

# **Birth experiences among Lithuanian immigrant women in Norway**

*Thesis submitted to the partial fulfillment of the Master of  
Philosophy Degree in International Community Health*



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## **Abstract**

Some studies show that ethnic minority women experience barriers in obtaining the same level of cultural sensitive maternity care compared to native-born women in the host society (Reitmanova & Gustafson, 2008; Essen & et al, 2000; Vangen, 2004). This study therefore, explores subjective voices of Lithuanian immigrant women on their childbirth experiences in Norway. An important segment of this research study was to illuminate in what ways do Lithuanian women's cultural conceptions of a 'safe pregnancy' and 'safe delivery' conflict with the guidelines and conceptions of the Norwegian model of midwifery. The starting point of this study was taken that perceptions about maternity care and birthing setting is socially and culturally constructed in every society. Therefore, a qualitative methodology using two in-depth interviews with six with women of Lithuanian ethnic origin residing in Norway has been employed. In addition, three informal interviews with midwives were performed to shed light on ways of accommodation of individuals and their cultural factors in Norwegian midwives' practices. The study findings suggest that considerable variation in maternity care across Lithuanian and Norwegian cultures impose and shape directly the experiences of migrant Lithuanian women; however, cannot be explained as due to cultural metamorphoses alone. The study concludes that the clash of 'authoritative knowledge' systems in terms of prenatal expectations, sociocultural values and reproductive politics demonstratively were articulated by Lithuanian women in the study.

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After writing this thesis I understood that research is a hard work, but with its progression it unfolds a lucid spirit of curiosity to understand things. Nevertheless, this thesis would not be possible without consistent support from others whose input I appreciate and value so much.

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## **ACRONYMS**

ANC -- Antenatal care

GP -- General Practitioner

HCG -- Human chorionic gonadotropin

MDG5 --Millennium Developmental Goal 5

PNC --Prenatal care

PND --Prenatal diagnosis

UN -- United Nations

WHO – World Health Organization



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# **1 INTRODUCTION**

## **1.1 Introduction**

For the last decades anthropologists through the qualitative tradition of ethnography, have been exploring birth experiences among ethnically diverse women around the globe. While birth is physiologically a universal process, the maternity care and birthing practice vary considerably among different societies in the world (Jordan, 1978; Sargent & Bascope, 1996; Davis-Floyd et al., 2009). Looking at birth experiences through the eyes of the migrant women provides useful insights into cultural, social, political and economical aspects of the host society, but also how these aspects shape the phenomena of pregnancy and birth.

Through a focus on the subjective voices of Lithuanian immigrant women, this project seeks to describe and critically explore birth experiences and perceptions of Norwegian maternity care among Lithuanian immigrant women in Norway. The concepts ‘Maternity care’ and ‘Birth experiences’ can each be used as a complex term to define the whole process of prenatal, labour and postnatal periods; however, in this particular study these terms have been used as shorthand notions to refer to prenatal and labour periods correspondently. Not only due time restriction of this research project, but also due to a particular interest, the main focus of this study was prenatal and labour experience of the Lithuanian women. The prenatal period and birth are the two periods when the woman’s interaction with maternal health care is most frequent, and as such most relevant to the topics explored in the research project.

## **1.2 Justification for the study**

As the immigration population increases exponentially in Norway, reproductive health faces challenges in achieving optimal maternal health in a culturally diverse society. Sympathetic and non-judgmental care provided by health care personnel during the prenatal period and delivery period is of great importance in supporting and sustaining one of the Millennium Developmental Goals (MDG5). The need for independent research on issues regarding birth experiences among ethnic minority women in Norway becomes even more important as there is a prominent gap in the research exploring migrant women's views on maternity care management in Norway

(Lyberg & et al., 2011). According to Viken (2004)<sup>1</sup> health care providers in Norway experience indecision towards providing culturally sensitive care.

To the researcher's best knowledge, there are a few research studies that have been made investigating birth complications and experiences among ethnic Pakistani and Somali women in Norway. Through a focus on the subjective voices of immigrant women, this project seeks to explore birth experiences and perception of Norwegian maternity care among Lithuanian immigrant women in Norway. This research study would be the first attempt to gather birth experiences of immigrant women of western origin in Norway. The knowledge derived from the study can add to a development of a framework for cultural competency in the maternity care health workforce in Norway. In addition, as migration constitutes a growing process worldwide, the information gained in the study can facilitate in building effective approaches to achieving woman-centered maternity health care services in other multicultural societies.

### **1.3 Research problem statement**

The aim of this study is not to provide a solution for managing cultural diversity in maternity care needs as such, nor does it argue for or against prenatal and birth care management rules and practices in Norway. Rather it calls for an understanding of maternity care experiences of minority pregnant women of Lithuanian origin in Norway. Moreover, it seeks to shed light over the variations in perceptions of practices of midwifery. A central argument in this study is that maternity care practices and management of pregnancy and labor vary from one society to another and the significantly marked practices result in different experiences for mothers.

#### *1.2.1 General Objectives*

- Explore birth experiences and health behaviors among Lithuanian minority women in Norway;

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<sup>1</sup> Viken, B. (2004). *Mødre I et Nytt Land, en Studie av Flyktninger som er Småbarnsmødre. Mothers in a new*

### 1.2.2 Specific Objectives

- Identify sources of cultural challenges, concerns and communication barriers in achieving optimum child birth experiences among a group of Lithuanian ethnic minority women in Norway;
- Gain a deeper understanding of how social network patterns influence birth experiences among ethnic minority women in the mainstream of the host society;
- Illuminate ethnically diverse migrant women's perceptions and views about the Norwegian maternity health care management;
- Identify midwives main concerns and reflections in terms of providing maternity care to ethnic minority women.

## 1.4 Organization of the thesis

This thesis is organized into six chapters. Following the introduction chapter,

*Chapter 2* covers the background of migration and health, identifying major health challenges for migrant people, particularly accentuating pregnancy and birth within the domain of reproduction. In addition, it provides brief overviews of maternal health care services and birth settings in Lithuania and Norway in order to both contextualize and provide a framework for issues raised in the study.

*Chapter 3* is a review of the relevant literature in order to build up a framework of information available on patterns surrounding the immigrant women's maternity experiences. Various anthropological and social science studies were reviewed in order to gain a deeper understanding on maternity care issues in ethnically diverse societies, including Norway. Finally, the gap presented in the literature is presented in order to fulfill the justification for this study.

*Chapter 4* discusses the chosen research design and methods employed in the study. Additionally, it describes the initial engagement and interest in childbirth experiences in Norway, as well as the inspiration of various theories throughout the research project. Moreover, methodology and its strengths and weaknesses are discussed in detail in this chapter. Lastly, the

significance of the researcher's reflexivity and ethical considerations are underlined and discussed in detail.

*Chapter 5* describes the main findings of this research study. It portrays the subjective experiences of Lithuanian immigrant women during the prenatal and birth periods in Norway.

*Chapter 6* concludes with the presented results of the study as well as provides recommendations of potential contribution of the results of this study.

## 2 BACKGROUND

### *2.1 Migration and health*

Migration has been always a part of human history; it has been a driver for shaping culture, economics and other factors important to humanity. Today, the flow of migration, however, has reached ‘the tip of iceberg’, where the speed and number of influx of migrants moving from one country to another is increasing rapidly and not without consequences. Whilst globalization brings for private business companies new opportunities within the field of economy, it has also brought complex cultural, social, ethical and infectious diseases challenges in the health care sector (Ingleby et al., 2005). Conversely, health by itself doesn’t stand alone in the domain of health care system. Many implicated factors such as legitimacy of policies, shortcomings or flaws in migration reform and lack of financial resources are just some of the issues that emerge through the lens when discussing these issues from the perspective of globalization. We see through this lens that sometimes health laws put in place to protect can actually restrict achieving a state of happy social well-being. The potential to receive non-quality health care services is often greater among ethnic minorities, which further brings the issue of social inclusion or exclusion factors in the host society. This potential is a barrier inextricably linked to the integration process of migrant groups:

Migrants who are burdened or handicapped by health problems are hampered in the task of integration. [...] Illness exacerbates marginalization and marginalization exacerbates illness, creating downward spiral. (Ingleby et al., 2005, p.1).

Migration affects women in different ways than it does men as obviously women biologically have certain health considerations unique only to their sex. Specifically, as “pregnancy is a possibility,” immigrant women face more vulnerability in a host country than men (Castaneda, 2008). Childbirth experiences and practices vary to a great extent among different societies worldwide. In many countries there are set of rules and guidelines to practice maternity care; however, it can be a challenge to become familiar with the maternity care guidelines for an expectant mother in a new country. Pregnant immigrant women are vulnerable not only to receive culturally-inappropriate maternity care, but also face an environment that might limit a pregnant woman's empowerment and assertiveness. An immigrant woman may even experience

fear and powerlessness under pressure of new circumstances in pregnancy and birth which can ultimately lead to a psychological and physical threat to her social well-being.

International Federation of Gynecology and Obstetrics in 1994 Worlds Report on Women's Health concluded, not having a position of decision-making in terms of pregnancy and childbirth, a woman can end up in a state of powerlessness, which is a serious health hazard (Fathalla, 1994). The patient is an integral part of the health care team and excluding or not giving a voice to the pregnant mother in the treatment decision making can have direct consequences. Therefore, the psychological state of the mother is of great importance not only to her but also to the infant's health, and in order to have a confident and safe beginning of a family of biological unit--the mother-baby dyad.

Consistent with most western democracies, Norway has gradually changed from being homogeneous to becoming a multi-ethnic society. Economically, Norway is one of the richest countries on the globe where immigrants are attracted by a high level of social well-being. According to Norwegian Statistical data (2013), there are 593,300 immigrants and 117,000 Norwegian-born persons with immigrant parents living in Norway. These two groups represent 14.1 percent of Norway's population (SSB, 2013)<sup>2</sup>. The third largest immigrant group residing in Norway is immigrants of Lithuanian background after Polish immigrant group being first and Swedish being second. During the year of 2012 there was 6000 Lithuanians who immigrated to Norway, composing a total of 28,600 persons with Lithuanians background living in Norway as up to January 1<sup>st</sup>, 2013 (SSB, 2013).

An increased rate of ethnocultural diversity confronts Norway's society with opportunities and challenges in labor markets, educational system, financial system and health care system. Ethnic disparities in maternity care have existed for centuries particularly in multicultural countries, where ethnic diversity constitutes an immense part of the population make-up. A large number of research studies indicate that ethnic disparities in maternal health care have existed for centuries in countries such as United States and Canada; however, ethnic disparities in maternity care have been also found in Norway (Vangen, 1999; Vangen, 2002a). As the immigration population

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<sup>2</sup> SSB refers to 'Statistisk sentralbyrå' (Statistics in Norway)

increases exponentially in Norway, reproductive health faces challenges in achieving optimal maternal health in a culturally diverse society.

Achieving one of the Millennium Development Goal (MDG5) is directly related to reproductive health as the World Health Organization (2010) emphasizes that optimal maternal and infant health is crucial for health and well-being. The path towards attaining the Millennium Development Goal starts with educating, empowering, and including the mother as an integral part of the health care decision making team. As a developed country, Norway has achieved the Millennium Developmental Goal; however, today the composition of the Norwegian society is very diverse and reproductive health issues and cultural competence within the field of women's health is of great importance.

## ***2.2 Maternity care in Lithuania***

Lithuania is one of the three Baltic countries that has experienced dramatic political, economic and social disruption since becoming an independent country after the collapse of the Soviet Union in 1990. Political disruption and quick change affected many different structures in the country including the health care sector. Modification and reconstruction of obstetric care delivery service implied an integration of obstetricians/gynecologists and family doctors, whereas in the Soviet Union midwives had a more authoritative role in providing maternity care. Medicalized approach to childbirth as seen in North America became more influential in the countries of Central and Eastern Europe after the collapse of Soviet Union (Chalmers in Davis-Floyd & Sargent, 1997). According to Chalmers in *Changing Childbirth in Eastern Europe*, midwifery care and home births “exist now only in the memories of the older women” (p.270). Further, the author claims that if the technology is available, it is usually overused or used whenever possible, especially repeated ultrasounds in the course of pregnancy and routine fetal monitors during birth (Chalmers in Davis-Floyd & Sargent, 1997, pp.273-277). Mutual accommodation of two birthing systems and rapid integration of modern medicine affected the practice in maternity care, where the midwife's position within the field of obstetrics declined significantly.

Consequently, current prenatal care in Lithuania is fundamentally shaped by obstetricians/gynecologists and family physicians (LRSAM, 1999)<sup>3</sup>. Literature sources confirm that women in Lithuania are more satisfied with the maternity care received by obstetricians/gynecologists simply because they are regarded as more confident in their knowledge than family doctors (Vanagiene et al., 2009).

Under the legislation (LRSAM, 1999), Lithuanian pregnant woman has the right to choose the desired specialist, either a family doctor or obstetrician/gynecologist, who would follow her through pregnancy and she can deliver with the same doctor if she/he is specialist in gynecology. If a woman chooses the specialist outside her area of residency, she would have to pay for the prenatal visits herself; otherwise public maternal care is financially covered by the Lithuanian national health care system. In case of a woman choosing to receive antenatal care by a family doctor, according to recommendations of Ministry of Health in Lithuania, she should have at least four additional visits and consultations with a gynecologist (LRSAM, 1999). The overall number of recommended visits during antenatal care is not stated in the recommendations of Lithuanian Ministry of Health, however, according to reviewed literature, there is a tendency to overuse available financial resources and sometimes women during the prenatal period have too many consultations with family doctor and/or obstetrician/gynecologist (Vanagiene et al., 2009).

In the course of a pregnancy the first visit to a doctor is recommended to take place as early as possible during the first trimester. The other visits depend on the agreement between the doctor and the woman herself. Every consultation and visit with the doctor involves various examinations such as blood pressure, weight, checking for signs of water retention (edema), urine tests, and from the 20th week examination and measurement of the symphysis. Fundal height, fetal heart rate and fetal position are measured from 36 weeks of gestation. Urine analysis (protein, glucose, leucocytes) – examination is performed at every visit, and vaginal smear at the first visit. Various serological blood tests are performed on indication. Two ultrasounds are offered at no cost to all pregnant women: one is at the 16-20 week of gestation and another between 32-36 weeks of gestation. Genetic prenatal testing is recommended to all women over

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<sup>3</sup> LRSAM refers to 'Lietuvos Respublikos Sveikatos Apsaugos Ministerija' (Lithuanian Ministry of Health and Care Services)



the age of 35; however, for the appropriate fee, the possibility to check the health status of the fetus is available at any private sector for women of all ages (Vasjanova et al., 2011).

Lithuania is one of the countries that have a low maternal mortality rate, 13 deaths per 100 000 live births (WHO, 2010). Almost all births take place in state and private hospitals today, where medical decisions are made mostly by the obstetrician at the birth setting, and which usually is the same obstetrician that has provided antenatal care for the woman. The birth is carried out by an obstetrician/gynecologist with midwives in attending to the mother. Very little literature exists in terms of detailed birth setting and medical transformations during labour that take place in Lithuania and countries of the former Soviet Union; therefore, it is “an arena that cries out for anthropological research” (Davis-Floyd & Sargent, 1997, p.13).

### ***2.3 Midwifery in Norway***

Maternity care (i.e. prenatal, labour and postnatal stages) in Norway is well-established and organized. Norway enjoys one of the lowest maternal mortality rates over the world with seven deaths per 100 000 live births in 2008 (WHO, 2010). The prenatal care in Norway is free, universal and comprehensive. Legally midwives began to provide maternal care at maternal and health care centers from 1995; however, it was not well coordinated in terms of cooperation between primary and secondary health care services. This led to the introduction of the ‘Coordination Reform’ (HOD, 2009) on January 1<sup>st</sup>, 2012; which targeted the midwives to have a fundamental role and be a part of collaboration between hospitals, general practitioners and public health care centers on the improvement and continuity of maternity care (p.70-71).

According to national clinical guidelines, routine prenatal care is managed by midwives in cooperation with family doctors (Retningslinjer for svangerskapsomsorgen, 2005)<sup>4</sup>. Pregnant women have a choice to attend pregnancy check-ups either at a public health care center (‘Helsestasjon’) or at the general practitioner’s office. It is possible to receive prenatal care at both the public health care center with a midwife as well as with general practitioner.

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<sup>4</sup> Retningslinjer for svangerskapsomsorgen (The rules and guidelines for pregnancy care) is issued by Norwegian Directorate of Health, which is an executive agency and competent authority subordinate to the Norwegian Ministry of Health and Care Services (HOD: Helse og omsorgsdepartement).

There are three types of professionals who manage maternity care in Norway: general practitioners, gynecologists and midwives. In case of medical complications during pregnancy, the family practitioner refers a woman for consultation with gynecologist (Boge & Karlsen, 2007).

In Norway during the first pregnancy it is recommended that a woman goes to 10-12 prenatal check-ups with a midwife or general practitioner. For the following pregnancies a woman is recommended to attend 8-12 prenatal check-ups. The first 32 weeks of gestation a woman goes to see a midwife or general practitioner once a month and then once every two weeks from week 36, followed by once a week after the week 36 until birth (Boge & Karlsen, 2007). However, the number of prenatal care visits is not limited to a certain number; some women require more medical attention than others because of particular medical conditions. It is safe for a woman to go for fewer prenatal check-ups if the pregnancy course is normal (Retningslinjer for svangerskapsomsorgen, 2005).

With every visit there are a series of examinations such as checking the weight, blood pressure, urine, water retention in the body (edema) and other medical tests if there is medical indication for it. The first ultrasound is offered to all women at the 17<sup>th</sup> to 19<sup>th</sup> week of gestation (Retningslinjer for svangerskapsomsorgen, 2005). Pregnant women are issued a health card, where the clinicians record the care provided to a woman as well as vital signs and test results during the pregnancy course. Every time a woman visits a clinician she should have a health card with her, so the other clinicians can see the pattern of prenatal care (Boge & Karlsen, 2007).

Regarding birth, midwives in Norway are well trained to distinguish between normal delivery and potential complications and abnormalities during an encounter of birth; in case of which Norwegian obstetric wards midwives inform obstetricians.

Lately taking care of women with diverse backgrounds has become a daily reality in Norway that midwives, obstetricians and other health care providers have to face. The findings of Lyberg & et al (2011) indicate the inadaptability of the Norwegian maternity care to migrant women's needs and highlights a prominent gap in the research in exploring migrant women's views on the

maternity care management. Effective communication and cultural competence is one of the necessary skills midwives need to embrace in today's diverse socio-cultural societies in order to achieve professionalism and mutual satisfaction in maternity care.



### **3 LITERATURE REVIEW**

When reviewing the literature, a special emphasis was placed on both anthropological and social sciences. This literature was researched in order to develop a framework of information available on patterns surrounding immigrant women's maternity experiences in other than "native" societies, as well as the birthing and midwifery roles and practices in Norway. Since the target group of this research is a minority group<sup>5</sup> in Norway, the literature search was performed with a particular emphasis on health of migrant women.

The initial literature review was performed during the planning phase in the spring of 2012 and continuously updated throughout the process of the research.

#### ***3.1 What women want?***

All women, regardless of ethnicity or social class, in the 12 year studies done by Ellen Lazarus in United States, wanted to receive what they considered quality medical care: "everything possible to have a healthy baby" (Lazarus cited in Davis-Floyd & Sargent, 1997, p.133).

In an integrative review of thirty six articles published between 1997 and 2007 on women's experience of prenatal care, Novick (2009) concluded that the most important prenatal care aspects for women were the following: reasonable waits, continuity, comprehensive care, flexibility, unhurried visits, and meaningful relationships with care providers and active participation in their own care. The study results strongly demonstrate women's need to have a trusted single care provider: a provider with whom they could have an informal relationship. If several health care providers were involved, coordinated and continuity of care is evident as being important to these women. In addition, women strongly spoke of the importance of meeting other pregnant women in their community in order to share pregnancy experiences (Novick, 2009).

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<sup>5</sup>According to Encyclopedia Britannica, I use 'minority group' by definition in this thesis as "culturally, ethnically, or racially distinct group that coexists with but is subordinate to a more dominant group. As the term is used in the social sciences, this subordinancy is the chief defining characteristic of a minority group.  
<http://global.britannica.com/EBchecked/topic/384500/minority>

### ***3.2 Childbirth as social control and production***

The most basic goal in anthropology is to understand and theorize a phenomenon and its social and cultural organization (Bodley, 2005). Women's experiences of childbirth in anthropological studies mostly describe and analyze how the biomedical model and technology in medicine influence childbirth. Anthropologists studying life experience, such as birth, generally position themselves outside of the positivist paradigm and focus on processes and actions in the encounter of birth. In other words anthropologists see behaviors, norms and actions as significant data and use an inductive or interpretive approach to data analysis (Rothe, 1993). Many discussions shed light upon the woman's body, which is usually described as separate and subjected to medical technological innovations. One notes an abandoning of birthing women to their own world while at the same time enabling others to exercise their authoritative knowledge (Jordan in Davis-Floyd & Sargent, 1997, pp.70-74).

Brigitte Jordan (1978) remarks that these type of acts reinforce core cultural beliefs and standards and vary from country to country. In *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*, Jordan describes childbirth as being "an intimate and complex transaction whose topic is physiological and whose language is cultural" (p.1). In addition, the author studying childbirth in four different countries observes carefully the role not just of a mother but rather of all participants. The author describes 'participant' in this sense as all persons, including herself, producing the birth event. Jordan (1978) discusses how childbirth embodies cooperation among participants in the birth arena, while at the same time she emphasizes that the birthing woman is expected to trust medical professionals which can be understood in terms of social control. Based on cross-cultural comparisons, the author strongly argues that childbirth is a culture-specific social event which should hold the common objective of producing the event of birth not only as medically safe but also emotionally rich (Jordan, 1978, p.89).

Anthropologist Davis-Floyd (1994) studying childbirth in United States emphasizes the domination of biomedical practice in the childbirth arena and discusses how strongly authoritative knowledge of American obstetricians facilitates social control. The author is

concerned how “technocratic routines” of childbirth leave no choice for birthing women while simultaneously constructing more controversial issues surrounding childbirth (Davis-Floyd, 1994). In contrast to Jordan, Davis-Floyd deepens his discussion even more on biomedicine as a dominant power structure in the aspects of pregnancy and childbirth. The author places emphasis on the value of biomedicine; recognising its strengths and weaknesses. This is done in order to gain an understanding of the complexity of social and cultural control of natural processes such as birth.

In more recent studies, a few anthropologists studying childbirth have placed emphasis on analyses from a feminist perspective and have focused extensively on the use of medical metaphors by which women perceive their bodies are treated or seen (Van Hollen, 2003; Martin, 1989). The anthropologist Martin (1989) has particularly focused on prevailing mechanistic view on a woman’s body:

They seem unable to resist the underlying assumptions behind those procedures: that self and body are separate, that contractions are involuntary, that birth is production. (p. 89)

Martin’s unique fieldwork laid emphasis on reproduction which according to her is not an isolated unit, but representing the reproduction of American society as a whole marked by distinctive culture and perceived as a form of social control. Anthropologist Cecilia Van Hollen (2003) echoes Martin’s explicit focus on ways of seeing reproduction as cultural reflection of society and as an “arena within which culture is produced, reproduced, and resisted” (p. 501).

### ***3.3 Migrant women experiences of childbirth***

After the migration journey, different cultures meet at a very special life event, birth. Wide horizons of understandings and perceptions of childbirth among health care providers and migrant women are portrayed in the literature review as a famine and major concern in maternity care (Reitmanova & Gustafson, 2008; Essen & et al., 2000; Manderson & Allotey, 2003).

In an integrative review, Novick (2009) conducted a descriptive qualitative analysis by critically analyzing published research from 1996 to 2007 (total of thirty-six articles) on women’s

experiences of prenatal care and found that some women experienced overall respectful individualized prenatal care, trusted their health care providers and were included receiving necessary information. Others, however, particularly low income and ethnic minority women perceived prenatal care as rushed, mechanistic or harsh (Novick, 2009).

Reitmanova and Gustafson (2008) carried out a qualitative study where they recruited six immigrant Muslim women to participate in in-depth semi-structured interviews in order to explore their maternity health care needs and barriers in St. John's, Canada. The findings highlighted limitations to accessing necessary health information. Also highlighted cultural and religious specific health care needs during pregnancy, birth and postpartum phases for the participants. The authors concluded that maternal health care system is designed to meet the needs of Canadian-born women and has not adapted to meet the needs of immigrant Muslim women. In addition, the authors argue the importance of social support during the childbirth period and identify the need for immigrant Muslim women to build social networks within the immigrant community; however usually failing to do so in the host society.

Essen & et al (2000) have also emphasized the importance of social support for Somalian immigrant women during their pregnancy in Sweden where they felt loneliness and isolation mostly due to the absence of their relatives. The authors conducted a qualitative study among fifteen Somalian immigrant women living in Sweden to explore the attitudes, habits and strategies related to pregnancy and childbirth experience. The objective was to gain an understanding as to how cultural factors might affect perinatal outcomes. After analyzing the data, the authors convey doubt towards the potential change of Somalian women's habits during pregnancy as long as health care providers remain uninformed of their motives. Therefore, a perinatal surveillance involving a more cultural sensitive approach is strongly suggested by the authors of the study.

Manderson and Allotey (2003) conducted a study using a combination of quantitative (survey) and qualitative data (in-depth interviews, clinical observations and focus group discussions) with an aim to explore reproductive health issues among refugees and immigrant women from Middle Eastern and Sahel African background in Melbourne, Australia. The authors illustrate immigrant



women's sensitive stories of reflection on "black babies" which illuminate miscommunication between immigrant women and health care providers. In addition, an unfamiliar health care system to new immigrants brings even more communication barriers for immigrant women, where they feel lost and powerless. The authors argue for provisions to improved health care services for immigrant women; meeting their health care needs and understanding inter-cultural factors that affect the quality of health care provided.

### ***3.4 Identified Gaps in the Literature***

As health problems topics of vulnerable migrant groups vary from country to country, the biggest attention in the literature is paid to challenges of control of infectious disease outbreaks. Solid data on the migrant women reproductive healthcare topics are considerably scarce. Research on migrant women's reproductive health in Norway is small-scale in nature; although, striking research study findings by Lyberg et. al (2011) emphasizing that "the Norwegian model for managing cultural diversity in maternity care needs to be developed" broke many debates in Norwegian maternity health care system and emphasized the need to carry out more studies on migrant women (Balaam et al., 2012; Viken, 2012). There are a few research studies that have investigated birth complications and experiences of maternity care among ethnic Pakistani and Somali women in Norway (Vangen, 1999; Vangen et al., 2004).

To my knowledge, however, at the time of conducting and writing this thesis there is no published in-depth research study exploring western origin ethnic minority women's birth experiences in Norway. To address this gap this research is conducted with the specific aim to explore social, cultural and maternity health care factors as well as to provide some context for understanding the perceived and experienced stories by Lithuanian pregnant women in Norway. When reviewing the literature a special emphasis was placed on both anthropological and social sciences. This literature was researched in order to develop a framework of information available on patterns surrounding the immigrant women's maternity experiences in other than "native" societies, as well as the birthing and midwifery roles and practices in Norway. Since the target group of this research is a minority group in Norway, the literature search was performed with a particular emphasis on health of migrant women.

The initial literature review was performed during the planning phase in the spring of 2012 and continuously updated throughout the process of the research.

## **4 RESEARCH DESIGN AND METHODOLOGY**

This chapter discusses the chosen research design and methodology. Firstly, I will describe the initial engagement of the interest in the phenomenon of childbirth among Lithuanian ethnic minority women in Norway. Secondly, I will elaborate on the theoretical framework and methodology including research methods used for data collection and analysis. Further, reflexivity of the researcher and ethical considerations of the study will be discussed. Finally, I will present the strengths and limitations of the research design and the qualitative inquiry pursued – a significant constituent that pervades the entire research study from the beginning to the end.

In order to support the subjectivity and not to lose close scrutiny in this qualitative study the researcher will use ‘I’ writing this research. Patton (2002) indicates using ‘I’ in qualitative research as an “active voice communicates the inquirer’s self-aware role in the inquiry” (p.65).

### ***4.1 Arriving at the research question***

This research project into experiences of childbirth in a new country stemmed first from an unusual experience of my neighbor, who called an ambulance because of bleeding at the end of her pregnancy. The unusual thing was that three ambulances came one after another just a few minutes apart creating confusion not only for the paramedical staff, but also for ‘dying out of curiosity’ watching neighbors to find out what was so critical with their neighbor. A day after I talked to my neighbor, who seemed well and gave me a thorough reasoning for calling the ambulance more than one time. She had been living in Norway for almost seven years at the time of incident and according to her opinion a person must overact and ‘act crazy’, so that the medical care he or she seeks would not be delayed. Such justification for some people might sound irrational; however, she strongly believed in it, therefore, was acting upon her belief. In this situation as she was brought to the emergency ward (‘legevakt’), the assigned doctor assessed her and claimed that small bleeding at the end of the pregnancy was totally normal. My neighbor replied that she was not sure what was ‘normal’ and ‘small’ in terms of bleeding at the end of pregnancy.

Other similar stories came to my ear after this particular incident, especially in relation to birth experiences in Norway. As I got to know more Lithuanian people in Norway, I found out that childbirth experience was a phenomenon that cried out for more investigation. For me it was not only a question to fulfill my curiosity about experience of childbirth of Lithuanian immigrant women, but more I saw a knotty childbirth phenomenon that needed to be explored further.

## ***4.2 Research Design***

The methodology and methods used for this research study were decided by its purpose. As the aim of the study was to understand thoroughly birth experiences of Lithuanian women in Norway, a qualitative research design was considered most suited. The answers to the research question put forward in this thesis simply cannot be "yes" or "no", hence the method of collection and analyzing data had to be suitable and complementary to each other. There are no universal rules in terms of selecting the "right" methodology, or analysis and evaluation of a qualitative research (Willig, 2001). However, the research method needs to be good in itself to mirror the reality of birth experiences and in order to articulate an understanding of giving birth in a new country as a phenomenon of human experience. Using a semi structured interview as a primary tool for data collection has provided an opportunity to acquire knowledge about birth experiences and highlight objectives of the research study.

## ***4.3 Theoretical framework and methodological reflections***

Understanding birth experiences among immigrant women can be challenging and should, therefore, be understood and interpreted in relation to the particular time frame and context of the research study. Malterud (2011) describes the selection of a theoretical framework as a continuous and dynamic process of a research study and which plays an important role in utilizing and understanding the findings and bringing them up into a final report. The data in this research study was approached inductively, meaning discovering and letting the themes emerge while interacting with data. Yet, in this study I was inspired by various anthropological and social science theories from the beginning of the research study to the end. Malterud (2011) stresses that a researcher who claims to approaching his data inductively, not using the basis of any theory, fails to recognize his own position which inevitably is affected by theory. The reader

is not obligated to guess the path of the findings, but rather the researcher has to present the description of the path of interpretation of data to the findings that concurrently saves the researcher from the threat of non-objectivity.

During the entire process of this research I was strongly inspired by the anthropologist and midwife Brigitte Jordan's (1978) multifaceted view of culture and her theoretical approach to the study of childbirth from a biosocial perspective. She strongly emphasizes: "A problem that specifically does not arise from within stable systems is a radical critical assessment of practices" (p.6). The criticisms came from many contemporary anthropologists who claimed that within the context of power relations, culture is "constantly constructed through social practice and that some perspectives can become hegemonic" (Bourdieu, 1977, p.19). However, inextricable links between cultural patterns and aspects of birth are foreseen strongly by many medical anthropologists such as: Cecilia Van Hollen, Robbie Davis-Floyd and Elizabeth Davis that will be explored further in the research project. In addition, during the first interviews when some of the resonant themes started to emerge and later approaching the data, I was inspired by anthropological research done by Brigitte Jordan and her elaboration on 'authoritative knowledge'<sup>6</sup> that emerged as highly relevant throughout this research study analyzing birth experiences among Lithuanian women.

Phenomenological approach as a theoretical frame of reference had a strong influence in the later stages of the research study particularly during interviews with the selected participants. It must be emphasized that phenomenology is a broad lifeworld theory which was first introduced by Husserl and his extensive writings on natural sciences and if it could be objectively established without losing the meaning of true life (Giorgi, 1994). In this thesis phenomenology is used as a methodological starting point, and not as a theoretical framework. Looking at women's birth experiences through a phenomenological lens, one must recognize that understanding experiences of the phenomenon of birth may differentiate between the speaker and the observer. Articulated experiences in terms of suffering, birthing or trauma are subjective perspectives of the women. The women are the ones who can illuminate the experience as it was lived at the

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<sup>6</sup> 'Authoritative knowledge' is defined as 'the knowledge that participants agree counts in a particular situation, that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action' (cited Jordan in Davis-Floyd & Sargent, 1997, p.58).

particular time and recall through consciousness. Giorgi (1994) brings the concept 'consciousness' as an important precursor in the realm of a human's lifeworld and considers it as the cause of human's experiences. Van Manen (1997) supports the views of Giorgi on consciousness and states:

Thus all we can ever know must present itself to consciousness. Whatever falls outside of consciousness therefore falls outside the bounds of our possible lived experience (p.9).

Throughout the process of both data collection and data analysis, a concept within phenomenology - hermeneutic phenomenological reflection - became an important facet of what I call the 'drive of thinking'. The focus of hermeneutic interpretive phenomenology is to achieve an understanding of the phenomenon through interpretation, incorporating the historical, political and socio-cultural context during the interpretation of the research data (Van Manen, 1997). Van Manen describes hermeneutic phenomenology as attentive to both descriptive (phenomenological) methodology and interpretive (hermeneutic) methodology. She argues that a researcher looks at the phenomenon through the descriptive lens as well as interpretive one because lived experience cannot exist as uninterpreted phenomena (Van Manen, 1997, p.180).

In addition, a lively and very active group called 'Oslo Mamytes'<sup>7</sup> (see Chapter 5) was introduced to me by one of the participants and provided an opportunity to observe how broader cultural factors and reflections of pregnancy and birth were actively discussed. Following discussions via internet with other pregnant women broadened the topic overall and enabled me to understand better the birth phenomenon, in addition to collecting data from the participants. With each individual step into the meaning of the phenomenon of birth and 'being committed' to the original topic, hermeneutics became increasingly important. In other words, rather than merely interpreting research data in a linear progression. I chose to pursue a dynamic approach to all the possibilities of the meaning, trying to grasp what truly matters in unveiling the phenomenon of birth experiences.

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<sup>7</sup> The meaning of 'Oslo Mamytes' cannot be translated precisely into English as 'Oslo Mothers', but rather as 'The little Mothers in Oslo'. Lithuanian language just like Spanish language has diminutives and use in this case Lithuanian diminutive suffix -ytes, often translated using the English word 'little' that has nothing to do with size of the person or object, but rather indicating more about the speaker's feelings.

#### ***4.4 The recruitment of research participants***

The participants were recruited via non-randomized, purposive and ‘snowballing methods’. An initial intention to recruit the participants at the maternal and child health care centers, where pregnant women usually are seen by the midwife, was unsuccessful. The reason to that was the unavailability of free time, as well as considerable workload, among the midwives. Thus, public places, where Lithuanian women mostly gather for public holidays, Lithuanian Embassy and two official internet groups ‘Oslo Mamytes’ (‘The Little Mothers in Oslo’) and ‘Norvegijos moteru klubas’ (‘Women’s club in Norway’) were used instead to find the participants. ‘Snowballing’ sampling technique was carried out to obtain research participants. This indicates that the researcher was referred by the women, who already agreed to participate in the study, to other women they knew. There were two of the participants who were introduced via ‘snowballing’ sampling technique and the other four participants voluntarily agreed to participate after posting the information letter (see Appendix 3) about the research project on the two Lithuanian internet sites listed above. One of the participants was referred to me by her mother, who I met accidentally at the University of Oslo Library. After getting to know each other and telling her about my thesis, she took initiative and called her daughter and explained about the project, and the participant with pseudonym Viola agreed to participate after receiving information letter and research description.

The purposeful selection of the participants was used in order to draw out rich and wide variety of stories for in-depth study. In qualitative research Patton (2002) described sixteen different purposeful nonrandom participants’ selection strategies in order to get extreme and deviant case sample. It was important to get as “thick descriptions” of birth experiences as possible, so that the phenomenon could be better understood and interpreted. One of the participants have had opportunity to give birth in Lithuania before this pregnancy and giving birth in Norway. Therefore, her story provided comparative reflections on the social and cultural aspects of birth in Norway as well as in Lithuania.

There are no clear cut and defined rules to determine the number of participants in a qualitative study; however, due to the limited amount of time and resources for the actual research fieldwork, the intentional number of research participants was 6 Lithuanian women. In addition,

at the first stage of the project it was not foreseen what type of information would emerge through interviews and how rich the data would be in relation to answering the research question. Many qualitative researchers argue for a 'saturation' principle. Lincoln and Guba (1985) have elaborated on the 'saturation' principle, where they emphasized the purpose of it to maximize research information. They underlined that "the sampling is terminated when no new information is forthcoming from newly sample units" (p.202). During the first phase of the study, when the sixth participant was interviewed, the core themes were repeated and no new information emerged; hence, it was decided not to look for more participants as the stories were rich and subtle for the forthcoming deeper analysis.

A total of six Lithuanian women (Table 1) were interviewed during the first phase (pregnancy phase) and five participants were interviewed during the second phase of the research (after the delivery). One of the participants had a spontaneous abortion at the second trimester into the pregnancy. The age range of the participants was 28 to 34 years. All of the participants were residing in Norway legally. Five of the participants resided in the area of Oslo and one of the participants lived outside Oslo city. All the women were in heterosexual relationship and shared the same living space with their spouses at the time of the interviews.

The inclusion criteria of the study participants were as follows: Women whose mother language is Lithuanian; active pregnancy at least a month before the estimated delivery due date; and prenatal care received in Norway. The exclusion criteria: women who have resided in Norway longer than 15 years.



Table 1. *Demographic information of the research participants*

Participants (Pseudonym)	Age	Education	Number of pregnancy	Norwegian fluent speaker	Duration of living in Norway (years)
Lilia	29	Bachelor	First	Poor	2 years
Viva	28	2 Masters Degrees	First	Poor	3 years
Vera	34	Masters	First	Poor	8 months
Rose	29	Bachelor	First	Poor	1.5 years
Emma	33	Bachelor	First	Good	5 years
Viola	32	Masters	Second	Good	2.5 years

In order to gain a deeper understanding of the studied phenomenon and practiced midwifery in Norway three midwives were interviewed. Two midwives agreed to have interviews after we sent out the information letter about the research inquiring for their contribution to the research study (see Appendix 4). One of the midwives (Midwife 2), Lithuanian with work experience here in Norway and Lithuania, was introduced to me via one of the participants.

#### ***4.5 Data collection methods and materials***

A set of complementary qualitative methods were used in order to explore birth experiences of Lithuanian women in Norway. In-depth interviews during pregnancy and after delivery with immigrant women of Lithuanian origin were conducted during the research time frame. In addition, interviews with three midwives were carried during the fieldwork. Interaction via internet with the Lithuanian women's group 'Oslo Mamytes' contributed to the reflection of the data from a different angle to study the objectives of this research.

### ***4.5.1 In-depth interview***

The researcher in a qualitative study plays an important role and can be biased herself, consequently in conducting the interviews the researcher (interviewer) is the main instrument in collecting the empirical data (Malterud, 2011). Coming to the point in the research study, when the researcher is ready to conduct the interviews, is a challenging step. The openness of the participant is pivotal in terms of it being a good and should strive to create an opportunity for the participant to recall and colorfully describe an event or experience.

A good interview is like a good conversation. Good conversation is a two-way affair. One person talks, while the other listens, respond and encourages. While the interviewer asks questions and may talk a little about themselves, most of the time the interviewer listens, and the focus of the observation is the experience of the interviewee. (Liamputtong & Ezzy, 2005, p.36).

This study used two data collection semi-structured or thematically structured interviews with six Lithuanian women. One semi-structured interview was conducted during the pregnancy stage of the participants (n=6) and another within two months after birth (n=5) apart from one participant who experienced a spontaneous abortion. All the interviews were conducted from August 2012 to January 2013. The duration of the interviews was from one to three hours. The interviews took place in a location suggested by the research participants, which was either the participant's house or a coffee bar. One of the interviews was conducted at a private university office, where the participant was writing her academic research.

After each interview I recorded my own feelings and thoughts in the field journal. The interviews were conducted in Lithuanian language which is the native language of the participants as well as the researcher's. All the interviews were audio-taped with the permission from the participant, translated into English and then transcribed into text. I tried to avoid taking notes during the interview, as it can be uncomfortable for the participant as well as establish unwanted formality to the interview, which again may affect negatively the openness of the participant. In addition to being sensitive and familiar with Lithuanian culture, taking notes during interview could have impeded on the trust between me and the participant. Taking notes cannot be a substitution for

the recording, and before the recording the researcher has to honestly explain informant why recording is necessary (Willig, 2001).

A thematic guide was constructed before the interview; however, open-ended questions were asked during the interview enabling the participants to explore deeper and elaborate on their own experience and understandings (see Appendix 1). The questions asked in the interview guide were guiding only and were planned to be used in order to explore the themes presented in the objectives. The reality of the interviews situation demonstrated that it was easy to be caught up in the story telling and the predetermined interview guide had to be continuously adjusted to the actual setting. Occasionally the participants themselves tried to give an already shaped opinion or interpretation of certain episodes, but as a researcher I tried to stay focused on their original stories with subtle details and carefully scrutinize the path to understanding their experiences. Kvale & Brinkmann (2009) emphasizes that in semi-structured interviews “it is neither an open every day conversation nor a closed questionnaire” (p. 27). Having the interview agenda was helpful, especially when talking about sensitive issues regarding pregnancy and birth, as some information was emotionally challenging to the participants. In order to maintain a certain coherence of the interview, they were asked to elaborate more on certain answers or simply asked to explore more. As an example: when the informant stated that her midwife “was very rude and didn’t even ask me what I want”, I asked her to tell me more what happened in that situation and how she perceived the rudeness. By using this technique the researcher tries to ensure the validity of the information collected, given by the informant (Kvale & Brinkmann, 2009).

As the study aimed to understand birth experiences on what it means to be pregnant and how delivery of the baby was experienced by the participants, usually open-ended questions were asked at the beginning of the interview. Statistical information was also asked towards the end, such as: the years spent in Norway and educational level. In addition, permission to use statistical information to be included in the final report was also asked from each of the participants. Culture sensitivity was an important aspect in the interview situation as well. As the researcher, I am an immigrant sharing the same culture and speaking the same language as the

participants, which could I believe have been positive in relation to assessing the validity of data in this particular research study.

#### ***4.5.2 Interviews with Midwives***

Interviews with three midwives (see Appendix 2) were conducted in order to understand the barriers and concerns that they face when providing maternity care for ethnically diverse women. In addition the interviews with the midwives added weight to understanding the findings better, as well as providing different angles and perspectives on themes raised by the women in the study. As Malterud (2011, p.196) states that the aim of triangulation is not criteria-based validation, but rather confirmation of data validity and agreement among different sources. Data collection methodological approaches were not firmly predetermined and were applied with flexibility and openness to change if needed during the fieldwork.

#### ***4.5.3 Online materials and interactions***

A lot of interaction took place online, especially at the social net group ‘Oslo Mamytes’, which I gained membership to through one of the participants. Active daily online discussions about pregnancy issues, new information about healthy pregnancy and midwifery in Norway served as data inputs throughout the fieldwork (see Chapter 5).

### ***4.6 Data analysis***

Data analysis started already during the first in-depth interview, especially as particular themes and analytical insights freely began to emerge during initial data collection. In this stage of the research I stressed the necessity of being aware of my own pre-understandings and judgments before each and every step of a new emerging theme or meaning. The specific intuitions and perceptions of mine were recorded in the journal after each interview in order to keep track of my own reflections and feelings. Verbatim transcription of each interview was done right after the interview and followed by translation. I must admit that the process of verbatim transcription was not easy, but rather long and overwhelming due to translation into English, and transcribing with sensitivity in order not to lose the true meaning of what had been said by the participants.

Van Manen (1997) discusses the issues of how true meaning can be lost because of being “beyond our linguistic reach” and adds weight to the essential part of the researcher being able “to recognize differentiated possibilities of meaning that adhere to the socio-cultural context to which a given language belongs” (p.xiii).

The re-writing process provided me with a thinking space and contributed to more clear views on the empirical data. Fragments and phrases were gathered under a few resonant themes or thematic statements, which shaped the pattern of understanding the research questions. Van Manen’s (1997, p.101) thematic analysis inspired me strongly to approach the data critically using “lifeworld existentials as guides to reflection” of the data incorporating the ‘lived body’, ‘lived space’, ‘lived time’ and ‘lived relation to the other’ not separately but rather in differentiated mode, where “one existential always calls forth the other aspects” (p.105).

The meaning of the studied phenomenon is multi-dimensional and after reading, writing and rewriting the transcripts, the attempt was to identify the themes that structurally articulate and make up into nearness the lived birth experience. Carefully analyzing the emerged themes, the subthemes arrived at certain pace: not in straightforward single session, but rather through a cyclic process approaching the phenomenon again and again. Consequently, I was aware that understanding is never articulated to the fullness. As Gadamer (1982) states: “discovery of true meaning is never finished, it is an infinite process” (p.26). In addition the interviews and all the events that took place during the fieldwork was continuously discussed, reflected and analyzed with main supervisor.

In the final stage of data analysis, the attention was directed towards illuminating a comprehensive understanding of the research phenomenon and summarizing the findings. The literature review was conducted again, yet with a different type of ‘lens’ or perspective, where more concentration was placed upon comparing the findings with other researches and generating a final overview of the research phenomenon.

## ***4.7 Reflexivity***

In contrast to traditional golden standard randomized control trial, where not only the participants but also the researcher can be blinded, in the qualitative research design the researcher simply is not able to stay on the outside or being detached from the participants. The intrusive nature of the researcher: individuality, moral integrity, relatedness to other people's virtue, sensitivity and other humanistic values play a major role in a qualitative research design such as this one (Malterud, 2011). The researcher's role and presence of 'human's touch' in the field is inevitable, as well as tacit preconceptions and beliefs the researcher holds, which can indirectly affect the interpretation of the research data collected during the field work.

Continuous and conscious evaluation of the researcher's presence and positioning is referred to the process of reflexivity, where the researcher is aware of his or hers personal and professional background, experiences, motivation and the way she or he chooses to approach the study of interest as well as presenting findings and drawing conclusions (Malterud, 2001; Malterud, 2011).

Qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner consistent with that position, and present their findings in a way that allows them to be evaluated properly (Madill et al., 2000, p.17). This criterion of evaluation feeds the aim of reflexivity and creates transparency so the reader can closely follow the researcher's reasoning and thinking (Sandelowski, 1986).

Regarding the topics of pregnancy and birth, the researcher usually holds some cultural as well as philosophical thoughts on birth as an event, which might influence the outcome of the research. As Malterud (2001) accentuates, previous experience of the researcher and the preconceptions are not biased. However, if the researcher ignores or do not mention them, ultimately they will become bias. Preconceptions and misunderstandings can be held by the participants as well, where they might not fully understand the research aim and process, but rather see the researcher as a therapist or health care provider. Dealing with this ethical dilemma the researcher has to take control by thoroughly explaining and assessing the participants understanding of the research agenda (Malterud, 2001). However, in case of psychological adverse events during pregnancy or birth, for the participants the sharing of the experience or

simply talking to the researcher will not necessarily be a therapeutic session, but can ultimately hold a therapeutic value. The awareness of the position of the researcher, the angle of investigation taken by the researcher, the preconceptions and theories about the potential risk factors, all serve to limit the subjectivity of the study, that is, if the role and position of the researcher are continuously evaluated from the very beginning to end-result of the final report.

#### ***4.7.1 My role as a researcher, nurse and Lithuanian***

I have lived my life to embracing and exploring healthcare sciences and pursuing a career in nursing and medicine. Therefore, my educational background in nursing and science has influenced to some extent this research study. A difficulty I encountered during fieldwork was that being a nurse and a patient's advocate that I strongly feel for, I would sometimes lead myself into the pitfall of confusion as to how much advice, on the request of my participant, I could actually give without influencing my research data. Two of my participants saw me more as a resource person and health care provider than a researcher. One of them called me on several occasions to find out the hemoglobin values which predispose pregnant women to a medical condition, called anemia. It was not easy to answer such a direct question and reply that the healthcare provider (either the family doctor or midwife) should provide this type of information. In addition, the rules of the normal values of hemoglobin slightly differ from country to country. I felt guilty not providing the information; however, I did try to keep a neutral position as much as possible.

It may be argued, notwithstanding the dilemma of shifting dual roles during fieldwork, I also had credibility among the participants, because I was just one of them--Lithuanian and immigrant. The openness from the participants was not only strongly sensed during the interviews, but also expressed by a few participants.

#### ***4.7.2 Preconceptions and prejudice***

Before I came to Norway, I have studied and worked as registered nurse in the United States for ten years and was exposed to maternity care rules and regulations there. Being a mother and having birth experience in the United States and Norway, I have my personal stories and

comparisons of birthing systems between these two countries. My biggest concern and apprehension as a pregnant woman in Norway, was not being followed by one obstetrician throughout antenatal, birth and postpartum periods as it was done in United States. I strongly felt the lack of continuity in maternity care in Norway, a feeling that I also brought with me into this research. Nevertheless, not all of my participants experienced this specific dispute and only three of them actually spoke about it as a negative aspect in their childbirth experiences (see Chapter 5).

In addition, the starting point of this study was that perceptions about maternity care and birthing setting are socially and culturally constructed in every society. Thus, my personal perceptions that I brought into fieldwork was that Lithuanian and Norwegian culture, as well as the very social construction of these societies, were very similar. Therefore, I thought I might not get any interesting research data in regards to birth experiences among Lithuanian women in Norway. This presumption stressed me in the beginning, however, after a few interviews it faded away as more rich data was collected about the Lithuanian women's birth experiences.

#### ***4.8 Ethical considerations***

Even though many research reports do not even mention the presence or solving of ethical problems during the research, carrying out research involving participants implies that their views should be respected and additionally not having to be exposed to the moral position of the researcher. Acknowledging society's cultural, political and economic context notes the integrity of the research; therefore, recognizing and not ignoring the critical points of ethical considerations adds the value on what counts as a good quality research (Patton, 2002). Ethical considerations should exclusively be a part of every research project with regard to possible developments, potential social benefits and risks.

##### ***a. Approval***

This research study was carried out in regards to ethical principles and practical solutions stated in the World Medical Association Declaration of Helsinki (CIOMS, 2002) and the Universal Declaration of the Human Rights (United Nations, 2007). Ethical approval was obtained from



the Norwegian Research Ethics Committee (REK) on June 5<sup>th</sup>, 2012. We received written verification that no formal permission was required since the research project was outside the remit of the Act on Medical and Health Research.

### ***b. Informed consent***

All research participants were given written information about the research project first, and then their agreement to participate was verified. The information letter was translated to Lithuanian language as well as was explained in details during the interviews if there was such necessity. The voluntary participation was underlined throughout the study.

Initially the attempt was made to sign the informed consent by the first participant; however, she felt uncomfortable to sign “any piece of paper” and claimed examples of the history of former Soviet Union where people end up being guilty if uttering anything against the system. Consequently, she preferred to give a verbal consent which was tape recorded. The second participant also expressed a hesitation to sign the informed consent and rather gave me an oral consent. It was foreseen before the fieldwork from cultural experience that signing “piece of paper” could be uncomfortable for a Lithuanian immigrant; however, the attempt to get a written consent still was made. Before the interview the information about the research project and the participants’ role in it as well as the publication of the results and participants’ anonymity were repeatedly stated. In the beginning of the research it was not very clear what type of information would be gathered and if anything unexpected would be collected during the interviews as a nature of qualitative study, so the dialogue with the participants in regards of how the data would be used was essential. Consequently, the informed consent was treated as a process, open for renegotiations throughout the research study (Richards & Schwartz, 2002).

### ***c. Confidentiality and anonymity***

The ethical aspect of confidentiality was emphasized as one of the priorities of the research aims. The site the interviews were conducted assured privacy and safety. In addition, pseudonyms were given to the participants and information gathered via interviews was transcribed by no means capable of identifying research participants. Kvale and Brinkmann (2009) raises a few

very important questions, "How can the identity of the subjects be disguised?" or "Who will have access to the interviews?" (pp.69-72). The researcher's role overall is very important throughout the research process and holding on to Hippocratic principle of respected autonomy is essential.

#### ***c. Data storage and handling***

Taped recordings and personal field notes were securely locked and protected by the password in my personal computer. All information about the participants and tape recordings will be destroyed after the master thesis is completed.

#### ***d. Sensitivity of the topic***

This research was conducted among healthy participants who do not represent a 'risk group'; therefore, not constituting a possibility for any potential harm to the well-being to the participants. The interview was not designed in a sensitive manner; nevertheless, the sensitivity was not ignored, as for some women birthing experience was emotional. Empathy towards the concerns and issues of the participants during antenatal period was facilitated.

Taking into concern sensitive issues underlying potential spontaneous abortion or traumatic birth, therefore, increasing vulnerability of the participant's well-being, the confidentiality is not fully guaranteed by the researcher, for example in the event of extreme circumstances such as a threat to participant's life. In this type of research design the methodology stays dynamic and can be adjusted to thorough considerations to unexpected and expected ethical issues (Brinkmann & Kvale, 2009).

### ***4.9 Strengths and limitations of the research design***

Inability of generalizing the findings to other population groups and lack of statistically extrapolated findings of this research can be seen as one of the limitations of the qualitative research design. The time frame to collect the data was limited and that could have affected the sample as being not heterogeneous with respect to parity, education level and age. Quite a few critics do not accent the recruitment of the sample or small sample as the limitation of the qualitative research design, but rather the original analysis of qualitative data which must be derived from quality (Mitchell, 1983). As Buchanan (1992) argues the research quality "cannot

be determined by the following formulas. Rather its quality lies in the power of its language to display a picture of the world in which we discover something about ourselves” (p.133).

Correspondingly, the phenomenological data analysis approach provides rich and thick descriptions of the meaning and experience of birth phenomenon, where the findings are not imposed by the researcher, but rather allowed freely to emerge constituting strength measure to the study (Malterud, 2011).

The thorough follow-up and second in-depth interview with the participants potentially increased the validity of the study results and helped to establish a more clear view of the psychological and physical state of the woman, as well as provide comparison between the expectations before delivery and after. Additional data was analyzed from the interviews with three midwives in order to view different perspectives and triangulate the collected material.

Because of the voluntarily recruitment from public places and the internet sites, the participants, who responded could have been the ones who experienced some issues with the pregnancy and had drawn conclusions and interpreted the stories their own particular way; therefore, introducing the bias. In narratives people have a tendency to make stories for interpersonal reasons, actively interpret their experiences, and tend to attract others; therefore, bolstering self-worth (Baumeister & Newman, 1994).

All the research participants were from Oslo except one who was from outside Oslo city. Data might lack the insights from the other rural areas or small towns in Norway, where the pregnancy and birth experiences might have been different. Data gathered from the fieldwork could have been affected by the fact that I had biomedical knowledge and experience in maternity care; therefore, the participants sought a few times medical advice and recommendation. On the other hand, my biomedical knowledge and experience in maternity care helped to understand deeper the information provided by the midwives as well as by the research participants. One of the participants was describing the exhaustion symptom and the extensive swelling towards the end of pregnancy, where she was send to the hospital for further evaluation. That participant was not aware the true reasoning until I read in the pregnancy sheet that the doctor was ruling out pulmonary embolism. In this case my own knowledge provided a deeper understanding of the participant’s experience. Empathy towards the concerns and issues of the participants was always facilitated, not necessarily seeing me as the therapist, but consequently holding a

therapeutic value. In addition my personal beliefs and academic knowledge might have also influenced the findings even though awareness of a researcher's own personal bias was foreseen and contemplated through all phases of the research.

Cultural sensitivity played a big role in this particular research study as one of the advantages for the data collection and analysis. Speaking the same language with the participants, being aware of cultural values and manners sustained closeness to the field; therefore, increased internal validity.

#### ***4.10 Dissemination of findings***

After the thesis is completed and submitted, a presentation of the work will be given with public access at the University of Oslo. The thesis will be later available at the University's library. Furthermore, the results and finding will be translated to Lithuanian language, distributed to the participants and presented one of the workshops by Lithuanian women in Oslo.

## 5 FINDINGS

The aim of this qualitative research study has been to explore birth experiences and health behaviors among Lithuanian minority women in Norway. This chapter of the thesis presents the findings and seeks to answer the research objectives outlined in chapter 1. Data was collected by in-depth interviews (one over the pregnancy period and another interview after the delivery). Continuous data analysis was performed which yielded four core themes: (1) *'Early in pregnancy'*, (2) *'Authoritative knowledge'* (3) *'Challenges of birth'*, (4) *'Relationship with clinicians'*.

During prenatal and birth periods immigrant women in a host society can experience vulnerability and powerlessness if their health care needs are not met. The cultural patterning of women's behavior during pregnancy is diverse and justified by cultural norms, expectations and forms of knowledge of a specific culture. Pregnancy in a new country can be stressful not only in terms being misunderstood by health care providers, but also in terms of an unfamiliar and sometimes culturally unacceptable maternal environment and care in a host society. In addition, the prenatal period is relatively long process (forty weeks) and for every woman, regardless of culture, it can be very different in terms of emotional and physical symptoms. Some women experience pregnancies as calm delight; yet, for many women these nine months are tempestuous and filled with anxiety and ambivalence.

### 5.1 *'Early in pregnancy'*

The core theme *'Early in pregnancy'* discusses experiences and perceptions of Lithuanian women towards maternity care in Norway regarding early prenatal period (up to the 13<sup>th</sup> week of gestation). The discussions and interviews with Lithuanian women provide a lens through which cultural challenges and concerns are recognized as major factors of maternity care experiences. Relatedly, this section provides a description of the domain of *'authoritative knowledge'* to which they integrate their decisions and health care behaviors early in their pregnancy. The ability to see the fetus early via ultrasound and have genetic testing to insure that it is a healthy baby was expressed by Lithuanian women in the study and formed part of the formation of and relations to, *'authoritative knowledge'* during prenatal care.

### 5.1.1 'Not pregnant enough'

Apprehending the reality of pregnancy plays an immense role in woman's life in early stages of pregnancy. During the first few interviews I was struck by the women's breadth of reflections upon the wish to receive a medical confirmation on their pregnancy via ultrasound or blood test. The women I talked to in this research study, found out about their pregnancy by means of a simple pregnancy test bought at a pharmacy counter, which measures elevated pregnancy hormone level (HCG) presented in urine (Olds et al., 2004). Nevertheless, they felt that such a test was not sufficient enough in terms of possessing the confirmation of their pregnancy.

The phrase "not pregnant enough", which I named the sub-theme after, was articulated by two of the women, who I interviewed during the first interviews.

*'I was very happy to find out, it wasn't unexpected. I had this feeling I might be pregnant and verified when I bought the pregnancy test from 'Apotek'. Then I tried to make the appointment with 'Jordmor' ('Midwife'), but when I called everything was booked until August as in July was many clinicians were on vacation. When I talked to her on the phone she was very strict and said that it's not needed to see me before the 4<sup>th</sup> month anyway... I was very surprised to hear that woman is considered as "not pregnant enough" until the 12 weeks into her pregnancy. The logic behind this is that women often abort naturally during this period. Even Symfyze fundusmål chart is conducted from the 12<sup>th</sup> week. (As she speaks she points at the green sheet lying at her table that a pregnant woman brings to a midwife or a doctor every visit). This logic made it difficult for me' (Emma).*

The other participant who voiced the phrase "not pregnant enough" was Viva<sup>8</sup>. Viva raised important questions, such as the definite time of considering a fetus as an important part of the society. At the end of the first interview, she passionately discussed philosophical questions such as the specific time when a fetus is considered "being valuable for society".

*'After the operation I got pregnant very fast. It started with very big somnolence, sometimes even insomnia and some other pregnancy symptoms. Anyway, no one from the health care system gave me any attention as in the beginning it is not even considered to be a real pregnancy. That was very difficult and it was the longest period of time I ever had in my life. Even if I felt very bad and I needed information, I had no*

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<sup>8</sup> The meaning of Viva is 'being alive' or more simply 'Live' from Latin language. I gave her this pseudonym, and she agreed with it as we talked, because of her concern of the time when the fetus is considered "being alive" in the society.

*access to that as I was “not pregnant enough”. It was very unpleasant. But I was doing my own research and I got information I needed from elsewhere’ (Viva).*

Being an educated woman, Viva appears to know not only the laws and regulations of midwifery in Norway; she also gets access to financial and marketing information about various medical wards at the hospitals in Norway and is currently involved in academic research in regards to those issues. During our talk she elaborated upon the prioritization of women in acute medical situations and compared it to the philosophical concept of ‘utilitarianism’. According to her point of view, “a woman in an early stage of her pregnancy is least prioritized at the medical encounter as Norwegian clinicians follow ‘utilitarianism’.

*‘I decided I will insist to visit my General Practitioner. The reason I went to my GP at the first time was that I wanted to get confirmation that I am pregnant by making blood and urine test as I couldn’t wait longer. Also to get basic information about health care, for example, how often should I visit my doctor? I was hoping that he would explain all the procedures I could expect. So I went to the doctor when I was 12.5 weeks pregnant and said that I did not feel well, that I had pelvic pain and that I was pregnant. To my surprise, he didn’t examine me, didn’t even touch me and only said that it sounded like I should go to the hospital as soon as possible, basically immediately. I thought that it was too dramatic, but agreed that it was better to go to the hospital and check what was wrong. Rikshospitalet refused to examine me as I was “not pregnant enough”. So I went to the Ullevål hospital where I had to wait for 4 hours. The reason again was being “not pregnant enough”, so other patients were prioritized. I know that they work under the principle of prioritization, which I don’t understand. This was the most dangerous time of pregnancy (12-13 weeks)! After the examination they asked me how I knew that I was pregnant. My husband and I were in shock. I answered that I made many pregnancy tests and I felt pregnancy symptoms. Afterwards, they did ultrasound and only then I could say that I was pregnant. After that I got all maternity leave documents without any problems’ (Viva).*

Implicit in this comment is the fact that Viva wished to be prepared for upcoming possibilities during pregnancy and birth; however, due to being in the early gestational period, she felt she couldn’t get answers to it.

According to Viva she perceived herself to be in “a dangerous time of pregnancy” and felt that she should have a higher priority than others. She pinpointed the period of early pregnancy as a special and critical time; however, was stunned about having to wait for four hours and reasoned it as being “not pregnant enough”. She brought up a passionate discussion and raised a number of questions during the interview: “So, I wonder, when the fetus is considered to be a fetus here? Is it only after 12 weeks? What is so special of the 12<sup>th</sup> week and not the 11<sup>th</sup> or 10<sup>th</sup> week?” She smiled while gently and calmly circling her hands over her small protruded belly and said, “Well, we passed that time, so now we are pregnant for real”.

‘Fetus’ is a well-established concept in today’s science and medical literature. The scientific definition of a fetus is “the embryo developed by the end of the eighth week” (Olds et al., 2004, p.243). However, in medical practice some clinicians identify the fetus about 10 days after actual conception, others consider fetus when the heart beat can be seen or detected via ultrasound, which happens at the sixth week into the pregnancy (Olds et al., 2004). Before the ultrasound scan was available, the fetus was considered a person only at the time when a mother felt the first movements of it (Squire, 2009). Different opinions create different views in every society affecting the cultural perception on the human development. In most parts of the world pregnancy is considered to last 40 weeks and the counting begins from the first day of the last menstrual period of a mother. Consequently, at the time of conception a woman is considered to be already two weeks pregnant. Nevertheless, scientifically proven the first three months 10 to 20 percent of pregnancies end up in spontaneous abortions, and more than 80 percent of these miscarriages occur before 12 weeks of gestation (Olds et al., 2004). Therefore, the highest risk for spontaneous abortion is considered to be during the first three months of pregnancy.

### *5.1.2 Morning sickness*

With growing gestational time, some women experience a number of changes in their body systems. Fluctuation of hormones that produce symptoms such as exhaustion, fluctuating moods, nausea and vomiting lead women to feeling very sick at times. The greatest concern expressed by the participants was not the degree of sickness they felt, but rather a letdown of the system in terms of access to medical advice during that time because of, as they stated, “lost medical records” or “it was too early in the pregnancy”. It seemed like they fell into a pitfall, where they



felt that there was no health care provider who they could talk to during this tough time of their pregnancy.

*'First three months were extremely difficult, because I could not understand what exactly was happening to my body – first symptoms, cicatrix pain and other things. I was so sick with nausea and vomiting, and still there was no doctor I could talk to about it. Finally three months passed and I was considered to be pregnant for real... (Smiles)'* (Viva).

The irony in Viva's statement emphasized her rigorous need to access medical information about her bodily changes and how to manage these changes during the pregnancy process.

The experience of sickness by Emma is slightly different from Viva, but presented in the same note of struggling related to access to health care providers.

*'I was very sick in the first months of pregnancy, I could not get an appointment with my doctor because we moved and they lost my personal records and without them I couldn't see the doctor. It was horrible... I lost 12 kg during these months. Don't want even to remember this time '* (Emma).

The confusion with Emma's lost medical records, because of relocation, made Emma very stressed. She physically went to the physician's office and asked why she couldn't make the appointment. She explained that when she contacted the previous physician's office they said that every single medical record had been sent. However, the records were lost and could not be located. Emma tried to argue with them and gave a few reasons, but then she just lost control and began to cry.

*'I couldn't say a word anymore. I was standing by this high table, saw a woman with a blank face nodding her head. I felt like I was not getting anywhere, this is it. I started crying right in front of her. Couldn't say a word, just crying....'* (Emma).

Emma described this early period of her pregnancy as "being nauseated and sick, as never coming out of this feeling of being dizzy and dull". Emma's burst into tears showed her vulnerability, exhaustion and overwhelming process of early gestation. I argue that during that time she lacked a supportive environment of reassurance and comfort.

Feeling exhausted and drained and combating morning sickness is not unusual and interpreted as a normal reaction to surging and raging pregnancy hormone levels. 'Morning sickness' is a

general term for nausea and vomiting during pregnancy. Usually nausea happens early in the morning, but for some women it can strike any time of the day. There is no right answer in the literature what causes morning sickness; however, medication is almost never prescribed because of potential birth defects (Olds et al., 2004).

I want to emphasize that the women in the study never mentioned anything about medications for nausea or vomiting or the need for it; however, they expressed a strong need to see the clinician and gain knowledge and be assured about natural physiological processes of pregnancy.

### *5.1.3 'Let nature take its course'*

The uncertainty about when clinicians in Norway draw the line between the necessities to implement medical intervention during miscarriage or let nature run its course was expressed by one woman in this research study. I called it sub- theme 'let nature take its course' as it was expressed by one of the physicians providing care for the woman in this study.

A young Lithuanian woman Lilia came to Norway in 2010 with her husband who was working here as a construction worker in one of the Norwegian companies. They had been planning for a baby for some time and were really happy to find out that she was expecting. However, during the 12<sup>th</sup> week of her pregnancy she experienced bleeding and cramps that just intensified with time. Medical care providers that she sought out during that time interpreted it as a spontaneous abortion which happens naturally in the first trimester of pregnancy.

*Researcher: How are you feeling now as being pregnant into the second trimester already?*

Now I feel really good and the little one is growing...We were very happy as I found out I am expecting the little one. It's our first one...We call him Jonukas...(Smile) Yeah, (Sighs). However, in the beginning of pregnancy the nausea and vomiting was horrible, but it went away..... Thank God. Nausea was 24 hours per day, nothing helped. My GP just said that all women experience that and there's no medicine for it. But the nausea is nothing compared to

what I had to go through starting from the 12<sup>th</sup> week.

*Researcher: Could you tell me more about it? What happened 12<sup>th</sup> week?*

I had an intense bleeding in the 12<sup>th</sup> week of the pregnancy. I went to see my General Practitioner and she just said that I shouldn't worry, because I will conceive again soon after this miscarriage. I couldn't believe my own ears...I was shell-shocked. However, she sent me to a midwife in the Fredrikstad hospital to be sure that the heart of fetus is not beating anymore. I went straight there. But that department of the hospital was closed already as it is open only until 3 pm. So I had to go to the emergency department where there were a lot of people. I felt very weak, but I had to wait and after some time they took my blood sample, checked my blood pressure and told me to wait. After about two hours of waiting, a woman came to me. She said that the doctor won't come to see me as he has an operation and it is not clear when he will finish it. I had to go home. *Pause.....Sighs...*

The same night much more intense bleeding started. It can be compared with the strong water stream. My husband brought me to the emergency. I was very surprised by what they told me. They asked me what I want and said, "let nature take its course – it will bleed, you will feel some pain and in some time it will be over" (Pause).... I was speechless after that.

Some days passed and I didn't feel better. I decided to go to Lithuania to get medical help there. I made an appointment with the doctor at a private A. Kildos clinic in Kaunas. When I went there they made all the tests within an hour. I was going to Lithuania with the worse thoughts and was ready for an abortion. I was still bleeding and after all I had no hope that there can be a life inside of me. The doctor made an ultrasound and told me the reason of the bleeding. He said that I cannot be more pregnant than I am now. I could not believe as it sounded like a miracle. I was bleeding because in the beginning I was pregnant with twins and later one died. It was a toxicosis of pregnancy and my body was rejecting them both. However, one was very strong and stayed alive. I could see him with an ultrasound – his legs, hands, beating heart. They showed me everything there! I was in the ninth heaven and called to tell the news to my husband. He did not believe it; we both were in shock and crying on the phone...

*Pause....*

*Researcher: How do you feel now?*

Now I am very scared for my further pregnancy, how it will go, what to expect from them again? So, yesterday I made again an appointment the doctor in Lithuania.

*Researcher: How did your GP (general practitioner) reacted to all the experience that you had to go through?*

My GP in Norway reacted very blankly to all of this. She was just surprised that I was still pregnant and said that doctors in Norway stand for natural selection. So she advised me not to take it very personally. Pause..... I don't know, is it just with me they behave like this or is this how they treat every single woman in Norway ?...

During the interview Lilia was questioning like a heavy stream: questions popped one after another: about the fairness and rights of a woman to know what is happening to her own body. The emotionally difficult time was obvious in her broken thoughts as well as in her body language as she constantly changed the position as she spoke.

This presented example highlights the subject of reproduction as being never simple or predetermined in biomedical manner. An unusual spontaneous abortion could have probably resolved by itself as a natural event; however, in Lilia's case one of the fetuses was still alive. The details of medical explanation and the obstetric practice in this particular case might stand out as selective and out of ordinary example; however, her statement "I don't know, is it just with me they behave like this..." noted devaluation of a young and pregnant woman, who it seemed, had entered a state of doubt in relation to the medical system.

The research done on early miscarriage confirms that even early losses can be very difficult and emotional for a woman. Moreover, "if a pregnancy has reached ten to twelve weeks of gestation,

spontaneous abortion may resemble labour” (Layne in Inhorn, 2007, p.79). One of the proposed models ‘prepared childbirth’ emphasizes the need to apply a feminist principle - “knowledge is power” - and provide early information to women about the possibility of miscarriage in order to address their physical, emotional and spiritual needs (Rothman, 1982, p.78)

As time passed I talked to Lilia via internet, sharing her joy of waiting for the survivor Jonukas; however, in the sixth month of her pregnancy she experienced a second spontaneous abortion, which left her devastated. She called me in the evening to inform about the flight the day after to Lithuania to see the gynecologist there. She told me that she felt medically insecure here because of the previous experience. Lilia appeared on the phone not very talkative. I tried to calm her and comfort her as I could hear her voice was shaking; however, she was falling back to tears. A month later, I invited her for the second interview, however; she refused politely as she was no longer pregnant and did not feel like she had anything more to say. Still, she wanted her story to be part of this research project and confirmed it on the phone.

Feministic analyst Rothman (1982) raised central questions in terms of women’s challenges as she goes through a process of pregnancy as well as prepares for labour. In addition, she argues that women should be prepared for pregnancy loss as well. She criticizes the fact that preparation for fetal loss as part of a ‘prepared childbirth’ has not come far in maternity care (Rothman, 1982).

#### *5.1.4 Travelling abroad*

As in the above presented example, where Lilia travelled to Lithuania to check the reason why she was bleeding so much, other women in the study travelled abroad as well. As most of the participants perceived pregnancy as a natural state in women’s life cycle, most of them at the same time considered the process as being “dangerous”. A special need to seek medical attention during this particular period was articulated by all the participants in the research study. For some women, who struggled to have their pregnancy confirmed by a general practitioner or midwife in Norway, it seemed like they had to rush to outsource health care assets available in Lithuania or other countries. For others, it was perceived as a fortune to reside at the time of early pregnancy in Lithuania, where they could do extra medical tests.

Even though the first interview was conducted already in the second or third trimester of the pregnancy, women still expressed quite emotional reactions in regards to the possibility to check the fetus before it is done routinely in Norway.

Two of the participants travelled abroad to get the first ultrasound done. The following example is a woman who struggled to conceive for 6 years. Vera is originally from Lithuania, but her mother is Latvian as well as her husband whom she has been married to for 10 years. She told me how strongly they had wished for a child and were even contemplating the thought of adoption because of unsuccessful series of conceptions. Ongoing breakthroughs in reproductive medicine gave a lot of hope for the couple, but to their own surprise she unexpectedly was able to conceive. At that time Vera and her husband were residing in Norway, where her husband had a good management position at a well-known company and she actively learned Norwegian. After finding out she was pregnant she travelled to Latvia, where she received pregnancy confirmation and medical treatment at the hospital.

*'When I came to Norway I found out that a woman cannot be registered as pregnant before the 12<sup>th</sup> week. I read it on the Internet also. I also read that there is only a possibility to visit a doctor at a private clinic and start going for the appointments there until the 12<sup>th</sup> week of pregnancy. Basic approach in Norway is that anything that happens before the 12<sup>th</sup> week is normal, a cause of nature. But...No one actually said it to me, I just read it. Therefore, I decided to go to Latvia to visit my doctor for the first time during my pregnancy. I trust him; he is a very good specialist. That happened in my 8<sup>th</sup> week of pregnancy. He examined me thoroughly (hormone level, blood and other things) and said that in general my health is good. The only thing was that my muscles were too tight that could lead to some problems such as spontaneous abortion. So my doctor sent me to the hospital where I spent two weeks (8<sup>th</sup> and 9<sup>th</sup> weeks) and had to have infusion of magnesium and take other medicines. I was not obligated to do that, however, we have waited for the child such a long time that I could do anything to keep it' (Vera).*

As Vera spoke, she appeared anxious and very concentrated upon her pregnancy. From now on, here in Norway, she went routinely to health checks with a private gynecologist once a month and saw a midwife every third week as they made such an agreement with her. Vera articulated

being explicitly lucky that she was able to be seen by Latvian gynecologist and get medical treatment there.

*'Here I found a private gynecologist. She has a Russian background, but had been living in Norway for 20 years. I think she is a very good specialist and psychologist which I think is very important. Of course, it cost money – 600 NOK per visit. But again – a woman has to decide if she needs that or not. She told me that the first three months nothing is done here in Norway. So if I would feel that I need to get medicine or treatment during the first three months of the pregnancy, I would have to go to the doctor and insist to give me the prescription for Ultragist (the name of medication), but obviously I have to have knowledge of that myself' (Vera).*

I found a spectrum of arguments in the research about advanced technology and extra screenings and medical tests in an early stage of pregnancy; however, from women's point of view, they want assurances even though the development and growth of the baby is normal, "most women accede to a medical evaluation of their condition regardless of how well informed they believe they are" (Lazarus cited in Davis-Floyd & Sargent, 1997, p.135).

The significance of establishing the reality of true pregnancy was articulated in the interview with the participant Viola. She expressed being fortunate, just like Vera, visiting Lithuania early in her pregnancy.

*"I found out that I was pregnant. As it was not my first pregnancy, I knew that when you got to see a doctor for the first time, they check if a woman is really pregnant. I was very lucky as at the time of my first visit to a doctor I was in Lithuania. He said that in general everything was alright, but there was a risk of miscarriage. When I came to Norway I went to see my doctor. I told him I was pregnant and I didn't get any reaction. I asked if they were not going to check. He said that if the test showed that, it means that I am pregnant and I have to wait until the 18<sup>th</sup> week for the first ultrasound. I told them that I had to have extra care, as there was a risk of miscarriage as the doctor in Lithuania had told me. In that case they referred me to a gynecologist. The gynecologist examined me and said that everything was alright. It was around 6<sup>th</sup>-8<sup>th</sup> weeks. And I had to wait until general examination in the 18<sup>th</sup> week' (Viola).*

### 5.1.5 A pleasure to see the image of fetus

The importance of examining the woman's and the baby's health status is a vital component to a happy well-being state of Lithuanian pregnant woman as it was articulated in all the interviews with the participants. In addition, an extensive spectrum of positive emotions emerged from all the participants I talked to as the clinicians confirmed their pregnancies via ultrasound in the early stage of their pregnancy. All the women uniformly articulated happiness and delight to be able to see the fetal image and to hear from clinician the verification of a true and positive pregnancy. The growing awareness of the baby and establishing its reality were positively valued by all the participants. For instance, Rose who appeared not very talkative and emotionally calm during the interviews couldn't hold the joy and bursts with pleased emotions as she articulated seeing the fetus image.

*“Well the first ultrasound I actually went privately to a Russian doctor that my boss had suggested. I called even the private Norwegian jordmor, but she said that she doesn't take pregnant women until they are in the 4<sup>th</sup> month of the pregnancy, so it was good that my boss knew who to contact. Really, I just wanted to know that everything was fine and if I was really pregnant, it's hard to accept it just from the pregnancy test. So, the private gynecologist did the ultrasound, confirmed that I was pregnant and said that everything was good. I was so happy really to see it ' ( Rose).*

Rose is quite new in the country (only one and a half years) and followed the advice of her Lithuanian boss who recommended her to go privately and check. According to her explanation, her boss is knowledgeable “in these women's things” because he has his own cleaning company, where only women work. Rose, unlike the other participants, doesn't question why specifically the midwife didn't want to see her until later in pregnancy. After the confirmation of her pregnancy via ultrasound, she calmed down and bought a little turtle for their home, and as she stated, she “has to take care of somebody while waiting for the baby to come” since her husband worked long hours.

The above example of finding out if the fetus was real and buying the turtle as an expression of happiness reflected the importance of an early ultrasound in Rose's life as a sensation of closeness to a baby. Much has been written and studied about the association between maternal and fetal attachment behavior prior, during and after birth. Reviewed literature adds weight to the



evidence of a mother's positive feelings and shows improved maternal-fetal bonding because of performed scans early in pregnancy (Lumley, 1990). Remarkably, according to the same study ultrasounds performed after a baby's detected movements (quickening) are not associated with mother-baby's attachment. Conversely, Brigitte Jordan (1978) discusses how ultrasound as electronic equipment displaying 'authoritative knowledge' and expressing power in the hierarchical engaged interactions between the medical doctor and women. Anthropologist Georges (1996) in addition studied Greek women's subjective experiences with ultrasonography and pointed out Greek women's sensual perceptions towards presenting the fetus as "real" as well as confirming the "reality" of pregnancies. Similarly, in another study, Australian women, were happy to see the early image of the fetus as a reassurance of the pregnancy, powerfully sensing the fetus in a body (Harris et al., 2004). This scientific and visual imaging of the reality of pregnancy relieves women's concerns and anxiety, giving them a confident path to go in order to adjust the body for further demands in their pregnancy.

#### *5.1.6 Facing prenatal genetic testing law and regulations*

Different patterns of biomedical management and control are practiced in every society. Reproductive rules and regulations vary from country to country. Today, availability of highly effective technology has brought many medical and ethical debates in the arena of reproductive health. Various fetal screening tests early in pregnancy, such as the maternal serum alpha-fetoprotein (MSAFP)<sup>9</sup> screening test, is not legal in Norway until a woman is 38 years old or unless there are preexisting conditions which put a woman within a high-risk category (Brunstad & Tegnander, 2010). Under special circumstances, a woman can apply to an ethical maternal committee, which will decide if a woman is eligible to carry out the specific test (Retningslinjer for svangerskapsomsorgen, 2005). Today there are many debates in the media and discussion over "villscreening" ("case-finding" or "disease-hunting"). "Villscreening" carries the meaning of a high number of expectant couples going to another country for various medical testing because it is not legal or not offered in Norway (Gulbrandsen, 2001).

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<sup>9</sup> MSAFP-- is a component of the screening test to screen pregnancies for Neural tube defects, Down syndrome and trisomy 18 (Olds et al., 546)

The sub-theme of genetic testing and concerns associated with fetal health and abnormalities emerged after the first few interviews with the women in the study. Vera was very concerned over the differences of biomedical approaches during the first trimester of pregnant women in Latvia and Norway. She talked about it also with the private gynecologist here in Norway.

*'The private gynecologist (that came from Russia around 20 years ago) works in Norway, so she has to apply Norwegian methods. However, she herself had suggested to the medical authorities and had written a few articles how to do things differently. For example, fight for the baby before the 12<sup>th</sup> week. But she understood that it is too difficult because it is just a different mindset' (Vera).*

Vera was searching for all possible resources and ways how she could do genetic testing here in Norway, because she was already in the 10<sup>th</sup> week of her pregnancy as she came to Norway. She visited a private clinic at Majorstua, where they agreed to do the ultrasound; however, stated that genetic blood testing was illegal to do in any health care sector in Norway. During the interview she described passionately her subjective opinion in regards to this matter.

*'When I visited my doctor in Latvia (at the 8<sup>th</sup> and 9<sup>th</sup> weeks of pregnancy), I couldn't make a genetic test as it was too early. In Norway my doctor said that it is not practiced at all. They only check blood group, hemoglobin and infections. So after all discussions I understood that in Norway a woman has to give birth even if something is wrong with a child. In Latvia and I think in Lithuania the approach is absolutely different. If something is wrong – recommendation is not to give birth' (Vera).*

In contrast to Vera, the participant Viva appeared quite calm talking about genetic testing, however, she mentioned that there was no discussion about it with: neither her midwife, nor her general practitioner.

*'No one advised me to do genetic fetus tests. I don't think I should be concerned about that because I don't drink alcohol, I don't smoke, I do exercise, I eat healthy food. The same applies to my husband. We are young; our families have no genetic problems. If something will happen, then it will happen. And these tests only bring stress for the period you have to wait for the result. But I completely understand that other people can think differently and might want to have these tests done, and women should definitely have a choice over their own body' (Viva).*

As I talked to participant Emma she just was surprised in general that prenatal genetic testing, as she stated, was not even a choice for a woman in Norway.

*'I just can't believe that a woman cannot even to find out what kind of child she has in a country such as Norway. So I don't even have a right to know, it seems like. In Lithuania just pay the fee and you get what you want'* (Emma).

Emma was frightened by the thought of carrying a baby with Down's syndrome. She made an appointment with her family doctor and asked "to check the fetal water", which medically is defined as 'amniocentesis'<sup>10</sup>. To her surprise, the doctor was very calm and after listening suggested her to go to Denmark if she wanted this type of test because in Norway she was not qualified to get it. As her Norwegian language skills were good, she signed herself in at the anonymous Norwegian pregnant women forum "Kvinneguiden", where she received additional information in regards the genetic testing in Denmark and Sweden. However, after the ultrasound at 20<sup>th</sup> week she calmed down because "everything looked alright".

This was one of the topics I as a researcher tried to avoid, simply because of any possibility to include researcher's bias. In addition, there are so many pros and cons about the sophisticated screening and scanning for the fetuses' abnormalities and so defined 'therapeutic abortions.' These hot topics can be traced back to Aristotle and Plato's historical times, however, today the changing social view of defining 'normality' and 'abnormality' play a crucial role in reproductive politics. Markedly, sociocultural perceptions and views shape women's choice and understandings about the early diagnostic tests performed during the pregnancy.

Gjertsen (2005) summarizes in details the rules and regulations about genetic testing and how it can be difficult to face potential chance of fetus abnormality. In addition, she underlines that Norway has very strict regulations for pregnant women in comparison to other countries, including Denmark and Sweden. Concepts such as 'utsortering' ('rejection') and 'sorteringssamfunn' ('selection in society') are used only in Norwegian culture, making it possible to have not only a homogeneous healthy society, but welcome all kinds of physical and

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<sup>10</sup> Amniocentesis--is a procedure used for genetic diagnosis which is performed between 15 and 20 weeks' gestation. A sterile needle is inserted into the uterine cavity through maternal abdomen so small amount of amniotic fluid can be removed, and genetic testing is performed (Olds et al., p.547)

mental disabilities. The threat of disappearing people with Down's syndrome in Scandinavian countries is highlighted in media as well (Solberg, 2008). However, in the literature review the prenatal diagnosis for women means not only the choice of the decision of abortion if the child is abnormal, but also the request to be informed about it and be prepared for it physically and psychologically. In a research study exploring couples' decision making and choices of prenatal genetic testing, one couple admitted that "This has nothing to do with abortion. It's only for knowing" (Browner as cited in Inhorn, 2007, p.158).

Gupta (2000) highlights various definitions of autonomy and reproductive freedom of women. He argues that women's reproductive autonomy is confined to national and international laws and regulations, new biotechnological developments and access to health resources which further restrict the entitlement of simple joy of reproductive freedom as an important constituent of human well-being.

Barbara Rothman (1984) argues that technology opens some reproductive choices for women, but closes others, particularly a natural childbirth (Rothman, 1984 in Davis-Floyd & Sargent, 1997, p.135). It is interesting to note the Dutch obstetrical system which strongly resisted affecting the autonomy of midwives in the rise of modern technology and science (Davis-Floyd et al., 2009). Home birth is available for Dutch women under the law and is usually described as *gezellig*<sup>11</sup> by Dutch women. Moreover, all the midwives, general practitioners and gynaecologists in Netherlands "have a duty to inform pregnant women above the age of 36 about the possibility of availing themselves of PND; failure to do so may result in sanctions by the medical disciplinary committee" (Gupta, 2000, p. 497). The idea that women are intended to think about possibilities that their children might have in the future is argued by Gupta (2000).

Detailed information regarding prenatal genetic testing in Lithuania was hard to locate in the reviewed literature; however, all women after age 35 are recommended for genetic consultation which they can refuse (LRSAM, 1999). In one of Lithuanian article, a mother, who had a child with Down's syndrome, was interviewed. During the interview the first question which was

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<sup>11</sup> *Gezellig* in Dutch means 'cozy', 'warmth' and 'enjoyment'. However, in the topic of birth, it means "birth at home is gezellig in a way birth in the hospital never can be" (Davis-Floyd, 2009, p.45)

posed to the mother was if she had done the prenatal testing. It seemed like that during the interview she was more or less forced to defend herself for having not chosen prenatal genetic testing to detect the baby's Down syndrome (Valeikaitė, 2013)<sup>12</sup>. I argue further that women's perceptions about genetic prenatal testing are strongly influenced by the historical and cultural transformations and views on disabilities in the society. Historically, it has been only twenty three years since Lithuania separated from Soviet Union (USSR), where disabilities were not publically seen and strongly discriminated (McCagg & Siegelbaum, 1989). Dramatic political disruption after the collapse of the Soviet Union brought many socio-cultural changes in Lithuania. Tolerance and empathy to human diversity as well, presence to disability were commenced and continue strongly be accentuated in today's media. Nevertheless, the strong adversary against disability in Lithuania thus far has traces in the cultural landscape representing stigma and intolerance to being different (Valeikaitė, 2013; Survilaite, 2012).

## **5.2 'Authoritative knowledge'**

In the core theme '*Authoritative knowledge*' I discuss different forms of knowledge which play an influential role in the selected behavior and thinking during prenatal and birth period of the participants. Attention was paid specifically to the sources of socially constructed knowledge, which shaped and formed many of these women's self-care and attitudes towards rules and regulations of Norwegian midwifery; therefore, clarifying and illuminating the specific objectives of this research study.

The core theme '*Authoritative knowledge*' is picked up not only in this particular section, but rather follows from the beginning to the end of this research study. The concept 'authoritative knowledge' elaborated by Brigitte Jordan (1978) studying the phenomenon of birth is described as the knowledge which is achieved systematically and collaboratively by the participants during a given social situation or process such as prenatal period. The procedures and protocols used by midwives and obstetricians during childbirth encounter or antenatal care are claimed to be 'authoritative knowledge'. Jordan (1978) emphasizes that 'authoritative knowledge' is already embedded in the cultural authority of midwifery even prior the specific medical event. In

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<sup>12</sup> Valeikaite, 2013, '*Dauno sindromas nėra kliūtis gyventi kaip visiems*' ('Down syndrome is not an obstacle to live just like others')

addition a number of knowledge forms coexist; however, some are more influential than others; therefore, the knowledge which pregnant women incorporate and follow the recommendations to, is said to be 'authoritative knowledge'. This type of knowledge holds the superiority and shapes women's subjective voices in regards to which recommendations to follow throughout the course of pregnancy (Jordan in Davis-Floyd & Sargent, 1997, p.58).

### 5.2.1 'Oslo Mamytes'

I came across a very socially active group by Lithuanian mothers in Oslo, called 'Oslo Mamytes'. Initially as I heard about it from the participant Emma, I didn't pay much attention; however, later in the study I saw the significance of it as an informal communication channel, which played a role of constructing biomedical and social, as well as, cultural authoritative knowledge of the Lithuanian women in Norway. It can be argued that the central feature of active communication in 'Oslo Mamytes' is openness and sharing of the knowledge in women-to-women interactions. In Lithuanian culture it is very appropriate to talk about pregnancy's ups and downs and not idealizing conditions which women have to go through their pregnancies and births. It is quite popular to tell a woman "what it is like to be pregnant" and give any possible advice how to avoid or treat a special condition. This type of knowledge sharing and transmission among Lithuanian women in Oslo illuminate the nature and extent of the role authoritative biomedical knowledge play in shaping the women's notions of birth in a new country.

Different communication patterns take place between the members of 'Oslo Mamytes'. Hot discussions over the internet, local meetings with or without children, and seminars held by Lithuanian psychologists attract over two hundred Lithuanian mothers in Oslo. One can be surprised just by reading the forums how much important and necessary information is shared. In addition, if there is a need for special medications such as antibiotics or cough medicine, Lithuanian women do not hesitate to seek for advice or simply ask to share, which others do not hesitate to do.

All the participants except Lilia were members of ‘Oslo Mamytes’; however, just one of the participants was actively discussing various themes on the internet. Emma appeared to be a very active group member of ‘Oslo Mamytes’, who invited me to join the group, because, as she stated, “I fitted the criteria of acceptance into the group: being Lithuanian and a mother”. During the first interview Emma was 35 weeks into her pregnancy and she spoke about the importance of all possible prenatal testing.

*“The last time when I visited my doctor I asked him about Streptococcol test, but he said that they don’t do it here in Norway. It’s not necessary he said. I was shocked, as I know from my girlfriend in Lithuania that they check every single woman for that, because if you miss that, the baby can die from the infection. When I posted that at ‘Oslo Mamytes’, many said the same thing, and told me to go to Volvat, where I went and got the test done. I am so happy that so much information is available, because these things they don’t tell you’ (Emma).*

Implicit in this statement is also the fact that she compared the information received from other sources and constructed her own domain of knowledge to which she decided on her behavior and actions.

Most of the participants in the study voiced skepticism about lack of prenatal testing in Norway. As Viva described, “Every time I have to demand to make blood test for me, no one is willing to do that. And every time discussion with my doctor takes around 5 minutes.” Similarly, Rose was concentrated on the same Streptococcol test that she found about it from ‘Oslo Mamytes’. She, as Viva, asked the doctor to do this kind of testing, but received a negative answer. In one of the forums about prenatal testing in ‘Oslo Mamytes’ she wrote, “I also asked about the Strep test, but my doctor said that they do not do it in Norway, not necessary, but from others heard that it is possible if you insist to do this testing and don’t leave the room without it”.

Women in the study appear to be doubtful if they received the necessary information, especially about the prenatal testing, from Norwegian health care providers. In addition, by comparing and at the same time constructing a domain of authoritative knowledge, they chose what kind of biomedical advice to follow and how to behave in particular situation. The participants indicated that they were hesitant to accept physician’s or midwives medical advice as authoritative, because of a tendency to feel that it was not done enough during prenatal period as far as to

achieve a healthy fetus. It is important to emphasize here that authoritative knowledge holds the power not because it is correct, but rather because it counts (Jordan in Davis-Floyd & Sargent, 1997, p.58).

### 5.2.2 Constructing authoritative knowledge

As most of the women travelled abroad to receive other medical treatment or get prenatal genetic testing, they came back to Norway and shared information with others. In the following case the knowledge was not only shared but also manipulated.

*'They gave me even some form to fill out, asking if I had been outside of Norway in another country and visited health care clinic there. I was not sure what they asked me about, but I said that I had not, although I had been. I had to lie because I wanted to know that everything is okay'* (Emma).

This example signifies and amplifies public health safety issues. Emma consciously lied about visiting Lithuania, where she took some prenatal testing. When I asked Emma if she knew, why exactly they asked about visiting other countries than Norway during pregnancy, she honestly replied 'no', therefore, demonstrating lack of communication between two parties.

*'But I know from 'Oslo Mamytes' as one woman checked the box and said that she was in Lithuania before this first ultrasound in Oslo. So they never did the ultrasound that day and they sent her out without it. She had to see the 'fastlege' ('family doctor') first, so her ultrasound was much delayed. I just didn't want that it to happen to me too. I think they ask for some sort of infection or something. I am not sure why...They never said anything, just gave me the form'* (Emma).

It's fair to conclude that through Lithuanian women's network site 'Oslo Mamytes', the knowledge is built, transmitted, elaborated and manipulated if needed. This example further illuminates Emma's personal evaluation of knowledge from all available sources. Subsequently, she made a self-care decision which she acted upon in this particular situation. I want to emphasize that this type of evaluation and shaping of knowledge is not an isolated event, but rather an ongoing process.



A strong will of the participants to seek for biomedical knowledge has served the focus of research data analysis. As some of the participants were struggling with finding out the true values of hemoglobin or the normal result of urine test were, all of them were seeking either biomedical advice or help outside the public Norwegian health care system. As the participant Emma received the letter notifying that her hemoglobin was on the low side and she should get iron pills from the pharmacy, she hesitated and called her mother in Lithuania.

*'I also called my mom in Lithuania; she consulted with our doctor there. It was good, she said what kind of food to eat, and that I should take bivalent iron as there is a risk to have anemia. I wish the doctor here had told me that if my hemoglobin drops below 100, then I need to drink the iron tablets and before that just eat more broccoli, grapes, beef tongue and etc.'*

( Emma)

The two other participants presented below described about bringing medications or prenatal vitamins to Norway because of two reasons: Firstly, the brand they were looking could not be found in Norway. Secondly, they were not sure what the name for folic acid was in the Norwegian language.

*'I bring iron pills from Lithuania, because in Norway pharmacy stores don't even know that this type of iron exists' (Viva).*

*'I also went to Lithuania in the second month of my pregnancy and bought the vitamins and folic acid, because I don't know what the name for it is here. My mom also said that I need to drink calcium as the baby takes everything from me' (Rose).*

Satisfaction was expressed by most of the participants who received additional biomedical advice or help from other health care sources in Norway.

*'I am glad that I have Lithuanian jordmor ('Lithuanian midwife') here in Oslo. She consults me a lot and helps me too. She even came to my house and showed me the birthing poses and provided a lot of information including breathing techniques during birth. It helped me to relax a little. I am very thankful to her, really' ( Emma).*

Birth in every society is defined by culture. For a woman who receives maternity care and gives birth in a new country authoritative knowledge provided by midwives, obstetricians or other medical personnel can play a little role in comparison with cultural underpinnings of beliefs and

practices. This type of knowledge is usually brought by cultural upbringing and at the same time developed different modes of knowledge shaped by problem driven situations, for example, a pregnancy in a new country. Ethnic minority groups usually share the knowledge as a social artifact and reach the path to overcome so called “shared” problems in a new country. Every immigrant woman carries a reproductive history which is shared through the process of communication and socialization.

### 5.2.3 *Struggling with the meaning of ‘normality’*

The resonant theme of ‘*normality*’ or even more the question ‘*What is normal*’ appeared in a few interviews with the participants. After the first question during the interview, one of the participants began the open dialogue about norms and normality.

*‘When it comes to Norway, I am mostly shocked with hearing “everything is normal” almost the time. For example, results of my urine tests differ all the time, but when I ask the doctor why it is so, I only hear, (“Helt normalt”) (“It is normal”). After such an answer I start to worry even more’ ( Emma).*

The same participant expressed even more anxiety as she talked about the hesitation in regards to normal hemoglobin values.

*‘My hemoglobin was low, but they even didn’t say what the hemoglobin value should be. Just said that “It’s a little low, but don’t worry all pregnant women have lower hemoglobin”. But then I was really surprised to get prescription for iron pills in post after hearing that low hemoglobin was normal. I think it would be unusual in Lithuania to get a prescription by mail, really strange’ ( Emma).*

The concerns regarding small weight as well as hemoglobin values were expressed by participant Viva, however, her extended knowledge about general health kept negative emotions away.

*‘In general regarding my health I was only surprised by my small weight, small belly and low level of hemoglobin (92, when it should to be 120). All doctors say that everything is all right and explicitly stated that I should take iron pills, that is little strange to me. I understand that many women are irritated by that, but I try to be positive, because I know exactly what I have to do and practically don’t pay attention to what medical personnel tell me.*

*I raise my hemoglobin myself by drinking iron pills (Tardyferon) that are best digestible with Vitamin C' (Viva).*

By these examples women showed a simple rule that if it was considered normal in the host society, the normal values and definition of 'normality' might be different in their home land. Participant Emma noticed that once the doctor repeated to her "Helt normalt" ("It is normal") or "It's a little low" without explaining, she started worrying even more; consequently increasing a sense of doubtfulness, where she started questioning the safety of the care being provided.

The concept 'normality' or expression that 'everything is normal' cannot carry the same meaning in Lithuanian and Norwegian languages. As the example 'normal' values without an accurate interpretation and not providing a reference range in Lithuanian language might lead to misunderstanding. If someone is stating that hemoglobin value is normal, he must give a reference range and explain where it falls in that range. Furthermore, in Lithuanian language the medical results are described as "being good" rather said "being normal".

Reviewing the literature in regards to comparing cross-cultural understanding of 'normality' and 'abnormality' concepts in relation to health and illness pose quite a few methodological issues, because of the linguistic expressions in the questions in different cultural environments. As an example, the Russian term 'normal' does not translate in English as a term denoting 'normal' (Wanner, 1998). Being very well familiar myself with the language and the culture I very much agree with Wanner that in post-Soviet societies emphasizing the term 'normal' is just very near to meaning 'not normal'.

The above presented examples describing 'normality' illuminate the clash between two different biomedical domains built in relation to social and cultural construction. Marked variation in cross-cultural perceptions of 'normality' and 'abnormality' has a direct negative impact on the birth experiences of Lithuanian women in Norway; further increasing lack of trust in Norwegian health clinicians. This research finding demonstrate further that the Lithuanian women did not consider prenatal care guidelines to be authoritative, because they were issued by Norwegian health care providers in ways that may not be fitting to their sociocultural frames of reference.

### ***5.3 'Challenges of birth'***

The fundamental theme '*Challenges of birth*' discusses and explores experiences and perceptions of Lithuanian women towards childbirth in Norway. The discussions and interviews of Lithuanian women emphasize emotional as well as bodily experiences through a challenging time, birth. This section of the research report reflects on the power of various forms of authoritative knowledge including women's intuition and husband's influential role in decision making process which further reflected through experiences of the women in the study.

#### *5.3.1 Reliance on Intuition*

When exploring Lithuanian women's experiences of birth, a core theme related to the nature of intuition emerged and implicated the authority to the reassurance of midwife's advices during the period of labour.

There are many different meanings of 'intuition' which has been reported in the literature, and as Epstein (2008) claims "it makes one wonder whether the term has any meaning at all" (p.23). Martin (1989) points out that since the times of Descartes, when the philosophical concept of conscious deductive reasoning was introduced, the logical explanation of cultural bodily experiences gained prominence. The devaluation of the nature of intuition in the West can be explained by necessity "to ratiocinate" or in other words "to reason and logically argument" which are central values today in western society (Laughlin cited in Davis-Floyd & Sargent, 1997, p.318).

In this research project two of the interviewed women took self-action and persisted to resist the advices of midwives, because of their inner sight opposing the standard advice from health care providers. Emma was already in the 40<sup>th</sup> week of her pregnancy when her water broke at two o'clock in the morning. Having good Norwegian language skills she called the hospital with confidence. The midwife on the phone instructed her to wait until her contractions became consistent and regular, at least five minutes apart. Emma patiently waited; however, she remembered the time as being "painful and was taking forever".

*'I waited for two hours. It was not easy, painful like a stone constantly pressing me from inside. I didn't know how to deal with this type of pain. I tried to breathe as I read in books. I leaned on all the walls in my apartment. Then, after two hours I couldn't wait longer. I calculated and the contractions were three minutes apart, so I called back the hospital. It was the same midwife, who answered again and she was mad that I called. I knew that from her strict voice. She said that I will not give birth until the next evening, because it is my first baby. Then she told me not to call until 8 o'clock in the morning. She also said that she had made the appointment with the doctor at 10 o'clock. I hang up, couldn't listen to her anymore because the pain was horrible. I was mad at that midwife. I didn't 'buy' what she said. It felt just not right for whatever reason' (Emma).*

With the latter described situation, Emma was certain that something was wrong; however, she couldn't name it, neither describe it. The feeling of uncertainty and doubt was raising psychological and physical pressure for Emma. In "horrible pain", as she stated, she waited until 8 o'clock in the morning, but couldn't wait any longer.

*'I called at 8 o'clock exactly. I don't remember how the conversation started and what I said exactly, but at that time I felt even that I had to push. I felt like the baby is coming soon. I just had this feeling... I felt that something was wrong. I felt I had to go to the hospital. I was in pain and scared. It was a different midwife on the phone, and she was very calm, was asking me questions if my contractions were regular. I didn't want to listen anymore to any of those questions because she never heard what I was telling her. I felt if I don't go to the hospital immediately, I would die. So I busted into tears and cried, "You have to tell me now that you will be responsible for me and my baby's death if I don't come to the hospital now..." Then I remember it was quite, and she finally said "come to the hospital". I called the taxi and we went. When we got there, they saw that my labour was not in the beginning and they found the room quickly and I delivered within ten minutes from the time I got there. No epidural, nothing...just like that...' (Emma).*

An obvious objection to the midwife's instructions illuminated the mother's intuitive knowledge as authoritative at the time when the midwife tried questioning Emma. Mother's intuitive knowledge and midwife's authority clashed and out of control Emma screamed at the midwife, because she felt that her baby was coming soon. Emma specifically didn't verbalize the word

“intuition”; however, she named it again and again as being “that feeling” or “I felt that something was wrong”.

Intuition is a feeling of risk, which further underlines “powerful means of communication, not only between individuals (e.g., via facial expressions) but also within the organism” (Betsch cited in Plessner et al., 2008, p.3). An obvious objection and resistance to listen to the midwife was Emma’s feeling of risk, that something was wrong or something bad will happen. She involuntarily burst into tears and voiced the fear of death, which further implied almost a hysterical psychological condition. I argue that such psychological and physical pressure of labour that Emma experienced was so intense that logical sequential reasoning and justification of the specific decision was not an option at that time.

The decision to “follow the gut” and be persistent on her intuitive judgments was experienced by another participant with pseudonym Viva. Even before starting the first interview, I remember her asking me if her belly was too little; however, taking into consideration her lean and fit body type, her belly looked appropriate for that time of gestation. Nevertheless, the thought of “her small belly” never left Viva alone.

*‘In my last interview I mentioned that I worried about my low weight and little tummy. I explicitly noted it every time I was meeting my midwife. However, she thought everything was alright and I couldn’t convince her to send me to make more thorough examinations. I was expecting an ultrasound. When maternity leave was getting closer, I was worried that no one would see my pregnancy when I was wearing a sweater. Fetus’ movements were slowing down. But I was told that if there is no significant difference, everything was alright. I was very sad and asked her if she could please make an appointment to check it further. So she called the hospital to ask whether they could receive me. She told them that I was very worried and in order not to affect the fetus, I could come in two weeks. After two weeks it had to be 37 weeks and 3 days of my pregnancy. When I came to the hospital after two weeks, they made an ultrasound. After it was done, the doctor (without commenting anything to me) invited two other doctors. They were talking in Norwegian with each other, and as I understood from what they were talking, there was not enough water for the baby. They said that she was small as well. I noticed that they were worried. The small size and little amount of water were so significant that she didn’t believe herself*

*and she asked her colleagues to double check it. When the colleagues got the same result, they called the head of the department. After it was checked three times, they asked me if I had a toothbrush. The plan was to induce the birth straight away. I didn't want to be induced right away. And we agreed that I'll come to the hospital the next morning, with all my things and my husband. Their plan was to induce me then. I was in shock as it was completely unexpected. The only thing which worried me was the size of my belly, but I was right the baby was small as well' (Viva).*

The above example of Viva's birth experience was not as dramatic as it was for Emma; however, the intuitive inside feeling lead her to be persistent to request addition examination for her fetus. At Viva's disposition for resolving her worry of her "small belly", she voiced a number of intuitive inferences to her midwife. The feeling of risk for her baby was almost as a driving force to lean on her intuition.

The insight feeling as described by both participants can be defined as 'instinctive knowledge', which further can be attributed to the fact that intuition played a central and authoritative role in the above presented experiences. And yet, this type of authoritative knowledge as property of intuition stands only as incomplete knowledge because of the complicated and stressful situation. Bastick (1982) points out that under the circumstances of facing a problem with not enough information and time, intuition "is most effective which highlights our incomplete knowledge" (p.347). What I would like to point out is that Viva had a lot of time to think about her "small belly"; however, the appointment time with midwife was limited and she had to be persistent to convince the midwife for one more ultrasound examination.

Many researchers underline a need for inquiry into intuition; however, due to controversy of the concept of 'intuition' between various groups of psychologists the research into intuition is scarce. Nevertheless, there are some ways intuition or insight pervades human's life. Bastick (1982) brings the discussion about so called 'woman's intuition' which can "judge a situation in which the evidence is insufficient or too complicated for a man to reason" (p.3).

In *Women's Intuition* (Davis, 1989) points out that those women's intuitive connections can be associated with the part of the brain, called corpus callosum, which appears to be larger than in men. In a research that studied American midwives and the role of intuition at birth, Davis-Floyd

& Davis (1997) concluded that intuition was just as an important part of the process of birth as technical diagnostic skills. In contrast to Bastick (1982) who emphasized the possibility of intuition to be incorrect, the midwives in Davis-Floyd & Davis (1997) research agreed that intuition must be right. In that case if intuition was wrong, it was the logical reasoning or simply rational mind that played a significant role in decision-making.

### 5.3.2 Husband's role

A few Lithuanian women in the study expressed appreciation and positive feelings towards their husbands' involvement in the decision-making process before and during labour.

*“When my due date came, I did not feel well. My midwife told me that I should go to the hospital when my due date arrived. So I called to the hospital that day. I told them that today is the due date. They replied that I should come after ten days. I told them that I did not feel well. They said that I still have to wait those ten days and only then they will examine me. I hunged up the phone and started to cry. I thought that I could wait for even 20 days if everything is alright, but I thought that they at least could have examined me. At the end of my pregnancy my whole body was itching. I had pain in the belly and I was scratching everywhere. After three days I felt more pain. My husband told me to be strict when I talked to them on the phone. He even instructed me about what kind of rights I have here in Norway and he told me again to be very strict with them. When I called them after those three days, I convinced them that I didn't feel well and they told me to come in 20 minutes. My husband was at home, so we arrived in time. The doctor asked if I was in Lithuania and if someone examined me there. I said yes and gave all the papers. She didn't even look at the papers. They checked me and my cervix was open up to 3 centimeters already. I had to stay in the hospital. They told me that if during the night I did not start to give birth, they would induce me. When I was in the room I realized that I did not want to be induced. So I started to massage my nipples to help the birth start naturally. And I was doing that all night. Other women in the same room were with inserted balloons to open the cervix as they all were late with giving birth. I didn't want any intervention. [.....]However, they told me that they had to puncture my waters, because the labour had started. When they did that I saw that waters were green already, and that is not good. So I am glad I didn't wait for 10 days more, who knows what would of happened then.” (Viola).*



Obstetrics works on women's bodies to make them stay on time and on course; this quest becomes more obsessively time-focused over time. The meaning of time in the analysis of childbirth plays an important part in a relation to both: time as a due date and time management in the labor. Being given an accurate due date, a woman is psychologically ready to give birth or by that time have had a baby already. In modern society where time is a crucial part of everyday life, where everyone expects the train to come precisely on time, the uncertainty becomes a mantra of psychological pandemonium. This happened in Viola's case as well. She waited for her due date to come in order to call the hospital to tell that she was not feeling well even though she was in this condition almost for the whole month. Her husband was supportive and worried as well as strongly involved in her decision to call back the hospital. As noted above, Viola listened to her husband's instructions about how to talk to the health care provider and what exactly she had to say. From this data, I would argue that her choices and decisions were under the influence of her husband, whom she saw as having more authoritative knowledge than herself, because he is a Norwegian citizen and had been living in Norway for twenty years. As Viola began to cry after the first conversation with one of the midwives on the phone, her husband's reaction was that he had to take some control in the situation. He claimed that he knew the system better than her and Viola "had to be strict with them, otherwise they don't listen". Hence, he instructed her again the way she should talk to the health care providers when she called them back in three days. Viola remembered also that her midwife the last time she visited her had said "to be strict when I come to the hospital".

The role and influence of male partner on women's behavior and practices on pregnancy and childbirth is unfortunately not studied enough within medical anthropology. Dudgeon & Inhorn (2004) summarized research and demographic literature to display men's influence on women's reproductive health including abortion, contraception, pregnancy and childbirth. The results revealed that there are contradictory behaviors in which men influence reproductive health problems, and the need of more anthropological and qualitative research studies is highlighted, particularly in relation to the cultural context. In addition, fathers seeing their partners in pain become anxious and concerned, so tend to behave in a way to protect their partners (Boseley, 2000 in Squire, 2009, pp.227-229).

During labour Viola's husband's was anxious and became frustrated even more as Viola's pain increased.

*'The pain was horrible, but I could rest at least the little time between the contractions. We (means her husband and her) asked for epidural before, but they said it was too early. Then I was trying to be patient and wait, but the pain just was stronger. It was very stressful for my husband, because he tried to massage my back as midwife instructed, and then rub my shoulders to distract me, but nothing helped. I saw him being stressed and told me "You have to say that you cannot take it anymore, that the pain is unbearable...this is it, because they don't take it serious, just start crying, they will react then. I will call the midwife"' (Viola).*

Viola was able to get epidural within fifteen minutes and she claimed that her husband's instructions "really worked".

This description complements the findings of Walters (2000) where he states that "men feel happier knowing that their wives are getting as much medical attention as possible". Another research supports the findings in the study, which claim that once being asked about pain control by their partners, women tend automatically to answer questions using the intellectual side of the brain instead of emotional one (Boseley, 2000 in Squire, 2003, p.228). Therefore, the hindrance to manage labor emotionally, leads women to decide to increase analgesia or receive more medical interventions during labor management.

There are a lot of discussions in the literature about the fathers' presence at birth. There is even controversy if fathers help and support birthing women or if they hinder the birthing process. This appears to be a difficult question to answer due to limited understanding and research into men's role in birthing process in both developing and industrialized countries.

Nevertheless, the decision of father's involvement in and attending the birth is solely between individual couple themselves. As the example below shows Rose's husband participated in the process of labour until the actual birth as it was planned by both of them early in the pregnancy. Once I asked if there was a specific reason for it, Rose claimed that her husband listened to other men's stories and decided that he would not attend the moment of the child's birth. Even during the first interview Rose was very sure and definite upon their decision.

*'It's usually huge amount of blood and I am all exposed. We just decided it would be better for both of us. I don't know if I want him to see me like this. Also, it might affect our sexual life later if he would be dramatized by the scene as his friend was' (Rose).*

During the second interview Rose stated that just before their son was born, her husband actually left the room and came back once she and her baby were cleaned up. Rose didn't even question or saw it as an important event. As she was telling me the birth story, she was quite calm and happy the way it went.

Active roles of fathers during birth were acknowledged by the late 1970's when hospitals made pragmatic changes and recognized the need of psychological support for birthing women (Squire, 2003). Until then the solid gender constructed roles and desexualized birth process had influenced the exclusion of men from the birth. However, as gender role transformations took place in western world, the sexuality topic is still a pertinent issue at birth. Seel (1994) observes that traumatic subjective experience among men during birth can consequently stifle sexual feelings and behavior for his partner.

*"Sexuality is a fundamental aspect of life and so must be involved in the momentous adjustments that are made by men and women on becoming parents, and that change which started with the pregnancy continues in the postnatal period onwards. "* (Walton, 1994 cited in Squire, 2003, p.227)

The decision of men not to be involved in birth process is sometimes negatively stereotyped or interpreted as not being interested or lack of involvement; however, it may appear sometimes that this is not the case.

### *5.3.3 Disempowerment and Empowerment*

In a clinical setting of birth there is always a midwife, maternity nurse, or gynecologist who has authority to make a decision and hierarchically go up or down distributing authoritative knowledge, however seldom involving all the participants jointly in a labor assignment. The ability of women to participate and discuss the events with a midwife or a doctor surrounding the birth process reflects the autonomy of the expression women's knowledge of her body. On the

contrary, devaluation of laboring women's personal experience of the body can lead to the separation of her body and inner self, or disempowering women.

The participant Viva had quite a long and very stressful delivery. She had to be induced, then her labor stopped progressing and they thought to do a Caesarean section; however, finally she was able to deliver herself, which she was very happy about. The paradox of her story is that she envisioned her labour being natural and without medications. Viva read extended amount of literature about natural birth and as she mentioned in the first interview, she was preparing herself for birth from being twelve years old. She was one of the participants in the study, who was certain to have warm baths and massages during labour; however, her birth experience was different than what she expected.

As Viva talked about her birth experience, she repeated a few times the phrases "but no one listened to me" and "no one explained" indicating that she was left apart from a decision-making process during labour.

*'As I was done with the shower, they made me go to bed again and didn't let me to get up. The doctor came to check at 3 a.m. He said that everything is alright, the progress is going well. The opening of the cervix was 4-5 cm. The doctor was Polish. There was something they couldn't see, so they were thinking about doing a Caesarean, only because they were not sure about some kind of change in parameter. As he was not sure, he called his colleague and several nurses. There were around 7-8 people in the room. At the moment I felt contractions, I was connected to all equipment and wasn't allowed to move. I was lying and meditating, and they were discussing what to do until 5 a.m. in the room. I could hear everything they were talking about. No one though explained what was happening to me.*

*At 5 a.m. I asked where my epidural was. They replied that they heard my request, but they didn't think I was serious, as I was controlling my pain so well. So they didn't invite anesthesia specialist at all this time. I understand that it looked like I am doing well as I was lying still. But when someone is talking around me all the time, try to connect or disconnect me to different equipment, checking my cervix, it is extremely difficult to concentrate for the self-hypnosis and to kill the pain. I said only two words, and allowed my husband to say everything else. I was extremely tired...It was not clear how long everything would be going on and they were doing nothing, so I needed painkillers as I could not do it anymore' (Viva).*

This example illuminated that Viva tried to meditate and relax, however, the difficulty she found it difficult that there were too many people around her, who were deciding upon the further process of labour. In addition, Viva felt like it was impossible for her to participate; things were done to her body as if it was an object that needed to be monitored. It seems like thoughtful individual attention towards Viva was to be entirely preempted. According to Jordan (1978) it can be defined as “modern obstetric environment”, where the machinery holds a central place and accompanying procedures used by right and claim to authoritative knowledge. In this context, one may question if authoritative knowledge can be successfully distributed and shared not hierarchically in a vertical, but rather in a horizontal position, legitimately accounting for the mother’s own knowledge. In such situation authoritative knowledge must emerge as a single authoritative knowledge through divergent paths of knowing. However, sharing the authoritative knowledge during a specific encounter such as birth can be problematic, because of different perceptions of the same phenomenon. In addition distrust and dissatisfaction with medical professionals during birth can lead to women’s experiences of birth trauma (Creedy et al., 2000).

Studying Somali women experiences in Norway, Vangen et al. (2004) found disempowerment and empowerment to be central features between Somalis and Norwegian health care providers. Empowerment in relation to birth is defined as methods and ways through which people are a part and take control over their own specific encounter (Lee, 1999). Disempowerment is defined as the opposite of empowerment.

I argue that Viva’s exclusion in the decision making process during labour can be seen as disempowering her. To put it more bluntly, it was two and a half hours when the clinicians discussed whether or not to perform Caesarean section without actively including her voice.

*‘They solved this, and at 5:30 I got epidural. And it was probably the best thing that happened to me during this labour. It’s ridiculous I say that, because I was preparing for a natural birth, I was hoping I would definitely not need an epidural. Thank God I got it, which was fantastic. They decided not to make the Caesarean. The shifts were changing, I was just lying and meditating, my husband was sitting next to my side and all this was just a complete pleasure. Of course I was feeling contractions, but they were easy to control and finally all the staff left me alone. They only checked the opening of cervix every two hours. I could rest and wait’ (Viva).*

As Viva's birth experience illuminated her position as devaluated and disempowered birthing woman, on the contrary, Vera who gave birth at the same hospital as Viva had a positive birth experience.

*'When they told me that I was ready to push, I pushed and was all excited that the baby would come soon. I really felt I could do it, but it wasn't that quick. It took almost two hours of pushing. At the end I was so exhausted and I remember I just said, "I can't do it anymore, I just can't." The midwife she was so nice, calmed me, encouraged me again and again not to give up. One time she even said, "We can do it, it's hard but possible". We were so excited when the midwife saw the baby's head; she was explaining everything how the baby moved in there and how. She was very nice...'*  
(Vera).

Positive and reciprocal relationship between the woman and the midwife is underlined in the reviewed literature. It is strongly emphasized the relationship has to be built incorporating the women in joint decision making and sharing the knowledge; consequently, empowering both the women and the midwife (Lundgren, 2004).

## **5.4 'Relationship with clinicians'**

This core theme '*Relationship with clinicians*' is composed of three sub-themes:

*'Communication with clinicians', 'Continuity of maternal care' and 'Midwives' perspectives'.*

All three sub-themes highlight the importance of the relationship and communication between a clinician and a woman as an essential building block for continuity in maternal care. In addition, reflections on challenges faced by midwives providing maternal care to migrant women in Norway are presented in the sub-theme '*Midwives' perspectives*'.

### *5.4.1 Communication with clinicians*

Effective communication between clinicians and patients is underlined in most of health care research and is considered as one of the most significant aspects of care. Language being a fundamental component of communication shapes and reflects the social and cultural realities the clinicians and patients are part of. Childbirth constitutes a moment where effective communication is highly relevant to the actual procedure of birth, as well as, the experience of birth. Hewison (1993) emphasizes the role of language as being able to bring the change and alter the experience of childbirth. The language importance is highlighted particularly in the arena of birth, where it constructs and reflects the broader social reality (Hewison, 1993).

All the participants in this research study were able to speak English very well and two of the participants spoke good Norwegian. Three of the participants reported that not knowing Norwegian language played a role in terms of receiving what they perceived as quality health care, even though they could have spoken English very well.

*'I speak with doctors in English. And I believe that everyone is able to speak English very well, but sometimes people have some inner barriers. Therefore I didn't have meetings with doctors where the only used language would be English. Norwegian is used to the same extent. The problem is that when two languages are used, miscommunication is possible. For example, I might lose some information' (Viva).*

*'I absolutely think that the Norwegian language is necessary. I understand that my Norwegian language level is just a little above the basic level. Of course I don't want to have a translator during the birth. Though I know that I have such an opportunity, but for me it is crazy. However my husband*

*speaks fluently Norwegian and I think he can help me. Moreover, I try to read books in Norwegian and I remember some terminology. I know that the lack of language skills should not be a big problem, but it will be inconvenient' (Vera).*

One of the participants expressed thankfulness that English language is quite popular in Norway and most health care providers can speak it.

Miscommunication may lead to mistrust between the patient and clinician and contribute to a devaluation of the authoritative knowledge of midwives and other clinicians. The language barrier can be one of the major components of disempowerment of a woman and hinder a woman to be empowered in the process of labour. As Viva experienced a long and difficult labour, she admitted that the language barrier was irritating and she had to develop her own strategies to patiently wait until someone came and explained everything in English.

*'We had to wait until the doctor came in to explain when the birth should be induced. The doctors spoke very good English, but not the nurses. I wish I could have spoken good Norwegian. Then I would have felt better, maybe.... (smiles)' (Viva).*

Two of the interviewed women talked about lost records and lack of communication between health care providers, midwife with the GP and vice versa. Viola's example provided below shows the gap of the communication and unclearness of the rules of registration for the birth.

*'When my due date came and when I called to the hospital, they told me that it is not me, but my doctor that has to call the hospital and register me to come after 10 days. My doctor is very busy and she was very surprised that she personally has to call to the hospital. She said she never experienced that before' (Viola).*

Some participants emphasized cultural differences in the manner of communication among health care providers. They accentuated a more personal and less authoritative form of communication among Norwegian clinicians in comparison to Lithuanian doctors.

*'I think their communication with the patient is little bit strange, because they talk in a very personal way, not like in Lithuania. You do not have personal talks with the doctor in Lithuania (smiles). As an example, when it comes to communicating about everyday life (vacation, financial*



*investments, learning simple words in Lithuanian), doctors in Norway are very open and informal, at least the ones I met' (Emma).*

Emma saw the communication style and having “personal talks” with the doctor as a positive thing; however, she still considered it being “strange” because of her frame of reference in terms of communication between a patient and a doctor in Lithuania. Cultural adjustment to the standards of health care provision is definitely a path that ethnic minority women have to go through as they come to a new country. Rose echoed Emma’s views in terms of communication patterns of Norwegian clinicians as compared to Lithuanian doctors.

*'Well, when I go there he is so personal, that makes me even sometimes uncomfortable. He touches my hands, says everything will be fine, and everything is okay. Maybe it's his culture or something but it's a little weird as usually doctors in Lithuania are kind of strict and to the point' (Rose).*

Different language and communication styles of clinicians reflect cultural diversity in biomedical world. Not mastering native language of a host country, symbols, culturally different views of a pregnant women’s body and other unfamiliar concepts-- all influence effective communication between migrant women and clinicians; therefore, shaping immigrant women’s childbirth experiences.

#### *5.4.2 Continuity of maternal care*

Prenatal care in Norway is predominantly the domain of midwives who organize and follow women. One of the advantages of such system is that great amount of workload are taken off the physicians’ shoulders; however, at the same time it can create an interruption in the continuity of maternal care. A very important theme in maternity care is continuity of care. This subject has been explored in more than a few research studies (Thomas, 2006; Page et al., 2001; McCourt & Stevens, 2006) and came up as an unavoidable theme in this research study. Three of the participants in the study mentioned what they saw as ‘individualized care’ and the impact of fragmented maternity care. Viola who had experience birth in both countries-- Lithuania and Norway-- admitted that she missed the continuity of care provided by Lithuanian gynecologist.

*'My midwife at birth was young and I felt like she was not experienced enough because of the way she acted. I saw her sweating also. My mom was worried about it too. I wish I could have just followed one doctor and*

*delivered with him when birth time came. It's different here. The midwife was totally unknown to me and when shift changed a different one came, again I had never seen her before, so that gap was always there, not like with my gynecologist in Lithuania' (Viola).*

From Viola's perspective she missed the informal relationship that she built with her doctor based on continuity throughout pregnancy and birth. In the integrative review by Novick (2009) many women expressed a preference to a single clinician or just a few, so that maternal care is well coordinated. In addition, women tend to seek for less formal and more 'intimate relationships', where they described it as being able to actively participate in the care they received (Novick, 2009). The other studies highlight the advantages expressed by women who knew the midwife providing maternal care (Page et al., 2001; McCourt and Stevens, 2006).

In addition the difference in midwifery system in Lithuania and Norway created mixed feelings towards the trust for health care providers here in Norway.

*'In Lithuania there are three people with a woman during the birth – a doctor, a midwife and a nurse. In Norway there is only a midwife. This gave me stress... Has she enough competence?' (Viola).*

*'They have a very good sponsorship in the baby and mother department. But all equipment is very different; the nurses are not taught how to use them. Communications is implemented by writing on paper. One shift doesn't know what the previous shift was doing, asking the same questions over and over. I thought I liked the way they have the system here, but after this experience I changed my opinion. I would rather pay extra to a gynecologist who would follow me from the first day of conception to the birth and after' (Viva).*

Viva's description illuminated her feeling of being disappointed with the midwifery system; however, she experienced a difficult birth process where she felt was not included and left out from opportunity to participate in it. It seems like this led to confusion and embedded sense of anger which further worsened birth experience for Viva.

In the reviewed literature the definition of 'continuity' comes across holding different descriptions. It can denote consistent antenatal and postnatal maternity care regardless of number of health care providers. The term 'continuity' can also be defined as a maternity care provided

by a single designated obstetrician, midwife or a number of small group clinicians (Novick, 2009). Describing different birth models Davis-Floyd et al. (2009) underlines hospital-based “shift midwifery” which he argues “interferes with full provision of the humanistic model--midwives leave after eight or ten hours no matter where the mother is in labor” (p.449). The authors further argue that if a birthing mother senses that a new midwife that replaced the previous one is not so gentle or practices technocratic care, it may interfere for the mother to give birth successfully (Davis-Floyd et al., 2009). This description provided by the authors reflects the experience of one of the participants in the study as provided below.

*‘It just happened that I delivered at 7 o’clock in the morning. I really didn’t know who would come next and what would happen. We had our baby in the room with us, me and my husband. I was exhausted, tired, just totally drained after the long night. Suddenly came a woman, which I understood was a new midwife, who didn’t ask anything, just said, “Okay, get ready. Go take a shower, we have to move you to the hotel, you have a room.” Her voice was strict and she was really rude. I looked at her and felt so lucky that she was not my midwife when I delivered. I was very lucky, really....(Pause). My husband looked at me and in a very calm but solid voice said, “Rose (original name), don’t worry. We will get ready when we can and once we are ready, only then we will go and there is no rush to it”’ (Rose).*

Lack of continuity of Norwegian maternity care is one of the major themes discussed in the literature and in the media. There are a few significant formal legislative reports presented in relation to maternity care in Norway. One of them was published in 2009, which was called “En gledelig begivenhet. Om en sammenhengende svangerskaps-, fødsels- og barselomsorg” (“A happy event. About a continuous pregnancy-, birth and post-natal care”) (HOD, 2009, p.7).

The report underlines the significance of improvement of organization, utilization of resources collaboration between health care workers, i.e. GPs, midwives and nurses. In addition, a few research studies came after in relation to challenges to the management of maternity care for Norwegian and migrant women (Severinsson et al., 2009; Lyberg et al., 2011). The major and most critical finding was that cultural sensitive treatment in maternity care was crucial to adapt to migrant women’s needs and ensure continuity and a trusting relationship between migrant women and clinicians (Lyberg et al., 2011).

### 5.4.3 Midwives' perspectives

As I interviewed three midwives in this research study, the relationship between a woman and a midwife was one of the major topics underlined by midwives when taking care of culturally diverse women.

The midwife, who works at a birth unit at one of the hospitals in Oslo, described the midwife's and woman's relationship as "equal partnership".

*'The woman has to trust the midwife. The communication is important, but more important is the trust that is built between them. If a woman trusts the midwife, the birth will be harmonious. Doing the birth together just like in an equal partnership. I think that is the most important aspect at birth, so the woman has a good birth experience'* (Midwife 3).

Another midwife, who has been working for twenty five years in Norway, admitted that one of the biggest challenges when taking care of migrant woman is language.

*'The big and number one problem is a language. Some women cannot speak English or Norwegian. Some of these women have taboos, don't talk about it. Some of them have experienced horrible things, not used to communicate with other people about problems'* (Midwife 1).

As she talked about continuity of Norwegian maternity care, she raised a concern about it still being unclear how much involvement in maternity care a general practitioner has or should have. She stated that women who come from another country can easily be lost in the system and they usually try to go and see a doctor first.

*'Most of the women see "fastlege" (the family doctor) first. Doctors like pregnant women as their patients because they are easy patients, nice talking to them, it's easy money, good money and they want to do consultations. Many of the doctors do not even refer to the midwife. But there are doctors that do. Also, only a doctor can write a sick leave'* (Midwife 1).

Implicit in the above statement by the midwife, the power of 'authoritative knowledge' can be seen as exercising the authority of a doctor and being able to "write a sick leave". However, in the encounter of birth, two of the midwives uniformly stated that "today everything is controlled by protocols and procedures at birth".

When I interviewed a Lithuanian midwife, who had experience as a midwife in Lithuania and Norway, she admitted that adjusting to a different birth model in Norway was a difficult time. She expressed particular related to the so-called 'normal births', which are handled by midwives.

*'I didn't know in the beginning and some other midwives were not sure either, when to call the doctor. Some of the doctors were mad if you called them for advice, some were nice. They told if this is a normal birth, don't need to bother. However, there were no rules what they considered so called 'normal births'. It was hard in the beginning' (Midwife 2).*

The concept of 'normality' in the arena of midwifery can complicate and confuse not only the birth process, but also from the perspectives of women receiving maternity care as articulated by many participants in the study. In addition, the social and cultural perceptions of so called 'normality' can bring in conflict sharing communication in ethnically diverse society.



## 6 CONCLUSION

This research study situated its objectives in relation to Lithuanian minority women's birth experiences in Norway. The study engaged directly into exploring sociocultural network patterns influencing and shaping Lithuanian women's birth experiences. Furthermore, investigating potential sources of cultural assumptions, concerns and communication barriers to achieve optimum childbirth experiences, the study also attempted to reflect on the main concerns expressed by the midwives while providing maternity care to ethnic minority women in Norway.

The discussion of the results is situated on the key finding 'authoritative knowledge' that is reflected in the experiences of Lithuanian women in the study from early stages of pregnancy through birth. A number of different 'authoritative knowledge' forms were enacted, altered and maintained by the participants in the study as a prominent role in the selected health behavior and rationalizing prenatal and birth process.

By means of the concept 'authoritative knowledge' elaborated by Jordan (1978) which outlines "the knowledge that counts", the responses of other researchers has been to suggest that any form of "knowledge is power" that is used to understand the reality and the experiences of human beings (Foucault 1980, p.46). In the early gestational period exclusively all the participants in the study expressed the desire to medically confirm the reality of pregnancy via ultrasound or the blood test; however, struggled with the pregnancy rules and regulations provided by health care providers in Norway. The women in the study responded favorably to being able to have an early ultrasound in order confirm the pregnancy as well as to check the health status of the fetus. The participants in the study felt unconvinced and hesitant that all indispensable prenatal information and testing were carried out in order to have a healthy fetus. As Greek and Australian women (Georges, 1996; Harris et al., 2004), the Lithuanian women in the study uniformly articulated happiness and delight to be able to see the fetal image and to hear from the clinician a verification of a true and positive pregnancy.

The stories of Lithuanian women demonstrate attempts to resolve the imminent prenatal worries with consultation health care providers in Lithuania as well as in Latvia. Furthermore, as some of

the participants travelled abroad to receive medical examinations, the others were actively searching for other forms of knowledge in regards to biomedical advices and existing medical resources in Norway. From the point of view of Lithuanian women in the study, the importance of prenatal diagnosis is incontrovertible and crucial in order to do all possible to assure the fetus' health.

Socially constructed knowledge was one of other forms of 'authoritative knowledge' that influenced the women's attitudes and behavior during prenatal period. One of the participants strongly relied on the collective knowledge from local Lithuanian social group 'Oslo Mamytes', which further played authority to Norwegian clinicians. The findings demonstrated that cyclic process of social knowledge was not only produced, transmitted and interpreted, but also manipulated in order to pass through health safety requirements in Norway. It's fair to conclude that such manipulation of knowledge is constructed upon unawareness and lack of communication between two parties, where the participant cannot feel full accountability and responsibility for her actions. I argue that manipulation of this type of knowledge may be not a one-time event, but a recurring action by other migrant women residing in Norway as the popularity of "villscreening" ("case-finding" or "disease-hunting") is a tendency not only among migrant groups in Norway, but also for local residents (Gulbrandsen, 2001). Therefore, this suggests the possibility that unconfirmed screening in other countries may signify a potential local public health issue if not medically monitored or recognized in time.

The facet of 'linguistic challenges' in maternity care must be recognized by health care providers while providing care in multicultural society. The topic of 'normality' was one issue that was highlighted in the description of childbirth experiences among Lithuanian women. The concept of 'normality' or the Norwegian expression "Helt normalt" ("Everything is normal") cannot hold the same meaning in both languages due to the lack of a shared reference frame to its actual definition. This suggested a possibility of further constraints in the communication patterns between the parties and the level of trust in Norwegian clinicians.

Trust between the Norwegian clinicians and the Lithuanian mothers were one of the major components of care which was either expressed as crucial by the participants or underlined as a



connector part of the maternity communication system. Therefore, losing trust in Norwegian clinicians, as it was experienced by two of the participants, left a gap in the maternity care experience. Consequently, such communication fissure further constrained the achievement of trust in the overall Norwegian medical system. Research carried out in Norway by (Lyberg et al., 2011) supports the findings of this study which suggested that if migrant women tend to compare the biomedical views with their native country and if they differed, the lack of trust in Norwegian clinicians were greater.

In the context of labour, a few women in the study relied on other forms of what they perceived as ‘authoritative knowledge’ such as intuition or husband’s role, which implicated the authority to the reassurance of midwives’ advices and recommendations. The need to involve mothers, to value the laboring women’s bodily knowledge and ‘empower’ them in decision making process in the arena of birth was expressed by a few participants. Relatedly, as one of the participants experienced ‘disempowerment’ and loss of the control of her own bodily knowledge through birth process, the predominant biomedical authority alienated her from her own private encounter, birth. This medical vision of birth as ‘potential pathology’ is documented in various sources in the literature of social science as well as broadly studied by anthropologists, who highlighted the woman’s body which “tells her has little status in the birth setting (Lazarus cited in Davis-Floyd & Sargent, 1997, p.134).

Reviewed literature on migrant women experiences of birth, particularly Islamic background women, who felt discriminated, isolated and saw the major significance of the knowledge of their religious and cultural practices to be incorporated in the maternity care they received (Reitmanova & Gustafson, 2008; Herrel et al., 2004). Lithuanian women in the study, on the other hand, never admitted to being discriminated, isolated or in other words being victims because of cultural differences. Differently than women of Islamic background women, the women in the study were actively searching for potential solutions by implementing various strategies to overcome faced barriers that seemed to be incongruent to their source of reference in practicing maternity care.

Childbirth being a universal phenomenon, the expressions of women of these experiences vary greatly among different cultures. Maternity care varies from one society to another; therefore, the significantly marked variations in health care practice directly shape the birth experiences of Lithuanian migrant women in the study.

To sum up, this research study strongly suggests that considerable variation in maternity care across Lithuanian and Norwegian cultures impose and shape directly the experiences of migrant Lithuanian women in Norway. The clash of ‘authoritative knowledge’ systems in terms of prenatal expectations, sociocultural values and reproductive politics demonstratively were articulated by Lithuanian women in the study.

The findings of this research may benefit not only Lithuanian women, but also other migrant women with a similar sociocultural background delivering cultural competence in maternal healthcare services. This research study suggests a need for more research on birth experiences by other ethnic minority groups in Norway in order to integrate and transform cultural knowledge into maternity care in an ethnically diverse society.

## REFERENCE LIST

- Ballam, M-C., Akerjordet, K., Lyberg, A., Kaiser, B., Schoening, E., Fredriksen, A-M., Ensel, A., Gounie, O. & Severinsson, E. (2012). Migrant women's perceptions of their needs and experiences related to pregnancy and childbirth—a qualitative synthesis. *Journal of Advanced Nursing*. In press.
- Bastick, T. (1982). *Intuition: How we think and act*. New York: John Wiley & Sons.
- Baumeister, R.F., & Newman, L. S. (1994). How stories make sense of personal experiences: motives that shape autobiographical narratives. *Personality and Social Psychology Bulletin*, 20(6): 676-690.
- Betsch, T. (2008). The nature of Intuition and Its Neglect in Research on Judgment and Decision Making. In H. Plessner., C. Betsch & T. Betsch (Ed.), *Intuition in Judgment and Decision Making* (pp.3-23). New York: Lawrence Erlbaum Associates.
- Bodley, J. H. (2005). *Understanding Culture. Cultural Anthropology: Tribes, states and the global system*. Boston: McGraw Hill Education (p.2-30).
- Boge, R. & Karlsen, K.S. (2007). Svangerskapsomsorgen. (Pregnancy care). Available at: [http://www.nettdoktor.no/graviditet\\_foedsel/artikler/graviditet/svangerskapskontroll.php](http://www.nettdoktor.no/graviditet_foedsel/artikler/graviditet/svangerskapskontroll.php) [Accessed 2. November 2012]
- Boseley, S. (2000). Anxious fathers may be bad for birth: 'Keep them away from the delivery room', advises childbirth guru. In C. Squire (Ed.), *The Social Context of Birth* (2003). U.K.: Radcliffe Publishing
- Bourdieu, P. (1977). *Outline of a theory of practice*. New York: Cambridge University Press.
- Browner, C.H. (2007). Can Gender "Equity" in Prenatal Genetic Services Unintentionally Reinforce Male Authority? In M.C. Inhorn (Ed.), *Reproductive Disruptions* (pp.147-165). Oxford: Berghahn Books.
- Brunstad, A., & Tegnander, E. (2010). *Jordmorboka: Ansvar, Funksjon og Arbeidsområde*. Oslo Akribe.

- Buchanan, D.R. (1992). An uneasy alliance: combining qualitative and quantitative research methods. *Health Education and Behavior*, 19, 117-35.
- Castenada, H. (2008). Paternity for sale: Anxieties over “Demographic Theft” and Undocumented Migrant Reproduction in Germany. *Medical Anthropology Quarterly*, 22(4), 340-359.
- Chalmers, B. (1997). Changing Childbirth in Eastern Europe. In Davis-Floyd & Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives* (p.263-283). Los Angeles: University of California Press.
- Council for International Organizations of Medical Sciences (CIOMS). *International Ethical Guidelines for Biomedical Research Involving Human Subjects*. Available at: [http://www.cioms.ch/publications/layout\\_guide2002.pdf](http://www.cioms.ch/publications/layout_guide2002.pdf) [Accessed 2. November 2012]
- Creedy, D., Shochet, I. & Horsfall, J. (2000). Childbirth and the development of acute trauma symptoms: Incidence and contributing factors. *Birth*, 27, 104-111.
- Davis, E. (1989). *Women’s Intuition*. Berkeley: Celestial Arts.
- Davis-Floyd, R. E. (1994). The technocratic body: American Childbirth as Cultural Expression. *Social Science and Medicine*, 38(8), 1125-1140.
- Davis-Floyd, R. & Davis, E. (1997). Intuition as Authoritative Knowledge in Midwifery and Home Birth. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives* (pp. 315-349). Los Angeles: University of California Press.
- Davis-Floyd, R.E. & Sargent, C.F. (1997). *Childbirth and Authoritative Knowledge : Cross-Cultural Perspectives*. Los Angeles: University of California Press.
- Davis-Floyd, R., Barclay, L., Daviss, B.A. & Tritten, A. (2009). *Birth models that work*. London: University of California Press.
- Dudgeon, M. R & Inhorn, M.C. (2004). Men’s influences on women’s reproductive health: medical anthropological perspectives. *Social Science and Medicine*, 59, 1379-1395.

- Epstein, S. (2008). Intuition from the Perspective of Cognitive-Experiential Self-Theory. In H. Plessner, C. Betsch & T. Betsch (Eds.), *Intuition in Judgment and Decision Making* (p.23-39). New York: Lawrence Erlbaum Associates.
- Essen, B., Johnsdotter, S., Hovellius, B., Gudmundsson, S., Sjöberg, N.O., Friedman, J., Östergren, P.O. (2000). Qualitative study of pregnancy and childbirth experiences in Somali women resident in Sweden. *British Journal of Obstetrics and Gynaecology*, 107, 1507-1512.
- Fathalla, M.F. (1994). Women's Health: An Overview. *International Journal of Obstetrics & Gynaecology*, 46, 105-18.
- Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings 1972-1977*. Brighton: Harvester Press.
- Gadamer, H.G. (1982). *Truth and method*. New York: Crossroad Publications.
- Georges, E. (1996). Fetal ultrasound imaging and the production of authoritative knowledge in Greece. *Medical Anthropology Quarterly*, 10(2): 157-175.
- Giorgi, A. (1994). A phenomenological perspective on certain qualitative research methods. *Journal of Phenomenological Psychology*, 25, 190-220.
- Gjertsen, G. (2005). Fosterdiagnostikk og vanskelige valg. *Genialt*, 14 (1), 15.
- Available at : <http://www.bion.no/filarkiv/2010/07/genialt1-2005.pdf>
- Gulbrandsen, P. (2001). Leve villscreening. *Tidsskrift for Den norske legeforening*, 121, 619-620.
- Gupta, J.A. (2000). *New reproductive technologies, women's health and autonomy*. Thousand Oaks, Calif.: Sage Publications.
- Harris, G., Connor, L., Bisits, A. & Higginbotham, N. "Seeing the baby": pleasures and dilemmas of ultrasound technologies for primiparous Australian women. *Medical Anthropology Quarterly*, 18(1), 23-47.

- Herrel, N., Olevitch, L., DuBois, D.K., Terry, P., Thorp, D., Kind, E. & Said, A. (2004). Somali refugee women speak out about their needs for care during pregnancy and delivery. *Journal of Midwifery and Women's Health*, 49, 345-349.
- Hewison, A. (1993). The language of labour: an examination of the discourses of childbirth. *Midwifery*, 9, 225-234.
- HOD. (2009). St.meld. nr. 12 (2008 – 2009). En gledelig begivenhet. Om en sammenhengende svangerskaps-, fødsels- og barselomsorg. [online] Available at: <http://www.regjeringen.no/pages/2206374/PDFS/STM200820090047000DDDPDFS.pdf> [Accessed 17. March 2013]
- HOD. (2009). St.meld. nr. 47 (2008 – 2009). Samhandlingsreformen. Rett behandling – på rett sted – til rett tid. [online] Available at: <http://www.regjeringen.no/pages/2206374/PDFS/STM200820090047000DDDPDFS.pdf> [Accessed 17. March 2013]
- Ingleby, D., Chimienti, M., Ormond, M & de Freitas, C. (2005). The role of health in integration. Available at: <http://www.ercomer.eu/downloads/ingIV.doc> [Accessed 21. November 2013].
- Jordan, B. (1978). *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. Montreal: Eden Press Women's Publications.
- Jordan, B. (1997). Authoritative Knowledge and Its Construction. In Davis-Floyd & Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives* (p.55-88). Los Angeles: University of California Press.
- Kvale, S., & Brinkmann, S. (2009). *Interviews: learning the craft of qualitative research interviewing*. Los Angeles, Calif.: Sage Publications.
- Layne, L. (2007). Designing a Woman-Centered Health Care Approach to Pregnancy Loss: Lessons from Feminist Models of Childbirth. In M.C. Inhorn (Ed.), *Reproductive Disruptions* (pp.79-97). Oxford: Berghahn Books.

- Lazarus, E. (1992). Brain, Symbol, and Experience: A Neurophenomenology of Human Consciousness. In Davis-Floyd & Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives* (p.318). Los Angeles: University of California Press.
- Lazarus, E. (1997). What do women want? Issues of Choice, Control, and Class in American Pregnancy and Childbirth. In Davis-Floyd & Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives* (p.132-158). Los Angeles: University of California Press.
- Lee, M.B. (1999). Power, self-care and health in women living in urban squatter settlements in Karachi, Pakistan: a test of Orem's theory. *Journal of Advanced Nursing*, 30, 248-59.
- Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods*. Oxford: Oxford University Press.
- Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Inquiry*. CA: Sage Publications.
- LRSAM (1999). Del nesciuju, gimdyviu ir naujagimiu sveikatos prieziuros tvarkos patvirtinimo. Nr.117. Retrieved from: <http://www.sam.lt/go.php/lit/745/3738/3950>
- LRSAM (1994). Lietuvos Respublikos sveikatos sistemos įstatymas. Nr.I-552. Retrieved from: <http://www.sam.lt/go.php/lit/745/3738/3720>
- Lyberg, A., Viken, B., Haruna, M. & Severinsson, E. (2011). Diversity and challenges in the management of maternity care for migrant women. *Journal of Nursing Management*, 20, 287-295.
- Lumley, J. (1990). Through a glass darkly: ultrasound and prenatal bonding. *Birth*. 17, 214-17.
- Lundgren, I. (2004). Releasing and relieving encounters: experiences of pregnancy and childbirth. *Scandinavian Journal of Caring Sciences* 18, 368-375.
- Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20

- Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, 358 (9280), 483-488.
- Malterud, K. (2011). *Kvalitative metoder i medisinsk forskning: en innføring*. Oslo: Universitetsforl.
- Manderson, L. & Pascale, A. (2003). Storytelling, Marginality, and Community in Australia: How immigrants Position Their Difference in Health Care settings. *Medical Anthropology*, 22, 1-21.
- Martin, E. (1989). *The Woman in the Body. A Cultural Analysis of Reproduction*. Buckingham: Open University Press.
- McCagg, W.O. & Siegelbaum, L.H. (1989). *The Disabled in the Soviet Union: past and present, theory and practice*. Pittsburgh: University of Pittsburgh Press.
- McCourt, C. & Stevens T. (2006) Continuity of carer - what does it mean and does it matter to midwives and birthing women? *Canadian Journal of Midwifery Research and Practice*, 4(3),10-20.
- Mitchell, J.C. (1983). Case and situational analysis. *Sociological Review*, 31(2), 187-211.
- Novick, G. (2009). Women's experience of Prenatal Care: An Integrative review. *Journal of Midwifery and Women's Health*, 54(3), 226-237.
- Olds, S.B., London, M.L., Ladewig, P.W. & Davidson, M.R. (2004). *Maternal-Newborn Nursing & Women's Health Care*. New Jersey: Pearson Prentice Hall.
- Page, L., Beake, S., Vail, A., McCourt, C. & Hewison, J. (2001). Clinical outcomes of one-to-one midwifery practice. *British Journal of Midwifery*, 9(11), 700-706.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods*. Thousand Oaks, CA.: Sage Publications.
- Reitmanova, S. & Gustafson, D.L. (2008). "They Can't Understand It": Maternity Health and Care Needs of Immigrant Muslim Women in St.John's, Newfoundland. *Maternal and Child Health Journal*, 12, 101-111.



Retningslinjer for svangerskapsomsorgen. Oslo: Helsedirektoratet, 2005. [online] Available

at: <http://www.helsedirektoratet.no/publikasjoner/nasjonalfagligretningslinje-forsvangerskapsomsorgen-fullversjon/Publikasjoner/nasjonalfagligretningslinje-forsvangerskapsomsorgen-fullversjon.pdf> [Accessed 17. March 2013]

Richards, H. M., & Schwartz, L. J. (2002). Ethics of qualitative research: Are there special issues for health services research. *Family Practice*, 19, 135-139.

Rothe, J. P. (1993). *Qualitative Research: A Practical Guide*. Toronto: RCI/PDE Publications.

Rothman, B. (1984). The meaning of choice in Reproductive Technology. In R. Davis-Floyd & C. Sargent (Eds.), *Childbirth and Authoritative knowledge: Cross-Cultural Perspectives*. Los Angeles: University of California Press.

Rothman, K.B. (1982). *In Labor: Women and Power in the Birthplace*. New York: Norton Publications.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.

Sargent, C. & Bascope, G. (1996). Ways of knowing about Birth in Three Cultures. *Medical Anthropology Quarterly*, 10(2), 203-236.

Seel, R. (1994). Men at birth. *New Generation*. 13,16-17.

Severinsson, E., Haruna, M. & Friberg, F. (2009). Midwives' group supervision and the influence of their continuity of care model – a pilot study. *Journal of Nursing Management*, 18, 400-408.

Solberg, B. (2008). Frykten for et samfunn uten Downs syndrom. (Fear of the society without Down's syndrome). *Etikk i praksis*, 2(1), p. 33–52. (in Norwegian).

SSB. (2013). Innvandrere og norskfødte med innvandrerforeldre. Januar 1st, 2013.

Available on: <http://www.ssb.no/innvbef/> [Accessed 11. March 2013].

Squire, C. (2009). *The Social Context of Birth*. U.K.: Radcliffe Publishing.

- Survilaite, D. (2012, April 11-13). Perception of stigma and discrimination by Lithuanian mental patients compared to international data. Message posted to:  
[http://www.hphconferences.org/uploads/tx\\_mhlbihphdb/O2.2\\_Survilaite.pdf](http://www.hphconferences.org/uploads/tx_mhlbihphdb/O2.2_Survilaite.pdf)
- Thomas, B.G. (2006). 'Making a difference': midwives' experiences of caring for women. *Evidence Based Midwifery*, 4(3), 83-88.
- United Nations (2007). The Universal Declaration of the Human Rights  
Available at:  
[http://www.un.org/events/humanrights/2007/hrphotos/declaration%20\\_eng.pdf](http://www.un.org/events/humanrights/2007/hrphotos/declaration%20_eng.pdf)  
[Accessed 2. November 2012]
- Valeikaite, L. (2013). Dauno sindromas nera kliutis gyventi kaip visiems. *Lietuvos sveikata*, 3, 22.
- Vanagiene, V., Zilaitiene, B. & Vanagas, T. (2009). Do the quality of health care services provided at personal health care institutions of Kaunas city and access to meet expectations of pregnant women. *Medicina*, 45(8).
- Van Hollen, C. (2003). *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.
- Vangen, S., Stoltenberg, C., Krondal, A., Magnus, P., Stray-Pedersen, B. (1999). Cesarean section among immigrants in Norway. *Acta Obstetrica Gynecologica Scandinavia*, 79, 553-558.
- Vangen, S., Stoltenberg, C., Johansen, E.B., Sundby, J., Stray-Pedersen, B. (2002a). Perinatal complications among ethnic Somalis in Norway. *Acta Obstetrica Gynecologica Scandinavia*, 81, 317-322.
- Vangen, S., Johansen, R.E, Sundby, J., Traeen, B & Stray-Pedersen, B. (2004). Qualitative study of perinatal care experiences among Somali women and local health care professionals in Norway. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, 112(1), 29-35.
- Van Manen, M. (1997). *Researching Lived Experience*. Ontario: The Althouse Press.

- Vasjanova, V., Kairys, J. & Panasenkiene, O. (2011). Prenatal care and medical law regulation and practice in Lithuania. *Health Sciences*, 21 (6), 104-114. Available in Lithuanian language at: <http://sm-hs.eu/index.php/smhs/article/view/178>
- Viken, B. (2004). *Mødre I et Nytt Land, en Studie av Flyktninger som er Småbarnsmødre*. Available at: [http://www-bib.hive.no/tekster/hveskrift/rapport/2004-03/rapp3\\_2004.pdf](http://www-bib.hive.no/tekster/hveskrift/rapport/2004-03/rapp3_2004.pdf) [Accessed 21. November 2013].
- Viken, B. (2012, August 6-9). Health Promotion Research: Diversity and Challenges in the Management of Maternity Care for Migrant women. Message posted to: <http://www.ntnu.edu/documents/8445058/16027110/Berit+Viken.pdf>
- Walters, C. (2000). Millennium Babies: current research on the health of the unborn generation. Families Magazine. Available at: <http://www.familiesonline.co.uk/Subjects/Articles/Millennium-Babies-Fathers-at-the-Birth> [Accessed 21. November 2013].
- Walton, I. (1994). Sexuality and Motherhood. In C. Squire (Ed.), *The Social Context of Birth* (2003). U.K.: Radcliffe Publishing
- Wanner, C. (1998). *Burden of Dreams: History and Identity in Post-Soviet Ukraine*. Philadelphia: University of Pennsylvania Press.
- WHO (2010). Trends in Maternal Mortality: 1990 to 2008. [online] Geneva: WHO Press. Available at: [http://whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf) [Accessed 21. November 2013]
- Willig, C. (2001). *Introducing Qualitative Research in Psychology*. Berkshire: McGraw-Hill Education.

## EPILOGUE

And a Man said, Speak to us of Self-Knowledge.

And he answered, saying:

Your hearts know in silence the secrets of the days and the nights.

But your ears thirst for the sound of heart's knowledge.

You would know in words that which you have always known in thought.

~ Kahlil Gibran~

## Appendix 1

### Questions for 1<sup>st</sup> in-depth interviews with participants

*(Note: the interviews are exploratory but thematically structured)*

1. As now being pregnant into (N) month, how are you feeling generally?
2. Could you tell me about the time when and how you found out being pregnant? (Explore)
3. Tell me what happened when you visited the doctor's office/ midwife last time?
4. Tell me about the challenging time when you had during pregnancy? How did you feel?
5. What do you feel is lacking in the health care system here for an immigrant pregnant women as you are?
6. What do you like most in the Norwegian health care system for monitoring the pregnant women?
7. How do you perceive the communication between you and health care provider (jordmor, family doctor)?
8. Have you felt that everything was explained to you properly regarding the pregnancy progress, the tests, the necessary nutritional habits, medications (if needed to be taken)? Could you tell me more about it?
9. How would you like your delivery to be if you have any preferences such as natural delivery or medically induced? Do you feel you have a choice?
10. What is your biggest fear regarding the delivery or maybe after the delivery?
11. Do you have a social network here in Oslo? Is your family/husband supportive?
12. What is your age?
13. What level is your education?
14. How long have you reside in Norway and where you came from?
15. How many children do you have? Are all of them were born in Norway?
16. What would you like to add or suggest for other immigrant women who are pregnant and don't speak the language?

## Questions for 2<sup>nd</sup> in-depth interviews with participants

*(Note: the interviews are exploratory but thematically structured)*

1. How are you feeling now since your delivery, emotionally and physically?
2. Could you tell me more about your delivery? How had it started?
3. How did you feel during that time? What mostly concerned you?
4. Tell me about the challenging time during the delivery?
5. How supportive and caring were the midwives/ doctors?
6. Is health station that you attend now with your baby helping you with the information available and necessary in terms of feeding the baby, proper nutrition, self-care after delivery?
7. What do you feel you need to know more?
8. What mostly concerns you now?
9. What would you do differently if so regarding your pregnancy and delivery? Are you mostly satisfied with your experience?
10. Is anything would you like to add?

Thanks!

## Appendix 2

### Questions for interviews with midwives

*(Note: the interviews are free to build an open conversation between the researcher and a midwife)*

1. How long have you been a midwife in Norway?
2. How do you think during these ...n...years have changed the nature of practice the midwifery in Norway?
3. Migration is on the rise in Norway. Have you experienced that different cultural beliefs of the pregnant immigrant women affect the care provision? How? (Explore)
4. What is most challenging for you as a midwife in terms of providing maternal care for immigrant women?
5. When and who should a pregnant woman make the appointment with once she finds out being pregnant?
6. What would you say is the most important in the process of building a relationship between a woman and a midwife (in the birth setting and during prenatal care)?

Thanks!

## Appendix 3

# Request for participation in a research project “Birth experiences among Lithuanian immigrant women in Norway”

### Background and purpose

My name is Kristina Pavydyte, and my personal background is science in nursing. Currently I am a Master student at the University of Oslo. At the moment I am doing research for my Master’s degree in International Community Public Health. This is a request for you to participate in a research study that intends to explore Lithuanian immigrant women’s birth experiences in Norway. There will be two in-depth interviews during which I would like to ask you questions about personal maternal health experiences, opinions and concerns during pregnancy period and birth in regards to Norwegian maternity health care system.

### What does the study entail?

Two interviews will be held on separate occasions (one during pregnancy and another after delivery). The interview generally lasts anywhere from 1 to 3 hours depending on your personal experience. During the interview you will be encouraged to attend to your health needs such as like taking breaks or stopping for the food or drink. You will have an opportunity to discuss the ideas, emotions and opinions regarding the maternity care during the pregnancy and birth of a child. If for any reason you would like to terminate the interview you may do so at any time.

### Risks and Discomforts:

There will be no discomfort associated with the interview process; however, the sensitivity can be triggered due to an unfortunate event during the pregnancy or birth.

### Potential Benefits:

According to the previous research studies exploring birth experiences, many participants who agreed to be interviewed have reported a “sense of relief”, or described the interview as an opportunity to “talk to someone who can understand” especially because pregnancy in a non-native country can be not an easy period in a women’s life. Your participation will also be contributing to a growing body of data that will help to bring attention to transcultural maternity care and help meet the diverse needs of immigrant women.

### What will happen to the information about you?

The information that is registered about you will only be used in accordance with the purpose of the study as described above. All the information will be processed without name, ID number or



other directly recognisable type of information. Only authorised project personnel will have access to the appropriate information collected during the interviews.

### **Alternative Recording Procedures:**

The interview you are voluntarily participating in may be recorded by the interviewer using IC recorder. However, if you do not wish to use an IC recorder you can refuse it, then I will take hand-written notes instead during the interview. The tape recordings will be deleted at the completion of the project, which is within 10 months.

### **Voluntary Participation:**

Participation in the study is voluntary. You can withdraw your consent to participate in the study at any time and without stating any particular reason. If you wish to participate, please e-mail me or contact me personally via phone. If you agree to participate at this time, you may later on withdraw your consent if you will no longer wish to participate in the study.

### **Approval:**

The project is approved by the Regional Ethical Committee, South, in Norway. I am an independent researcher and doing this out of my own interest. I do not work for any organization and I am not paid by anyone to do this research.

### **Contact Information:**

If you have any questions or concerns regarding your participation in the interview process as well as any questions or concerns you might have about the interviewer, please feel free to contact me, Kristina Zemaite via e-mail: [kristina.pavydyte@studmed.uio.no](mailto:kristina.pavydyte@studmed.uio.no) or phone number: 46 36 4114 and my primary supervisor Benedikte Victoria Lindskog via e-mail: [b.v.lindskog@medisin.uio.no](mailto:b.v.lindskog@medisin.uio.no) or my secondary supervisor Marit Helene Hem via e-mail: [m.h.hem@medisin.uio.no](mailto:m.h.hem@medisin.uio.no)

## Appendix 4

### UiO Det medisinske fakultet Universitetet i Oslo

Hei,

Jeg skriver på vegne av masterstudenten Kristina Pavydyte, som jeg er veileder for. Kristina er på et masterprogram på Internasjonal Helse, Institutt for Helse og Samfunn, Universitetet i Oslo. Hun er utdannet i sykepleievitenskap og vil etter jul starte legestudie ved Universitetet i Oslo. Hun gjør for tiden feltarbeid, og i forbindelse med innsamling av data vil en helsestasjon kunne være til god hjelp for studien hennes. Vi ønsker derfor å forhøre oss om muligheten for at Kristina kan gjennomføre 1-2 intervjuer med jordmødre på deres helsestasjon. Intervjuene vil være korte og vil ikke ta mye av deres tid.

Forskningsprosjektet er en kvalitativ studie av litauiske innvandrerkvinnens erfaringer og forståelse av egen helse knyttet til graviditet og fødsel i Oslo. Målet for studien er å samle inn informasjon om hvordan disse kvinnene opplever møtet med norsk helsevesen og jordmødre, samt hvordan jordmødre håndterer kulturelle og sosiale faktorer i kvinnenes kunnskap og forståelse av egen kropp under graviditet og fødsel. Prosjektet er godkjent av Regional Etske Komité (REK) .

Migrasjon og innvandring til Norge er økende. Dette bidrar til nye utfordringer innenfor reproduktiv helse, spesielt i forhold til å oppnå optimal mødre helse blant kvinner med ulik etnisk bakgrunn. Studien ønsker å bidra og fremskaffe kunnskap rundt fødselsomsorg i Oslo. Samtidig har prosjektet som mål å fokusere på de eventuelle barrierer og utfordringer jordmødre må håndtere daglig i deres virke som profesjonelle helsearbeidere, og i deres møte med innvandrerkvinner.

Fokuset vil være på gravide og nybakte mødre med litauisk innvandrerbakgrunn. Prosjektet har som mål å bruke kvalitativ metode gjennom dybdeintervjuer og samtaler. Utvalget av informanter består per i dag av 5 kvinner fra Litauen og 2 jordmødre som ikke arbeider ved en helsestasjon. Studien vil være anonym og data vil håndteres sikkert og bli destruert ved innlevering av oppgaven.

Da alle hennes litauiske informanter er tilknyttet ulike helsestasjoner i Oslo vil det være av betydning for hennes prosjekt å få jordmødrenes egne perspektiver, samt innsikt i deres profesjonelle hverdag på en helsestasjon.

Hvis dere føler at dere har kapasitet og mulighet til å bidra i forbindelse med Kristinas prosjekt hadde vi satt enormt pris på det. Dere kan kontakte meg på mail eller på telefon, også eventuelt kontakte Kristina direkte på mail: [kristina.pavydyte@studmed.uio.no](mailto:kristina.pavydyte@studmed.uio.no) eller på telefon: 46364114

Med vennlig hilsen, Dr. Benedikte V. Lindskog

## Appendix 5



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<b>Region:</b> REK nord	<b>Saksbehandler:</b>	<b>Telefon:</b>	<b>Vår dato:</b> 05.06.2012	<b>Vår referanse:</b> 2012/762/REK nord
			<b>Deres dato:</b> 24.04.2012	<b>Deres referanse:</b>

Vår referanse må oppgis ved alle henvendelser

Benedikte Victoria Lindskog

### 2012/762 Fødselserfaringer blant kvinner med ulik etnisk bakgrunn i Oslo

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK nord) i møtet 24.05.2012.

**Forskningsansvarlig institusjon :** Universitetet i Oslo ved Benedikte V. Lindskog

**Prosjektleder:** Benedikte Victoria Lindskog

#### Prosjektleders prosjekttale

*Forskningprosjektet er en kvalitativ studie av innvandrerkvinnens erfaringer og forståelse av egen helse knyttet til graviditet og fødsel i Oslo. Målet for studien er å samle inn informasjon om hvordan disse kvinnene opplever møtet med norsk helsevesen og jordmødre, samt hvordan jordmødre håndterer kulturelle og sosiale faktorer i kvinnes kunnskap og forståelse av egen kropp under graviditet og fødsel. Migrasjon og innvandring til Norge er økende. Dette bidrar til nye utfordringer innenfor reproduktiv helse, spesielt i forhold til å oppnå optimal mødre helse blant kvinner med ulik etnisk bakgrunn. Studien ønsker å bidra og fremskaffe kunnskap rundt fødselsomsorg i Oslo og i hvilken grad innvandrerkvinnens behov og ønsker blir ivare tatt.*

#### Komiteens merknader

##### Framleggingsplikt

De prosjektene som skal framlegges for REK er prosjekt som dreier seg om "medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger", jf. helseforskningsloven (h) § 2. "Medisinsk og helsefaglig forskning" er i h § 4 a) definert som "virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom". Det er altså formålet med studien som avgjør om et prosjekt skal anses som framleggelsespliktig for REK eller ikke.

Målet for studien er ikke å skaffe til veie ny kunnskap om sykdom eller helse, men å samle inn kunnskap om hvordan innvandrerkvinner opplever møtet med norsk helsevesen og jordmødre, samt hvordan jordmødre håndterer kulturelle og sosiale faktorer i kvinnes kunnskap og forståelse av egen kropp under graviditet og fødsel. Prosjektet skal således ikke vurderes etter helseforskningsloven.

Komiteen gjør oppmerksom på at prosjekter som skal behandle personvernsopplysninger, må legges frem for personvernombudet.

##### Vedtak

*Prosjektet er ikke fremleggelsespliktig, jf. helseforskningslovens § 10, jf. forskningsetikkloven § 4, 2. ledd.*

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**Besøksadresse:**  
TANN-bygget Universitetet i  
Tromsø 9037 Tromsø

**Telefon:** 77646140  
**E-post:** rek-nord@lagmed.uit.no  
**Web:** <http://helseforskning.etikkom.no/>

All post og e-post som inngår i  
saksbehandlingen, bes adressert til  
REK nord og ikke til enkelte  
personer

Kindly address all mail and e-mails  
to the Regional Ethics Committee,  
REK nord, not to individual staff

**Klageadgang**

Du kan klage på komiteens vedtak, jf. helseforskningslovens § 10 tredje ledd og forvaltningslovens § 28 flg. Klagen sendes til REK nord. Klagefristen er tre uker fra du mottar dette e-brevet. Dersom vedtaket opprettholdes av REK nord, sender REK nord klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

May Britt Rossvoll  
sekretariatsleder

Monika Rydland Gaare  
seniorkonsulent

**Kopi til:** [postmottak@uio.no](mailto:postmottak@uio.no)