) Det hjalp veldig. Jeg husker hvor redd jeg var at jeg ikke...jeg tenkte kanskje babyen min har det ikke så bra, så at hun viste meg på en måte, at hun faktisk sa, "nei, du må se, alder, vekt, alt det der, som objektivt, det er ikke noe som er galt med barnet ditt." Ja, det hjelper.

[61] Edna: Han støttet meg, jeg skal si at han støttet meg, men...vår kultur er nok veldig mye sånn kvinnedominert (…). Så han prøvde så mye han kunne, så, men, selv om han sa at jeg må ikke høre på det, eller ikke tenke på det de sier, så var det ikke så enkelt, jeg gjorde jo, det påvirket meg jo likevel.

[62] Ada: …hun (storesøster) er litt mer sånn...regler, skal følges etter. Så hun har vært mye til hjelp, sånn sett. Hun har liksom sagt, "ja, hvis det er sånn, så må det være sånn. Du må si nei til folk. Ikke la de mase, eller...Ja. Så hun har hjulpet sånn sett.

[63] Edna: …når du har så lite barn, (...) du går ikke ut, du gjør ikke så mye, du treffer ikke så mange, så....du er veldig isolert og vil gjerne at de rundt deg på en måte gir deg den anerkjennelsen, ja. (…) Problemet var bare at jeg var den eneste i min omgangskrets som hadde barn, (...) for vi var jo veldig unge, ikke sant, så…de norske venninne mine, de hadde jo ingen

peiling på hva jeg gikk gjennom, og de somaliske venninne mine, de var, for det bare dem så var det bare det som de er vant med fra dems hjem, ikke sant, så for dem var, ja, sånn var det bare, det er ikke noe diskusjon på en måte.

[64] Ada: Jeg tror jeg ble med dem kanskje i to måneder. En gang i uka. Men det var ikke så mange, vi var kanskje tre, fire stykker av gangen. (…) Men så, som sagt så hadde jeg noen venner som jeg var gravid sammen med. Da var det litt som da hadde vi en barselgruppe sammen. Så jeg sluttet å dra på den barseltreffer vi hadde med i helsestasjonen. (…) som sagt hadde jeg min egen vennegruppe, som var mye bedre og koseligere å være sammen med…ja det blir mye lettere å snakke med dem, for å si det sånn. De er jo tyrkere alle sammen. Så de skjønner litt mer hvordan det er. (…) De er jo gift med tyrkiske menn de også. Det er jo mye forskjell mellom (?) tyrkiske og de som er født og oppvokst her. Og mennene våre kommer fra samme landsby og, så det er liksom mye...Kulturen er veldig likt. Så du får liksom vekslet litt info om hvordan de har det hjemme og om de får liksom den hjelpen eller...svigerforeldrene. Svigerforeldre for eksempel. Så vi har mye likt til felles, det er mye lettere (...) å snakke med dem og diskutere og ser at mye er likt er også veldig beroligende…"

[65] Edna: Ja, jeg var der bare en gang. Og så, som sagt, det var jo veldig annerledes. Den barselgruppen bare bestod jo bare av norske kvinner, ikke sant? Og vi hadde så totalt forskjellige opplevelser av barseltid, at jeg fant ikke noe ting som vi hadde til felles, med den barselgruppen, så jeg sluttet også. (…) For det første er jo, de var jo mye eldre enn meg. (…) alle på en måte snakket om hvor slitne de var, (...) klaget jo over at de sov for lite, de hadde så lite hjelp. Nei, jeg må jo si at jeg var jo heldig der, ikke sant? Jeg hadde jo mye hjelp, det var jo ikke noe som på en måte, ja. (…) jeg følte og at på en måte, jeg kunne ikke relatere til de problemstillingene de kom med. Og jeg turte heller ikke å komme med mine egne problemstillinger, for jeg følte at det var så bare....på en måte, sånn skikkelig rar. Jeg hadde mye annerledes problemstillinger som jeg følte at jeg ikke kunne presentere for gruppen. Og da valgte jeg bare å, på en måte, holde kjeft.

[66] Edna: Ja, så det som skjedde etter at jeg fikk barnet, var at da fikk de jo, så da måtte jeg jo bare si at det er ikke mulig å få, å komme på besøk på barsel, men det stoppet dem ikke, fordi de kom, og så var de nede i kantina. Ja, alle, de samlet seg der, så de var der, så å si, alle de tre dagene, (...) så kom vi hjem, og da var de allerede hjemme og lagde mat og ordna og styra og ventet bare på at (...) vi skulle komme hjem med barnet, ja. Og så begynner besøkene. For da kommer det alle og enhver som på en måte kommer på besøk. Det spiller ikke noe rolle om du kjenner dem godt, så lenge de kjenner foreldrene dine godt, da kommer de for å på en måte få de levere gaver og se på babyen og lignende. Så vi hadde besøk så å si, nesten daglig.

[67] Edna: Ja, jeg tror at jeg har også lært å ikke svare alt helt som de vil, at jeg bare skal si "ja, men det går bra, jeg har gjort det". Og hvis de sier, har du gitt babyen nan, så sier jeg, "ja, jeg har gjort det". For å slutte, for å på en måte slippe «the berating» på en måte, sånn, hvorfor gjør du ikke det? Ja, så bare for å, "nei, vet du hva, jeg har gjort det, jeg har gjort det, jeg har gjort det, ja." Så det kommer et tidspunkt hvor du er lei av å krangle hele tiden, og hele tiden prøve å overbevise, så sier du bare, ja, "nei, jeg har gjort det, jeg har gjort det."

[68] Edna: Men svigerfamilien har mye mer, (…) de kommer ned i banen med vilje etter fødsel. Fordi de har veldig mye de skulle ha sagt om hvordan babyen skal spise, når babyen skal spise, babyens navn. Da skal de, de føler at de skal ha mye de skulle ha sagt. (...) I hvert fall i min kultur så er det mer sånn.

[69] Edna: Det var absolutt utfordrende, for jeg var jo på en måte litt redd, ikke sant. (...) Det var den tiden tror jeg var en eller annen typ influensa som gikk, og da sa helsesøster at det var veldig viktig at ikke alle kan kose med babyen, babyen burde ligge hos deg, og det å sette en sånn grense var veldig, veldig vanskelig. Jeg hadde babyen min inntil meg hele tiden, ja, så det var vanskelig de ganger, for 'alle skal holde, alle skal holde, alle skal holde' (...). Du føler at de eier babyen med deg, at det ikke bare er ditt barn, men det er alles barn. Og så var det litt deilig akkurat i gangene, hvor på en måte babyen greine hele tiden, og du var så sliten, at da hadde du plutselig noen som kunne gå med babyen for deg, at du ikke trengte å slite deg helt ut. Så det var begge deler, absolutt begge deler.

[70] Ada: For moren til mannen min, hun er litt mer...(ler) sann, svigermor er litt mer, tradisjon og kultur, liksom. "Vi kan gjøre sånn, vi kan gjøre sånn." Det har vært litt vanskelig for meg å si nei til henne. I stedet for å si det til mamma. Med mamma kan jeg bare snakke som jeg vil. Men med svigermor så var det litt mer vanskeligere. Jeg tenkte at hvis jeg sier noe feil nå, så kan hun bli lei seg eller hun kan tenke at det er urespektfullt, ikke sant. Så jeg måtte alltid si ifra til mannen min, "Kan du ikke si moren din at hun skal slappe av litt," for eksempel. At vi ikke gjør sånn med barnet. Vi gir ikke henne mat, ikke sant. Vi ammer, vi bare ammer, ikke noe mer. Jeg måtte advare henne et par ganger. Jeg synes at hun ikke tok det imot så godt som mamma gjorde. Jeg føler det.

[71] Edna: Derfor var det en stor betryggelse på barsel. Fordi på barsel, da hadde jeg plutselig ikke noe valg. Det var ikke jeg som sa nei. (...) Da var det en som sa nei, "dere får ikke komme til. Det er bare de tre her, mamma, pappa og barnet som kommer inn. Alle andre må gå." Det husker jeg og var liksom veldig rart. Jeg tenkte at nå kommer de sikkert til å bli sur. Det var ikke noe jeg kunne si. Det var ikke noe pappa sa. Det var det som de sa. Det husker jeg at jeg tenkte "så deilig det var"".

[72] Forsker: Var det noe som du for eksempel hadde ønsket at kanskje fagfolk kunne heller ha sagt direkte til moren din, eller mannen din som var så viktig på den tiden?

Ada: Nei, jeg tenker at de ikke trenger å dra inn mamma sa mye. Jeg er litt, jeg tenker (...) [at det] skal være familie, ikke sant. Ok jeg er jo kjempeglad i mamma, det er jeg. Jeg prøver jo å involvere henne mye inn. Men allikevel når det gjelder sånne ting, så tenker jeg at vi kan ta avgjørelser med vår egen familie. Så jeg tenker at mamma ikke trengte å få så mye informasjon. (...) Hun trenger ikke å vite så mye. Men mannen min, jeg tenker at han burde få vite alt jeg får vite om. Og de har jo vært mye til hjelp. (...) Men jeg synes det er viktig også, for han må vite hvordan jeg har det. Eller hvordan barna har det.

[73] Forsker: Har dere hatt noen diskusjoner om hva slags oppdragelse han skal ha?

Jina: Ja, vi har snakket veldig mye om før vi ble engang gravide. Hvordan skal vi være? Hvordan ønsker vi at vi skal være? Hva er det vi skal begge jobbe med? Det snakket vi også om mens jeg var gravid. Så veldig mange, på sånne programmer, diskusjonsprogrammer, debatt og sånt, og snakket sammen. Det vi ville unngå var å være sånn strenge innvandrer-parents, liksom førstegangsinnvandrere. Som kommer til landet med ingenting, ikke sant, og jobber seg fra bunnen opp. (...) Vi er jo ikke det samme i samme situasjon som første gang som innvandrere da. Så det å ikke vite, ikke være informert, (...) det er ikke en ting som gjelder for oss da, jeg og mannen, for vi er jo da andregangsinnvandrer. (...) Så da har vi sagt at vi blir nesten ganske like som alle andre her i landet da. Prøver å (...) oppfostrer derved å sosialisere....og kanskje ikke liksom kjefte. (...) "Gentle parenting?" Det er den retningen vi ønsker å gå. Ikke sann, "det er så dyre, det her, du må høre på meg. Jeg er forelderen."

[74] Kim: I Norge har man en demokratisk tradisjon, ikke sant? En ikke-autoritær tradisjon. Ja, hvor det er likhet. Og hvor man lytter, og hvor man snakker med noen og prøver å holde en dialog åpen. Og ikke misbruke makt. Og det tenker jeg er veldig viktig da. (...) Så jeg tror, det er det man må ha. Det tror jeg er vanskelig, ikke sant? For asiatiske foreldre.

[75] Jina: Mannen min er mer sånn...han må prøve å....bryte ut av den der, at "du skal høre på meg, jeg vet best og sånn", men han er jo ikke sånn da. Han fortalte meg at da han var ung, så fikk han bank da hjemme. Så det er noe han lovte seg selv, at han aldri skal være som faren sin (...) og være så aggressiv da. Så han er ikke en aggressiv type i det hele tatt. Han er veldig, veldig rolig og tålmodig. Så det ser jeg veldig da nå, hos ham. Det er veldig fint.

[76] Edna: Nei, da var det jeg som veiledet han igjen. Jeg sa at du gjør det, du må gjøre det på denne måten her og på denne måten her. Han var...involverte seg nok ganger til at han etter hvert skjønte selv hvordan han skulle, bytte, både bytte bleie, trøste babyen og lignende. Men jo da, da var det på meg som skulle lære han opp til det. I stedet for at vi to skulle lære sammen.

[77] Edna: Jeg tror de [familien min] var veldig overrasket over at han var så hjelpelig. Han fikk jo veldig mye ros for de tingene han gjorde. Mens hvis det var forventet av meg, så fikk han mye ros.

[78] Forsker: Synes du at han hadde nok f.eks. kunnskap eller kompetanse?

Ada: Nei. (veldig direkte, uten tvil) Det gjør jeg ikke. Bare si det rett ut. Som sagt jeg har lest mye om oppdragelse på henne, og hva er farlig, hva kan hun gjøre, hva kan hun spise og hva kan hun ikke spise. Både fra starten og etter hvert. Hvordan skal hun sove for eksempel. Jeg har vært veldig mye på å lese og undersøkte. Jeg har vært på eksempel Facebook-grupper og lest mye på Instagram og litt sånne ting. (…) Men han har vært omvendt. Han har til og med sagt "nei, jeg tror ikke på det du leser". Han har alltid vært, "ja men det er liksom forskning, det kan endres dagen etter, ikke sånt?" Han har vært liksom, omvendt.

Forsker: Men tok han eget initiativ for å bevise deg omvendt eller?

Ada: Nei. Eller nei, han har jo sagt at "Ja foreldrene mine har jo oppdraget meg sånn. Så da er det sikkert greit." Men jeg har liksom, "Ja nei det var i gamle dager, og det har ikke vært greit den dagen og. Du hadde kanskje vært en annerledes person hvis foreldrene dine hadde gjort ting annerledes for eksempel." Men jeg måtte liksom ha et par samtaler for å overbevise han sånn at han til slutt sa ok.

Forsker: Og for at det er krevende for deg å måtte...

Ada: Det var jo det egentlig, for jeg sleit jo allerede. Og så å prøve å overbevise han og liksom og se at han ikke tror på det jeg sier har vært liksom krevende, det har det vært.

[79] Ada: Sa svigermor, "det er jo alltid han som passer der nede, ikke sant?" Så hun begynte liksom å forsvare sønnen med en gang. Så jeg har liksom opplevd et par sånne....sånne episoder, ja. Men da sa jeg ifra, men det gjør han ikke. (...) Så vi fant ut at det var han som sa, han tullet litt for mye. Og sa, "ja, jeg passer hele tiden," ikke sant? (…) Men allikevel så kan hun fort synes synd på sønnen sin. (...) "Han må hvile. Han kan ikke passe på henne hele tiden."

[80] Ada: Hun mener at han må hjelpe til, men jeg må ha hovedansvar, og han må hjelpe til. (…) Men heldigvis er ikke han enig. (...) Så sier han, ja det er jo like mye barnet mitt som det er ditt. Så jeg må jo også gjøre noe. Men allikevel så føler jeg at jeg har hovedansvaret. (…) Det som også kan være helt vanskelig for meg, er at mannen min, han ikke er vokst opp her. Jeg kan fort se mye forskjell. Jeg føler forskjellen. (...) Men jeg føler at han begynner å bli vant til det. (...) Men det er ikke mye likestilling når det gjelder å oppdra barn i Tyrkia. Det endrer seg jo veldig mye nå, men mannen min kommer fra en landsby. Og i landsby så er det ikke, går ikke ting så fort. (...) Så er jeg heldigvis mannen min ikke så... Er ikke der på en måte. Han tenker og hjelper veldig mye til når det gjelder å oppdra henne.

[81] Ada: Ammingen var mest vanskelig. Jeg føler at det gjorde at jeg, det var kanskje en av de tingene som gjorde mest at jeg fikk fødselsdepresjon, tenker jeg. (...) Jeg tenkte mye at jeg ikke kunne gå ut, for var hun sulten ikke sant. Da var det ikke så lett å amme henne utenfor heller ikke sant. Da kunne jeg sitte og amme veldig lenge. Det orket jeg ikke, ikke sant. (…) Jeg tenkte veldig mye, "Ok, mannen min for eksempel, han gikk på skole. Jeg tenkte okay, han kan bare gå på skolen. Han kan bare flytte ut. Jeg må sitte her og passe på henne. Alle kan gjøre hva de vil. Jeg må sitte hjemme og ikke gjøre noe annet ikke sant. Nå høres det veldig rart ut for meg å tenke sånn, men da tenkte jeg bare sånn, ikke sant. Så det synes jeg var veldig vanskelig. Med en gang jeg gikk på Instagram for eksempel og så noen var ute for eksempel og satte og drakk en kaffe sammen. Da tenkte jeg at de kan bare gå ut som de vil. Jeg må sitte her, amme henne hele tiden. (…) Det følte som om jeg amma hele dagen. Det synes jeg var veldig vanskelig."

[82] Ada: Jeg følte at jeg ble mye bedre når noen kom innom. En andre fjes. I starten, når familien min kom, da jeg skulle amme henne, da var liksom pappa, han var med oss. Da tenkte jeg at jeg

ikke kunne amme ved siden av ham. Så jeg gikk på rommet, men det tok veldig lang tid. Jeg syntes det var veldig kjedelig å sitte på rommet alene og liksom amme. Og til slutt sa jeg, vet du hva, jeg bare går inn og ammer. Det er faren min, det går jo bra. Det er ikke sånn at jeg ikke vil amme ved siden av ham, men det er liksom respekt og kultur, ikke sant, som at jeg ikke er urespektert. Han bryr seg aldri om det egentlig. (...) Så jeg satt sammen med ham etter hvert og amma. Og gjør det fortsatt.

[83] Ada: Det har vært litt mer vanskeligere der nede… å bo sammen med dem, ikke sant. Det tok veldig lang tid å amme. Jeg vil ikke amme ved siden av dem. Jeg gikk på rommet vårt og amma. (…) Da var jeg en del inne på rommet vårt. Jeg amma, det tok allerede lang tid, og så sov hun mens vi amma. Da hendte jeg at jeg var mye på rommet, og da hørte jeg mye at hun sa, "Hvorfor er hun inne på rommet? Hvorfor kommer hun ikke ut? Jeg vil se barnebarnet mitt", og sanne ting. Jeg tenker at det ble litt for mye den ferien. Eller litt for lang."

[84] Jina: Jeg tenkte på det ganske god tid ass etterpå, to til tre måneder etterpå, for å på en måte akseptere eller på en mate forstå at de er bare mennesker alle sammen. De prøvde jo sikkert det beste for meg og for barna da. (...) Men så gikk det som det gikk ikke sant. (...) Men den siste timen av fødselen gikk jo veldig fort, så det var det som gjorde sånn at jeg tenkte lenge (...) hva skjedde der. Jeg har jo forsont med meg selv, jeg har jo blitt, liksom akseptert det, og tenkt at det her er bare noe som måtte skje. Hvis ikke så kunne det jo blitt verre, jeg tror det.

[85] Jina: Jeg tror det er en tid alle tenker på, men det var ikke en depresjon, da jeg tenkte sanne, "jeg må ta avstand fra barnet mitt." At jeg kommer til å tenke at jeg kommer til å gjøre noe som skader barnet mitt eller at jeg....At jeg måtte distansere meg fra barnet mitt, fordi jeg følte at jeg på en måte mistet litt følelse, kontakt med barnet mitt. Det var ikke noe sånt, heldigvis. Det var mye hvordan selve fødselen var. Var det noe som kunne blitt gjort annerledes? Fordi jeg er sann, jo en perfektionist liksom på ting da. Men jeg har innsett nå at vi alle er mennesker, og menneskelig feil kan skje, og det viktigste var jo at barnet mitt ikke døde, eller ble syk. Ordentlig syk liksom. Ehh...holder med på a komme over den. Den kneiket på en måte. Men det var veldig tøft altså.

[86] Edna: Jeg var bare veldig lite forberedet på hvordan det kunne påvirke mentalt, fordi at på en måte spesielt, det å...ligge på samme stilling som du skal bli, ikke sant? (...) Når du blir omskjært så er det mange som holder deg. Ja, for at de skal holde deg på plass. Og i en fødselssammenheng så hender det at det kommer et tidspunkt hvor folk (...) holde deg, men ikke for a holde deg mot din vilje, mer for å støtte, ikke sant, fordi du skal presse på en spesiell måte, så da holder de deg. Og det kan skape en slags, på en måte, flashbacks. (...) Jeg må jo si at mye av minnene kom tilbake mye mer tydeligere etter fødsel enn før fødsel. Det er kanskje det som var mest ubehagelig.

[87] Edna: Jeg føler på en måte helsestasjonene, det var (...) når du var ferdig med graviditet, så var det egentlig ingen som så deg. Da var det på en måte fokus på om babyen vokste, om babyen spiste, soverutiner, mat rutiner, vaksinasjon og lignende. Så det var egentlig ikke noen som på en

måte nødvendigvis spurte (...) meg om hvordan jeg hadde det.

[88] Jina: Ja, hun jordmoren som jeg fikk utdelt gjennom kommunen, (...) spurte hvordan det gikk med meg og liksom...kroppen og...så kom jeg litt mer med mine bekymringer rundt omkring det med kroppen. Renselsen (…) og sånne ting. Og så sa hun sånn, "Ja det går sikkert fint, ja ja, det går bra liksom." Så var hun også veldig interessert i å se barnet, jeg følte liksom at det tok mest plass der med, det med barnet, men jeg skjønner jo.

[89] Ada: De gangene jeg nevnte at hun var så vanskelig og sånne ting, så sa hun (mamma) "Ja men hun er den fineste i verden vi har sett. Du vet ikke hvordan de andre er. De har veldig syke barn, og de gråter hele tiden og sover ikke om natta." Hun sa alltid at jeg var heldig og måtte være takknemlig, men jeg følte da at hun ikke skjønte helt hvordan jeg opplevde det. Det her har liksom hendt at hun både har vært veldig mye til hjelp og litt omvendt.

[90] Edna: Du blir litt glemt, jeg tror. (...) Du skal ikke på en måte ha problemer, nå skal du være i en tid hvor du bare skal være lykkelig. Ikke sant? (…) Og ikke gråte, ikke være lei deg, du har fått et litt friskt barn, du har veldig mye å være takknemlig for, så forventning om at du bare skal være takknemlig var stor. Ja, de forventet bare takknemlighet og ingenting annet. Og derfor er det også veldig vanskelig å klage, eller å si nei, kan ikke dere gå hjem tidlig eller ikke komme i dag?

[91] Edna: Jeg synes det var kanskje litt flaut å kjenne på den følelsen når du har…"full house" (…) så jeg sa ingenting til noen. Men jeg skjønte jo da etterhvert at det var helt normalt. Og jeg tror det er mange som har det sånn, som for eksempel jeg har en svigerinne som fortalte meg at det hun syntes var veldig rart var at når hun fikk hennes første barn, mens jeg på en måte ville bare holde babyen og jeg ville ikke at de skulle ta, men for henne, hun følte ingenting. Hun var likegyldig og sa at hun ikke brydde seg i det hele tatt. (…) Men i dag så skjønner jeg (…) at den opplevelsen hun hadde (…) at du ikke har noe «connection» med babyen er jo en veldig typisk for fødselsdepresjon. Men hun skjønte jo ikke det, eller det var jo ingen som så det da. (…) Fordi at...det er ingen som tenker at det er rart at alle andre holder babyen, for sånn var det. Alle holder babyen utenom henne. (…) Og da kan man tenke bare at hun følger bare reglene og kulturen og ikke klager. Mens hun sleit veldig.

Sikt

Notification Form

Reference number
218628

Which personal data will be processed?

- Name
- Contact information
- Voice on audio recordings
- Background information that, when combined, can be used to identify an individual
- Ethnicity
- Religious beliefs
- Health data
- Sex life

Describe the background information
Age, gender, household and family structure, education, employment status

Project information

Title
Crossroads at the Cradle: Negotiating Postnatal Care and Multicultural Belonging among Second-Generation Immigrant Women in Norway

Summary
This project will explore how multicultural belonging shapes how second-generation immigrant women in Norway navigate postnatal recovery, support, and care. The objective of this inquiry is to a) broaden understanding of how mothers who are second-generation immigrants manage the processes of recovering from childbirth and transitioning to motherhood while navigating and negotiating the norms and expectations of both the Norwegian majority and their cultures of origin; b) identify areas of tension and unmet need among second-generation mothers and analyze how they correspond with criticisms of Norwegian postnatal care voiced from the majority perspective; and c) produce a cross-cultural understanding of effective postnatal care and support that can advance the capacity of Norway's systems of care to foster psychosocial well-being for all new mothers with culturally-sensitive and culturally-responsive services.

If the personal data will be used for other purposes, please describe
N/A

Provide a justification for the need to process the personal data
The following personal data is needed to gather knowledge on research participants' lived experiences, perceptions, and expectations to answer the research question of how second-generation women navigate and negotiate postnatal care recovery and support: Name, address, and telephone: necessary for the purposes of participant contact and coordination, and to obtain informed consent. Addresses will only be requested in the event the participant elects to have interview in their own home. Will be omitted from transcripts and publications. Sound recordings: necessary to document responses to interview questions; researcher will seek each participant's explicit consent to be recorded via audio, and recordings will be destroyed after transcription is completed. Age and gender: necessary to assess alignment with recruitment criteria as well as important for understanding participants' experiences of social norms, especially around gender roles, and access to social/economic resources. Education level: necessary as a factor influencing participant's access to social/economic resources, health literacy, spheres of influence, experiences of social norms (particularly around gender), as well as important to characterize the sample in comparison to the broader population Employment status: necessary as a factor influencing participant's access to social/economic resources, perspective on social norms, division of labor/roles in the household, spheres of influence, and concerns for the future (i.e. returning to work). Household and family structure: Multigenerational households are more common among immigrant families. Data on whether the participant's household is multigenerational or nuclear is necessary to illustrate the participants' living environment, access to support, and connections to the diaspora community, which are influenced by who is present in their household. Health data: information about participants' health and health service utilization will be necessary to explore and examine participants' access, experiences, perceptions, and expectations of health services and healthcare providers, and of their own health, well-being, and need for care and support during their postnatal recovery period. Any health information obtained would be disclosed by the participants themselves as opposed to through health records. Questions will not be asked directly about participants' specific conditions, diagnoses, conditions, or treatments, but participants may choose to mention these when explaining their general health, well-being, and functioning. Racial/ethnic origin and religious beliefs: necessary as it is often tied to cultural norms and belief systems and participant's

experiences living as a minority/with migration background in Norwegian society, all of which are central to this project's investigation of the role of multicultural identity in postnatal care experiences. Sex life or sexual orientation: this information will not be sought explicitly/directly but could potentially be disclosed by the participant if relevant to their experience of postnatal recovery and/or relationships to sources of support or cultural norms (e.g. postpartum recovery has negatively affected their sex life, the gender of their partner, if they have strained relationships with their families due to their sexual orientation). It will not be processed outside of this context.

External funding

- Other

Other source of funding

Masterstipend from Osloforskning (Oslo kommune and Universitetet i Oslo)

Type of project

Master's

Contact information, student

Lucia L Hsiao, l.l.hsiao@studmed.uio.no, tlf: +19174003410

Data controller

Institution responsible for the project

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Project leader

Benedikte Lindskog, b.v.lindskog@medisin.uio.no, tlf: 98818637

Do multiple institutions share responsibility (joint data controllers)?

No

Sample 1

Describe the sample

Norwegian-born or raised mothers with two foreign-born parents

Describe how you will identify or contact the sample

Personnel at community-based mother-child health clinics (Helsestasjon) in Oslo, Norwegian social welfare/voluntary organizations, and immigrant community groups will be asked to share information about the project with their consumers, and refer potential participants (postpartum women who are Norwegian-born to immigrant parents) to the lead researcher. The lead researcher will speak with potential participants to ascertain alignment with the project's recruitment criteria/desired diversity in participant composition. The lead researcher will also disseminate information about the project through digital and physical platforms, such as via Norwegian university social media groups.

Age group

20 - 49

Which personal data will be processed for sample {{i}}? 1

- Name
- Contact information
- Voice on audio recordings
- Background information that, when combined, can be used to identify an individual
- Ethnicity
- Religious beliefs
- Health data
- Sex life

How is the data relating to sample 1 collected?

Personal interview

Attachment

Interview guide - individual.docx

Legal basis for processing general personal data

Consent (General Data Protection Regulation art. 6 nr. 1 a)

Legal basis for processing special personal data

Explicit consent (General Data Protection Regulation art. 9 nr. 2 a)

Justify the choice of legal basis for processing

Group interview

Attachment

Interview guide - group discussion.docx

Legal basis for processing general personal data
Consent (General Data Protection Regulation art. 6 nr. 1 a)

Legal basis for processing special personal data
Explicit consent (General Data Protection Regulation art. 9 nr. 2 a)

Justify the choice of legal basis for processing

Information for sample 1

Does the sample receive information about the processing of personal data?
Yes

How does the sample receive information about the processing?
Written (on paper or electronically)

Information letter

Information letter - sample 1.doc

Sample 2

Describe the sample
Immigrant women with a Norwegian-born daughter who has given birth in Norway

Describe how you will identify or contact the sample
Recruited through the participants in sample 1

Age group
35 - 75

Which personal data will be processed for sample {{i}}? 2

- Name
- Contact information
- Voice on audio recordings
- Background information that, when combined, can be used to identify an individual
- Ethnicity
- Religious beliefs
- Health data

How is the data relating to sample 2 collected?

Group interview

Attachment

Interview guide - mother daughter dyads.docx

Legal basis for processing general personal data
Consent (General Data Protection Regulation art. 6 nr. 1 a)

Legal basis for processing special personal data
Explicit consent (General Data Protection Regulation art. 9 nr. 2 a)

Justify the choice of legal basis for processing

Information for sample 2

Does the sample receive information about the processing of personal data?
Yes

How does the sample receive information about the processing?
Written (on paper or electronically)

Information letter

Information letter - sample 2.doc

Third persons

Does the project collect information about third parties?
Yes

Describe the third persons
Because the project will explore participants' experiences of postnatal care and support, the researcher will ask about third persons who have been important influences in participants' experience, particularly partners and parents. Since cultural influence on postnatal care and support is a focus of the research, the racial, ethnic, or religious background of third persons may also be discussed. The researcher will not directly inquire about third persons' health, but it may be mentioned by the participant as a basis for their own perceptions and expectations. Participants will be asked to omit names or any identifiable information about third persons. If mentioned, names will be omitted/deleted from notes or transcripts. However, information relevant to the research question, such as third party's relationship to the research participant, may constitute background data that can identify a person. Other groups/individuals with a role in supporting or influencing the research participant's experiences or expectations, such as health care providers or others in their broader social network, may also be discussed in the interview. Questions will be framed in a way that does not inquire about individuals, and participants will be asked to omit names or any identifiable information about third persons. If mentioned, names and identifiable information will be omitted/deleted from notes or transcripts. Since cultural influence on postnatal care and support is a focus of the research, the racial, ethnic, or religious background of third persons may also be discussed. The researcher will not directly inquire about third persons' health, but it may be mentioned by the participant as a source for their own perceptions and expectations.

Which personal data will you be processed for third persons?
- Background information that, when combined, can be used to identify an individual
- Ethnicity
- Religious beliefs
- Health data

Which sample will give information relating to third persons?
- Sample 1: Norwegian-born or raised mothers with two foreign-born parents
- Sample 2: Immigrant women with a Norwegian-born daughter who has given birth in Norway

Will third persons consent to the processing of their data?
No

Will third persons receive information about the processing of their data?
No

Explain why third persons will not be informed
Because social support networks/relationships are a central theme in this topic, mention of third parties will likely be unavoidable. The potential third parties can be generalized in two categories: providers and persons from the participant's broader social network (who will remain completely anonymous); and family members/partners (who can only be de-identified). Informing/obtaining consent from third persons would compromise the research participants' privacy and anonymity. The researcher will also not obtain third persons' names or contact information. To avoid misusing third party data, information will be strictly analyzed and clearly presented as from the primary participants' perspectives. Information collected about third parties will only be anecdotal and not be the main basis of analysis and data collection. Any information about third parties will be de-identified in transcripts.

Documentation

How will consent be documented?
- Manually (on paper)

How can consent be withdrawn?
Consent can be withdrawn during and after data collection by contacting the researcher or the supervisor by email or phone.

How can data subjects get access to their personal data or have their personal data corrected or deleted?
Subjects can request access to interview transcripts and submit corrections to either the researcher or the supervisor by email or phone.

Total number of data subjects in the project
1-99

Approvals

Will any of the following approvals or permits be obtained?

- Other approval

Other approval

Universitet i Oslo Department of Community Medicine and Global Health internal assessment; pre-assessment from REC confirming their approval is not applicable to this project

Approvals

Svarbrev, Fremleggingsvurdering, {ordningstittel} vurderes som ikke fremleggingspliktig av REK.pdf

ICH program ethical committee statement.pdf

Security measures

Will the personal data be stored separately from other data?

Yes

Which technical and practical measures will be used to secure the personal data?

- Continuous anonymisation
- Restricted access
- Multi-factor authentication
- Encrypted storage
- Encrypted transmission

Where will the personal data be processed

- Mobile devices
- ?
- Hardware

Who has access to the personal data?

- Student (student project)
- Project leader
- Data processor

Which data processor will be processing/have access to the collected personal data?

TSD

Are personal data transferred to a third country?

No

Closure

Project period

15.07.2022 - 30.06.2024

What happens to the data at the end of the project?

Personal data will be anonymised (deleting or rewriting identifiable data)

Which anonymisation measures will be taken?

- Any sound or video recordings will be deleted
- The identification key will be deleted
- Personally identifiable information will be removed, re-written or categorized

Will the data subjects be identifiable in publications?

No

Additional information

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst D	Finn Skre Fjordholm	+47 22 84 58 21	19.05.2022	486273

Heidi E. Fjeld

Fremleggingsvurdering: Veikrysset ved vuggen: forhandling av barselomsorg og flerkulturell tilhørighet blant barn av innvandrere i Norge
Søknadsnummer: 486273
Forskningsansvarlig institusjon: Universitetet i Oslo

Prosjektet vurderes som ikke fremleggingspliktig

Søkers beskrivelse

Formålet med prosjektet er å utforske hvordan flerkulturell bakgrunn påvirker mødre og hvordan de opplever og håndterer barselomsorg og støtte etter fødsel. Studiepopulasjon skal være nybakte kvinner som har født mindre enn ett år tilbake i tid, som bor og er født i Norge og defineres som norskfødt barn av innvandrere. Deltakerne vil først bli intervjuet alene for deretter å inviteres til å delta i 1) gruppeintervju med sin mor, 2) fokusgruppe sammen med andre mødre med flerkulturell bakgrunn. De individuelle Intervjuene med kvinnene vil handle om hvordan flerkulturell tilhørighet former forventningene deres om barseltid, restitusjon og overgangsperiode til morsrollen, om rollene som slektninger og partnere spiller i denne perioden, og hvordan dette påvirker deres navigering av støtte- og omsorgstjenester. Prosjektet vil analysere hvordan prosessen og kravene til å forhandle mangfoldige kulturelle normer påvirker forholdene på tvers av generasjoner, mellom foreldre, og mellom pasienter og fagfolk i helsesystemet.

Viser til din forespørsel om fremleggingsvurdering for prosjektet «Veikrysset ved vuggen: forhandling av barselomsorg og flerkulturell tilhørighet blant barn av innvandrere i Norge» (vår ref. 486273).

Sekretariatet i REK sør-øst D har vurdert henvendelsen.

REKs vurdering

Det er satt opp følgende problemstilling: *How does multicultural belonging shape how second-generation immigrant women in Norway navigate postnatal recovery, support, and care?*

Formålet med prosjektet er spesifisert slik:

a. *broaden understanding of how mothers who are second-generation immigrants manage these processes while navigating and negotiating the norms and expectations of both the Norwegian hegemony and their cultures of origin;*
b. *identify areas of tensions and unmet need among second-generation mothers and analyze how they correspond with criticisms of Norwegian postnatal care voiced from the majority perspective; and*
c. *produce a cross-cultural understanding of effective postnatal care and support that can advance the capacity of Norway's systems of care to foster psychosocial well-being for all new mothers through culturally-sensitive and culturally-responsive postnatal care.*

Data skal hentes inn gjennom individuelle og fokusgruppeintervju med førstegangsmødre med bakgrunn som andregenerasjons innvandrere. Det er lagt frem en intervjuguide med temaer som er planlagt berørt i intervjuene.

REK vurderer dette som et interessant prosjekt som vil kunne gi viktig kunnskap om hvordan den aktuelle gruppen opplever møtet med svangerskapsomsorgen og tilværelsen som mor, og gi en bedre forståelse av hvordan de orienterer seg i helsetilbudet i den postnatale perioden. Den fremlagte intervjueguiden viser at temaene som skal tas opp er deltagernes erfaringer, forventninger og opplevde normer i denne tiden.

Sekretariatet vurderer at prosjektet, slik det er presentert i søknad og protokoll, ikke vil gi ny kunnskap om helse og sykdom som sådan. Prosjektet faller derfor utenfor REKs mandat etter helseforskningsloven, som forutsetter at formålet med prosjektet er å skaffe til veie "ny kunnskap om helse og sykdom", se lovens § 2 og § 4 bokstav a).

Konklusjon

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2 og § 4 bokstav a). Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern samt innhenting av stedlige godkjenninger.

Vi gjør oppmerksom på at konklusjonen er å anse som veiledende jfr. forvaltningsloven § 11. Dersom du likevel ønsker å søke REK vil søknaden bli behandlet i komitémøte, og det vil bli fattet et enkeltvedtak etter forvaltningsloven.

Med vennlig hilsen,

Jacob Hølen

sekretariatsleder

REK sør-øst

Finn Skre Fjordholm

rådgiver

REK sør-øst

Kopi til:
Universitetet i Oslo