UiO : University of Oslo

Perceptions and Experiences with family planning services among women and midwives at Health Stations in Oslo

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“Thesis submitted as part of the Master of Philosophy Degree in
International Community Health”

May 2022

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1.0 Introduction

“Sexual and reproductive health is recognized as a fundamental and universal right”- UNFPA Executive Director Addresses Human Rights Council (UNFPA (b), 2014)

Insufficient access to family planning services and contraception persists as a significant reproductive health barrier for women around the world (WHO, 2018). Reproductive Health refers to a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Therefore, reproductive health implies in people have a satisfying and safe sex life and at the time, can reproduce with the freedom to decide if, when, and how often to do so. This is fundamental for both men and women to be informed about the methods of family planning including methods for the regulation of fertility. Hence this method needs to be within the existing law. Access to safe, effective, affordable and acceptable family planning methods is essential to access the appropriate health care services to enable women to have a safe pregnancy and childbirth this will eventually provide a couple with the best chance of having a healthy infant (UNFPA (a), 2014). Thus, reproductive health includes a criterion that indicates its broad spectrum and complexity in a way to achieve it. Here right of access to appropriate health care services includes a bunch of considerations including the health system of a particular country or region, legal rights to access health care services, cost of health service and many more. All these considerations can be embraced under a particular term called reproductive rights. Reproductive rights are basic human rights that are recognized as the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their reproduction. This right includes all the rights documented in the human rights documents, free of discrimination while making decisions concerning discrimination, coercion and violence and other basic human rights (UNFPA (a), 2014). These rights are already recognized in national laws, international laws and international human rights documents and other consensus documents. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (UNFPA (a), 2014). This means reproductive health is beyond public health it includes challenges and issues of social justice that the Human Rights Council’s leadership the same issues such as maternal mortality and morbidity as human rights (UNFPA (b), 2014). Equality and non-discrimination in the workplace have been considered a responsibility of the state if it gets breached with having the reasonability to intervene. At the workplace, for instance, a private employer cannot discriminate against a woman due to her marital status and the fact that she is in her reproductive years. If that happens, the state should intervene. These rights will also be breached if anyone’s access to health care gets denied based on this person’s attachment to a particular group, nationality, gender, age, HIV status, etc. (UNFPA (a), 2014)

A most recent study conducted in the last 30 years period analyzed that there had been a decline in the unintended pregnancy rate, in 2015–19, there were 121 million unintended pregnancies annually and the trend was observed in countries where abortion was restricted, the proportion of unintended pregnancies ending in abortion had increased compared with the proportion for 1990–94, and the unintended pregnancy rates were higher than in countries where abortion was broadly legal (Bearak, 2020). This situation refers to a situation causing higher rates of maternal mortality and morbidity. Singh et.al (2018) highlighted the situation of induced abortion has changed markedly over the past few decades. The abortion rate declined significantly in developed regions from 1990 to 1994 referring to the data of 2010–2014, an estimated 36 abortions occur each year per 1,000 women aged 15–44 in developing regions, compared with 27 in developed regions. In terms of unintended abortion, the rate in developed and developing regions are 45 and 65 per 1,000 women aged 15–44, respectively. Globally the rate of unintended pregnancies ending in induced abortion is 56% compared with the 70% range. It is because of the improved access to modern contraceptives to ensure better control over the timing of their births to meet the growing preferences for smaller families. In the European region, the levels of unmet need for modern contraception are much higher among single, sexually active women than among in-union women because stigma continues to impede single women especially adolescents from getting contraceptive counseling and services.

Researchers have illustrated that immigrant women show higher rates of unwanted pregnancy which raises questions about acquiring access to quality contraceptive education and family planning services (Dias, 2010, De, 2013). Family planning allows people to attain their desired number of children and determine the spacing of pregnancies these services generally enable women in planning and spacing of pregnancies and can delay pregnancies in young women at increased risk of health problems and death from early childbearing (UNFPA (a), 2014). Primary family planning concepts help in decision-making regarding safe maternity and later guide the parents in raising children. A woman's ability to choose when to become pregnant has a direct impact on her health and well-being (Maine, 1981). By preventing unintended pregnancies family planning enables women who wish to limit the size of their families to do so and reduced the risk faced by older women related to pregnancy. Evidence suggests that women who have more than 4 children are at increased risk of maternal mortality. Family planning enables people to make informed choices about their sexual and reproductive health. And by reducing rates of unintended pregnancies, family planning also reduces the need for unsafe abortion (Maine, 1981). A smaller family allows parents to invest more time in a single child, Children with fewer siblings tend to stay in school longer than those with many siblings which eventually enables the parents to offer better childhood to their children. On the other hand, family planning is an opportunity for women to pursue additional education and participate in public life, including paid employment in non-family organizations (Canning, 2012). According to the World Health Organization (WHO) and the United Nations (UN), it is important that family planning is widely available and easily accessible through midwives and other trained health workers to anyone sexually active, including adolescents (WHO, 2015).

Midwives are the front line of family planning, except for medical methods of control like birth sterilization when a patient must be referred to clinician midwives are the first attendant to serve the mother. These services open doors for young women to pursue educational activities or training, paid employment and overall, participation in socialization. Midwives are trained to provide locally available and culturally acceptable contraceptive methods (Kolak, 2017). World Health Organization (WHO) has widely been advocating for facilitated access to family planning services through midwives and other professional and community health workers among all the women especially those with culturally diverse backgrounds (WHO, 2015;). Midwives are reportedly professionally trained in providing counseling and some family planning methods such as pills and condoms and other trained health workers, for example, community health workers are also enlisted to provide counseling and some family planning methods. This method includes Informed choice counseling, Combined oral contraceptives (COCs), Progestin-only oral contraceptives POPs), Emergency contraceptive pills (ECPs), Standard Days Method and Two Day Method, Lactational amenorrhea method (LAM), Condoms (male & female), diaphragms, caps, spermic (WHO, 2018). Some matters that have been emphasized across several studies are the following: lack of knowledge, low socioeconomic status, and bad experience from using contraceptives (Akerman 2019; Morete 2015; Poncet 2013; Wiebe 2013; Ngum 2015). Some efforts have been made to address this by implementing reproductive health and family planning service initiatives among immigrant women, and some studies have documented these processes and produced knowledge about what happened. A study about the experiences of nurses involved in a family planning initiative in Spain found that the nurse plays a key role in the knowledge and use of new contraceptive methods by immigrant women (Morete 2015). Another study about the experiences of midwives done in southern Sweden found some similar findings, but also some differences, such as the finding that “Midwives require knowledge and understanding of cultures and religions to provide contraception counseling to immigrant women” (Kolak 2017).

1.1 Study Background

Immigrants make up a considerable portion of Norway’s population. Since the 1960s, immigration to Norway has increased, peaking in 2012. However, the rate is declining currently due to, among other things, stricter migration policies throughout Europe. In this study context, the term “immigrants” refers to a woman who was born abroad to two foreign-born parents and has immigrated to Norway or was born in Norway with two foreign-born parents (FAFUS, 2016).

Immigrants by reason for immigration and first citizenship, 2020						
	Total, %	Labour, %	Family, %	Refuge, %	Education, %	Other, %

Europe except Turkey	13549, 55.44%	9320, 83.68%	3144, 37.89%	21, 0.84%	782, 35.97%	269, 81.02%
Africa	2025, 8.28%	131, 1.17%	1106, 13.33%	635, 25.62%	123, 5.65%	28, 8.43%
Asia including Turkey	6931, 28.36%	1068, 9.58%	3082, 37.15%	1739, 70.17%	1021, 46.96%	19, 5.72%
North America	838, 3.42%	305, 2.73%	374, 4.50%	0, 0%	149, 6.85%	9, 2.71%
South- and Central-America	820, 3.357%	207, 1.85%	492, 5.93%	36, 1.45%	79, 3.63%	5, 1.50%
Oceania	174, 0.71%	99, 0.88%	55, 0.66%	0, 0%	17, 0.78%	1, 0.30%
Stateless	101, 0.41%	7, 0.06%	43, 0.51%	47, 1.89%	3, 0.13%	1, 0.30%

	Total, %	Labour, %	Family, %	Refuge, %	Education, %	Other, %
Total immigration since 1990	931958, 100%	319933, 34.32%	334032, 35.84%	175978, 18.88%	95675, 10.26%	5636, 0.60%
Total, 2020	24438, 100%	11137, 45.57%	8296, 33.94%	2478, 10.13%	2174, 8.89%	332, 1.35%

At the beginning of the year 2020, the country's population was way 5367580, in this particular year, 24438 new immigrants entered the country (Statistisk sentralbyra, 2021). The immigrant population is a compilation of diverse groups with different genetic backgrounds, risk factors and immigration history, which all affect their health. The research has suggested that immigrant women have different needs and traditions concerning hormonal contraceptives when compared to the native population. Sustainable development goals are global targets that the member states are obliged to achieve combined. In a world where 35 (42%) a million children below 18 years of age are forcibly displaced among the total of 82.4 million global refugees indicates a crisis alarming their role of countries is questionable. The UN, among others, has criticized Norway for failing to ensure that undocumented migrants receive healthcare beyond emergency assistance. Restrictive Norwegian policies have created particularly striking differences between the healthcare services available to undocumented migrants and those available to members of the Norwegian welfare state (Kvamme 2021). And when it comes to family planning consultations, the scenario is even worse (Bains, 2021). Norway is at the forefront of efforts to promote gender equality and women's health at the international level. It has a long history of good reproductive health care, with some of the world's best reproductive health indicators. Early reduction of maternal mortality, good services for abortion, contraception and prevention and treatment for sexually transmitted diseases, a low rate of adolescent pregnancies and a low number of people with HIV are examples all these achievements become possible through funded publicly provided integrated health care package. Despite being considered the pioneer in providing qualified reproductive health care Norway’s achievements in ensuring reproductive health facilities are only restricted to local populations. The government continues to confront challenges in providing structured reproductive health services to people of migrant backgrounds.

Still, some citizens are not reached, especially concerning family planning services and contraception, potentially due to a lack of knowledge, disability, unemployment, drug addiction, cultural barriers, or other forms of disadvantage (Sandvik 2012). This choice of contraceptives changes over time and varies with the duration of stay and adaptation to a new country of residence (Omland, 2014). Low education is associated with a lower frequency of child delivery but a higher frequency of induced abortion (Eskild, 2017). One sub-group of immigrant women understood to be especially vulnerable to unmet reproductive health needs in Norway are those without legal residency, otherwise known as 'undocumented migrants', given their restricted rights to health care (Balaam, 2013). This sub-group is indicated as undocumented migrants hesitant to use health services due to a lack of knowledge and fear of deportation among the migrants in Europe (De Jong et.al, 2017).

Research suggests that this may be due to several reasons, such as cultures that value multiple and closely-spaced children and religious beliefs that contradict common forms of contraception (Morete, 2015; Dias, 2010). In the Somalian culture, a woman's status is enhanced by her ability of child production. For a Somali woman, child reproduction is the only way to secure her marriage and get loved by her husband since in polygamous societies the husband very usually gets married several times to produce as many as children to strengthen the family dominance in the society. In Australia, Watts (2015), conducted a qualitative study among immigrant women themselves, and their significant findings were that young African Australian mothers with refugee backgrounds face multiple barriers, including social, educational and economic disadvantages. The article indicates that there is low sexual health literacy, including knowledge of contraception, among young African Australian mothers and African Australian parents. And eventually, when the family migrates to another country the social circumstance may get change but the family gets stuck with the culture to take as much as children to make their marriage stronger and safer (Gele, 2019). Thus, understanding the cultural background of the immigrants is essential for further policy development. This cultural knowledge of the immigrants' originating country may shape attitudes and practices relevant to reproductive health and it may mediate immigrants' response to knowledge. Research also suggests that this might be due, in part, to lower rates of reproductive health service access among immigrant women (Lauria 2014). A systematic review by Leppälä (2020) on Sweden, Norway and Finland concludes that humanitarian migrant women face obstacles in maternity care broadly due to three reasons (1) diminished negotiation power, (2) sense of insecurity, and (3) experienced care-related discrimination.

1.1.1 Diminished negotiation power on care

Proper negation is one of the pre-determinants of a successful medical session example: ANC, any clinical or hospital setting. For that patient preliminary level of literacy about the health system is one of the pre-determinants. Limitation in health literacy in versatile forms was reported as a potential hindrance to optimal maternal health in multiple studies, difficulty in interpreting very specific medical terminology about pre-natal diagnostics in antenatal care (Garnweidner et al., (2013); Viken et al., 2015; Byrskog et al., 2016; Carlsson et al., 2016; Glavin and Saeteren, 2016) Sometimes humanitarian migrant women had declined invitations to participate antenatal care group sessions because of not being able to behave in the groups during the session (Glavin and Saeteren, 2016). This lack of knowledge eventually sometimes escalated into great fear of childbirth (Lillrank, 2015).

Problematic representation and overload of information both create difficulty for the migrants to experience nutrition-related information in antenatal care. Information dissemination regarding the antenatal care program was found problematic since some participants had objections regarding the availability of information only on request, only in writing, or too late in regards to the gestation weeks (Garnweidner et al., 2013). Moreover, this information can be sometimes incongruent with the cultural beliefs and habits of the participants. Incongruent information and the care professionals' lacking recognition of culture-specific issues even result in miscommunication in the caregiving process. Sometimes the health care professionals unrecognized and underestimate the mothers' perceived care needs and by making them unheard they lose their trust. Sometimes the patient gets triggered by a personal attack from the care professional (Robertson, 2015).

1.1.2 Sense of insecurity

The language barrier is one of the significant barriers to seeking and receiving adequate maternity care, it is even difficult for an immigrant when a technology comes in between which requires another third party to intervene. Ultimately, obstacles in conveying one's needs are the main barrier to availing of health care facilities. Participants in her study reported the telephone booking system as a huge problem for care-seeking because it requires a third party like a family member to intervene in the care-seeking decision and forms (Robertson, 2015). Again, addressing mistrust towards interpreters' women reported fear of being misinterpreted in maternity care by incorrect language translation (Barkensjö et al., 2018). Similarly, the maternity care-seeking women asked questions regarding the usefulness of the provided care (Byrskog et al., 2016), even the motive of the care professionals which indicates their fear of negative consequences regarding seeking care.

1.1.3 Experienced care-related discrimination

Access to maternal health care for Humanitarian migrant women is complicated and sometimes refers to negative attitudes and behavior of the health professionals toward humanitarian migrant women. Related to these types of incidents several cases have been reported that bear the evidence of discrimination toward the humanitarian migrant women from the system and people. Unfriendly communication, lack of interest, intolerance and inflexibility, lack of respect, distant and absent behavior and treating one with indifference (Viken et al., 2015; Barkensjö et al., 2018)

The latest WHO report on the health care system of Norway denotes it as one of the world's strongest. This Nordic country, with a population of 5.3 million, is sparsely populated where the majority of the population are residents of the coastal region in the south-eastern and the south-western parts of the country. The per capita gross domestic product (GDP) of Norway is the highest in the world with one of the lowest income inequalities among the EEA countries and in terms of gender equality and female participation rates are high in education, the labor market and political life this country rank high. Life expectancy has continued to increase and reached 82.7 years in 2017 – among the highest in Europe. Cancers, circulatory diseases and musculoskeletal disorders had the largest contribution to the burden of disease in Norway as measured by disability-adjusted life years (DALYs). Despite some common trends in the developed countries, Norway is good at many health factors such as the share of the adult population who exercise regularly improving factors such as decreasing the share of smokers. The health system is semi-decentralized where the four Regional Health Authorities (RHAs) are responsible for specialist care and municipalities responsible for primary care and social services. According to the changes in the Public Health Act in 2011 the Health in All Policies approach is featured centrally. In terms of expenditure, Norway stands at 10.4% of GDP in 2017 which is the fifth-highest in the WHO European Region. With this high GDP per capita in the world, the country's per capita health expenditure is also much higher than in most countries – over US$6500 PPP, second only to Switzerland. The Norway health care system offers a ratio of doctors to inhabitants which is the highest in Europe, with doctors (4.7 per 1000 inhabitants) and nurses (17.7 per 1000) the same as the ratio of nurses to doctors. All residents of Norway are entitled to essential medical care where the private health financing mostly comes from households' out-of-pocket payments, of which most is spent on pharmaceuticals, dental care and long-term care. However, to protect the population from excessive health care expenditure an annual cost-sharing ceiling is also there. The financing structure is aimed at both containing costs and giving providers sufficient flexibility to ensure the best mix of services for patients. For family planning and antenatal services, the country depends on the municipalities. Midwife at the local Maternity and Child Health Care Centre (helsestasjon) or by the regular GP provide this service on regular basis. The maternal health service usually includes eight antenatal appointments, including one ultrasound screening during pregnancy with consultations free of charge. In the working culture, working women who are pregnant have the right to paid time off work for attending antenatal appointments (Sperre, 2020).

Compared to the host population, immigrant women of non-Western backgrounds have high rates of both fertility and induced abortions. For African women's families pressure is one of the reasons to do so (Gele, 2019), on other hand, a religious belief like the revival of life with the same sexual organ makes the women take the decision not to use contradictive to stay productive in their second life. Cultural values and religious beliefs contradict common forms of contraception use, on the other hand, access to reproductive health care for the immigrant people is also an issue to be concerned with are the research outcomes available. (Morete, 2015; Dias, 2010; Lauria 2014). Watts (2015) observed low sexual health literacy, knowledge of contraception and other social, educational and economical disadvantages hamper the reproductive health care of immigrant women. And again, several studies also suggest that women of non-Western immigrant backgrounds are less likely to use hormonal contraception (Millar, 2017) which is extensively depicted in the discussion further. Our study will aim to explore and understand the experiences of both the midwives and women who have participated in a family planning services initiative at one of the Oslo health stations.

FAFUS is a dedicated program for immigrant women in Norway, these initiatives were taken by the Norwegian government to ensure accessibly reproductive health and family services among immigrant women. According to the Norwegian Government's Integration Strategy 2019-2022, integration is the main goal of the government and to make it possible efforts, participation and contribution from the immigrant's side are expected (The Norwegian Government's Integration Strategy, 2019-2022) and thus the Norwegian government had taken several initiatives including better implementation of reproductive health and family services among immigrant women. FAFUS was initiated in September 2010 with the objective of the prevention of unwanted pregnancy and abortion for immigrant women, through the program was a low threshold outpatient offering to immigrant women and completed within a very short period. The handbook written incorporating the experiences of FAFUS was published in 2016, FAFUS was a weekly based program on the premises at Ullevål Hospital. The program was family planning focused involving information, guidance and counseling about the different methods of contraception, insertion of coil and P-Rod, as well as cell sampling from the cervix. During the time of five years 2010-2015, the FAFUS program served 1841 women with consultation service and 3263 consultations were conducted and controlled by the health personnel. The project has received very good feedback, both from the women and the health personnel, and it shows that such an offer is needed. When the information is adapted to the individual woman based on the level of education, knowledge, experience, culture and language, attitudes, values and religion, the probability is greater that one can reach the woman.

The required information was provided for the woman to be able to participate and capacity building to make the decisions right to an individual such as the selection of suitable contraceptive methods. The outcome of FAFUS is interesting, immigrant woman's birth control and abortions are affected by the factors where the most important one is the health care available to the citizen. Among other things, FAFUS found that there is a gap in communication between the health center and the general practitioner (GP) in connection with the contraception guidance in general, and at the 6-week check after birth in particular. FAFUS showed that today's health services are somehow insufficient for immigrant women but necessary to provide services by using other methods to safeguard the right to equal health services. A low threshold offers where immigrant women do not face such obstacles that they face in general hospitals or GPs has therefore increased their accessibility to avail health services. Since the service was offered at the premises of Ullevål hospital, it still does not satisfy all requirements for the definition low threshold and as it is affiliated with the specialist health service and the location was not nearby the immediate area where the woman lives and only available during the night time once a week. Another important premise for women to have to seek FAFUS is that it was free, both guidance and long-acting contraceptives. Free of cost is that’s why a major cause behind FAFUS become so popular. Also, it offers the women to get the hour fast, either by ordering by phone or by "drop-in". There has also been plenty of time for the consultation and everyone has been offered post-control.

Figures based on consultations during the period January 2013 to September 2015 show that the women who met at FAFUS were between 31-35 years. Women from 71 countries participated in the program where most of them were from Somalia, Iraq, Pakistan and Afghanistan. Furthermore, the figures showed that 28% of women have lived in Norway for less than 5 years whereas 65 (4%) said they were not in income-generating work. Among the total participants, 74% were married with the fertility rate among the women who met up for the program is 2.9 which the way higher than the rate (1.53%) in Norway in 2019 (Worldbank, 2022). 14.2% of women had five or more children each and 14.3% have had an abortion when it was concerning. In terms of communication and Norwegian knowledge, 63% of the women reported that they spoke Norwegian, and 29% said they spoke a little Norwegian, the rest said that they have no Norwegian knowledge. When it comes to the main reason they visited the offer, they said it was that they wanted birth control (63%) and that they wanted cell samples (23%). FAFUS has come out with some interesting insights that showed that many of the women who took advantage of the offer had little knowledge about their own body and health, and limited knowledge of the

Norwegian health care service. A large proportion of women had many children and great challenges both because of limited Norwegian knowledge, social isolation, cramped housing and poor economy. About one-third of the women reported that the consultation and the offer of contraception needed to be free. For many of these women who were unable to consult a GP is a real alternative when applying for reproductive health services.

One has also seen through FAFUS that many had not taken a cell sample from the cervix of their doctor according to guidelines for the screening program. They had little knowledge of the danger of cervical cancer and were not encouraged to take a cell sample. Several women were referred to by FAFUS midwives for surgical treatment after precursors of cervical cancer were detected in the cell sample. Ultimately, the research is limited. Though we have a statistical understanding that immigrant women as less likely than non-immigrant women to participate in family planning services or make use of contraception, and though some studies have begun to suggest reasons for why, we still lack a comprehensive understanding of the diverse and interdependent factors in which this is potentially implicated, and the limited number of studies that have been undertaken, have suggested a clear need for further research. In particular, we still lack understanding of the perceptions and perspectives of these women themselves, and there is a need for further insight into the experiences of the midwives and health personnel who provide such service.

2.0 Aim of the study

The guiding research aims to explore perceptions, perspectives and experiences related to a family planning initiative undertaken at some maternal and child health stations in Oslo, Norway, predominantly among women who have received services, but also among the midwives and health professionals who have provided these services. The study results would certainly help in exploring perceptions of contraceptives among women who have participated in these family planning services. The research also allowed to generate insight into their experiences with this service offer, particularly concerning the consultations, information, guidance, and contraception they received as well as considering the women’s suggestions for service changes and improvements. It will explore the experiences and perspectives of the midwives and health professionals who provided these services, particularly concerning their perceived challenges and successes, as well as advice for moving forward. Besides, considering the current situation of women immigrants and the report of FAFUS the research needs to be carried out with socio-economically marginalized women, as the study will explore how the burden of conditions associated with the unmet need for contraceptives is associated with socioeconomic inequities. Conducting this research with a less vulnerable group would have prevented the researcher from investigating these issues, as affluent women have better access to health services such as safe abortions. However, interviewing women who have already received a lot of attention may add to the existing burden of knowledge so this study approached from a different point of view. In this study, the researcher attempts to understand the perceptions and perspectives of both immigrant women and midwives and other health professionals regarding receiving and providing family planning initiatives respectively. This study will be interviewing women who have less access to health facilities it is likely that they will belong to a vulnerable group.

2.1 Objectives

The study objectives are as follows:

1. To explore perceptions of contraceptives among women who have participated in these family planning services

2. To generate insight into their experiences with this service offer, particularly for the consultations, information, guidance, and contraception they received

3. To consider the women’s suggestions for service changes and improvements

4. To explore the experiences and perspectives of the midwives and health professionals who provided these services, particularly to their perceived challenges and successes, as well as advice for moving forward.

3.0 Methodology

Research in medical science is complex, even when clinical evidence conflicts with scientific pieces of evidence. Clinical is an intervention based so they are experimental studies on humans and the other one is observationally-based. Since the base of medical research depends on multiple evidence according to the purpose of research, similarly in recent times, development in molecular biological, genetic, biochemical and morphological methods have drawn a clear distinction line between molecular biological, genetic, biochemical and morphological methods (Laake et al., (Eds.) 2007). That means a potential level of diversity exists in the methodological application of these sub-fields. Diversity in medical research is no more in theory anymore rather the practical scenario is more complex involving huge methodological diversity too. Harmony in the knowledge domain can only be secured by preventing this methodological separatism and supremacy. Diversity will expand the field only if methodological unity exists among the researcher (Malterud, 2001).

One of the applications of the qualitative method in research is to explore human perception, perspective and experiences regarding any situation. The purpose of this research is to explore the women's and midwives' opinions regarding any situation related to a family planning initiative undertaken by the maternal and child health stations in Oslo, Norway. To meet the aim of this study qualitative method has been selected, answer to all of the research questions of this study will be based on different theories and methods and all of these will be discussed and elaborated in different stages of this chapter.

Qualitative and quantitative methods are widely used in the research arena though in terms of purpose, strengths and logics there are completely different (Maxwell, 2004a; Maxwell & Loomis, 2002). Clinically medical science research depends on lab-based evidence whereas at the community level researchers get multiple options to choose from depending on the level of criteria met up. Selecting any research method requires a certain level of self-questioning, this process suggests a researcher select the method for his/her research to fulfill the aim. Mason (2017) suggested some possible considerations why one might wish to use qualitative interviewing as a method in his/her research-

1. One of the reasons behind qualitative interviewing is to explore meaningful properties of the social reality like people's knowledge, views, understandings, interpretations, experiences, interactions, etc. A researcher may be interested in the constitution of language, or discursive constructions of the social or the self.

2. Qualitative research offers a researcher an epistemological position that allows a researcher a legitimate or meaningful way to generate Knowledge based on particular ontological properties by talking interactively with people, asking them questions, listening to them, gaining access to their accounts and articulations, or analyzing their use of language and construction of discourse. Thus, Qualitative research is heavily dependent on people's capacities to verbalize, interact, conceptualize and memorize.
3. An interview is like any other interaction in a social situation which makes researchers to viewed qualitative research as situational knowledge. For this reason, qualitative research prefers contextual knowledge-based questions which offer an interviewee to generate maximum opportunity for the construction of contextual knowledge by focusing on relevant specifics in each interview instead of asking abstract questions. At the same time, the Focus Group Discussion option allows a researcher to observe account actualization workout and negotiation in a particular situation of interaction. To maximize the interview's ability to produce situated knowledge research will need to be flexible and sensitive to the specific dynamics of each interaction to take cues from the ongoing dialogue rather than going through an entirely pre-scripted one. That's how Qualitative research helps in extracting inside from each line of the interview based on their context.
4. Semi-structured interviewing is another method of the qualitative interview to control bias in the interview since it is quite impossible to separate the interview from the social interaction in which it was produced. As a solution Semi-structured interviewing offers tension to reduce the complexities in the interview and helps a researcher to understand the complexities and develop a sense of how context and situation work during an interview setting.
5. Qualitative interviewing offers a depth and roundedness of understanding of a particular area, rather than a broad understanding of surface patterns. This particular feature helps a researcher to understand people's situated or contextual accounts and experiences rather than a more superficial analysis of surface comparability between accounts of a large number of people which offers a distinctive approach to comparison, analyzing data and the construction of

arguments to the generation of cross-contextual generalities. The point of comparison therefore will be unlikely to be straightforwardly cited at the level of differences or similarities in people's answers to the same set of questions Nevertheless this process requires the researcher to ensure to generate data that will be appropriate comparisons.

6. In Qualitative research, active and reflexive are vital in the process of data generation considering that no data collector is neutral. So it is important to address the reflexive properly during the process.
7. The availability of data in a presentation format can be a reason behind picking a qualitative interviewing approach, asking people for their accounts and talking and listening to them can be the only source of data. Data regarding this type of practical situation may not be available in records of existing research, documents, letters, diaries, and so on, in this type of situation a researcher should consider how good a substitute for the preferred method is a 'conversation with a purpose of this kind.
8. To form methodological triangulation Qualitative data can be e one of the several methods to explore a particle Research question. Since we cannot expect different methods to produce some kind of data Qualitative data in research can add dimension and also can help to judge the same question from a different angle or in better depth.
9. Particular views in research ethics and politics can also be a reason behind selecting qualitative interviewing as a method. There are many ethical considerations in research, especially during an interview ensuring an appropriate mindset of an interviewee while answering, similarly, the freedom in and control of the interview situation than is permitted with 'structured' approaches. Responsiveness, joyfulness all these particular emotions of each interviewee can be observed by the interviewer during a qualitative interview which takes an interviewer in an ethically better position in terms of data collection, though the level of data precession should not turn the interview into a 'therapeutic encounter'.

As this project's purpose was to get an in-depth understanding of peoples' experiences, qualitative methods were the most appropriate for the study to generate insight from both the service receiver and the provider's point of view. Qualitative research techniques include ‘small-group discussions’ for investigating beliefs, attitudes and concepts of normative behavior; ‘semi-structured interviews’, to seek views on a focused topic or, with key informants, for background information or an institutional perspective; ‘in-depth interviews’ to understand a condition, experience (Hammerberg, 2016). An anthropological approach will enable a focus on the subjective perceptions and experiences of the research participants themselves, as viewed, to the greatest extent possible, from their perspective and situated within the contexts of their cultures and lives.

3.1 Study Site

The study data was collected from two health stations located in Oslo, Norway. The health system of Norway is semi-decentralized and empowered by Regional Health Authorities (RHAs) response to specialist care and primary care and social services come under the responsibility of the municipalities. According to Oslo byleksikon (English: Oslo City Encyclopedia), which is an encyclopedia on Oslo, Norway's capital city publishing in 1938, health centers run preventive work for pregnant women, infants, toddlers and adolescents. After the reorganization and closure of the Health Council on 30 June 1988, this facility was administered by the Department of District Health Nursing Services in 1988, on that time 54 health stations were established the Department of Maternal and Child Health 3 stations which were also connected to the Family Counseling Office and the Maternal Hygiene Office. The responsibility for the health stations was transferred to the districts on 1 July 1988. At the current time, all 15 districts in Oslo have a health station service and health stations for young people (Oslo byleksikon, 2020). These health stations are municipalities based on the boundary and population size each municipality has its health station. Study sites were selected based on the density of the immigrants predominantly, in the last few decades the city has faced a great transition in terms of the ethnic background of its citizen. The western part of the city may be density by local Norwegian with only 5% immigrants whereas the eastern part already facing an ethnical transition where up to 97% of children in school are immigrants and 40% of children in primary school in the city speak a foreign language rather than Norwegian or Sami. In terms of religion, the Oslo in the city has 19% fewer members of the church in comparison with the national average. According to the latest data, Pakistanis in Oslo are the largest ethnic minority followed by immigrants from Sweden, Somalia, and Poland. There are also sizable communities of people from Iraq, Iran, Vietnam, Turkey, Morocco, the Philippines, and Sri Lanka. This population altogether covers 30% of the whole population of Oslo (World Population Review, 2022).

3.1.1 Gronland

The first site Gronland was located near the city center situated in the Eastern inner part of Oslo City, it is very commonly translated as Greenland however the current pronunciation is “grurn-lan”. Gronland is known for its diverse background population with mostly immigrants, due to this reason this place is surrounded by people of different ethnicity and speakers of multiple languages. The net population of Gronland is 9,852 which is 1.4 % of the total population of the Oslo city with a much higher population density of 18967/km^2 , interesting 78.6% of this population belongs to the reproductive age group between 20 to 66 years (City Population (a), 2021). Due to its diverse culture and cheap price Grønland is a popular place outing (David, 2011). Gronland is predominantly populated with immigrant women from Somalia, Vietnam and Nigeria.

3.1.2 Bogerud

And the other one is Bogerud which is located at a little distance from the city center but reachable through local transport. Bogerud’s current population is 1748 which is 0.25% of the total population of Oslo city with a dominating people from the age group 20-66 years slightly higher ratio of women (53.4%) (City Population (b), (2021). The Bogerud municipality is populated predominantly by immigrant women from the war crisis region like Syria, Palestine and Turkey.

3.2 Study Population

The population growth of the OSLO city after the 1980s within influenced by the increased natural growth (birth surplus) and increased net immigration to the city with a noticeable birth rate in the mid-1980s. Till now the city has faced its highest birth rate of 10,267 births in 2010 in the history of it. Behind the strong population growth since the 1980s are several demographic conditions that have seemed fairly parallel: increased natural growth (birth surplus) and increased net immigration to the city. Increased birth rates from the mid-1980s are particularly noticeable. In 2010, the city had 10,267 births, the highest birth rate in the city's history. Though the birth rate actually increased due to very natural reasons like overall fertility rate and more resident women of childbearing age the overall population growth get a sudden boast which significant increase in natural growth, as a result, the negative rate before 1988 turned +5959 surplus in 2010 and +5415 surplus in 2018. However, during this time natural growth has declined. Fortunately, the city gets a declining trend after 2010 and record 9,309 birth in 2018. It’s due to the fall fertility rate peaked in 2009 at 1.88, but had fallen to 1.44 in 2018 (the national fertility rate was 1.56 during the same period; the difference between Oslo and the whole country of 0.12), in real life which means- the number of children that a woman gives birth to through her fertile age is returning. In comparison with the national trend, the population growth had somehow declined after the 1960s. The difference between the national and the city fertility rate had dropped to around 0.68 which was 0.1 around the turn of the century which indicates a net natural growth influx from the mid-1980s except to the year 2000. In tradition Oslo recipes a significant net emigration to Akershus internally and a net emigration from the country's other counties. As a result, small changes year to year caused large fluctuations in the population balance of the country, especially since the first half of the 1990s a clear increase in immigration and a somewhat smaller increase in emigration from the city. Finally, after 2014 the net migration to Oslo has declined somewhat as a result of increased migration (Oslo Byleksikon (b), 2020).

Studies have come out with several reasons behind health access inequality and unintentional pregnancy in Scandinavian countries like Norway, especially in the big cities like Oslo (Leppälä et al., 2020). Oslo is the fastest-growing capital in Europe (22.3%/10 years) developing and providing services to first-time mothers and their infants in an Oslo district serving 53% of minorities from 142 countries is described. This rapid shift to a heterogeneous society with substantial variations in educational attainment, tradition, health literacy, and financial means creates challenges across the health and social services. Norway's example (World Population Review, 2016). Factors hindering maternity care are (1) diminished negotiation power, (2) a sense of insecurity, and (3) experiencing care-related discrimination (Leppälä et al., 2020)). Besides, lack of knowledge, low sexual health literacy and religious beliefs regarding the use of contradicting are major reasons behind health access inequality (Morete, 2015; Dias, 2010). In addition, fear of deportation and lack of knowledge regarding the health facilities of the migrated country also make the immigrants hesitant to avail health services (De Jong et.al, 2017). For this study, the participants were recruited considering their different cultural backgrounds, predominantly from Somalian, Vietnamese, Nigerian and Norwegian.

3.3 Sampling and Recruitment:

In qualitative research, the purpose of the target audience is to provide in-depth knowledge about the study scenario. Participants are selected to take part to share their experience with family planning services from the health care center. Their perceptions of contraceptives and family planning services will provide insight into the service and contraception needs of the migrant people. In this study site both the health care provider and receiver have their point of view regarding their service, this study addressed both of them. The sampling was conducted considering the cultural and ethnic diversity of the emigrant. Considering their cultural and country backgrounds participants were selected purposively, finally, five regular service receivers and two midwives working in the health center were selected.

3.4 Timeframe

This study was formatted according to the guideline of the Master of Philosophy degree in International Community Health at the University of Oslo (UiO). Primarily the protocol was submitted to the supervisor in May 2019 and later the study was approved by the ethical committee in November 2019. The actual survey was conducted December 2019 to January 2020

3.5 Data Collection Procedure:

The interview is one of the most popular data collection methods used in qualitative research. It can be used in several research settings to collect information on a specific theme or topic. Conducting an interview can be semi-structured however, it can hardly be structured. Unlike a conversation, an interview is completely objective-driven. Interviews have very few examples to be unstructured. During an interview, a respondent firstly wants to demand from the interviewer, what he/she wants to know and accordingly make choices about the kind of information s/he will provide. For this reason, no matter how much straightforward it seems there are some important factors to keep in mind during conducting any interview. In a real-life scenario, an interview may be a relatively natural flow of conversation between interviewer and interviewee however an effective interview is restricted by a strict set of doing and don’ts. In terms of place, convenience may not necessarily be sitting somewhere private for an interview but rather collecting data from the interviewee from their working place during the active period. An interviewee from a socially restricted community may not speak out so easily, moreover, the interviewer may be a stranger or a person who belongs to a completely different class. Again, the interviewee may represent his/herself in a very general way. For instance, in a male dominating society the female person may come up with no objection or issue with the male dominance however, there might be serious gender violence against women. The level of intimacy or familiarity with the respondence will result in a better study outcome, however, the depth of the information will depend on the researcher’s social characteristics and the way the interviewer has related to the people during the interview. On the other hand, a relaxed interview may seem enough data generating but those will be nothing but the public presentation of the respondent, an interviewer must oversee the inner meaning of the statement.

3.5.1 Observation and informal conversations

This project was an invited interview with the researcher from one of the midwives from Gronland Healthcare station and later bogerud was also suggested by a midwife. To observe the setting and service structure the health station researcher visited the previous day before conducting the survey. Normally no outsiders are allowed to enter the building without an appointment and the building space is divided into finely decorated hall rooms. These hall rooms are assigned based on the patient's requirement to receive seminars for one-to-one counseling from the midwives. On the interview day, the researchers faced the service receiving women, this woman in a particular hall room, the researcher found the environment of the health station friendly and well coming and since it was an invited project health station members welcomed the researcher. The health station authority was very welcoming and well behaved with all the patients and their questions though strictness of time and schedule maintenance were observed in their behavior. Timeliness is a part of the Norwegian culture that most of the time is missing among the immigrant who belongs to a cross-culture. During the interview time, participating women were interactive and supportive to the researcher, no cultural or behavioral issue was observed among the midwives and the women by the researcher unless it was dormant.

3.5.2 Semi-structured interviews

Semi-structured interviews were conducted to get an insight into women's knowledge and perceptions after using services from the health station. The interview can be of many types depending on the required types of information, this information can be facts, meanings, experiences and observations. Depending on the criteria interviews are of several types wherein in semi-structured interviews the interview is conducted on a loosely structured topic guide or checklist of topics you want to cover. Mix types of questions are asked in this type of interview, interviews contain closed-ended and open-ended questions, and cover fairly specific topics or themes. Semi-structured interviews are not typical questionnaires because the interviewee can respond freely to what is asked. The probe questionnaire consisted of follow-up questions and exit questions. The extensive interviews provided an opportunity to have an insight into the relationship between the health care providers and participants. The questions are mainly for the referential purpose to keep the conversation within the specific topics or theme, the additional question may be included or questions may also be eliminated according to the flow of the interview. The full responses of all 7 participants are given in the appendix. A semi-structured interview offers better analysis and data comparison between multiple interviews by using asking main questions and using similar wording used across interviews.

Another popular type of interview used in qualitative research is an unstructured interview, typically no research can be unstructured since in research questions are always asked with an aim and the respondents are least constrained in their responses by the questions asked. As result, these interviews most closely resemble a conversation. Things are discussed from the point of view of a broad idea but the interview needs to start with a single question which eventually forms a bigger context. All these conversations are picked up under different themes to define a different stream of the outcome.

3.5.2.1 Interview with women

The responses from 5 different women were recorded where their background and personal history including information about age, educational level, number of children, underlying physical conditions, use of contraceptives; experiences regarding receiving reproductive health services, the decision of contacting the health professionals and suggestion for the services.

3.5.2.2 Interview with midwives

On the other hand, the interview questions for the midwives working in Gronland and Bogerud health stations included Challenges of working in Gronland and Bogerud Health stations, Challenges of working with FAFUS Candidates, personal experiences, initial challenges, current situation, overall challenges and personal experiences.

3.5.3 Other sources of data

For similarities in purpose and objective the outcome of FAFUS can be a reliable data source. The program meets Women from 71 countries participating in the program mostly from Somalia, Iraq, Pakistan and Afghanistan. Low earning capacity, high fertility, tendency to take a higher number of children were the characteristics found among this population. Little knowledge about Norwegian and the Norwegian health care service and health literacy including their body, social isolation, cramped housing and poor economy are the big challenges to ensuring a proper health care system for the immigrants where their major findings of the study.

3.6 Questionnaire:

The questionnaire was made as assistance during the interview, the interview was divided into two sections one for the participating women and another one for the midwives. The first segment contained questions of six categories, background information, birth and children, contraceptives, experience after using, on health station, and current needs. Questions were designed to get maximum insight regarding the perceptions of contraceptives and family planning services of the women including follow-up questions and exit questions. The demographic information is general information, age, residence, level of education, job experience, etc. Information regarding the women’s reproductive history was most significant for this study that’s why the questions included in this section are the number child taken, decision making before taking a child, the culture of family planning in the community, gender discrimination from the community. The use of contraceptives is another indicator of access to health care, women’s conception regarding the use of contraceptives, the practice of using contraceptives, and influence in decision making before use and the point of view of the community regarding the use of contraceptives. Their user experience of contraceptives was also asked, the current practice of using contraceptives, what was experienced firsthand, which method they are using currently and who took the decision, was there any switch in method, any complication, duration of use and the reason behind stopping if stopped. Maternity and Child Health Care Centre in Norway is responsible for offering all citizens a better life, this health station offers primary maternity care from a midwife or their General Practitioner. Questions were asked regarding the health station and its services, its accessibility and service quality including the quality of the service providers. And finally, their level of satisfaction regarding the service was asked with their suggestions regarding implementing new services. In the second part of the interview, midwives were asked questions regarding involvement in the project, change in experience during the period, their experience with the ‘vulnerable’ patients and involvement of the migrant women. Immigrant’s pressure in the health care service results in challenging situations for the service providers including the midwives. Midwives were asked about the current challenges they are facing at the current time, the extra precautions they used while serving migrants, their way of dealing with people with different cultural and religious views while providing contraceptive methods and the centers’ resources available to help their target population. Besides all this, there were exit questions for the participants to end the interview anytime. The complete version of the questionnaire is attached in Appendix 1.

3.7 Role of the translator:

Since the survey participants were immigrants, the researcher required a language translator to communicate with them. The language translator was a Norway-grown Somalian women physician in the profession. Three out of five have a limited or moderate level of fluency in English and since the translator was a female person the service receiving women found the conversation more comfortable than with the researcher.

3.8 Data Analysis:

Data analysis in qualitative research is human-centric and an ongoing process. This data analysis is a process of qualitative research completely different from the data analysis in the quantitative method, depending on the position, experience and perspective of the researchers the analysis varies a lot. As a result, the same subject in qualitative research can be approached from a different perspective. Data from multiple sources need to consider in qualitative research, this process is called research triangulation. Triangulation in research is mostly used in qualitative research however, quantitative researchers are also using this methodical technic to get a better outcome from their existing data. In the current scenario, mixed-method research is the most common example of Triangulation in research. Triangulation increases the validity and comes out with a more credible finding.

The analysis process of qualitative data is described differently by different authors, Step by step procedure has already been documented by The Scholars for the implementation of this technique. In a general sense, analysis means to extend the meaning of the data and use them in a broader context. It involves understanding the meaning of the data beyond the general meaning of that particular text and interpreting or understanding the observation from a third-person point of view.

3.8.1 Data management

Data generated from the survey was managed confidentially following the guideline of the General Data Protection Regulation and Personal Data Act. Personal audio data of the participants recorded in the interview and group discussion had limited access. None but the researcher and the translator had access to those data. All identical information of the participants was intentionally removed after the interview was completed and replaced with a code number. Recorder with all the recordings were being out from the study site slightly and stored in a secure domain of the University of Oslo network. This domain is public inaccessible and at the same time protected with a double layer password system so it can be considered protected from any third-party access. For data analysis purposes access to data was provided to the translator with set conditions. All this information is kept private with limited access to others and at the same time, it may be impossible for one to track the participant's name due to the conversion of the name into a coded format that may only be interpreted by the researcher. Overall, the highest level of privacy protection initiative has been taken to secure the data of the participants.

3.8.2 Translation

The study may not be possible unless the researcher considered the participant's medium of communication, the language and the culture, since this research required to include people from different backgrounds and cultures. The level of literacy and education in the language is the main consideration when including a translator in an interview. In this study setting participating women were from diverse cultural and educational backgrounds.

3.8.3 Steps of analysis

The data analysis process in qualitative analysis can be divided into some phrases, these phrases can be similar or overlapping but they are not the same in general practice, many researchers have defined these steps according to their experience. In starting qualitative research, the process is considered as important as the outcome, so proper coding of information is essential to define and describe the insights. After getting the data on hand the process starts with observation. The data analysis process starts with getting involved to construct meaning from the data by moving backward and forward through the entire dataset and code for extracting Particular meaning from the information set. writing down the outcome is the initial phase of data analysis this outcome can be the result of the researcher's understanding or it can be the result of a statistical analysis of the text, The idea of getting shot down from the data is presented through a single line as a reference to a particular portion of the dataset. There is a controversy regarding getting consultation from the literature during the analysis, earlier consultation with the literature main narrows down the analysis on the other hand literature can enhance the outcome of analysis by adding more stable features of the data (Tuckett, 2005).

Braun & Clarke (2006) describe the risk analysis process into six steps-

1. Familiarizing yourself with your data

The data analysis process inequality research method starts from an initial interesting thought regarding the data, in the case if the person who is conducting the analysis is the researcher himself we have prior knowledge of the interaction during the interview and the data. This phase is an iterative one that involves the repeated reading of the same text to understand the structure of the data, semantic themes and relating factors. Reading and reading the same data can be time-consuming and it may be skipped some particular concepts hidden in the data, so to extract meaning the researcher needs to take notes from the beginning to tune the ideas into code in later phases.

2. Generating initial codes

Initial code generation Refers to the most basic segment or element of data that Contains Phenomenological features. Data can be coded based on two types of themes ‘data driven’ or ‘theory driven’. Theme can be based on data but ultimately these codes will be represented by the specific questions in mind who is the answer, The full data set can be coded for particular features can be coded using the software program. It is better to code as many potential themes/patterns and keep a little of the surrounding data if relevant To avoid the risk of losing track, the same data can be coded under multiple themes so it is better to code a particular code as many times as possible.

3. Searching for themes

The transformation from code to them is a complex process, it involves a set of analyses. Tables or mind-mapping may help in this process considering the relationship between codes, between themes, and between different levels of themes. Depending on the content, code can be classified into main themes, sub-themes, some additional themes called miscellaneously and other codes will be discarded. The decision of discussing code will come in the next stage after evaluating them in the next stage.

4. Reviewing themes

Internal and external heterogeneity are two considerations in this phrase. The review process can be divided into two separate levels with an additional step to refine the themes. Level one involves reviewing at the level of the coded data extracts whereas the second level involves the same process whereas an extended version involves a similar process, but concerning the entire data set. This process is iterative because If the theme does not fit within a coherent the process will start from the initial code generation two erase any problem in the code. However, in this phase, only the name can be changeable.

5. Defining and naming themes

Naming the codes involves defining the codes and refining them for another analysis. To understand the essence of the code and determine what aspect it captures. Proper justification of the concept is viral here and further refinement of the theme is needed depending on the scope and the content of each theme.

6. Producing the report

This phase starts with finalized themes, these themes involve interaction and writing the complete report. In this writing, the researcher will visualize the story in a convincing way to the reader. The extracts will eventually illustrate the story the researcher is telling about your data where an analytic narrative will be embedded, this analytic narrative needs to go beyond the description of the data. Eventually, this argument will relation the research question.

3.9 Methodological Discussion

This chapter will discuss the methodological validation and relevance of the research and will also investigate the impact of the method. Proper design of methods justifies the validation and quality of the study, in this way it can be said what the study has found and it's meaning of it.

3.10 Validity

In qualitative research, it will not be satirical to compare the researcher with an analytical tool. Considering that the researcher is the main analytical tool in qualitative research, it is important to be aware of the risk of bias. Biases can appear from three considerable procedural points of view, the more common is reflexivity. Reflexivity indicates the contemporary theory of knowledge acknowledges the effect of a researcher's position and perspectives and disputes the belief of a neutral observer. Transferability is the adequate degree of transferability of the particular research study. Generation of information that is globally distributable and can be applied beyond the study setting. The transferability of a study design needs to come under thorough consideration based on the research question by presenting a relevant sampling strategy. No study can provide findings that are universally transferable irrespective of the method used. Interpretation is another considerable part of qualitative research, data generated from the survey are developed into theory resulting in research outcomes. The result of research cannot be just a representation of data, data represented in the theoretical framework of the previous work is called interpretation. For instance, the researcher may be inclined to select data that fits into a pre-established theoretical framework. Among the common research practices risk of bias can be minimized through the triangulation of methods. The idea originated from a craft used by land surveyors, to validate maps land surveyors measure different angles. These angular differences can be compared with viewing a particular research topic from a different point of view based on different sources of data. Observing the same phenomenon from different points of view can enrich the description, for example- from above and below even an elephant may look completely different. As a result, triangulation of methods comes up with a holistic picture of a particular object. The same goes for reading a report as part of a better understanding of what goes on in a medical consultation by comparing data from various sources, such as doctors and patients, that have been combined. Triangulation aims to increase the understanding of complex phenomena, not criteria-based validation, in which agreement among different sources confirms validity. In the context of this research, triangulation will be formed by using the interview data of both the participants and the care providers to get an insight into the issue from two different points of view.

3.11 Methodical challenges

The researchers reflect upon how her role as a researcher may influence the findings through her social positing and own preconceptions. Continuous and conscious evaluation of the researcher’s presence and positioning is referred to as the process of reflexivity where the researcher is aware of his personal and professional background, experiences, motivation and the way she or he chooses to approach the study or interest as well as presenting and drawing conclusions. In this study setting the considerations were the researcher's profession, gender and relation. The researcher of this study is a physician by profession with more than 10-year experience in the medical field and academia and for being active in research during the Master's program his level of familiarization with these medical and contraceptive-related things is higher than that of a normal person.

Researchers have talked with people about family planning issues and served them different methods. But here I need to keep in mind, that my role is completely different. I should not try to influence my participants with any pre-existing concepts. However, my knowledge will be beneficial in terms of understanding the adverse consequences (primary and long-lasting) women usually experience after using contraceptives. My gender can be a potential barrier. Talking to an unknown man about personal sensitive issues could restrict a woman from explaining her real feelings. Moreover, there is a large group of Muslim women who received contraceptives from the health station, which will impose a challenge. With the help of the translator and the midwives, I need to make the participants understand that my role is to only gather information. I need to concentrate on my behavior and body language while in an interview to make my participants feel free to talk their hearts out. I should not use many critical terms during interviews. Participants should not feel that they are categorized or a subject of sympathy.

3.12 Pilot study

However officially there was no pilot study for this study but the outcome of FAFUS from January 2013- to September 2015 can be considered similar. The handbook published in 2016 incorporating the experience of FAFUS found that the project has received very good feedback both from the women and the health professionals meaning that this type of program is needed. The FAFUS program served 1841 women with consultation services and 3263 consultations were conducted and controlled by the health personnel. The major insight of the study is that the level of education, knowledge, experience, culture and language, attitudes, values and religion has a better probability to research a woman. The age group of the participating women is between 31 to 35 years from 71 countries predominantly from Somalia, Iraq, Pakistan and Afghanistan. This study setting and the population is quickly similar to mine and the state shown in this study is the base of this study.

Figures based on consultations during the period January 2013 to September 2015 showed that the women who met at FAFUS were between 31-35 years. Women from 71 countries participated in the program where most of them were from Somalia, Iraq, Pakistan and Afghanistan. Among the participants, 28% of women have lived in Norway for less than 5 years where 65 (4%) said they were not in income-generating work and 74% among the total participants were married with a fertility rate of 2.9 which the way higher than the rate (1.53%) of Norway in 2019 (Worldbank, 2022). 14.2% of women had five or more children each and 14.3% have had an abortion when it was concerning. In terms of communication and Norwegian knowledge, 63% of the women reported that they spoke Norwegian, and 29% said they spoke a little Norwegian, the rest said that they have no Norwegian knowledge. When it comes to the main reason they visited the offer, they said it was that they wanted birth control (63%) and that they wanted cell samples (23%). Little knowledge of the Norwegian health care service and health literacy including their body, social isolation, cramped housing and poor economy are the big challenges to ensuring a proper health care system for the immigrants.

The study is somehow incomplete since there is a lack of understanding regarding the perceptions and perspectives. The high rate of non-immigrant women participating in family planning services compared with the immigrant women in the program and a limited number of studies in this particular field indicates the scope of opportunity to explore the scenario for further program development.

4.0 Ethical Consideration:

“ethics” comes from a Greek term called ethos, the English meaning of the term is custom or character. Ethics in research deal with conflict arising from moral imperatives, it provides an understanding of the conflict and most probable solutions (Thatte et al). The duties of both clinicians and patients are defined by certain ethical codes and policies, similarly, their relations also come under the same policy. Eventually, it determines all our actions and decisions within a certain limit, ethical codes are some kind of obligations formed by humans for humans, so the dilemma is very common to arise. This human involvement shapes the principles by considering universal and cultural relativeness, development of ethical principles requires enough consideration from the viewpoints of both the Universalist and the pluralist. The challenge here is to apply the universal principles in all settings including both developing and developed countries since the culture in the health care system varies a lot depending on the area, population and environment.

One of the notable incidents that raised the concern about medical research has occurred in the United States back in the early 1960s when it was reported that unethical medical research has experimented on a volunteer, this particular instance was highlighted as a scenario of significant risks of harm and obvious disrespect to a vulnerable or terminally sick person (Thomson, 2012). Following that the current development of ethical principles in research is the result of a gradual understanding of the importance of ethics learned from several incidences of unethical medical research reported by volunteers around the world. The most ferocious one was conducted during WW2 by the Nazi doctors which resulted in a sound scientific research protocol and consent called the Nuremberg Code (1947) (Tribunal, 1996). This code consists of ten paragraphs and includes some of the statements of modern research ethics. Nuremberg Code is the first standard that stated voluntary consent to acknowledge the participants about the purpose, nature, duration, methods and inconveniences also probable hazards and effects of the research. It emphasized prior knowledge of the research area and avoiding all sorts of injury, disabilities, or risk of death. A study setting should be equipped with proper preparation and facilities be provided to protect subjects against even the remote possibility of injury, disability, or death, additionally, not conduct any study that may cause death and disabling injuries to occur. The qualification of the person conducting the research is also highlighted in the paper (Utley Ed., 1992). This code is considered the founding document of contemporary research ethics based on which the current emphasis on sound scientific research protocol and consent has developed. Due to the failure to address the upcoming challenges of medical research ethics in 1964 ' the Declaration of Helsinki' was published by the World Medical Association (WMA). It was a general assembly of the World Medical Association (WMA) which came up with 32 principles that emphasized the requirement of a protocol in medical research, informed consent, the confidentiality of data, vulnerable populations, review of the ethical committee, etc. However, it emphasized some scientific standards that allowed the physician to exercise more freedom and even in special circumstances to omit the application of consent procedures. In 1975, it was revised by incorporating an independent research ethics committee for the assessment of research protocols, with that a furnished version of the internationally accepted norms and principles appeared with a firm system to conduct research on human subjects. The Declaration of Helsinki is still one of the recognized and vital documents to conduct research on the human subject.

The Declaration of Helsinki resulted in multiple communities in the medical research, these communities eventually developed their own stream of knowledge based on their experiences. Later on, a study titled ‘Tuskegee Study of Untreated Syphilis in the Negro Male.’ stirred the global community where 600 black men among whom 399 had syphilis were studied by the U.S. National Health Service conducted in the US without following any ethical conduct even though they were not informed for nearly 40 years from 1932 to 1972. This study was nothing but a thumbs down to all efforts of scholars and the victims who labor and sacrificed their lives to develop the previous standards, through this incident US authorities got liable to take instant action and ushered the Belmont Report in 1979. According to the Belmont Report (1978), vulnerable populations in medical research include “racial minorities, the economically disadvantaged, the very sick, and the institutionalized” (US Department of Health and Human Services, 1979). The Belmont report is the foundation for regulations regarding ethics and human subjects’ research in the US. In the meantime, globally the pharmaceutical industries had grown very rapidly and began to insist that governments allow them to conduct pharmaceutical research on the human subject in the developing and underdeveloped countries. To begin regulation and avoid malpractice, in 1982 the Council for International Organizations of Medical Sciences (CIOMS) developed “International Ethical Guidelines for Biomedical Research Involving Human Subjects" in association with the “World Health Organization”. The International Ethical Guidelines for Biomedical Research Involving Human Subjects, developed by the Council for International Organizations of Medical Sciences (CIOMS), define vulnerable persons as those who may be less capable of making informed decisions in their own best interest (CIOMS, 2002). These can include people with low education or intelligence, lack of power, resources and strength (CIOMS, 2002). Considering that this research participant mostly belongs to immigrant groups having a poor socioeconomic background where they are likely to have low education, be economically disadvantaged, and have a lack of power and resources. Thus, they can be defined as part of a vulnerable group according to The Belmont Report and the CIOMS guidelines, which requires special ethical consideration.

4.1 Voluntary participation

Participation of human objects in the research is obligatory to be voluntary. This survey includes reproductive health care receiving women as human objects, these women are vulnerable and economically unstable which makes them the perfect candidate for this study. They were provided with all sorts of information regarding this survey with informed consent about their rights and protection of their data. They were informed that they were facilitated with the right to know everything relevant to their involvement with this study. They can avoid any questions and can quit the interview at any moment they want. The information they provide during the survey will be preserved for a limited time following the guideline of the General Data Protection Regulation and will be destroyed after that. Lastly, they were assured of having no negative consequences if they choose not to participate or later decide to withdraw.

4.2 Approvals and permissions

Ethical clearance for the study was obtained from the Norwegian Centre for Research Data (NSD). NSD is a national center for Norway that makes data about people and society available for research and facilitates the archival of research data and provides support services. Based on an agreement between the University of Oslo and The Norwegian Centre for Research Data (NSD), it has been assessed that the processing of personal data in this project is following data protection legislation.

4.3 Informed consent

In research informed consent is a vital factor in medical research especially when any human subject gets involved, it ensures the security of a subject’s voluntariness and demand for information. Informed written consent was sought and obtained from all study participants. Before starting the interview, the participants were well informed with all the information regarding the study through consulting a patient information sheet. There was no pressure from the health station or the midwives, they participated in the interviews and were very easygoing. After consulting a consent form the participants were assured that all the information will provide will be confidential and anonymous, additionally, they can withdraw from the study at any time. Since language was one of the interaction barriers during this interview firstly the form was encoded in the native language and later it was translated into the first language of immigrant participants verbally by the translator.

4.4 Patient information sheet

A patient information sheet was prepared including all the relevant public information regarding the study and printed into hard copies for distribution. After that once informed consent was obtained, the research subject was provided with the patient information sheet detailing the following aspects of the study:

1. Title of the research project
2. Invitation to participate in the research
3. Purpose and significance of research
4. Time commitments
5. Termination of participation, an indication of voluntary contribution
6. Risks involved
7. Costs and compensation
8. Anonymity and confidentiality

4.5 Anonymity

Collected data from the interviewee were coded properly to maintain the privacy of the data. The whole interview procedure was performed after the explanation of the aim of the research and also it was informed that as the interviewer was not from the health station, their answers would not influence the health facility for them in the future. There were assured that the identity of the interviewee will be secured for any cause and only be used for the sake of service development of the health station and there will be no option for the health station authority to know their identity.

4.6 Confidentiality

In research the collected data are confidential, due to the long history of malpractice in medical research, the use of personal data in research is restricted by several policies. The General Data Protection Regulation and Personal Data Act are two of them applicable to Europeans. Confidentiality binds a researcher to restrict research data from a group of people and allows the data to be disclosable among very few. It applies to any authority local and foreign to access someone's personal data to follow the guideline before accessing one's data. There are a bunch of policies that confine confidentiality in research, there are various dimensions suggested in the literature including human rights, true anonymization of data, cancer and genetic registers, domestic violence, fertility, confidentiality in young persons, the validity of consent for disclosure, involuntary disclosure, and safeguards (Woodward & Argent 2005).

According to (Mandl et al., 2001), there will be no breach of confidentiality if the records mentioned below are used for any purpose of the research.

a. Conventional X-rays
b. Images were taken from pathology slides
c. Laparoscopic images of the inside of the abdominal cavity
d. Images of internal organs
e. Ultrasound images

Even confidentiality implies in data collection involves minimum data to collect from the subject to reach a research conclusion. Data that is only required to collect, keep the data anonymous, keep the name and data separate using proper coding and providing limited access to the code, using other protection measures like secure server or computer data storage and password-protected data files. Confidentiality helps research to avoid any form of hardship, discrimination or stigmatization for the participants who participated in the research. All data collected from the survey were kept confidential excluding the name often respondents through codification. Respondent names were removed from the recorded materials to avoid disclosure of the identity of the participants.

4.7 Data Protection

All interviews were audio-recorded and transcribed to conduct a thorough analysis of the collected data. The data were anonymized; that is, the names of the participants were coded with a number in audio recordings, field notes, and transcriptions. The field notes were locked in a closet, and data were stored safely on a password-protected domain on the University of Oslo network, accessed via a password-protected computer. Only the researcher and the translator had access to audio recordings and transcriptions, and non-anonymized data that matched participant names to the coded numbers were only accessible to the researcher. During the data collection period, the researcher was engaged in ongoing analysis to adapt the study accordingly and after complete data collection data were processed in a fully systematic way for thematic analysis. A confidentiality agreement was established with the translators. All non-anonymous data were deleted upon completion of the project.

4.8 Respect and responsibility

Respect implies two things, respect for people and respect for truth. People have the right to be informed about the purpose of everything they are getting involved in and respect for truth implies probity during the research. Besides, in research researchers have to consider others' work through acknowledgment by respecting their intellectual rights which emphasizes avoiding malpractices like plagiarism at the same time to over and underemphasizing any result including clinical false presentation of conclusions (Tauber, 2005).

On the other hand, the responsibility of the human subject involves voluntary informed consent, avoiding deception, rewards and incentives, privacy, disclosure, etc. Besides, it is also under the responsibility of the researcher to maintain the quality of their research work to uphold the reputation of academic research. Additionally in terms of publication both the researcher and investigator should be transparent about their interest, benefit, or financial interest.

4.9 Potential for harm

One of the potential risks of harm that could cause biases in the response of the participants was the fear of getting avoided or isolated from the health care facility. To address this the researcher clearly mentioned this issue in the informed consent. General the criteria of potential was deeply in the Nuremberg Code (Tribunal 1996) that any risk of life loss during excitement should cause immediate closure to the study. Additionally, maximum prevention attempts should be ensured within the study setting, this risk of harm can be either mental or physical. The fear of getting deprived of the health facility can be a potential risk of mental harm. Thus, this issue is addressed by the researcher very seriously.

4.10 Beneficence and usefulness

There was no incentive or tangible beneficence for the participants of the study. During a time of taking informed consent, it was clarified that there will be no benefit for participating in the survey. Their participation will be completely voluntary however, there were some refreshment facilities from the health station to make the patients feel better by reducing their environmental and social stress. This refreshment facility cannot be compared with any tangible benefit to collecting data. During the survey a woman asked for beneficence for taking her interview, the researcher remind her about the informed consent at the beginning of the study and explained the legal and ethical considerations of the study to her. Later on, the matter was dissolved through her self-understanding.

5.0 Findings

5.1 General knowledge about sexual health and contraceptive

The majority of the participants demonstrated a good level of knowledge about contraceptive methods. Nearly all women interviewed in this study reported having a prior concept of contraception.

I knew about contraceptives; it was in my mind. But both of us wanted our child. So, we did not use anything and got our child within 1st year of marriage (p5).

Midwives observed a level of ignorance among some of the patients. They come to know about contraceptives from their teachers as sex education and experienced friends. One shared her experience of switching different methods,

When I started dating my boyfriend, I started pills. I tried it for three months and changed it because I felt nauseating always. Whenever I saw food at family gatherings I felt like, I need to throw up tried. I "Yasmin" after this. But often got spotting which was stressful for me. Then finally I switched to "papillae" and used it until we got married (p2).

Some of them had detailed ideas on contraceptives from school. They have learned about contraceptives from their friend as well.

my teachers in school show so many things about prevention, as sex education was part of our curriculum. And also, my friends who had boyfriends gave me some idea about this (p2).

I am very fertile and often talk with my friends about this. I heard from them about different types of contraceptives (p3).

The immigrants have less knowledge about family planning & contraceptives. Thus, midwives need to explain all information in detail, which is time-consuming and tiring. They are also unaware of the health system and their rights.

Immigrants have so many kids, that they visit here very often. They have less knowledge about their body, how to get contraceptives – the system in Norway, how to plan their families. A single meeting is not enough to give them all the information. We need to meet them repeatedly (m1).

5.2 Service quality

One of the rising issues during the interview was with providing insufficient information due to the short consultation period and workload. The participants mentioned short working sessions and in-person consultation, additionally, they provide short answers to their questions, mostly yes/no.

My appointments were hour-long, but they often finished before that. Because my midwife gave me short answers, mostly yes/no. I have to come to her repeatedly with (p5).

Despite the women being satisfied with the family planning services offered there were some negative experiences as well. Sometimes midwives failed to give information about complicated deliveries. One woman complained that she did not get help after delivery and other women complained that they have to rely on the internet for further delivery of information.

you get information if you ask. Sometimes if I am not confident enough with that information, I go to search for it myself on the net and return to them again (p5).

Many of the participants mentioned this receiving lack of information and support from their midwives, midwives were unable to suggest to them their desired method of contraception, adequate space between two kids and information regarding special cases.

This was my 1st pregnancy and everything was new for me. The head of my child was growing faster and it was identified after scanning. My midwife never informed me this can also happen. They should give more information that the outcome of pregnancy can be different (p5).

Culture and religious beliefs are most influential for the immigrant women to decide on the use of contraceptives and among many castes, a permanent method is not permissible. The most common contraceptive method midwives suggest is the Intrauterine device (IUD) though there are cultural and religious issues related to it.

I'm an African and we believe in life after death. I will return the way I leave. So, I don't want to cut (Permanent method – Ligation). Also, my current boyfriend is the only child of his parents. So, he wants to have as many children as possible because his parents want a big family (p3).

5.3 Decision making

The decision to use contraceptives varies on culture, censuses of partner and social background. Sometimes it is a combined decision, some mothers' and some the decision come from another elder member of the family. For the vulnerable groups most of the time the decision is made by the mother alone. The midwives always encourage the mother to decide on their own.

Not every woman brings her partner with her. Often for some nationalities that are with their families, they bring their mother-in-law because they are very young like Pakistani, some nationality who are here as a result of warlike Syrian, and prostitutes – they come alone (m1).

Among the five participants, three of them said that using contraceptives was their own decision. The remaining two of them said that it was a combined decision.

I came here with my husband and the midwife explained to us all the methods. We understood everything but my husband said nothing. I took the decision of using contraceptives and chose the method which I felt feasible (p1).

My husband lives in the UK. When I came here after my second delivery my midwife shows me the contraceptives. I was so confused. I went home and called my husband. And finally, we agreed on using contraceptives. For us it was a combined decision (p4).

Though husbands don't accompany their wives currently Somali ladies are educated and they know the importance of bringing husbands during consultation. This also refers to the decision of using contraceptives does not belong to the women solely. One midwife complained that Pakistani women bring their mothers-in-law rather than husbands who usually take the decision. Another midwife also said that the participants have no influence on the choice-making of contraceptive midwives.

If women can choose themselves what they need based on their needs, they are much happier. I always try to say to them, it's your body, your life, the future of your other children. You have to think about what will be the best for you and your family. So, you decide (m2).

Since the immigrant population is relatively new in the Noridian society and culture, some of them were facing cultural anxiety since they were not familiar with the health stations' environment and culture.

In Africa, we use water after using the toilet. But here, there is no water supply in the toilets. I don't feel comfortable whenever I need to use this wash cabin(p3).

5.4 Preference

One of the participants mentioned her discomfort with General practitioners (GP) since they used to with a busy schedule and do not specialize in consulting gynecological issues. Again, people of some cultures prefer the only female doctor to check their cervix and the Noridian health care system is more like female dominating.

When I got pregnant, I had the option to go to GP and a midwife. But I preferred to here because my GP is a man. And I feel he is not into gynecological things rather more in general. He has so many patients and has no time to talk about pregnancy. But it was my first child and I want to get everything perfect. I wanted all information and a good time too (p2).

The findings from this study found that the respondents experienced very good communication and relationship with midwives. They commented that they have always received information related to contraceptives and family planning from midwives. The women found it easy to approach midwives with any family planning issues they may have or have experienced. Almost all participants mentioned that getting help from this station (Gronland) is easier than going to GP. If GP is a Man (Male Doctor) he is not empathic, moreover, some women feel shy to talk with men about gynecological issues and contraceptives. Most women prefer midwives rather than GP for consultation.

Some of them, especially Muslim women, they don't want to have a male doctor for the checks of the cervix (m1).

5.5 Negligence

Some participants, mostly of Somali origin don't want to use any contraceptives because the couple lives separately in another town or country. They often become pregnant when they meet with husbands for even a single time due to the lack of any kind of contraception. Sometimes it is difficult to convince some participants as for some women it is important to menstruate due to cultural and religious perceptions.

I don't want to generalize, but among Somali couples, they are often split. Husband lives abroad, in Africa or UK or another city. So very often I get feedback that they don't need any contraceptives. Then what happens? They have just one visit and she became pregnant (m2).

In this locality IUD is the most common form used. If the women are open and ask for a recommendation, I suggest IUD. Then it depends, there are cultural and religious issues. It is important for some woman to have their periods (m2).

5.6 Bad experiences

Sometimes midwives force them to have implants after delivery.

My first child was delivered with the vacuumed method and it was so painful for me. I could not walk for almost six weeks. But when I visited my midwife, she wanted me to have the implant and I said no (p2).

One woman complained that midwives do not provide information on the side effects of contraceptives and another woman did not find midwives helpful as they only describe the options available rather than motivate to use contraceptives.

Sometimes you know about the things, but you still need someone to push you. My midwife only describes the methods, and never motivates me to use them (p4).

I am living in Oslo alone. It is difficult for me to take care of two kids at the same time. My midwife knows my husband is in UK but did not help me getting appointment for my kid's injection (vaccination (p3)).

One woman who suggested more motivation on birth control so that women can understand the importance of birth spacing. Some of them also suggested providing more information about contraceptives and eventful pregnancy.

It is important to have adequate space between two kids. So that the mother raise them with more care and work for at the same time. But the midwife never suggested anything like this to me (p1).

The service of this health station is very good, but the building does not look professional. Also, the elevator is outdated. I am often scared while using it (p1).

5.7 Good experiences

One patient was sharing they are follow-up experience with her midwife, bonding with her midwife builds trust in their service and makes the patient feel relaxed. Another referred to her experience with midwives solving her conjugal issues and referred them to the family center for counseling.

I was happy to have the same midwife because I feel that she knows me from the 1st one. I don't need to tell all the stories to her again - how the first pregnancy was and I am here for the 2nd pregnancy. She has much time for me. She asked me – how I was feeling, check the belly, check the baby. There is bonding from the beginning. I felt relax, I felt safe (p2).

One of the participants commented that the midwives also help the couples by referencing them to the family center to solve conjugal issues between husbands and wives.

I had issues with my boyfriend and we used to fight a lot at home, in front of my elder daughter which makes me feel so low. I share all these with my midwife and she gave me mental support like a friend. She also referred us to the family center for counseling from where we got many advices (p3).

After the delivery, midwives visit the participants at their houses for follow-up, help to choose appropriate & suitable contraceptives for that period, and provide necessary health advice for the post-partum period. Almost all of the women commented that the midwives not only provide advice to them but also provide care for their kids as well as help with vaccination.

After my delivery, my midwife came to my house to follow up on my child. She talked about contraceptives and also fixed an appointment of child nurse for me (p1).

5.8 Experience from FAFUS

Similarly, the midwives find satisfaction in empowering the women and expect to resume FAFUS with more capacity to serve everyone. Midwives mentioned their struggle to manage essential medical examination equipment like gynecological examination bench and other technical tools. Overwhelming participation indicates the success of the FAFUS project, midwives suggested extending the program including more health stations and resources to give holistic follow-up to the patients.

We included one more midwife to reduce workload. But after that more women started coming here. So, the workload is still huge. We need more helping hands. FAFUS can invest more to appoint new midwives. Or they can include more health stations in the project (m1).

Currently, only five midwives at Gronland health station and two midwives at Bogerud health station are working with FAFUS. The area is immigrant dominant and densely populated which results in more patient consultations and more workload. Social problems related to poverty, drugs and crime are also common here. The workload is also intense at Bogerud health station.

there is no formal evaluation but the oral evaluation is that the women are very satisfied that they can come to midwife. Midwives are female health personnel, so there is no issues with religious beliefs and obstacle. The biggest challenge is time, I only have 10% in my time book. In my experience, for the women to get satisfied they need to get enough information. And it takes time. And I use a lot of translators to be able to inform them in a correct way (m2).

The language was one of the major obstacles during FAFUS, midwives were concerned to pay off the translators. It's hard to offer sufficient information precisely with low language knowledge.

We use translators a lot, because here in Gronland Oslo we have many immigrants. I don't know how they are got paid. Initially we pay them from the health station, then we get pay back from FAFUS. I am not sure but we need them often (m1).

Both of the midwives suggested increasing the number of midwives to reduce the workload as well as to increase the logistic support: gynecological examination table, forceps, speculums for example.

At the moment it is only me who is involved with FAFUS in this health station. There should be at least two. My boss is a midwife and now she has joined me in this project. She is trying hard to get one more gynecological examination bench. Then I will have one in my office also. And of course, we need some more equipment for the new office (m2)

5.9 Patient midwives' relationship

The overall personal experiences of the midwives were positive. They were satisfied as they can help women for a longer period thus making a good relationship with them. They also felt good that they could help poor people economically and encourage women to participate in using contraceptives, which in turn improves their health.

It is very satisfying to teach them about their body and to empower them (m1).

It is fantastic for me to work with FAFUS. It gives opportunity to work with women and give them holistic follow up. We give continue take care. We are experts on women's health. And we have a lot knowledge on the whole aspect of family. It is my dream for the future that we get a little bit more resources and we can offer everyone (m2).

6.0 Discussion

6.1 Sexual health literacy and awareness

The majority of the participants demonstrated a good level of knowledge about contraceptive methods mostly learned from school and friends. Nearly all women interviewed in this study reported having a prior concept of contraception. Ngum (2015) explored multiple barriers among the African-Australian mothers with refugee backgrounds for low sexual health literacy where lack of education was a significant one. The majority of the participants in this study demonstrated a good level of knowledge about contraceptive methods. However, Midwives observed a level of ignorance among some of the patients. They come to know about contraceptives from their teachers as sex education and experienced friends. One shared her experience of switching different methods. Due to their lack of unaware of the health system and their rights the midwives need to explain all information in detail.

6.2 Service quality and work balance

Patients complained about the busy schedules of midwives and not providing sufficient answers and the midwives about the lack of logistic support. There is a communication gap due to cultural and religious aspects. Kolak (2017) emphasized on midwives' or nurses know and understand the cultural and religious aspects of immigrant women. The fewer number of midwives, lack of logistic support and workload are other the reasons behind failure to take more detailed sessions. Insufficient infrastructure and human resources were the main obstacles of FAFUS, the one-stop service setting faced a high patient load thus limited resources hampered the service quality.

6.3 Cultural and religious stigma

Among the participants, cultural and religious beliefs are the main restrictions they face while taking decisions and language with unawareness about the rights of family planning & contraceptives. Similarly, they face obstacles while communicating with the midwives. The midwives who experienced FAFUS said that in immigrant dominant areas women prefer a midwife over a GP mostly where low empathy and workload of the GPs additionally cultural and religious norms are common reasons mostly. And studies have also suggested that women of non-Western immigrant backgrounds are less likely to use hormonal contraception (Millar, 2017). Thus, knowing the cultures and religious aspects of the immigrant women is essential for the midwives (Kolak 2017).

6.4 Woman empowerment in family planning

Again, in terms of decision making the women consult their husband/boyfriend, at some time close family members like mother-in-law also intervene the process, however, some groups like war refugees and prostitutes make their decision on their own. The midwives always encourage the women to make their decision on their own since it’s the body matter of their child. Sometimes the family members the decision over the women without knowing their condition.

6.5 Achievements of FAFUS

FAFUS is very unique in terms of scoping the audience and reaching them on their premises. The midwives find satisfaction in empowering the women and expect to resume FAFUS with more capacity to serve everyone. Low resources setting and improper human resource allocation turned out as the downside of the service. Midwives mentioned their struggle to manage essential medical examination equipment like gynecological examination bench and other technical tools. The language was one of the major obstacles during FAFUS which concerned the midwives most due to the payment of the translators. Also, they have suggested increasing the number of midwives to reduce the workload. Above all, overwhelming participation indicates the success of the FAFUS project. Midwives are enthusiasts to service the women with a little better setting by increasing the investment and can include more health stations in the project.

6.6 Better family planning education and services

Overall, positive feedback is from both sides, midwives do admit they are lacking in providing impressive service due to workload and communication gaps. Still, the women mention their good relationship and experience with the midwives. Similarly, the midwives also had positive motivation to serve the women in a better setting. In this crucial point, to overcome all these flaws the midwives require not only the knowledge of sexual health and contraceptive but need to understand the cultural and religious gaps of immigrants (Kolak 2017). For that, the education and training programs of the midwives need to be inclusive and diverted.

7.0 Strengths, limitations and future research opportunities

This qualitative study has been able to show some key perceptiveness towards family planning services but with limitations. Some particular questions regarding the perceptions and perspectives of these women are still unresolved which emphasized further extensive study on the Norwegian health system and FAFUS. These limitations will explore new research scopes of research.

7.1 Low participation

A low sample size indicates more generalized perceptions of a particular event, especially, in exploratory research low number of attending participants express their personal experiences which in many cases is not the actual scenario. With low participation, the study somehow lacks transferability when the outcomes will be applied in a broader context (Malterud, 2001). The study comes up with valuable outcomes which are relevant to the study scenario but unlikely to refer to for decision making. Future studies on the same topic will have to incorporate statically significant sampling.

7.2 Comparatively less relevant information source

The problem is not a major one but one of the assumptions of this study was to collect the feedback from the most relevant audience to measure the effectiveness of FAFUS. The less time a migrant spent in the new country makes them more vulnerable to receiving health services. Participants who attended this study are staying for quite a long time which indicates their level of health literacy and adaptability to receiving the health service. The newly arrived women in the country could be a better source of information related to FAFUS. In this regard, undocumented immigrants are more vulnerable in the health system especially while seeking health care. Reaching undocumented immigrants is quite impossible in the formal health setting, so in later studies the researchers need to emphasize on figuring out an empirical method to collected data from the undocumenteds.

7.3 Dormant information

In a social environment like a hospital and clinic, it requires extra care to make sure that the patient is not feeling uncomfortable expressing herself. In this study setting, the interviewer was a male person so the women could not freely provide information about their contraceptives using experiences in depth. Influencing factors that make the partners choose their contraceptive method and cultural beliefs, etc. are real sensitive issues.

8.0 Conclusion and recommendations

With many limitations, this qualitative study presented changing scenario of family planning services after the implementation of the FAFUS program in the Oslo Health

Stations. It has been able to rectify some valuable suggestions which can be implemented to structure the FAFUS program shortly. The audience may understand that experiences from the FAFUS attendees are rare to collect since the program was a one-stop service in a limited setting. Despite such limitations, the results of the research are surely able to contribute to the existing body of knowledge on the importance of family planning services for Norwegian immigrants. Recommendations for the health system include-

1. The most potential outcome of this study is probably figuring out the cultural and religious aspects of the immigrants. The health system needs to address this demand of the midwives and design their training programs accordingly.

2. Emphasize the patient-midwife relationship to make sure proper understanding of the immigrant women to avail them of their desired health service. These positive changes can only be possible by focusing on family planning education and services.

3. Recruiting more midwives with scheduled time slots may reduce the workload. Additionally, paid remuneration will secure the service quality of FAFUS in long term.

4. Ensure proper essential logistic support and supply of examination tools such as gynecological examination tables, forceps, speculums, etc. in the future FAFUS setting when necessary.

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