Norwegian midwives' perceptions of their practice and care challenges for recently-arrived migrant women

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June 2022

Thesis submission for the Master in Philosophy in International Community Health

ACKNOWLEDGEMENTS

The first person I would like to thank is Benedikte V. Lindskog, who I met five years ago while still pursuing my Bachelor's degree and has been a mentor and a friend in the years since. The gentle guidance, patience, and care she has shown me has carried me with grace through this project in its hiccoughs and triumphs, and I feel so lucky to have her on my team.

Next, I would like to thank my other supervisor, Sukhjeet Bains. I am absolutely in awe of her clinical and research expertise, and I can't wait to see what she does next in her career. She guided me through the entire process of developing and executing an original research project, something I have never done before, from the planning stages to the writing stage. I have learned a lot from her guidance and can't wait to see what she does next.

Finally, I would like to thank my third supervisor, Johanne Sundby, who stayed on this project even after her retirement in December. As a young researcher seeking a career in medicine, she has given me a lot to look up to over the past five years. It has been an honor to have her and her knowledge on my team.

Next, I would like to thank the MiPreg project group, Ingvil Krarup Sørbye, Siri Vangen, Benedikte Lindskog, SuJohanne Sundby, Katrine M. Owe, Susan Akubar Ibrahim, Sukhjeet Bains, Fatou Jatta, and Hanna Søli Ottesen, for allowing me to join in on this important project and sharing their data.

To the members of my master's program – we went through quite a difficult time, pursuing an international program during a global pandemic. Good luck in your projects and careers, it was a pleasure to hear your stories and perspectives. A special thank you to Kali, Johan, Furqan, and Jelena for their friendship that has carried from Zoom to Oslo to life beyond.

Thank you to the leadership of the International Community Health master's program, particularly the efforts of Birthe Neset, Terese Eriksen, and Elia Mmbaga. I can imagine that the efforts of coordinating our program across time zones and infection control restrictions were immense. Their work did not go unnoticed, and I am grateful for the opportunity they gave me to come to Norway.

Without the scholarship I received from the Centre for Sustainable Health Education, this project wouldn't have been possible. Thank you for supporting me and other students in our efforts to promote a healthier world.

To my participants, thank you for sharing your stories. It was an honor to meet you and learn about the care and attention you put into your patients. You have taught me many lessons about how to be a better advocate and provider for my own patients that I have taken with me back to the United States. I hope this project makes you proud.

Finally, a huge thank you to my family. Mom, Dad, Cameron, and Jackson, thank you for believing in me no matter where in the world I find myself.

A NOTE ON LANGUAGE:

In order to clearly discuss my study and its findings, and to provide congruity in rhetoric across the two languages used in this study, I had to make several decisions about the rhetoric that I used to define certain groups of individuals. The first decision that I made was in the use of "woman-centered" language, as in, defining all patients who interact with the Norwegian maternity services as cis-women. This is an assumption that in recent years, after increased visibility of gender-diverse and transgender individuals in global society, has become increasingly critiqued (Stroumsa & Wu, 2018, p.585). Not all individuals who need obstetric and gynecological care identify as women. In the effort to recognize and protect the needs of this marginalized group, many individual providers and institutions have begun moving towards using gender-inclusive language that removes cis-normative language from clinical vocabularies (Stroumsa & Wu, 2018, p.585). However, in the global health space this switch in language has yet to become routine. In order to provide congruity of language across the cited sources used in this thesis and the interviews conducted in English and Norwegian languages, where the predominant rhetoric was "woman-centered," I made the decision to keep the language consistent for clarity in my analysis. This is not intended to erase the experiences or continue to participate in the production of knowledge that is exclusionary to marginalized and victimized groups in global society, rather to avoid confusion in the discussion.

There are many words and definitions used to describe persons who move across borders – immigrants, migrants, non-resident aliens, refugees, asylum seekers, irregular migrants, undocumented migrants, just to name a few. The experience of migration varies significantly depending on the reason for migration, however for the purposes of this study, I aimed to look at the needs of the population of migrants as a whole. The International Organization for Migration (IOM) defines a migrant as "any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status, whether the movement is voluntary or involuntary, what the causes for the movement are, and what the length of stay is" (IOM, 2019). This decision deviates from Norway's official working definitions for these groups, who have primarily divided the general population of legally recognized resident migrants to Norway into "innvandrere" ("immigrants") and "norskfødte med invandreforeldre" ("Norwegians born to immigrant parents"). Those not included in official population counts are considered to either be "papirløse migranter," ("paperless migrants") or "asylsøker," ("asylum seeker"). In order to cover the experiences of all groups, unless one group was specifically identified within interviews by a midwife or in literature, I decided to define the population as a whole using the IOM all-encompassing definition of "migrant."

Finally, while more than half of the interviews were conducted in Norwegian, I made the decision to represent all of the interview data in the analysis chapters in English. As a non-native and intermediate Norwegian speaker, I made every effort to maintain meaning across the language translation. However, language carries many cultural nuances that are challenging to translate or discern as a non-native speaker. In the effort to maintain transparency in the representations of the voices of my participants, all translated quotes can be found in their original Norwegian form in Appendix F.

ABSTRACT

Every woman who resides in Norway is entitled to free and comprehensive antenatal, labor, and postpartum care through the Norwegian maternity service, irrespective of migration status. Located at the center of the service are midwives, maternal health practitioners that provide the majority of routine perinatal care. Past studies have determined that migrant women suffer disproportionately worse maternal and neonatal health outcomes compared to Norwegian women. This study aimed to determine how midwives working in greater Oslo, Norway, construct and act upon the vulnerability of migrant women, before and during the first year of the COVID-19 pandemic.

To elucidate this, a qualitative study was performed, using a combination of semi-structured interviews and textual analysis of previously-collected interviews from 2019. Midwives working in the greater Oslo area, with experience working with women with a migration background were recruited to participate. This study is in partnership with the MiPreg project, which aims to map the current status of the Norwegian maternity care system in its care for women with a migration background. Face-to-face interviews with recruited participants were conducted in several locations around Oslo, Norway. The interviews analyzed using textual analysis were collected from interviews conducted December 2019 to February 2020, and the in-person interviews were performed from August to December 2021.

A total of 13 midwives were interviewed, and they shared several challenges in providing migrant-centered care, including accessing translation services, communicating across cultural and linguistic boundaries, providing supplemental patient education, and explaining the Norwegian health and social services structures. In addition, the midwives reported general workplace dissatisfaction, related to low staffing levels, increased workload, lack of care continuity, and increased medicalization of pregnancy and birth, which were reported to add additional strain on providing migrant-centered care. During the COVID-19 pandemic, the midwives reported suspensions of certain maternity service offerings, increased workloads, increased social isolation and decreased social support for migrant women. Additionally, higher proportions of COVID-19 vaccine hesitancy amongst pregnant migrant women were reported.

This study's findings suggest that midwives working in the Norwegian maternity service need more support, resources, and training in order to provide higher quality migrant-centered care. The COVID-19 and infection control guidelines drastically increased midwives' workload and decreased staffing levels and available maternity service offerings, which made providing migrant-centered care more challenging. The implications of midwife burnout and lack of training in migrant-centered care have implications in quality of care provision, maternal and neonatal health outcomes in migrant populations, and migrant patients' satisfaction in care.

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INTRODUCTION

When I began conceptualizing this study, I was reeling in the aftermath of my experiences working as paramedic in Boston during the first year of the COVID-19 pandemic. Through my six years of service in Massachusetts I encountered many points of tension as a provider, between the policies and procedures set by the state and my employer, my patient's needs, and my own wellbeing. There were many points in my career, especially during the pandemic, where I simultaneously juggled feelings of pride and purpose, with feelings of powerlessness and burnout. As a result, I knew that I wanted to center the voice of providers, who in my experience desire the best for their patients, all the while working within systems that are often failing to provide the support and consideration needed to work happily and healthily.

When I moved to Norway to pursue my master's degree, I was given the opportunity to explore a health system other than my own. While the United States has been engaged in one of the most important battles for reproductive rights and maternal health in our history, Norway has a lengthy reputation of protecting access to safe, comprehensive reproductive healthcare within their rights-based approach to health. As I dove into Norway's maternity care system, I was immediately drawn to the practitioners who lie at the center of care – the midwives. They are professionals in a medicalized field who, against the pressures of heavy workloads and the encroaching influences of biomedicine, provide attentive, empowering, and highly individualized care. In light of the unsettling statistics of maternal and neonatal outcomes for women with a migration background in Norway, I felt that the midwives' voices as professionals who provide such close and attentive care were essential to understanding where the Norwegian maternity falls short for this population.

This master's thesis will dive into the stories of thirteen midwives working in health stations and maternity wards in the greater Oslo area. Their perspectives, which they shared with me and my MiPreg associates through semi-structured interviews, I will highlight the challenges they experience in their work lives, how they construct the concept of 'vulnerability' and adjust their care to promote health equity, and common challenges they perceive in providing care to women with a migration background. Through the course of this thesis, I will illuminate the adaptability and compassion of the providers within this profession, and the areas in which their strengths need to be further supported, particularly in the areas of migrant-friendly care and cross-cultural communication.

This study was conducted in partnership with the MiPreg study, a multidimensional, interdisciplinary project mapping the current status of the Norwegian maternity care system in its care

for women with a migration background, evaluating the specific needs of pregnant migrant women, and introducing an intervention aiming to close potential gaps in maternity care delivery. This study follows the results of several studies that have found that women with a migration background are experiencing disproportionately worse maternal and neonatal health outcomes in the Norwegian maternity care system, and aims to emphasize the expert perspective of midwives, whose voices have been drastically underrepresented in Norwegian literature. The MiPreg study provided data from interviews collected prior to the COVID-19 pandemic and have been an invaluable source of information and support for this project.

Chapter One will provide the necessary context that will serve as the background of the remainder of this thesis. I will introduce the Norwegian maternity system, its structure, recent movements towards centralization and medicalization, and what care those in Norway are entitled to. I then will introduce relevant statistics regarding maternal and neonatal outcomes for migrant women who become pregnant and give birth in Norway, as well as the results of qualitative studies outlining their experiences and satisfaction with the system. Then, I will orient the reader to the field of midwifery, its history within Norway, and the midwifery approach to maternity care provision. I will also introduce the multicultural doula program and its impacts so far. Finally, I will briefly outline the impact of the COVID-19 pandemic in Norway and the barriers the virus introduced to the maternity system.

Chapter Two will outline my research methodology, where I used qualitative methodology to explore the perspectives of the midwives as they reflected on their approach to care and challenges while providing maternity oversight to women with a migration background. This chapter will introduce the MiPreg project, the supervising group of this study, and then later explain my recruitment strategies, a description of my sample, data collection strategies, funding, strengths and limitations, and ethical considerations.

Chapter Three will introduce the three main concepts that were used in the analysis of this paper. As I was reviewing my transcribed interviews, I quickly realized that the responses required analysis drawing from multiple concepts and theories, rather than forcing my analyses to fit within a singular framework. As a result, I draw upon the concepts of structural vulnerability, the social-ecological model of health promotion, and the theory of labor welfare in my discussions of the findings from my field work.

The subsequent four chapters will cover my findings from my field work. Prior to discussing the specific challenges as related to caring for women with a migration background, I wanted to discuss

the challenges associated with being a midwife in Norway. In Chapter Four I discuss the labor conditions of the Norwegian maternity service through the eyes of the midwives. This chapter will reveal the midwives' love and enthusiasm for their profession within a system that does not provide staffing levels or the working conditions sufficient for them to work within their profession's framework. The implications of substandard workplace conditions and a lack of support negatively impacts patient care, and limits their capacity to provide high quality care to those in need of more attention and resources, like women with a migration background.

Chapter Five begins the discussions of my findings as related to women with a migration background. In this chapter, I discuss how the midwives conceptualize 'vulnerability', what factors may make an individual or group more vulnerable, how they assess their patients' vulnerability, and how they adapt their care to address vulnerabilities. I found that the midwives consider 'vulnerability' as both a static and dynamic process within the complexity of individual circumstances and structural factors. Within their position, the midwives shared how they adjust their care to meet the needs of those most vulnerable, with many giving examples of acting against institutional policy or outside of their professional responsibilities to ensure that their vulnerable patients receive high quality care.

Chapters Six and Seven illuminate the common challenges the midwives perceive while providing care to women with a migration background, resources that were available to them, and resources they wished they had to aid in their care for this specific population. Chapter Six follows challenges in communication as a result of limited accessibility to, and quality of, translation services, and difficulty in providing health information and patient education materials cross-culturally and linguistically. The chapter ends by discussing the multicultural doula program, which was initiated in 2017 to provide social support and cultural advocacy to recently-arrived or low-resource pregnant migrant women in Norway, and how it has been an important resource the midwives have found immense value in.

Chapter Seven discusses how midwives are agents of social support for women with a migration background, especially for those who have recently arrived in Norway. The midwives shared that their patients with a migration background often have limited social networks, as well as limited understanding of the Norwegian health and social welfare services. This chapter discusses how in their positions, beyond their clinical responsibilities, midwives often a guiding role to orient their patients to life in Norway. However, this expectation appears to be an important source of stress for the midwives, who indicated that they lack the training and expertise, as well as the time for this role. This chapter finishes by discussing the perspective of one midwife who works closely with irregular

migrant women in Oslo, for whom these challenges become even more pronounced, and are further complicated by experiences of "illegality" (De Genova, 2002, p.422) while interacting with the Norwegian health and social services.

Finally, Chapter 8 will briefly discuss how the COVID-19 pandemic added further strain on the Norwegian maternity system, and exacerbated many of the challenges that the midwives perceive in their professional lives while providing care to women with a migration background. In this chapter, the midwives share how during the pandemic, there was decreased access to the maternity service and halting of several maternity services offerings, increased social isolation and decreased social support for migrant women, increased workload for midwives and insufficient staffing, and challenges with vague vaccination guidelines for pregnant women.

This thesis will conclude with discussions of the resources and training that the midwives have shared that they need to provide high quality care to women with a migration background. Throughout the thesis, the midwives described a deep love for their framework of care and their patients, however as a result of a lack of institutional support and resources, they are falling short for patients who require more time and coordination, like women with a migration background. With globalization, climate change, conflict, education, and labor, Norway will continue to experience an increasing migrant population. As a result, the Norwegian maternity system will need to adapt to ensure that accessibility to and quality of their services is matching the needs of the country's residents. In the face of increasing medicalization of birth in Norway and threats to pregnant patients' agency and empowerment in birth, the midwives I interviewed and their ability to adapt their care to meet the needs of individual patients only underscored how essential this group of providers is to the Norwegian maternity service. Based on my findings, this thesis will suggest that in order to improve the provision of migrant-friendly care, the midwives need more institutional support, as well as migrant-centered training and resources.

CHAPTER ONE: BACKGROUND AND LITERATURE REVIEW

1.0 INTRODUCTION

Due to globalization, climate change, education, conflict, or labor, there is an increasing number of people crossing international borders to reside in nations that they were not born in. As of 2020, there are estimated to be 272 million persons residing internationally, which is approximately 3.5% of the global population (IOM World Migration Report, 2020, p.3). European and Asian countries collectively host 61% of international migrants, and have seen the sharpest increase in migrant populations as a result of several humanitarian crises in neighboring regions (IOM World Migration Report, 2020, p.24). Norway is a small country with a population of 5.435 million people (Statistisk Sentralbyrå, 2022), and over the past several decades has seen an increase in immigration and emigration from the country (Cappelen, Ouren, & Skjerpen, 2011, p.4). Of their population, 18.9% are immigrants and children born to immigrant parents (Statistisk Sentralbyrå, 2022). Many chose to settle or were placed in the country's capital, Oslo, and now make up approximately one-third of the city's population (Statistisk Sentralbyrå, 2022), however there are additionally refugee asylum reception centers located in smaller cities around Norway (UDI, 2022). The majority of registered migrants are labor migrants, followed by those who arrive by family reunification, then refuge, and education (Statistisk Sentralbyrå, 2022). Roughly half, 48%, of documented migrants and children born to documented migrant parents are women (Statistisk Sentralbyrå, 2022).

The Norwegian Directorate of Health has ensured that every woman who is pregnant has the right to free and comprehensive antenatal, labor, postpartum, and postnatal care, regardless of official immigration status (Helsenorge, 2022). These essential antenatal care services include 8-9 clinical visits where the patients are monitored over the progression of the pregnancy, including fetal growth, screening for life-threatening conditions like pre-eclampsia, gestational diabetes, anemia, and placental abnormalities, as well as psychosocial support (Helsenorge, 2022). Patients are also entitled to specialist referral and oversight if clinical presentation requires it (Helsenorge, 2022). When it comes time for labor, all patients have a right to labor in a facility with skilled birth attendance, and have the option to choose their facility, with the stipulations of availability and the clinical progression of the patient's pregnancy (Helsenorge, 2022). After delivery, the woman is entitled to clinical follow-up for her and her infant, including a home visit, where she is evaluated for postpartum complications and given breastfeeding, psychosocial, and infant care support by a midwife, physician, or a public health nurse (Helsenorge, 2022). All of these services are included within the larger preventative care

strategies that were introduced by the 2012 Public Health Act (*Folkehelseloven*) to promote the well-being of pregnant women, children, parents of children, and young persons (Regjeringen, 2012, No.4).

As a result of their commitment to the provision of comprehensive antenatal and obstetric care, Norway has some of the best obstetrical and neonatal outcomes in the world. The maternal death rate, or the number of women who died from health or management complications during pregnancy and birth, in 2017 was 2 deaths per 100,000 live births (UNICEF, 2017). This is significantly lower than that of the United States, another high-income country, who in 2020 reported the maternal death rate to be 23.8 deaths per 100,000 live births, and 55.3 deaths per 100,000 live births for non-Hispanic Black women (Hoyert, 2020, p.1). Norway's maternal death rate is appreciably lower than that of the countries many women migrate to Norway from. For example, Somalia's maternal mortality rate is 692 deaths per 100,000 live births (Somalia Health Demographic Survey, 2020). The odds of a fifteen-year-old woman delivering in Norway eventually dying from a maternal cause is 1 to 25,700, the fourth best odds in the world and the best in Scandinavia (UNICEF, 2017). The neonatal mortality rate, or the number of deaths of children 28 days or younger, in Norway as of 2020 was 1.2 deaths per 1000 live births, the lowest it has ever been (UNICEF, 2020). This is half the rate of the United States, which reported 3 neonatal deaths per 1000 live births in 2020 (UNICEF, 2020). Somalia has a neonatal mortality rate 30 times that of Norway's, at 36.8 deaths per 1000 live births (UNICEF, 2020). The infant mortality rate, or the number of deaths of children less than 1 year old, in Norway as of 2019 was 2 deaths per 1000 live births (World Bank, 2020), compared the United States' 5 deaths per 1000 live births (UNICEF, 2020) or Somalia's 73 deaths per 1000 live births (UNICEF, 2020).

1.1 MATERNITY SYSTEM NAVIGATION CHALLENGES FOR MIGRANT WOMEN

All women who live in Norway are entitled to free and comprehensive pregnancy care, regardless of immigration status. These services are directly integrated into the primary care system. However, even with these facilitating factors, there are many institutional and systemic barriers to care that specifically impact expecting parents with a migration background. Almost one quarter of babies born in Norway were to a mother with a migration background (Tønnessen, 2014, p.19), so it is with growing importance that the Norwegian maternity services are adapted to better meet the needs of those with a migration background. The Health Directorate states that healthcare should be individualized, and that patients have a right to information in their own language (Helsedirektoratet,

2022). The official language of the Norwegian health system is, naturally, Norwegian, however most health professionals in the system also speak English. The Norwegian Interpretation Law (*Tolkeloven*) emphasized in 2022 the obligation to use qualified remote or physical interpreters in the public sector, including the health service, for any who need interpretation (Lovdata, 2022). Despite this legal obligation, for patients who speak neither Norwegian nor English, there are many studies that indicate that within the Norwegian maternity system, access to adequate translation has proven to be a major challenge, both from the health provider and the patient perspectives. Across the entire Norwegian public health services, there is a trend amongst providers of under-utilization of available translation services (Kale & Syed, 2010, p.190). Health professionals in Norway have indicated difficulty with accessing translation services as a reason for under-utilization, and have stated that there are not enough available translators, both in quantity and in available languages or dialects, to meet the demands of their patients (Viken, Lyberg, & Severinsson, 2015, p.2). Many Norwegian health stations have reported challenges with scheduling a translator for antenatal care appointments due to limited hours of availability, and have instead utilized family members or friends for interpretation (Egge, Kvellestad, & Glavin, 2018, p.9). One study found that only 19% of women who needed translation services through their pregnancy received it (Bains, et al. 2021, p.8). Translator certification in Norway is a relatively rigorous process, typically requiring a Bachelor's degree or specialization courses, as well as testing (Integrerings-og mangfoldsdirektoratet, 2022), which are important to ensure the quality of translation rendered. However, these requirements may be contributing to the insufficient supply of available translators, which may contribute to health providers' use of alternative translation means, like patient family members or friends.

However, increasing the working hours or training more available interpreters would likely not fully address provider challenges in accessing translation services. Past research outside of Norway has also indicated that providers underutilize translation services due to time constraints during consultations and limited availability of translation services during acute scenarios (Jaeger, et al. 2019, p.5). Additionally, Polish migrant women reported that providers often overestimated their Norwegian language skills, and cited cost of interpreters as a reason providers did not book qualified interpretation for health consultations (Czapka, Gerwing, & Sagbakken, 2018, p.11). With the new guidance in the 2022 Norwegian Interpretation Law (*Tolkeloven*) that reinforced the obligation of public service workers to use qualified interpretation for all appointments with those with limited Norwegian proficiency, there will be health service policy and procedure change that will further facilitate the integration of interpretation services into health appointments. Some interventions to

explore in future research could include integration of 24-hour emergency telephone interpretation into the maternity service, expanding health care expenditure on interpretation use, and consistent pre-appointment screening for interpretation needs.

In addition to poor access to translation services, there is an established need for pregnancy information and educational materials in languages other than Norwegian and English. For those who have access to the Norwegian health system's primary health communication and information system, Helsenorge (which requires resident status and provision of a Norwegian Birth Number, *fødselsnummer*), they will find a portal almost entirely in Norwegian. To be able to message a provider, find out test results, schedule appointments, and keep track of your prescriptions requires knowledge of some Norwegian. There is some pregnancy information, which also includes information regarding health system navigation, available through Helsenorge and the Norwegian Health Directorate in English (Helsenorge, 2022; Helsedirektoratet, 2022). With that being said, Helsenorge has integrated a health information platform from Germany, called Zanzu, which has relevant information regarding pregnancy, reproductive health, and patient rights in Norway, translated to French, Turkish, Arabic, Farsi, Polish, Somali, and Tigrinya, and also has the option for dictation of the information for those with low literacy (Zanzu, 2022). Zanzu does not include information or advice regarding Norwegian Health system navigation (Zanzu, 2022). In addition, any information through the official Oslo Municipality website regarding pregnancy and childcare through health stations, including how to locate the nearest one, is entirely in Norwegian Bokmål (Oslo Kommune, 2022). While the Norwegian service has undoubtedly developed their health infrastructure around the majority population, there is a need for translation of pertinent information regarding the Norwegian maternity service and important health information into languages that reflect existing migrant populations in Norway.

In addition to online health information materials from the Norwegian health services and Oslo Municipality, the Norwegian maternity services additionally offer antenatal care courses, birth preparation courses, and lactation courses. However, most of these courses have associated fees, and rarely are in languages other than Norwegian or English. They are offered through hospitals, health stations, and private individuals or organizations, and are led by physicians, midwives, and/or public health nurses.

For patients, especially those with little or no English or Norwegian proficiency, the lack of access to information in their native language has resulted in recently-arrived migrant women reporting poorer understanding of important pregnancy-related information (Bains, et al. 2021, p.7).

One recent study of recently-arrived migrant women found that one-third reported poor understanding of important pregnancy and reproductive health information, including family planning, formula feeding, postpartum mood disturbance, and recommended medical tests during pregnancy (Bains, et al. 2021, p.7). Garnweidner, Pettersen, & Mosdøl (2013) found that migrant participants in their study were not provided with adequate nutrition and weight management information during their antenatal care visits. Another study found that Somali migrants in Norway felt unprepared for birth, and were not given adequate information on potentially dangerous symptoms during pregnancy (Glavin & Sæteren, 2016, p.5; Vangen, et al. 2004, p.33). Factors that increased risk of poor understanding of information for migrant women included low Norwegian proficiency, no or up to secondary school education, unemployment, and no offer or receipt of interpretation during pregnancy (Bains, et al. 2021, p.6). Another study found that midwives have experienced discomfort and uncertainty in discussing sensitive cultural practices, like circumcision, during consultations, which impacted Somali patients' satisfaction with care and understanding of health concepts (Vangen, et al. 2004, p.33).

Related to poorer understanding of important health information, previous studies have indicated that migrant women have challenges understanding the structure of the Norwegian healthcare system and which services they have a right to access (Bains, et al. 2021, p.5). As previously stated, all women have a right to comprehensive care related to their pregnancy, as well as essential and emergency services. However, despite the right to this care, there may be associated financial costs that are difficult to discern or plan for. Migrant women have reported difficulty understanding the structure and procedures of the Norwegian health system, and have indicated that they hope or expect for health providers in the maternity service to be sources of information and guidance (Bains, et al, 2021, p.5). Additionally, migrant women have reported difficulty navigating social welfare services, like unemployment assistance, child benefit, applying for kindergarten (starting one year after birth), and parental benefit (Bains, et al, 2021, p.5; Egge, Kvellestad, & Glavin, 2018, p.15; Glavin & Sæteren, 2016, p.6), and will sometimes seek guidance from their providers (Egge, Kvellestad, & Glavin, 2018, p.15).

For those who reside in Norway without legal documentation of residence, there are additional barriers to accessing the maternity services that superimpose those previously discussed. In Norway, research in this topic is vastly underrepresented. While undocumented migrants have equal rights to accessing the Norwegian maternity services, including access to abortion care, at no cost, outside of the maternity system undocumented women are only entitled to "absolutely necessary" medical

services at low or no cost (Helsedirektoratet, 2022). “Absolutely necessary” medical care includes preventative care and treatment for some infectious diseases, necessary healthcare that cannot wait, and emergency care (Helsedirektoratet, 2022). As such, undocumented migrants are responsible for providing full payment for most treatments and visits, which oddly enough sometimes includes costs associated with childbirth (Kvamme & Ytrehus, 2015, p.3). However, if they absolutely cannot pay the provider must cover the expenses (Helsenorge, 2022). General practitioners and specialists who render care to undocumented migrants do not get their costs reimbursed (Melberg, et al. 2017, p.2). Additional barriers to accessing the maternity service are related to the precarity of existing without documentation in Norway. Financial challenges as a result of working in the informal labor sector has been reported to negatively impact health-seeking behavior and transportation to appointments due to concerns about cost (Kvamme & Ytrehus, 2015, p.7). Undocumented individuals have also shared that barriers to accessing the health services included fear of being reported to police or immigration authorities and lack of knowledge about rights to certain services like antenatal care (Kvamme & Ytrehus, 2015, p.8). Health providers working with undocumented migrants reported challenges in maintaining contact with their patients due to housing insecurity and deportation, as well as building trust with their fearful patients (Kvamme & Voldner, 2021, p.288). In Oslo, there is the Health Center for Undocumented Migrants (*Helsesenteret for Papirløse Migranter*), which is run outside of the Norwegian public health service by the Red Cross and the Kirkens Bymision, where undocumented migrants can schedule appointments with a physician, nurse, midwife, psychologist, or a dentist, as well as access laboratory testing, contraceptives, and prescription medications at no cost. This center additionally offers comprehensive perinatal care through a midwife, however they also aid in placing their patients under the care of health station midwives. There is a significant gap in literature detailing the experiences and outcomes for pregnant undocumented migrant women in Norway. Further research is needed to map maternal health outcomes and challenges in providing maternity care to this vulnerable population.

1.2 MIGRANT WOMEN’S SATISFACTION IN MATERNITY SERVICES

Unfortunately, there are several studies that reported instances where women with a migration background have experienced discrimination and bias from providers in the maternity service. One study reported that Somali women noted instances of harassment and felt dismissed by their providers when cultural differences arose while discussing practices around pregnancy (Glavin & Sæteren, 2016, p.5). This study’s findings are consistent with the findings in Small, et al. 2014, where migrant

women interviewed about their pregnancy experiences in Norway reported situations of abuse from their providers, particularly in relation to requests for accommodation of cultural or religious beliefs and practices. Another study found that Somali women reported offensive and ignorant comments, as well as seeing their providers express surprise and disgust regarding their circumcision while receiving perinatal care in Norway (Vangen, et al. 2004, p.33). Other studies have found that women with a refugee background felt that they were treated differently by providers on the basis of their race, religion, and language spoken (Bains, et al. 2021, p.5; Leppälä et al., 2020, p.8). One study reported that one in five of their respondents reported experiences where a health worker made a decision without considering their wishes (Bains, et al. 2021, p.5).

In addition to experiences of discrimination, women with a migration background, especially those who are recently-arrived (have lived in Norway less than five years), have been shown to experience feelings of loneliness, depression, and anxiety during pregnancy. Bains, et al. (2021, p.8) found that of the migrant women interviewed after birth, 24% reported feeling afraid or anxious, 15% reported feeling hopeless for the future, and 30% reported loneliness. The study also found the interviewed women to have a very limited social network beyond their and their partner's families (Bains, et al. 2021, p.8). Other studies have indicated that migrant women feel uncomfortable with discussing intimate topics with providers in maternity care appointments, like menstruation, intercourse, female genital cutting, grief, and pain (Lyberg, et al. 2012, p.290-291).

Despite the challenges stated above, overall, migrant women feel generally satisfied with the Norwegian maternity services. However reported dissatisfaction with maternity services was tied to factors like high education, good Norwegian language skills, having a Norwegian partner, and having an unplanned pregnancy (Bains, et al. 2021, p.5). This same study discusses that feelings of satisfaction with the maternity service can be intricately tied to expectations – having low expectations or lacking knowledge of what to expect from the maternity service can potentially lead to higher satisfaction with care received (Bains, et al. 2021, p.6). Viken, Lyberg, & Severinssen (2015,), discusses coping mechanisms that migrant women have employed during their pregnancies to supplement feelings of imbalance or lack of support, including leaning on cultural and religious traditions for comfort while slowly integrating Norwegian customs, building and maintaining social networks in Norway and abroad, seeking knowledge from the Norwegian health system and other women in their network, and placing emphasis on flexibility and openness to new experiences (p.6-8). Future priority needs to be placed on expanding the accessibility of translation services,

developing supplementary pregnancy education materials and courses for patients with multicultural backgrounds, and expanding cultural competency training for healthcare workers.

1.3 OBSTETRICAL OUTCOMES OF MIGRANT WOMEN IN NORWAY

While Norway certainly has excellent obstetrical and neonatal outcomes on a global scale, past research has shown that women with a migration background are especially vulnerable to poorer obstetrical and neonatal outcomes compared to ethnic Norwegian women. Migrant women who come from countries with high perinatal mortality typically have a reduced risk for perinatal mortality when they become pregnant and give birth in Norway (Naimy, et al. 2013, p.3). However, some groups, including migrants from Afghanistan, Iraq, and Somalia, have higher perinatal mortality rates than those of women born in Norway, with Afghani women having four times the risk of perinatal mortality (Naimy, et al. 2013, p.3).

Women with a migration background also have higher risk of developing several pregnancy complications. Some risk factors that have been previously cited to increase risk for poor maternal health outcomes for migrant women in Europe include low socioeconomic status, gestational diabetes, high BMI, fetopelvic disproportion, inadequate antenatal care, and communication barriers (Keygnaert, et al. 2016, p.8). However, there is currently no consensus regarding personal or behavioral risk factors (for example, smoking or exposure to violence) that increase risk for migrant women (Keygnaert, et al. 2016, p.8). In the Norwegian context, the proportion of women with gestational diabetes is seven times higher than that of ethnic Norwegians (Holan, et al. 2008, p.128). Gestational diabetes is associated with several complications in pregnancy and childbirth, including cesarean section, pre-eclampsia, high birth weight, and placental malperfusion (Scifries, et al. 2016, p.1). Women with a migration background across all geographic regions of birth had a higher risk of developing hyperemesis gravidarum, a potentially fatal condition of severe nausea and vomiting during pregnancy that can cause dehydration, electrolyte imbalance, and nutritional deficiency, and ultimately restricted fetal growth (Vikanes, et al. 2008, p.460-461). Women from sub-Saharan Africa, particularly from Ethiopia, are more at risk than ethnic Norwegians for developing placental abruption (Mæland, et al. 2020, p.661), a life-threatening complication where the placenta prematurely separates from the uterine wall, causing hemorrhage in the mother and oxygen deprivation for the fetus. Women from Africa and Asia were more likely to have intrauterine growth restriction, or slow growth of the fetus (Abebe, 2010, p.61). Somali migrants, one of the largest migrant groups in Norway, have been shown to have the highest risk for adverse obstetric outcomes including

emergency cesarean section, post-term birth, small-for-gestational-age infant, and fetal distress during birth in comparison to Norwegian women (Bakken, Skjeldal, & Stray-Pedersen, 2015, p.4). While migrant women generally have a lower prevalence of preeclampsia, or high blood pressure during pregnancy that can lead to seizures and death if not addressed, women with a refugee background have increased odds of developing preterm preeclampsia (Nilsen, et al. 2018, p.4). Another study found that the risk for developing preeclampsia in pregnant women with a migrant background increases with length of residence (Naimy, et al. 2014, p.862).

Many of these trends continue as complications during birth. One study found that women with a migration background are 29% more likely to deliver preterm (Sørbye, et al. 2014, p.5), and have an increased risk of stillborn birth (Skeie, et al. 2003, p.1013). Another study found that non-Western women have an increased odds for stillbirth, potentially a consequence of a substantially increased risk for receiving suboptimal obstetric care in the Norwegian maternity system (Saastad, Vangen, & Frøen, 2010, p.446, 447). One study found that women from sub-Saharan Africa have twice the prevalence of emergency cesarean section to ethnic Norwegian women, and that women from Latin America & the Caribbean have 1.7 times the prevalence (Jatta, et al. 2021, p.6). Another study found that migrant women have a 51-75% higher risk of emergency cesarean section than that of Norwegian women, and that the risk for emergency cesarean section increases after two years of residence in Norway (Sørbye, et al. 2014, p.81). Women with a refugee background and who have recently-arrived had the lowest provision of epidural analgesia during birth (Aasheim, et al. 2020, p.5).

These risks are not isolated to pregnancy and birth, they also continue into neonatal and infant outcomes. Unfortunately, recently-arrived migrant women coming from countries with high infant mortality rates also experience high infant mortality risk in Norway (Kinge & Kornstad, 2014, p.803). However, an assimilation effect is seen with this data, where infant mortality rate does decrease with increasing length of residence in Norway (Kinge & Kornstad, 20144, p.803). Migrant women who had their first child outside of Norway have increased odds of adverse neonatal outcomes in subsequent births in Norway, compared to those who had their first birth in Norway (Vik, et al. 2020, p.4).

Norway's migrant population is expected to double by year 2040 (Statistisk Sentralbyrå, 2016), so it is important that the Norwegian maternity service looks critically at the health and social vulnerabilities of migrant women, and makes steps to address these obstetric disparities. An important perspective that needs to be centered in future research is that of health providers and the challenges

that they identify while providing care to this population. As such, this will be an aim of this study. Further analysis of individual and systemic factors identified by providers, combined with the identified perspectives of migrant women, can provide evidence to support institutional and political adjustments to improve health outcomes for this vulnerable group.

1.4 THE ROLE OF MIDWIVES IN THE NORWEGIAN MATERNITY SYSTEM

In Norwegian Bokmål, the word for midwife is *jordmor*, which directly translated means "earth mother" or "soil mother." Some have hypothesized that the word's origin is meant to reflect in the Norwegian language imagery that across many other languages cultures was associated with pregnancy and motherhood – earth, growth, and nature (Jahr, 2011, p.318). However, the majority of linguists have hypothesized that the name describes the actions of birthing attendants. One theory suggested that the term *jordmor* emerged out of Norwegian birthing practice, where women would deliver their child while lying on the earth, where the newborn was rumored to stay until the family decided to accept it (Jahr, 2011, p.322). Once the child was accepted, the person who lifted the infant from the earth to the mother, who was typically the birth attendant, was the one who was denoted the name *jordmor* (Jahr, 2011, p.322). Linguist Ernst Håkon Jahr argued that the term is a distortion of old Norse *jódmóðir,* which can mean offspring or fetus (Jahr, 2011, p.324-325). In other Nordic languages, the term for midwife has many other meanings. For example, Icelandic's *ljósmóður* meaning "light mother" or "redeemer," refers to the person "freeing" the child from the mother or removing the weight of the fetus, thus making the mother "lighter." In the Nordic birthing cultures like Norway, the language used to describe the practitioners conveys not only the actions associated with the profession, but also illuminates the relational aspect of midwifery – the relationship between practitioner and patient, the relationship between the mother and the earth. While the birthing culture has changed a substantial amount in Norway since the days where women delivered directly onto the earth, the name designated to this profession carries its history and cultural meaning to the present day.

Located at the center of current day's Norwegian maternity system lie midwives, registered nurses with additional specialization in obstetrics and gynecology, who render the majority of routine antenatal, birth, postpartum, and postnatal care. The profession arose in Nordic countries in the 1700s in response to the Lutheran Church's dedication to reducing the staggering maternal and infant mortality rates (Pajalić, Pajalić & Saplacan, 2019, p.128). Seeing how the growth of the profession in France, Holland, England, and Germany had had positive effects on their respective maternal health

outcomes, the church began instituting laws that laid the foundation for the earliest form of the midwifery in the Nordic region (*Ibid.*, p.128). Since then, drawing heavily upon obstetric information and procedures developed in Germany, midwives became skilled birth attendants who worked in tandem with physicians to expand the reach and accessibility of the maternity service (*Ibid.,* p.128). This, combined with the introduction of aseptic technique during birth, dramatically reduced the maternal mortality and morbidity rates (Högberg, 2004, p.1317).

In current day, midwives typically operate out of health stations, specialist centers, and maternity wards. In addition to their essential roles in monitoring the health of the pregnant women before, during, and after birth, they also play an essential supportive role to the lives of their patients. The model of care employed by midwives is one that is patient-centered, individualized, and aids women in developing embodied connections to their physiological changes during pregnancy (Berg, Ólafsdóttir, & Lundgren, 2012, p.2). Patient-centered care as a care framework was described by Enid Balint as "understanding the patient as a unique human being," rather than centering the patient's illness or injury (Balint, 1969, p.269). For many women, midwives are a conduit for conveying important health information about pregnancy management, infant care, and psychosocial wellbeing. Due to the intimate nature of pregnancy, women have reported developing very close emotional bonds to their provider, describing their relationships as being akin to that of a sister or friend (Egge, Kvellestad, & Glavin, 2018, p.12). As a result of these close relationships, combined with the specialization that midwives have, many women prefer to receive their antenatal and postnatal follow-up from midwives rather than general practitioners (*Ibid.,* p.12).

Despite the ability to supervise all stages of the perinatal period, it is rare to have the same midwife during pregnancy and labor, due to the fragmentation of the Norwegian maternity service (Bains, et al. 2021, p.2). Due to this differentiation between these different sides of the maternity care system, there are challenges in maintaining continuity of care across a woman's entire pregnancy, which has the potential to impact patient trust and comfort in their providers (Lukasse & Henriksen, 2019, p.1567)**.** As a result of the differences in work responsibilities and the lack of continuity between the two sides of the system, midwives who work in the antenatal and postnatal periods relate differently to their patients than those who work in the labor and postpartum wards. Midwives who work in the antenatal care setting have a much longer time to get to know their patients, since they see their patients through their entire pregnancy, and have a larger professional capacity to provide psychosocial support, referrals to social services, and guidance on navigating other parts of the health system. It is also important to note that beyond their responsibilities in the maternity service,

midwives who work in the health stations also have important capacities in gynecological health, including STI testing, contraceptive advising and provision, routine gynecological exams and counseling, and lactation consultation. As a result, over a lifetime of a woman's reproductive health, she has the opportunity to develop long-term relationships with the midwives who operate in the primary care setting.

On the other side, but not in opposition to those who work in health stations, midwives who operate out of labor and post-partum wards have unique capacities for developing relationships quickly with the women that they care for. Given the relative acuity of birth, with labor spanning minutes to days, midwives who work in the maternity wards must quickly assess, build trust with, and support their patients' medical needs. The "transfer of care" communication between the midwives attending the antenatal care visits and those that assist with the labor and delivery comes almost exclusively in the form of the physical "maternal health passport" (Appendix E). Their roles in the maternity ward are to lead low-risk patients through their births, with intervention from or in partnership with the specialist physicians as needed. After birth, when the woman is moved to the postpartum ward, midwives shepherd new parents into the next phase in their life by helping them bond with their child, providing education about recovery after birth and the postpartum period, assisting with infant care, and coaching women with lactation. In this side of the maternity system, midwives are trained to provide efficient assessment and triage, as well as develop close relationships quickly to help expecting mothers give birth safely and securely.

Past studies have indicated that midwives working in the Norwegian maternity service face institutional challenges while providing routine patient care. One study found that despite an increasing number of births and an increasing number of extra duties from a lack of available support personnel, that the Norwegian maternity system has not expanded staffing levels, which is causing midwives to feel overwhelmed, anxious, burnt out, and fearful that they may eventually cause an adverse advent (Lukasse & Henriksen, 2019, p.1563). Despite Norway's efforts to expand the maternity and preventative care services, there has been no translation of these efforts into improving provider staffing levels (Statens helsetilsyn, 2012; Johansen, et al. 2017, p.6). Midwives also described feelings of frustration about transitions in the maternity system away from a midwifery foundation that is patient-centered into a medical model of care focused on interventions, which is making Norwegian midwives feel underutilized to their whole competence (Lukasse & Henriksen, 2019, p.1566). Midwives have stressed the importance of establishing continuity with other providers in the maternity system but have indicated challenges with regards to communication (Aune, Tysland,

& Vollheim, 2020, p.11; Lukasse & Henriksen, 2019, p.1563), which is impacting the service's ability to provide integrated and comprehensive care. Many Norwegian midwives are advocating for the re-establishment of comprehensive midwifery services to center relational continuity and empower providers in the Norwegian maternity services (Aune, Tysland, & Vollheim, 2020, p.11). Over the past few decades, the Norwegian maternity service has also experienced a trend of centralization, the process of the closure of small, midwifery-led wards, in favor of the expansion of large specialist wards. The Norwegian health service authorities have emphasized that the maternity services should be decentralized (Helse-og Omsorgsdepartementet, 2008-2009, p.9), in order to keep maternity care accessible, however over the past decade have made several decisions that have led to the closure of eight low-risk maternity wards (Skogheim & Lundgren, 2021, p.4). This trend is in part due to increasing attitudes from professionals and the public, who fear for small maternity wards' capacity to manage unforeseen labor complications without available obstetricians on staff (Moster, Lie, & Markestad, 2005, p.2818). This trend of maternity ward closures continues in Oslo, with the 2022 announcement of the closure of the well-known and well-loved ABC clinic by 2040, one of only two midwife-run clinics in Norway. This has been met with dismay from the midwife community (Drægni, 2022), who have felt increasingly disenfranchised and devalued within the Norwegian maternity service as increased medicalization has challenged the midwifery framework of care (McCool & Simeone, 2002, p.740; Blakka & Schauer, 2008, p.348; Nilsson, et al. 2019, p.8).

Given the framework of knowledge that midwives utilize to assess, monitor, and support their patients, they are located in an advantageous position for assessing key social and structural factors within the Norwegian health system that facilitate or impede quality of care provision to women with a migration background. With that being said, there is little research that focuses on key challenges Norwegian midwives identify within the bounds of their professional lives. Studies in other Scandinavian countries have discussed unique care challenges, such as those outlined by Akhavan (2012): Having consistent access to translation services; inadequate quality of translation services;), having enough appointments to address health information questions and concerns; developing trust with patients with different cultural and linguistic backgrounds; and difficulty communicating important health concepts cross-culturally (Akhavan, 2012, p.7). In addition to these, Egge, Kvellestad, & Glavin (2018, p.15) have discussed the challenge of integrating discussions of social welfare schemes. Also, managing expectations of care from other health knowledges, religion, and culture has been cited as an important challenge for providers (Bains, et al. 2021, p.10). This study aims to add some knowledge that will shrink these research gaps by centering the voices of midwives

working in the Norwegian maternity services as they reflect on their experiences providing care to this population.

1.5 MULTICULTURAL DOULA PROGRAM

The project, "Vulnerable, pregnant and new in Norway – Safe during childbirth with a multicultural doula," was initiated at Oslo University Hospital in fall of 2017, which aimed to improve health services access and perceived quality of care for vulnerable migrant women through the integration of multicultural doulas into the Norwegian maternity service (Oslo universitetssykehus, 2020). This program was initiated after seeing success in a similar program in Göteborg, Sweden, where they introduced community-based doulas to offer support to migrant women during childbirth in 2008, with large success, especially for those with low social network and limited knowledge of the Swedish maternity system (Akhavan & Edge, 2012, p.842). Under the Norwegian program, women who have lived in Norway for less than two years, with a limited social network, and limited Norwegian language proficiency are entitled to support from a multicultural doula (Kielland, 2020, p.2). As of 2021, there are 80 multicultural doulas, speaking 17 different languages, who serve Oslo University Hospital, Akershus University Hospital, St. Olav's Hospital, Drammen Hospital, Bærum Hospital, Haukeland University Hospital, Stavanger University Hospital, and Kristiansand Hospital (Oslo universitetssykehus, 2021). To become a multicultural doula, the individual must have experience with pregnancy and labor in Norway or another Nordic country, and must have high Norwegian proficiency (Haugaard, et al. 2020, p.2). The training to become a multicultural doula involves a 56-hour training course that covers topics related to pregnancy, birth, communication, expectations for the role, and perinatal care, and following the training the doulas also meet regularly for supervision (Haugaard, et al. 2020, p.2). The program only allows up to 20 hours of care per woman, split up into one to two appointments during pregnancy, childbirth, and one to two appointments after birth (Haugaard, et al. 2020, p.2).

The role of the multicultural doula within this program is to be a support resource for women and their families, a guide to the Norwegian maternity system, and to mediate cultural or communication barriers between women and health professionals (Haugaard, et al. 2020, p.1-2). Studies evaluating this program have found that the use of multicultural doulas have improved patient satisfaction with the Norwegian maternity system, improved communication between health staff and patients, and improved patient understanding of pregnancy-related topics and the Norwegian maternity system (Haugaard, et al. 2020, p.5-6). Additionally, the multicultural doulas helped reduce

pain, anxiety, and fear during birth, provided emotional support like that of a friend, family member, or mother, and additionally helped support and integrate partners through pregnancy, birth, and the postpartum period (Kielland, 2020, p. 8-9). However, one challenge reported by multicultural doulas was with health professionals using them for translation in place of qualified interpreters, which is not within their scope of care (Haugaard, et al. 2020, p.5; Kielland, 2020, p.10). The providers interviewed in this study reflected on the use of the multicultural doulas in their work, but more studies are needed to evaluate the perspectives of providers, patients, and the doulas on the strengths and limitations of this program, as well as the effect of this program on obstetric and neonatal outcomes for recently-arrived migrant women.

1.6 MATERNITY SERVICES IN THE COVID-19 PANDEMIC

Given the temporal location of this study, it is important to also discuss how the COVID-19 pandemic and associated infection control restrictions in Norway exacerbated or introduced new barriers to providing quality care. Under the global strain of the COVID-19 pandemic, many countries have seen massive alterations to their structure, priorities, and delivery of care. At the time of writing, the world reached a global death toll of 6.29 million (WHO, 2022). Norway, likely as a result of a health system devoted to preventative care and adherence to strict infection control guidelines, has only had approximately 3,141 deaths over the past two years (Reuters, 2022). With that being said, it is likely that the pandemic has had an impact on the Norwegian maternity system. Past studies have shown that patient health-seeking behavior has been negatively impacted by fear of infection, and has delayed patients in accessing care (Masroor, 2020, p.2). The pandemic has also exacerbated divisions in health and wellness along socioeconomic and ethnic lines, facilitated by disparities in accessibility to the health system, chronic illness, employment, ability to follow infection control recommendations, and health literacy (Blumenthal, et al., 2020, p. 1483). As such, during this crisis, patients are relating differently to health systems and providers, and systems and providers are not relating to their patients in the same way either. Data has yet to emerge regarding the obstetric and neonatal experiences and outcomes of women with a migration background, but likely challenges and frustrations shared by migrant women prior to the pandemic have been very much underlined or exacerbated by the pandemic.

From the midwives' perspective, one study found that in Norway, both antenatal care and maternity ward contexts were severely impacted by social distancing and stay-at-home orders, with regards to amount of time spent with providers, the use of telemedicine and phone visits, and the

temporary pause of home-visits (Asefa, et al., 2021, p.5). Midwives from other European countries reported confusion over the management of laboring mothers infected with SARS-CoV-2, larger workloads due to additional infection control measures and reduced staffing, bans on partners or family visits, and the use of personal protective equipment impeding normal social functions and trust as additional challenges during the pandemic. There is a large gap in research in how the pandemic has affected women with a migration background seeking care in the Norwegian maternity services, and how the pandemic affected the professional lives of midwives. This study incorporates lines of questioning that focus on the COVID-19 pandemic in order to shed light on the ways in which women with a migration background were affected by the crisis in the Norwegian context.

CHAPTER TWO: METHODOLOGY

2.1 AIMS AND OBJECTIVES

The primary aim of this study was to center the perspective of midwives who work in the Norwegian maternity system to understand current challenges in providing care to recently-arrived migrant women. In the Norwegian maternity system, midwives lie at the center of caregiving, performing the majority of antenatal, labor, postpartum, and postnatal care. As such, their lived experiences hold immense value in describing the challenges, on both personal and systematic levels, in providing care to this vulnerable population. This study follows several other qualitative and quantitative studies within the MiPreg study, which have established that recently-arrived migrant women are suffering disproportionately worse health outcomes, as well as poorer understanding of important maternal health information. This occurs even though every woman is entitled to free and comprehensive pregnancy care regardless of their migration status. There are likely several factors that may describe the causes behind these disparities, including accessibility to the health system, health prior to migration, Norwegian language proficiency, provider error, provider attitudes, and more. However, there is a large gap in research that aims to understand the perspectives of health providers, especially midwives, as they reflect on their professional education and experiences providing care to this population. As such, midwives in Norway, given their important and expert position in maternity service, was the focus for this qualitative study.

The aim of this study, as described above, came with several subsequent objectives. The first objective was to understand how midwives may adapt their care approach and daily work practices to specifically accommodate the care of migrant women seeking maternity care. The second objective was to learn how midwives engage in conversations with migrant patients to interpret and translate important health concepts across cultural, social, and linguistic differences. The third objective was to describe the efficacy and accessibility of state or local resources for migrant women that are available to midwives. The fourth objective was to illuminate potential differences in how health station and maternity ward midwives address the specific needs of women with a migration background within their respective work environments. Finally, given that this study occurred within the context of the global COVID-19 pandemic, the fifth objective was to illuminate how infection control measures and anxiety around the virus has affected the quality of care provided to recently-arrived migrant women. There is a gap in qualitative research in Norway that discusses challenges in maternity care provision from the perspective of midwives. This qualitative study centered the voices of thirteen midwives who work in health stations and hospitals in the greater Oslo area as they

discussed their work lives, shared main care challenges for women with a migration background, and discussed additional challenges to care under the COVID-19 pandemic.

2.2 INTRODUCTION TO THE MIPREG STUDY AND PROJECT ORIGIN

This study was conducted as part of the larger MiPreg study, a large mixed-methods and intervention study with the aim of evaluating the Norwegian maternity care system and its care of pregnant patients with a migration background, evaluating the specific needs of pregnant migrant women, and closing potential gaps in maternity care delivery. The MiPreg study's team is a multidisciplinary group of female professionals made up of health workers, health researchers, and social scientists. All of the researchers have a background in women's health and are very passionate about improving healthcare delivery to vulnerable groups in Norway. The MiPreg study's four work packages are as follows:

Objective 1: Determine disparities in pregnancy outcomes according to migration status
Objective 2: Mapping of current maternity service challenges
Objective 3: Measure Migrant Friendly Maternity Care
Objective 4: Design and pilot a Migrant Friendly Maternity Care Package

When I joined this project group in February of 2021, I was inspired by the results of the data collected by other group members, detailing the maternal and neonatal outcomes of migrant women who have delivered in Norway. There are many reasons that can contribute to migrant women's' vulnerability to poorer health outcomes in Norway, ranging from individual factors like poverty, low social network, poor health prior to arrival, and poor understanding of pregnancy information, to systemic factors like barriers to accessing information and services, social exclusion, or discrimination. The path to this answer is complex and demands a qualitative approach to unpack the lived experiences around many of these factors, from the perspective of not only the women accessing the maternity services, but also from providers, health administration, health authority representatives, and other stakeholders in the ideological and practical realities of the Norwegian health system.

As a health provider, I have experienced how my approach to care can be influenced by external factors like peer and supervisory support, available resources, my mental and physical health, and my training. When I worked in emergency care during the first year of the COVID-19 pandemic, there were times where I was not the provider that I aspired to be or had been in the past, due to fear from limited access to personal protective equipment, uncertainty about best practices for COVID-19 patient management, long hours and high patient volumes, and more. As such, when I was exposed

to the data from projects within the MiPreg study, I felt moved to learn more about the daily realities of midwives in Norway, given the profession's proximity to their patients. Given the position of power that health professionals have while they care for vulnerable populations, it can be easy to solely place blame on providers when bad outcomes occur. As discussed in Chapter 1, midwives are responsible for most of the maternity care responsibilities for medically uncomplicated pregnant patients. They spend the most time with the majority of the pregnant patient population, and as such are critically important voices in understanding challenges they face while trying to provide high quality medical and psychosocial care to women with a migration background. In this thesis, it is my intention to dive into the daily realities of the labor conditions for midwives, into the resources they have available to them to aide in their care, and challenges they face that might impact their ability to perform their job responsibilities. By setting this baseline, I hope to illuminate potential gaps in the Norwegian maternity care system that especially have the potential to impact the health of recently-arrived migrant women.

Accordingly, this project falls within the second of the four objectives in the MiPreg study – "Mapping of current maternity service challenges." To meet the objective, this study used a combination of six semi-structured interviews and textual analysis of seven prior interviews conducted by the MiPreg research team. We interviewed midwives with experience providing maternity care to migrant women in the greater Oslo area. This study focused on the perspectives of midwives working in antenatal care, postnatal care, labor care, and postpartum care, through the participation of midwives working in both health station and hospital contexts. Data collection and analysis occurred over an eight-month period between August 2021 and March 2022, as well as utilized transcribed interviews that were collected between December 2019 and February 2020. All data collection was performed in Oslo, Norway, and analysis occurred in both Oslo, Norway, and Palo Alto, California.

2.3 DETERMINING STUDY DESIGN (THE CASE FOR QUALITATIVE METHODOLOGY)

In the health sciences, there is a growing utilization of qualitative research methodologies to find answers that cannot be described with quantitative methodologies alone. Elfenbein and Schwarze (2020, p.250) state in their "Qualitative Methods" chapter, that qualitative methods are critically important in health research, because they "identify subtle and critical distinctions that are not appreciable in quantitative analysis." Beverly Taylor and Karen Francis (2013, p.17) go on to say in their book, 'Qualitative Research in the Health Sciences: Methodologies, Methods, and Processes':

"…qualitative research invites you to inquire about the human condition, because it explores the meaning of human experiences and creates the possibilities of change." If quantitative research helps us to describe our world around us as it is, qualitative research helps us to add depth to these descriptions, allowing us to explore the "why's" and "how's" of critical issues that relate to the health and wellbeing of individuals and communities. This study aims to explore the experiences and perspectives of midwives working in Norway, which are very much impacted by factors within their social world that would be difficult to discern with quantitative methodology. Additionally, this study relies entirely on data collected in in-depth interviews. Moen and Middelthon's book chapter, "Qualitative Research Methods" (2015, p.322), frames qualitative interviewing as "a special form of conversation involving a researcher, a research participant, and a theme." They go on to discuss how qualitative interviews are "venues for exploration" (*Ibid.,* p.345) of participants' position, perspectives, and phenomena. In order to explore how culture, policy, and personal and professional values may influence the quality of care rendered to women with a migration background, this study used qualitative methodology and interviewing, drawing from the disciplines of sociology and anthropology, and the theories of vulnerability, social ecology, and labor welfare.

Kielmann, Cataldo, & Seeley, (2012, p.9) discussed how qualitative methodology can be strengthened through the "triangulation" of multiple methods to examine the same question or area. Utilizing triangulation in designing a qualitative study can add additional dimensions to the same concept or idea that may not be appreciable using one approach alone (*Ibid.,* p.16). In the initially submitted protocol, it was my intention to additionally conduct some participant observation in the health station and maternity wards. However, due to record COVID-19 infection rates and the emergence of the Omicron variant in Oslo in fall and winter of 2021, this became no longer possible within the necessary time frame.

To meet the aims of this study in the context of some of the research challenges introduced by the COVID-19 pandemic, this study used a combination of semi-structured interviews collected in Fall 2021, and textual analysis of interviews provided by the MiPreg project Fall 2019. All interviews for this study were conducted with permission from the Data Protection Officer at Oslo University Hospital and with permission from the University of Oslo Institute of Health and Society's internal ethical review committee.

2.4 PARTICIPANT SELECTION AND SAMPLING

Participants for this study were recruited through a combination of open calls for participation to each greater Oslo Health Station and Norwegian midwife Facebook groups, as well as convenience and snowball sampling methods. Participants were included if they were midwives registered to practice in Norway, who were currently working in the greater Oslo area, and possessed experience working with migrant women. In the submitted protocol, it was intended to recruit between eight and twelve midwives. However, the majority of recruitment occurred in the time immediately after Norway's initial reopening of society in July of 2021 and during their most significant COVID-19 surge. This created several challenges with recruitment: some potential midwife participants indicated hesitancy with infection spread, a loss of free time due to midwives taking on additional COVID-19 responsibilities, and emotional burnout as reasons for not participating in the study. Additionally, I suspect that there were some challenges with recruitment due to my position as a researcher and the aims of this study – I am an American citizen, who did not grow up in Norway, with moderate fluency in the Norwegian language. Despite having a healthcare background as a paramedic, I do not work in the Norwegian health system, nor primarily in women's health. As such, in many regards, it is possible that midwives would have preferred to speak with another midwife, or a native Norwegian speaker. Participants were offered interpretation or to conduct the interviews with one of my study's supervisors, which was denied by all participants. To mitigate many of these initial recruitment challenges, a member of the MiPreg study, a maternity ward midwife who works for one of the larger hospitals in Oslo, aided in recruiting participants amongst her professional contacts. Several of these midwives were enthusiastic about the project, and additionally provided names for potential participants. Ultimately, seven midwives were recruited and included from health stations, and six were recruited from maternity wards.

The recruitment methods, with the reliance on convenience and snowball sampling, can be seen as a potential weakness to the study. Snowball sampling and convenience sampling have been lauded for their utility in reaching populations that are hidden or difficult to recruit from (Woodley & Lockard, 2016, p. 323). However, these methods have also been critiqued as not being representative of the population as a result of selection bias creating a lack of demographic and ideological diversity (Woodley & Lockard, 2016, p.323). While I attempted to mitigate these critiques by providing open calls for participation over Facebook midwife groups, and by emailing and calling health stations in the greater Oslo area, all participants who ultimately joined the study were recruited through convenience and snowball sampling. Even with these additional recruitment methods to expand the

diversity of participants, it is difficult to imagine how the challenges to recruitment explained above could be further mitigated within the time and situational constraints of this study. With that being said, the participants who ultimately joined the study were enthusiastic and thoughtful respondents, who were eager to have their voices heard. They all had a vested interest in both the health of their patients and the happiness of midwives in their work lives, and I believe that parties who have this type of investment ultimately provide the most thoughtful and interesting responses.

2.5 CHARACTERISTICS OF SAMPLE

Of the fourteen participants included, all the midwives identified as women and were between the ages of 31 and 55 years old. The midwifery profession in Norway has only begun admitting men in 1973, and as of 2021 there are only 22 male midwives of 6711 registered for authorization in all of Norway (Renbert, Sommerseth, & Johannessen, 2022, p.3). In the sample, all but one midwife were Norwegian citizens who grew up in Norway. They came from a variety of workplaces, representing four health stations, a specialty health clinic for migrants, and three maternity and postpartum wards in the greater Oslo area. There was a wide range of work experience in midwifery, with the shortest length of authorization being 3 years, and the longest being 28 years. The average length of work experience in midwifery across those interviewed was 13 years. All participants have worked in both maternity ward and health station contexts in their employment history. Six of the participants reported midwifery experience outside of Norway, through NGO partnership, employment, or education exchange.

2.6 DATA COLLECTION

The seven interviews collected between December 2019 and February 2020 were conducted by researcher and MiPreg study leader, Dr. Benedikte Lindskog from Oslo Metropolitan University. She developed the interview guides, performed the interviews, and transcribed them in 2020. Transcriptions were anonymized prior to sharing. After I obtained the transcripts, they were translated these interviews from Norwegian to English for coding, with the assistance of members of the MiPreg group. The transcriptions that arrived to this study were previously coded according to the MiPreg study's priorities, however were re-coded under this study's objectives.

The transcribed interviews were used to not only incorporate more voices into the challenges that midwives face in providing care to migrant women in the Norwegian maternity system, but also as a point of reference to discuss the maternity system without the additional challenges created by the COVID-19 pandemic. To create continuity between the two studies and time points, the interview

guide for the previous interviews (see Appendix A) influenced the new guide, but was also built upon within the conceptual framework of this study to include questions that explored topics of 'vulnerability,' additional care challenges in the COVID-19 pandemic, and the daily work-lives of the midwives (see Appendix B). While for both groups of interviews, semi-structured interviewing was used, the interview technique that was used for the second group recruited for the study had relatively less structure, given some of the more difficult subject matter and more frequent use of English. This was done with the purpose of promoting a comfortable interviewing environment for the participants, which would hopefully ultimately lead to more open responses.

The second group of interviews were collected between October and December of 2021. The interviews were conducted in a variety of locations around Oslo, including health stations, hospitals, at the University of Oslo, and private residences. All participants were shared the study's protocol and consent documents for review prior to interviews, so that participants could review the materials and aims in their own time. Once they arrived to the interview location, the consent documents and the aims of the study were reviewed verbally, with any questions or concerns addressed prior to the start of the interviews. The consent documents were the only retained articles that have the participant's name, and are stored securely in a locked storage cabinet. The interviews varied in length, from 31 minutes to 2 hours, 14 minutes. While all participants were offered a translator or to provide their responses in Norwegian, all interviews were in the English language. Interviews were recorded via a handheld digital voice recorder, and audio files were subsequently uploaded to Services for Sensitive Data (TSD) secure server and deleted from device. The interviewees were encouraged to avoid disclosing their name, location of work, and any other potentially identifying characteristics.

Recordings were directly transcribed, including audio descriptions of non-conversational sounds, like laughter or clapping, into Microsoft Word documents stored in TSD. While the interviews did not ask for any identifying information, these details were redacted during transcription if they arose. Additional information was redacted at the request of the participants after the interviews.

The privacy of the participants of this study were protected in accordance with standard ethical guidelines in academia and Norwegian law. Participants were given numerical codes for the purpose of identifying relevant transcripts and audio files, and were given a pseudonym attached to their quotes in this thesis. Storage of the anonymizing key, audio files, raw and translated transcripts without anonymization, and interview notes are maintained in the TSD secure data servers. The only persons with access to these items are myself and the project supervisors. It was the intention of the

study to center the anonymity and privacy of the participants so as to build trust in the credibility of the study, so that their participation was as honest and open as possible. Centering confidentiality within the study ensures that participants maintain their right to have control over their perspectives and how they are used.

Thematic analysis was used to analyze the anonymized interview transcripts. After the interviews were transcribed, I began the coding process by first reading and re-reading the interviews in their entirely, looking for themes that connected across the different midwives' perspectives. Then, I began to loosely code the interviews, using NVivo 12 software, assigning individual sentences or sections of text specific codes like, "frustration," "midwife peer support," "trusting the midwife," and "communicating health concepts." The smaller codes were grouped together into intermediate themes, which were then used to structure the argument of this thesis. For example, the codes "communicating health concepts," "information gaps," "accessing pregnancy information," and "access to translation" were grouped together into the larger theme, "communication challenges." Some other examples of intermediate themes that emerged were, "vulnerability," "labor challenges," "COVID-19 challenges," "health system navigation," and "resources for migrant women." These themes were then further analyzed and grouped together to develop the over-arching themes that would become this thesis' chapters. This was achieved by both similarity of the intermediate themes and by drawing in the multiple theories and concepts that defined the conceptual framework of the study: the social ecological model of health provision, structural vulnerability, and the theory of labor welfare.

As a result, I narrowed the themes and codes down to the five final groups, which became the five findings chapters of the thesis. The first group of themes highlights the labor conditions of the Norwegian maternity service and the midwives' perceptions about their capacity in their work conditions to accommodate vulnerable patients' needs. The second group of themes discusses how the midwives construct the concept of 'vulnerability', who they perceive to be vulnerable, and how they adjust their care within or outside of their work conditions to address specific vulnerabilities. The third group discusses communication challenges between the midwives and migrant women, which includes accessing appropriate and qualified interpretation, communicating concepts cross-culturally, patient education, and, a resource of support, the multicultural doula program. The fourth group discusses how midwives act as agents of social support in supporting patients' psychosocial wellbeing while also assisting with navigation of the Norwegian health and social services. Finally, the fifth grouping shares how the COVID-19 pandemic exacerbated existing challenges within the

labor conditions of the Norwegian maternity services, which especially harmed migrant women's access to and quality of care.

2.6.1 COVID-19 Planning

It is important to acknowledge the temporality of this research project, as a health study occurring within a global pandemic. Given the arrival of new SARS-CoV-2 variants, weekly changes in infection control guidelines, and challenges in the EU vaccination programs, it has been an extremely difficult time for all who conduct qualitative research. As a researcher planning a study involving face-to-face interviews with essential health workers, I needed to be flexible in how I was to conduct this research for the safety of myself and my participants. As such, in the protocol that was submitted for ethical and department clearance in April 2021, I incorporated a "COVID-19 Contingency Plan" in advance of any potential future stay-at-home orders or restrictions on personal contacts. Part one of this plan was ensuring the safety of myself and my participants by receiving the COVID-19 vaccination series, and ensuring that all Oslo infection control guidelines were followed (masking, social distancing, and conducting interviews in private rooms) if interviews were permitted to be conducted in person.

If it became necessary to conduct interviews remotely, either due to participant request or to Oslo commune's public health guidelines, then the contingency plan was to conduct the interviews via Zoom video conferencing, in order to still be able to glean information from participant body language, facial expressions, and gestures while they respond to the interview questions. Fortunately, infection control guidelines did not force this contingency plan, and participants felt comfortable with interviewing in person. As such, all interviews were conducted face-to-face.

2.6.2 Funding

This project is funded in part by the Centre for Sustainable Health Education at the University of Oslo, who awarded 6000 NOK to assist with research expenditure. This funding was used to cover transcription assistance, interview materials (food and coffee for participants, notebook, consent and information packet printing cost), and to cover the cost of some reading materials for analysis.

2.7 ETHICAL CONSIDERATIONS AND CLEARANCE

Given the long and difficult history of harm and coercion of research participants justified in the interest of scientific exploration, it is critically important that all research studies that involve human

participation uphold the expectation to follow rigorous ethical processes to determine potential benefits and harms.

In the development of this study, it was important that the results of the study would act not only in the benefit of producing knowledge in this field, but also to improve the work-lives of the participants as well. As such, the risks and benefits were examined closely. The participants benefit by having their voices and experiences as health workers critical to the Norwegian maternity system centered and valued in this study. Their responses will produce research that may help to close a large knowledge gap in our understanding of maternity service provision for migrant women in Norway. As later chapters within this thesis will demonstrate, the midwives' perspectives highlight a need for policy reform and resource reallocation that not only aids in their ability to provide safe, competent, and compassionate care to women with a migration background, but also improve their overall satisfaction with their workplace.

Risks to the participants' anonymity were mitigated by not asking for, recording, or maintaining any information that may identify them. This was at the specific request of the study population, so that they could have the opportunity to speak freely without fear of social or employment repercussions. COVID-19 guidelines were followed to reduce the risk of transmission during in-person interviewing – at least one meter's distance, participants and interviewer were fully vaccinated (masks were worn if not), so there was a low risk of bodily harm to the participants in the participation in this study. The interviews held a small risk of emotional distress if the participants chose to share or reflect on a potentially embarrassing or harmful experience.

Given that the data controller for the MiPreg project is Oslo University Hospital, this study received clearance from the Data Protection Officer at Oslo University Hospital through submission of the study's protocol, consent form (Appendix C), and information sheet (Appendix D). Approval was given September 1, 2021, with the reference number 21/17793 (Appendix G).

In addition to the assessment for risks, benefits, and external approvals, the following ethical principles were central to the project's development, collection, and analysis periods of the study:

2.7.1 Respect for Persons

Midwives who work in the Norwegian maternity service are medical professionals with years of training and experience. As workers who provide wrap-around maternity care services, they are critically important to the aims of the MiPreg study to map the current challenges of the Norwegian maternity service in providing care to women with a migration background. Midwives' professional

experiences and evaluations are immensely valuable to understanding what they need to care for this vulnerable and growing population.

The study's interviews were conducted in an open and encouraging environment, where ideas could be freely exchanged without the risk of consequences to their employment or social standings. It was the intent of the study to perform the interview either partially or entirely in the Norwegian language through the assistance of one of the supervisors on this project so as to make the participants most comfortable to express themselves how they prefer, however participants indicated comfort with English, so the second group of interviews were performed in English. Their anonymity was protected in the questioning, recordings, and transcriptions through redaction of identifying or requested information. All participants' right to autonomy was respected by ensuring that participation was voluntary, and that consent was informed.

2.7.2 Informed Consent:

As previously stated, it is imperative that consent to the study is informed and voluntary. It was important to provide the participants with consent documents that include the study's aims, research questions, data management and protection strategy, timeline, use of data, and length of data storage, which came in the forms of the consent document, information packet, and study protocol. All information was given to the patients prior to their participation, and participants were given space to raise questions or concerns. Consent for all participants was given voluntarily, and can be withdrawn freely at any time with no repercussions, with the immediate removal of all or a portion of the data in question. All participants participated to the extent of their comfort, and could change or withdraw their consent to all or parts of the study at any point. Additionally, participants were provided access to any data collected about them, including their own audio files and transcriptions, as well as the main findings of the study, on request.

2.8 STRENGTHS AND LIMITATIONS

As with any research study, it is important to be self-reflexive about the strengths and limitations of the design and researchers involved in this qualitative study. The first factor I would like to address is my position as a researcher, which I consider to be both a strength and a limitation for this study. As a researcher and a health worker who was born and raised outside of Norway, I bring with me a fresh perspective that may reveal potential pieces of information that may be normalized or hidden to a Norwegian researcher. I myself entered Norway as a migrant, and understand the challenges that many migrant persons experience interacting with the health, social,

and immigration systems. However, my foreign upbringing also meant that I had to spend a significant amount of time and energy understanding the Norwegian health system and its actors and values, to the same degree that a Norwegian researcher may have already understood. I already discussed in the data sampling section of this chapter how recruitment for this study was challenging, which I suspected to be in part due to my moderate proficiency in Norwegian and because I was not a health provider in Norway. This challenge of looking in on the Norwegian system from the outside also introduced challenges in my project planning, data collection, and analysis phases, where I was often in the position to 'unlearn' my understanding of health delivery, maternity care, social vulnerability, and even pregnancy as they had been constructed in the social and political contexts of the United States. As a result, it was my aim to place my participants' voices at the forefront of my analysis and reporting of my findings.

Methodologically, this study has several strengths, particularly in the use of semi-structured interviewing to allow for deep exploration of the concepts that emerged in the discussions. This approach appeared to improve rapport between the participants and myself, and often increased the richness and thoughtfulness of the responses. Additionally, using this method of interviewing, combined with my efforts to place the midwives' experiences at the center of this study, mutual respect and trust was fostered between myself and the participants. All of the participants who joined the study were enthusiastic about the health and wellbeing of migrant women, however this is also a potential limitation of the study. As is the case with many methodological approaches, this study has a large potential for selection bias, especially given the use of convenience and snowball sampling. With the combination of the sampling methods and the small sample size, it is likely that many of the findings would not be generalizable to represent the attitudes and approaches of midwives across Norway. However, as this thesis will reveal, there are still several very important lessons to learn from midwives who have the interest and investment in the health and wellbeing of pregnant women with a migration background. The findings of this study can still provide insight into the experiences of midwives in Oslo, and could potentially be utilized to compare the experiences of Oslo midwives against the experiences of midwives in other communities.

Another potential limitation of this study was the barriers to the addition of participant observation of the health stations and maternity wards due to infection control restrictions during the ongoing COVID-19 pandemic. By adding this layer, I had hoped to glean additional data from the actions and routines of the midwives in order to add an additional level of validity to the findings of this study. As Kielmann, Cataldo, & Seeley (2012, p.9, 16) discuss, "triangulation" of

multiple methods to examine the same question can add additional information and data that would not be appreciable with one method alone. However, the COVID-19 pandemic introduced many challenges to researchers around the world, and I was fortunate to have had the opportunity to engage with my participants without many of the restrictions or additional precautions that other studies have had to encounter.

CHAPTER THREE: CONCEPTUAL FRAMEWORK

3.0 INTRODUCTION

When I was initially planning the study, I had hoped to build my conceptual framework around the theories of structural vulnerability and the social ecological model of health, so that I may be able to understand not only the multitude of layers by which women with a migration background may experience challenges within the Norwegian maternity system, but also the structural layers that midwives encounter while rendering care to this population. However, through the interview and analysis processes, I have additionally decided to add an analysis that incorporates the theory of labor welfare, as a way to analyze how the midwives' model of care is enacted within boundaries of the policies, culture, and resources that govern their professional conditions.

3.1 SOCIAL ECOLOGICAL MODEL

Over the past several decades, a major priority within health research and policy has been on the "social determinants of health," to better understand the forces outside of the individual and the health system that influence health outcomes and practices. Some of these factors include socioeconomic status, education, physical environment, social network, housing, and employment. A model that helps organize these factors is described as the Social-Ecological model, a hierarchical model that aims to represent the complex ways in which these factors influence each other to impact public health. The model divides the levels by which these factors influence an individual's health into the following hierarchical categories (UNICEF, 2022):

1. Individual – Knowledge, attitudes, and behaviors that a person possesses or gains through interactions with the higher levels.
2. Interpersonal – Influences from family, friends, and acquaintances within a person's network.
3. Organizational – Influences from private and public institutions, like schools, universities, corporations, religious organizations, community or professional organizations, unions, health care institutions, research institutions, and more.
4. Community- Influences that emerge from the relationships between these organizations and with informal networks.
5. Policy/Environment – Influence from laws and policies that influence practice, education, budgets, and norms. Additionally can include influences from the physical environment that may dictate priorities and actions.

This model has been employed in the public health field as a structure to organize health-promotion intervention strategies across each or multiple levels (Golden & Earp, 2012, p.1-2). However, in addition to its applicability in the public health space, it is additionally an important tool

to evaluate health access disparity for vulnerable groups (Harper & Brookmeyer, 2018, p.1) for utilization at provider or policymaker levels. This model provides an important framework to understand not only the multiple layers of vulnerability that women either permanently or temporarily enter into when they migrate to a new country and become pregnant, but also the layers of challenges, at individual, interpersonal, organizational, and institutional levels that midwives perceive while providing care to their patients. This study centers the perspectives of midwives in the Norwegian maternity services, and the challenges across these levels that they experience in routine maternity care, in migrant-centered care, and finally in the COVID-19 pandemic.

3.2 STRUCTURAL VULNERABILITY

Beyond the social-ecological model of health, which only aimed to define and categorize the multiple levels of influence, that impact an individual's health, is the concept of structural vulnerability. This concept is born out of the work of the Norwegian sociologist, Johan Galtung in his 1969 essay, *Violence, peace, and peace research.* In this essay, Galtung introduced the concept of "structural violence," that examines how social, political, and economic forces that interact and compound to produce disproportionate harm for those who live in poverty (Galtung, 1969, p.171). This concept was further discussed in the late anthropologist, Paul Farmer's 2006 article, "The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people" (Farmer, et al. 2006, p.2).

The concept of "vulnerability" has been historically ambiguous in its definition. Past scholarship has conceptualized "vulnerability" as an individual or community at disproportionate risk either due to structural causes or external circumstance, but has also been used to convey social precarity and powerlessness (Whittle, et al. 2020, p.5). Some definitions have framed "vulnerability" as an "embodied process" where cyclical relationship between social oppression and structural violence produce and reinforce barriers to wellbeing, accessing care, and recovery that become engrained within the body across generations (Quesada, et al. 2012, p.808). Others have claimed the opposite, that a person's vulnerability is a process that ebbs and flows throughout a life course as a result of factors of individual circumstance, physical environment, and social conditions (Zarowsky, Haddad, & Nguyen, 2012, p.6). A definition that captures the complexity of this concept was found in Zarowsky, et al. (2013, p.5) which framed "vulnerability" as "simultaneously a condition and a process- a conditioned of heightened fragility of a population or specific group, and a process that is potentially reversible or avoidable through appropriate interventions."

The concepts of "structural violence," "the social determinants of health," and "vulnerability" have built upon each other to produce the concept of "structural vulnerability." "Structural vulnerability" is the understanding that structural inequality produced by several forces including racial discrimination, economic exploitation, and prejudice on the basis of gender, play a very important role in the ways in which patients develop, experience, and manage injury and illness (Bourgois, et al. 2017, p.299). Whittle et al. (2020, p.5) emphasized that the effects of structural vulnerability are chronic, with long-term alterations in "perceptions, behavior, affect, and cognition" as a result of distant, immovable, and powerful forces. The concept of "vulnerability" has been incorporated heavily into health research as a way to center and understand the health needs of populations that were previously erased, underrepresented, or exploited (Ryan, et al., 1979, p.8).

Pregnancy has been categorized in discourse as a vulnerable period that many women around the world enter into, that demands additional resources and support from both within health systems and society. While the maternal death rate in Norway is among the lowest in the world, migrant women, especially those who have recently arrived in a new country, are considered to be among the most structurally vulnerable groups who interact with health systems. They are vulnerable as a result of overlapping and compounding factors like race, class, gender, socioeconomic status, legal residency status, education, language, social networks, and exposure to violence. These factors have varying degrees of temporality and have the ability to interact and amplify each other, producing unique challenges while trying to manage their own health (Bourgois, 2017, p.299). Additionally, the combined layers of pregnancy and migration could have a compounding effect- an essential consideration for health practitioners as they develop care plans. As the number of individuals who move across borders continues to increase as a result of war, climate change, education, and employment, it is critical that research priorities continue to center the specific vulnerabilities that migrant women, especially those who have recently arrived, experience while interacting with systems and institutions in their destination countries.

Despite these vulnerabilities, it is also important to not also necessarily construct migrant women as victims or without agency. Social science literature has criticized the concept of vulnerability as paternalistic, because framing an individual or group as 'vulnerable' can be used as a means of removing agency, can implicitly reinforce oppressive ideologies, and can deepen stigmatization, "othering," and social exclusion (Brown, 2011, p.315-318). It is not my intention in this study to construct vulnerability as an inherent or essentialized quality of this population, who has no ability or agency to overcome or find solutions within these challenges. Viken, Lyberg, &

Severinsson (2015) has discussed how migrant women who reside in Norway have developed unique capabilities that can also facilitate interactions with the Norwegian maternity system. The experience of migration is not universal, and each individual brings with them both capabilities and vulnerabilities that need to be both strengthened and supported. Assessing vulnerability can be used as an important tool to determine specific needs for care and resources, so as to promote health equity within the health system.

Midwives working in the Norwegian maternity system regularly employ in-depth interviewing so as to assess the capabilities and vulnerabilities of their patients (Espejord, Kvitno, & Lukasse, 2022, p.3). One study from Sweden found that midwives additionally expand their appointment slots to allow for extra time to explain concepts to migrant women, introduce women to the Swedish maternity system and their health rights, and provide extra education about pregnancy development and other sexual and reproductive health concepts (Oscarsson & Stevenson-Ågren, 2020, p.2). There is little research within the Norwegian health context that discusses how midwives who work in the Norwegian maternity service adapt their practices of care to address the vulnerabilities of women with a migration background. Accordingly, this study has sought to determine how midwives in Norway construct and act upon the perceived vulnerabilities and resiliencies of their pregnant patients with a migration background.

3.3 LABOR WELFARE

An important qualifying factor that impacts the capacity that the midwives who participated in this study have to provide compassionate and individualized care is the quality of the labor environment in which they work. Labor welfare was first defined by the U.S. Bureau of Labor Statistics in 1916 as "anything for the comfort and improvement, intellectual or social, of the employees, over and above wages paid, which is not a necessity of the industry nor required by law" (Arena, 2014, p.85). This theory laid the groundwork for research in management, human resources, and organizational structure, and was based originally out of the deplorable and dangerous working conditions of factory workers post-Industrial Revolution (Arena, 2014, p.86-88). At its core, the theory of labor welfare is built on the belief that under a global capitalist regime, workers who are happier and healthier within their labor conditions are ultimately more productive and perform at higher standards (Arena, 2014, p.97).

Norway is considered to be one of the best places in the world for labor welfare, with laws and policies that promote the happiness and health of employees. The majority of employers are

mandated by the Norwegian Working Environment Act (Arbeidsmiljøloven) through rigorous standards for workplace safety, caps on work weeks, mandatory compensation for overtime work, at least four weeks of paid holiday leave, paid sickness benefits, and at least 43 weeks of paid parental leave (Arbeidsmiljøloven, 2022). One of the key tenants of the Arbeidsmiljøloven is that employers have the responsibility to produce a "working environment… [that is] fully justifiable on the basis of an individual and overall assessment of factors in the work environment that may affect the employee's physical and mental health and welfare," (Arbeidsmiljøloven, 2022) and that the quality of this environment must at "all times be developed and improved in accordance with developments in society" (Arbeidsmiljøloven, 2022).

These standards for labor welfare also exist for Norwegian midwives, but past studies have indicated concerning trends of workplace dissatisfaction, which have potential implications on quality of care provision, availability of care providers, and the future of the profession itself. The work-lives of Norwegian midwives can certainly be perceived as difficult for many, with long hours, shift work, and inconsistency of the workload shift-to-shift (Lukasse & Henriksen, 2019, p.1559). The demands and quality of the work can be challenging, emotionally taxing, and at times traumatic (Wahlberg, et al. 2015, p.1266). One study from Sweden found that 71% of interviewed midwives experienced at least one traumatic event over the course of their work (Wahlberg, et al. 2015, p.1266).

Additionally, studies are showing that the external pressures of biomedicine are infiltrating the birthing space, directly threatening the core values and care approach of midwifery. As discussed more extensively in Chapter 2, there are systemic challenges in the Norwegian maternity service that impact the labor conditions of midwives. With 'best practices' emphasizing increased technical and medical intervention (McCool & Simeone, 2002, p.740), decreased lengths of time available for personal attendance to patients (Zwelling, 2008, p.87), and demands from management for increased cost-effectiveness is decreasing post-birth hospital stays (Brown, et al. 2002, p.291), midwives are experiencing a paradigm shift in the birthing space that directly contradicts the individualized, embodied, and intuitive approach that they were taught (Aune, Holsether, & Kristensen, 2018, p.135). One study representing approximately 20% of the Norwegian midwife population found that 20% of surveyed midwives were experiencing work- or personal-related burnout (Henriksen & Lukasse, 2016, p.44). Previous studies have found that contributing factors to midwife work dissatisfaction in the Norwegian maternity service are insufficient staffing with increasing workload, a lack of support from midwife supervisors, desiring more professional development, and a loss of influence and respect compared to physicians (Lukasse & Henriksen, 2019, p.1562-1565). In the context of these

challenges, the question can be raised about how the current Norwegian labor standards are not meeting the labor welfare needs of midwives. In this study, the interviewed midwives were also asked to reflect on their work-lives outside of migrant-centered care as a way to evaluate the Norwegian health system's base capacity for accommodating their less vulnerable populations.

CHAPTER FOUR: LABOR CONDITIONS OF MATERNITY SERVICE

4.0 INTRODUCTION

While this study aimed to investigate specific care challenges that the interviewed midwives perceive while providing care to women with a migration background, the midwives additionally shared several systemic care challenges that also significantly impact their work. Past studies have indicated that midwives are experiencing increasing work dissatisfaction as a result of increasing workload, difficult hours, increased stress, a lack of support from other providers and management, loss of influence and respect compared to physicians, and fewer opportunities for educational and professional growth (Hildingsson, Westlund, & Wiklund, 2013, p.89; Henriksen & Lukasse, 2016, p.1662-1565). Henriksen & Lukasse (2016, p.1559), found that approximately 20% of surveyed Norwegian midwives reported personal or work-related burnout. Burnout has been defined as a "multidimensional syndrome consisting of three components: emotional exhaustion, depersonalization, and reduced personal accomplishment" (Maslach, Jackson, & Leiter, 1996, p.192). Midwives work in an extremely demanding work-environment, with a high potential for experiencing traumatic or stressful events (Wahlberg, et al. 2015, p.1266). Additionally, there are the existential pressures of biomedicine that are infiltrating the birthing space and threatening the approach and framework of midwifery care. With increasing emphasis on technological and medical intervention in pregnancy and birth (McCool & Simeone, 2002, p.740), shorter patient-provider interaction length (Zwelling, 2008, p.87), and demands for cost-effectiveness in medical care causing shorter hospital stays after birth (Brown, et al. 2002, p.291), the individualized and patient-centered model of midwifery care is becoming increasingly more challenging to provide. The midwives interviewed for this study reflected on several of these factors, including workload, burnout, birth framework clashes, communication, continuity of care, and peer support.

The Norwegian Working Environment Act (Arbeidsmiljøloven) states that employers have the responsibility to produce a "fully justifiable [working environment] on the basis of individual and overall assessment of factors in the work environment that may affect the employee's physical and mental health and welfare," that must be "at all times developed and improved in accordance with developments in society" (Arbeidsmiljøloven, 2022). Despite this legal framework that should support the welfare of the midwives working in the Norwegian maternity system, the large proportion of midwives reporting burnout (Henriksen & Lukasse, 2016, p.1662-1565) and the increasing workplace dissatisfaction (Hildingsson, Westlund, & Wiklund, 2013, p.89) have potential implications on quality of care provision, availability of care providers, desire for future providers to

enter the force, and ultimately, the future of the midwifery profession. While these effects have the potential to impact all women who interact with the Norwegian maternity service, socially vulnerable patients or patients who need additional resources will disproportionately experience the consequences of decreased quality of care provision and provider availability.

4.1 LOVE FOR THE PROFESSION

Important metrics of workplace satisfaction are enthusiasm for the field and feeling valued in the profession (Gregory, 2011, p.29, 32). Before discussing aspects of their careers that they find to be challenging, many of the midwives who participated in this study shared that they were extremely enthusiastic about their profession and patients. Several of them reflected on their love for midwifery, including Ingrid a midwife currently working in a maternity ward, but in the past has enjoyed exploring the various sides of women's health in her position. She discussed how she happily moves between the antenatal, postpartum, and labor sides of maternity care, because of her love for her patients and her profession:

> *I think I am above average enthusiastic about my own profession. I love every aspect of it. I see many midwives that say they only want to work with labor and delivery or work with antenatal care. For me, it's nothing like that. I want to work in every part of this. (Ingrid, Maternity Ward Midwife)*

Her enthusiasm for the profession was also reflected by several of the others who were interviewed. Another midwife, Line, discussed how she loves providing care to women throughout their life course, including maternity care. She shared how she also enjoys providing counseling on contraception, performing pap smears and breast exams, and referring for mammography. She smiled as she commented, *"to work as a midwife here, you have a broader sense of women's health."* Oline, a health station midwife, discussed how she loves the quality of her patient interactions, *"There is joy around the work we do. You connect maybe even more."* She also shared that she enjoys how individualized midwifery care is, and that having patients from diverse backgrounds keeps her work exciting and interesting.

In addition to their love for their profession, several of the midwives working in both the maternity wards and health stations shared deep feelings of responsibility and compassion for their patients, which they shared through self-reflection of their position as providers. The University of British Columbia's Indigenous Initiatives defines positionality as "how differences in social position and power shape identities and access in society." Power is defined as one's ability to exert influence

over others, and is present in all interpersonal relationships, but especially those in medicine (Drinka & Ray, 1986, p.45). Midwives hold a position of authority over their patients, not only through their expertise but through the medical decisions that they have to make while assessing and providing care. Many of the midwives indicated that they were conscious of the power dynamic between themselves and their patients, and often framed their power as a "responsibility." This responsibility was not only framed as a duty as prescribed by their profession, but also as an internal driver of being *responsible* for the wellbeing of their patients. For many of the midwives, despite the challenges they experience within their daily professional lives, the responsibility they felt to their patients and their care was an important factor that kept the midwives engaged and enthusiastic about their work. As Oline, a health station midwife, commented, "… *And there's my job – as a midwife. I will take care of the mother and child, the husband too. But, I have to see [them] too – and try to understand them and help them as best I can."*

To the midwives who were interviewed in this study, their love for the profession and their patients, as well as the sense of responsibility that they have identified in their position as health providers, drive feelings of satisfaction that they feel about their work. However, as I will cover in the subsequent sections, there are also important institutional challenges that are greatly impacting many of the interviewed midwives' happiness in their positions, and the quality of care they feel that they are able to provide on a day-to-day basis.

4.2 WORKLOAD

The challenge that was shared amongst all of the midwives was the feeling that there were not enough midwives on staff to consistently meet the needs of the populations they serve. This was a consistent finding between the health station midwives and the maternity ward midwives. While it is impossible to predict how many women will become pregnant or give birth, through these interviews it became apparent that there were few times staffing levels were appropriate. Several of the midwives observed that there were large fluctuations in the number of patients needing care over the course of a year. However, the overall consensus was that for the majority of the year, staffing was not sufficient.

For the health station midwives, there was a consistent discussion of having to prioritize some patients over others due to staffing shortages, because they were unable to provide care to all women who requested it. One health station midwife, Oline, shared that, "*In relation to following up everyone who wants it, then it does not work."* As a result, patients were turned away to their general practitioners, who have the capacity to provide antenatal care follow-up. With that being said, general

practitioners are not specialized in women's health like midwives, and are often not the preference for women in Norway (Egge, Kvellestad, & Glavin, 2018, p.12). For patients who still would wish to receive their care from midwives but are not prioritized, the initiation of their care is delayed to later in their pregnancy, which has the potential for adverse consequences due to lack of surveillance and information.

Two of the midwives suggested that up to 50% of pregnant women who call the health stations are turned away or delayed in initiating care, however further studies are needed to further investigate this phenomenon. It was also a common observation that there was not enough labor capacity to provide the home visitation offer to every new mother, as noted by Heidi:

> *There are an incredible number of pregnant women who call all the time, and want to be on our lists. So we have to be careful to be able to do a good job. That we prioritize correctly, and set aside enough time for those who need it… No, we do not have [enough coverage]. There are over 1000 births a year, but we have been on a little over 500 home visits, so it is part of the remaining 500 who have not received. (Heidi, Health Station Midwife)*

When the midwives who shared the perception that staffing levels were too low were asked what factors might be contributing to staffing challenges, a couple of the midwives cited funding. One midwife shared that she believed there would never be a time where staffing levels will be sufficient, due to cost of additional employee salaries and training: "*We are never enough. That's too much economy*."

In addition to staffing challenges, a couple of the midwives have perceived an increase in work responsibilities. Kari, a health station midwife, shared that the addition of appointments for contraception advising and home visitation has given her an increase in workload. Kjersti, a maternity ward midwife, shared that in the hospitals, she has felt that she has also often has to take on additional roles normally conducted by hospital and clinical support staff, like collecting lab tests, collecting and delivering food, and cleaning rooms and equipment. Kjersti, further shared that she felt that the increase in workload and short staffing has impacted how much time and individual attention she can give her birthing mothers:

> *But often, no it's not [enough midwives]. But we try the best we can to be there as much as possible. And I think that everyone should have the one-to-one experience with their midwives. They should be there all the time, by their side, taking care of one birthing mother at a time. But sometimes you have three! [I am] running between the places. And sometimes an acute situation occurs in another room and you have to leave. It is so stressful sometimes, but we try our best. (Kjersti, Maternity Ward Midwife)*

Some of the midwives were asked what they perceived would help them in managing the increased workload, like higher salary, more benefits, more support staff, more support from supervisors, and the most common response was a desire for more midwives. One maternity ward midwife, Ingrid, shared that she felt overwhelmed with her current workload, and that increasing the number of midwives on staff would make her feel more comfortable and happier at work:

> *More midwives, we just need more midwives. People talk about paying us more, and that's fine of course, but if I have to choose between a higher salary or more midwives per shift, I would choose the latter. Because the tempo we are working in now, for it to feel worth it in terms of payment, you should triple my pay. We do not have any benefits at all. (Ingrid, Maternity Ward Midwife)*

4.3 DESIRE FOR CONTINUITY OF CARE

Continuity of care in the maternity services is defined by Aune, Tysland, & Volleheim, (2021, p.6) as "the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent within the patient's medical needs and personal context." The simplest way to provide continuity of care in pregnancy is through limiting the number of providers managing care to one individual, however this is not always possible within given healthcare resource constraints. Care continuity can also be established through unified protocols and care approaches, where the provider changes but the quality does not. An essential aspect of the latter is communication – communication between different professions (obstetricians, midwives, general practitioners), and communication between providers of the same level (health station midwives and maternity ward midwives). Midwives who work in continuity of care contexts have been shown to experience less symptoms of emotional burnout, and feel more feelings of empowerment as compared to those who do not (Fenwick, et al. 2018, p. 40). Past research has shown that women who experience different attitudes, advice, and practices between providers are more likely to have negative experiences in maternity care (Jenkins, et al. 2015, p.27).

In the Norwegian maternity service, it is rare for a midwife to maintain care for a woman throughout the entire perinatal period. Typically, midwifery care is divided between the health stations, where midwives conduct the majority of antenatal and postpartum surveillance for women with healthy pregnancies, and the maternity wards, where the midwives assist with labor, delivery, and postpartum care. These two areas of the maternity service are typically distinct, with different staff, meaning that a woman will not have the same midwife during her pregnancy and her labor. While there is inconsistency in methods for measuring patient satisfaction, Sandall, et al. (2016, p.16)

found that women who experienced continuity of midwifery care have been shown to report higher care satisfaction. In addition, women who experienced continuity of midwifery care had lower risk of neonatal death, and lower rates of medical intervention, including episiotomy, instrumental birth, and amniotomy (*Ibid.,* p.20). There are only two locations in Norway where midwives follow the same woman with normal pregnancies throughout the entire perinatal care, the ABC maternity ward in Oslo and the Storken maternity ward in Bergen. However, this option will ultimately become more difficult to access, as the ABC clinic will be closing its doors in conjunction with Ullevål hospital's expected closure by 2040. Several of the midwives indicated that they and their patients wished for the ability to provide more continuity of care, either from the same midwife or same group of midwives. Kari, a health station midwife, shared that it can be difficult to tell women that she has developed a relationship with through their pregnancies that she will not be present for their birth. She also stated that not knowing who will be present for their birth can be a source of anxiety for her patients and their partners. One midwife, who works in a midwife-run clinic that follows patients through their pregnancies and birth, discussed how her patients have valued having continuity of providers across their care. She perceives that her patients have better outcomes and higher satisfaction with their care because she and her coworkers in her ward share the same information and approach to pregnancy and birth:

> *I think so of the concept of continuity of care is that the whole team of midwives share the same philosophy so that we give the same information to women and have the same way of working. So when the woman comes in in labor, even though she doesn't get the primary midwife, she will get the care that she has the expectation to get… And when women feel safe and they feel seen labor goes better and the pregnancy goes better according to research. (Ingrid, Maternity Ward Midwife)*

Given that a woman will see several midwives through the course of her pregnancy in Norway, it is important for midwives to have the capacity to communicate between each other important information about their patients. However, it became apparent during the course of this study's interviews, that communication was largely absent between health stations and maternity wards. There is a physical "maternal health card," that patients bring with them to all of their health appointments, but limited digital communication options exist between the different providers that the patient may come into contact with through her pregnancy.

Oline, a health station midwife, shared how the health station midwives, maternity ward midwives, and the general practitioners have no shared electronic system to monitor the activities of the others with the respect to a patient's pregnancy follow-up. This is additionally a challenge when

trying to follow a pregnancy while the patient also has a chronic medical condition that may impact pregnancy follow-up, like diabetes or hypertension, where a patient has to see additional specialists or coordinate more often with her general practitioner. Oline further related that the patients often become the conduit to share the findings or information from meetings with other providers, which she perceives as a factor that impacts her patients' satisfaction with their care quality.

> *Yes, it is a bit complicated. You have us, there is the GP, and then there is the hospital – and there is no common computer system. We each sit on our toes, and then the poor pregnant person becomes the primary person who will tell [the providers] everything – and that is so unprofessional. It's so stressful, and you get so tired of it, and then you do not feel completely safe and taken care of either when health professionals ask, "what has happened before," somehow. (Oline, Health Station Midwife)*

Some of the midwives have shared that in times where it was especially important to know the actions of other providers, they would call the provider over the phone. Oline discussed how a new electronic exchange system has been introduced, that notifies the midwives when a patient goes to a clinic or if they have given birth, however these announcements are not accompanied by a detailed note about the visit or birth.

Another large lapse in communication is noted between the health stations and the maternity wards. All of the maternity ward midwives reported that they consistently receive women in labor with little or no information from their care team about their health status or pregnancy. Kjersti, a maternity ward midwife, discussed how the "maternal health cards" are often partially or poorly completed:

> *Because we have this paper, the helsekort, why is that? It should have been digital in Helsenorge.no* [The digital health platform for the population of Norway]. *It could have been more, you could write a little bit more about the consultations, so that we can get to know this woman more before she arrives to us…I can only see the health card, and there there's one line, and often it says, "She feels good, urine okay, blood pressure…" It's nothing! It's just a few lines. (Kjersti, Maternity Ward Midwife)*

Kjersti went on to discuss how some women will come in with "birth letters" (*fødebrev*), where the woman and her partner will detail any wishes she has for the birth, like pain management, desire for information on health status, breastfeeding, the partner's role, and more. Sometimes these letters can be helpful for obtaining information about the pregnancy, if they include the woman's medical history. However, these birth letters are of the parents' initiative, so it is not consistently present across all expecting parents. The maternity ward midwives expressed wishes for a phone call or a

short note from the provider who was in charge of the antenatal care in advance of a patient's labor, even if the entire pregnancy went smoothly, so that they could be more prepared when the woman arrives for birth. As noted by Kjersti, a maternity ward midwife: "…*the communication between the midwife at the healthcare station and the midwifes at the hospital. You know, we don't know so much what's going on there. The communication is absent."*

Creating continuity of care between the different areas and providers within the Norwegian maternity system was a consistent source of frustration for the midwives interviewed in this study. An important aspect of creating continuity is communication between the different providers managing the care of a patient, which midwives in both the health stations and maternity wards reported to be insufficient or absent. Several of the midwives also shared that they wished for better continuity between providers regarding medical advice and approach, because the lack of consistent information or approaches sometimes creates difficult situations with their patients. In the light of decreasing opportunity for patients to seek continuity within midwifery care from the same provider or group of providers in the Oslo area as a result of the upcoming closure of the ABC clinic in Oslo, more investment is needed to improve communication between the fragmented sections of the Norwegian system.

4.4 INGRID'S STORY

Medicalization is defined as a "biomedical tendency to pathologize otherwise normal bodily processes and states [that] leads to incumbent medical management" (Inhorn, 2006, p. 354). The process of medicalization has been observed within the birthing space, with increasing global rates of medical interventions like cesarean sections and labor induction, as well as the normalization of technological surveillance during pregnancy (Parry, 2006, p.784), all of which occurring irrespective of medical indication. This process of pathologizing a physiological process within a woman's body has produced a dominant construction of pregnancy and birth as dangerous, and in need of constant medical monitoring and intervention (Parry, 2006, p.785). Associated with perceptions of risk and moral obligations to medical surveillance and intervention, there is an additional consequence of increased medicalization within pregnancy and a loss of patient autonomy. Within the medicalized space, the source of knowledge and authority about the status of a woman's health becomes displaced from the woman's embodied experiences to the expertise of the medical establishment, which removes the woman's agency and control over her own pregnancy (Young, 2001, p. 280). More simply, Young (2001, p.280) calls this process alienation, and defines it as "the objectification or

appropriation of one subject by another subject's body, action, or product of action." As a result of this construction and displacement of knowledge and control over pregnancy away from women, pregnant women ultimately become helpless and powerless in the medical establishment. Moving forward, it is difficult to imagine pregnancy and birth to ever be considered a non-medical event again.

Working within this context and operating as a force of resistance against it, midwives promote patient-centered care that centers agency, embodied connections between mother and fetus, and approaches medical interventions based on medical indication (Shaw, 2013, p.530). The midwifery perspective frames pregnancy and birth as natural and physiological processes (Parry, 2008, p.790). There is evidence to show that midwife-led maternity care is associated with lower rates of medical intervention (instrumental birth, epidural analgesia, and episiotomy) with no difference in maternal or neonatal mortality rates (Sandall, et al. 2016, p.21). Additionally, women who deliver within a midwifery model of care are more likely to have a spontaneous vaginal delivery, as a result of higher mobility during labor due to lower use of analgesics and philosophy of care (Sandall, et al. 2016, p.22). Ingrid, a maternity ward midwife, discussed extensively her perceptions about her own profession, and the increasing trend of medicalization of birth within Norway. She discussed some of the challenges with using some of the common terminologies associated with de-medicalized birth: "normal," and "natural." Instead, she advocates for describing birth as a "physiological" process, driven by the individual woman's internal biological and embodied processes. This construction of birth removes the midwife from the authoritative position and places the midwife in a location of support and assistance, only if indicated, as pointed out by Ingrid:

> *I think we [midwives] see birth as a family event and a rite of passage for the woman's life, not as a medical procedure. And I think that most women see birth as an important event in a woman's life… I don't like the word "natural," because what is natural? It could be natural that a woman bleeds to death. And I don't like the term "normal" either, because if you talk about a "normal birth" in Norway, then a "normal birth" is with an epidural and a Pitocin drip – that's totally normal, but it is not physiological. I think physiological birth is a better term. (Ingrid, Maternity Ward Midwife)*

Ingrid went on to discuss the impact of medicalization on her own approach to care, which she observes when she moves between midwife-led maternity units and high-risk obstetric units during her shifts. The Norwegian maternity service has adopted a more medicalized approach to birth over the past several decades. This is in part due to an increase in complicated pregnancies and deliveries, with an increasing proportion of obesity amongst women in Norway (Meyer & Torgersen Vollrath,

2017, p.9), and the increased use of assistive reproductive technologies (Goisis, et al. 2020, p.1443) facilitating pregnancies for women whose age or comorbidities might have prevented them from conceiving in the past. The vast majority of births occur in a hospital, with only a 0.12-0.29% prevalence of planned home births (Norwegian Birth Register, 2018). Additionally, there have been reported increases in the use of medical intervention like oxytocin for birth augmentation (Gaudernack, et al. 2018, p.2), elective and emergency cesarean section (Kolås, et al. 2003, p.868), and operative vaginal delivery (Bernitz, et al. 2011, p. 1362). Ingrid describes medicalization as an unconscious and almost "infectious" process within the "higher risk" obstetric areas, where she feels heavily influenced by the biomedical perspectives of the providers around her:

> *When I move birth into a high-risk obstetric unit, something happens, and I don't know what it is. It's in a way invisible, you can't see it. When I'm at the obstetric unit, I feel more stressed about this birth than when I am at the midwifery unit. And there is really no difference between the birth, a healthy woman is a healthy woman. So, I have been thinking a lot about this and how the phenomenon even affects me, who trusts in birth and is very comfortable with physiological birth. (Ingrid, Maternity Ward Midwife)*

She elaborated on this tension between her approach to birth and that of the biomedical perspective. In the obstetric units, she recounted experiencing increased use of medical interventions and monitoring for patients that are deemed higher risk due to comorbidity factors, but with clinical presentations that did not necessitate this level of surveillance. She discussed how a dependence on biomedicine in the obstetric units encouraged what she described as "inflicted pathology," where women who were determined to be "high risk" in birth were transformed into high-risk patients and experienced increased interventions outside of medical necessity:

> *I think if you're looking for trouble and deviances, and if you look hard enough you will find something…. That being said, I am not against interventions in birth at all, I think it's a wonderful tool and I love that we have the opportunity to give epidurals and to get Pitocin drip, to give C-sections, vacuum, forceps when it's needed. I have nothing against pathology or interventions, but I do have a big problem with pathology when it is inflicted by healthcare professionals. (Ingrid, Maternity Ward Midwife)*

She finished this discussion by relating her perception of the role of the modern midwife within an increasingly medicalized context, where she denoted a split between midwives who have adapted to the biomedical framework and those who resist. In the former, she constructs midwives who work within the biomedical framework as "obstetric nurses," who work in large obstetrical wards who lack the time or resources to allow midwives to work within their framework, which encourages increased

interventionism and removes women from their own birthing experience. She argues that the transition of midwifery to "obstetrical nurses" is an increasing trend within her profession in Norway, which is in turn devaluing midwives who work with a more intuitive and patient-centered approach. She expressed feelings of extreme frustration over this trend, and admitted that it is burning her out of her own profession:

> *The system that is right now I feel sometimes that it inhibits me to do my work properly and it just shits on my profession and I'm angry about it.*
>
> *For me I think that every decision I make is so difficult and I think that's why I cannot work 100% as a midwife. It's too tiring. It was no problem when I was a nurse, but as a midwife, I never see myself working 100%. (Ingrid, Maternity Ward Midwife)*

She went on to add that she believes that this shift in approach to care within the Norwegian maternity system that reduces the autonomy and capacity of midwives, combined with the long work hours and high stress, are discouraging interested nurses from pursuing midwifery studies. In addition to her discussion about medicalization within the birthing space, Ingrid also was very open about her approach to care and how it impacts her own mental health. She shared how as a midwife, she emotionally invests in the wellbeing and comfort of her patients, which she perceives to be an expectation unique to midwifery. Midwifery as a profession requires a high degree of emotional care work, given the intimate and vulnerable nature of pregnancy and birth. As professionals who provide patient-centered care, midwives navigate the emotional landscapes of their patients while also regulating their own emotional responses in order to be a source of comfort and support (Yörük & Acikgoz, 2022, p.25). Ingrid noted:

> *I don't know if it's because I'm so emotionally attuned to the women I have in my care and that's why I feel most tired emotionally when I am done at work. And I think it's different from for example doctors, because I think doctors aren't so emotionally involved as we are. Don't get me wrong, I love the doctors, but it's different. You know having a stillbirth for example, that can have me emotionally exhausted for a week even though it was a beautiful birth. Sad, but beautiful at the same time, but it's just exhausting to be in the presence of someone's despair and grief for so long. (Ingrid, Maternity Ward Midwife)*

Protective factors against emotional burnout in the health professions include years working in the profession (Humpel & Caputi, 2001, p.401), having strong self-management skills (Taormina & Law, 2000, p.90), and having a strong sense of community with other providers (*Ibid.,* p.92). One study in the Netherlands has found that midwives who worked in wards with obstetricians experienced a power imbalance, with a lack of trust and mutual acquaintanceship (van der Lee, Driessen, & Scheele,

2014, p. 73-74). Additionally, interventions that combined peer support resources, workshops for symptom recognition, and accessibility to trauma-informed psychological care have been shown to reduce levels of depersonalization towards care, improve job satisfaction, and reduce post-traumatic stress disorder symptomology in European midwives (Slade, et al. 2018, p.8). When I asked Ingrid if she had any resources within her work that she could use to support her emotional wellbeing, she shared that she perceived a general lack of support and resources for her profession:

> *No, there were no extra resources for us and that's very typical for labor delivery and post-partum, it is women's health that is not regarded as important. All politicians say that they regard it as important, but they don't show it at all. (Ingrid, Maternity Ward Midwife)*

Ingrid's observations about working as a midwife in an increasingly medicalized context in the Norwegian maternity system is unfortunately a common trend for midwives around the world. She shared how midwives in Norway are increasingly pressured to adhere to the biomedical framework, where pregnant and birthing women are placed in positions of inflicted pathology and risk, and how this is coinciding with a reduction in available midwife-run clinics and centers. These observations also have specific implications for the care and maternal health outcomes for women with a migration background, who have disproportionate risk for medical intervention during pregnancy and birth. In Ingrid's experience, the midwifery approach to care is threatened, which is stripping midwives of their agency and comfort working within their framework. In addition, she has observed that the emotional demands of the profession and lack of support make working in the profession unsustainable. This was an extremely distressing conversation, coming from a midwife who also described herself as "above average enthusiastic" about her profession. However, I believe her observations tell an important story about pregnancy and birth in Norway, and indicate that there are midwives who work in the Norwegian maternity service who feel disenfranchised within their positions.

4.5 PEER SUPPORT

Despite the professional challenges that the midwives shared over the course of the interviews, one factor that the majority of the midwives shared as an important contributor to managing workplace stress and professional happiness was the community of support produced by their peer group. As mentioned in the previous section, having a strong sense of community with other providers has been shown to be a protective factor against workplace burnout amongst health professionals (Taormina

& Law, 2000, p.92). Seven of the thirteen respondents discussed how peer support was an important part of managing their own psychosocial support:

> *I face challenges, of course I do, but I feel…. I have colleagues, right? So I can ask a little, and then we can discuss a little, then we can find out things together. (Oline, Health Station Midwife)*

> *I think back when I was a new midwife you just take everything with you, and you cannot do that. You have to put a bit aside. Then I talk to my colleagues here if I have tough cases. (Line, Health Station Midwife)*

Additionally, the midwives indicated that their peers were an important source of professional support for advice on clinically challenging cases. One midwife shared that she is involved in midwife groups outside of her place of employment, who she reaches out to for professional support. Another midwife, Signe, shared how the midwives in her health station regularly take advantage of each other's strengths to provide better support for their patients: "*We have a very open door… We use each other for anything, because you are never sort of fully skilled in everything. We use each other."*

The midwives who participated in this study indicated that their peers were an important resource that they regularly use for professional and emotional support, which has been established important protective factor against workplace stress and burnout. It is important that these relationships and community continues to be fostered within the Norwegian maternity service, so as to maintain this resource of support for midwives.

4.6 PROFESSIONAL SATISFACTION

As discussed in the previous sections, the midwives who were interviewed in this study shared several factors that impact their workplace satisfaction. The midwives in this study indicated an enthusiasm and love for midwifery as a profession, a support network fostered amongst peers, and a deep care for their patients.

However, there were several factors related to the realities of their work environment that have produced work dissatisfaction for the interviewed midwives. The first and most significant cause for workplace dissatisfaction for many of the midwives was the perception of an increased workload without hiring additional staff. The second challenge was difficulty with creating continuity of care as a result of communication challenges with other providers in the maternity service, and fragmentation of the midwifery profession between the birthing and antenatal care spaces. The final

challenge, as discussed by one midwife, Ingrid, is the midwifery profession's existential threat of biomedicine and medical interventionism in the birthing space. For Ingrid, the medicalization of childbirth lies at the center of factors that relate to midwife workplace dissatisfaction – workload, reductions in lengths of personal attendance to patients, loss of respect from other providers, and less time to manage one's own mental health. Ingrid was very open about her experience with burnout, however expressions of burnout were also noted with a couple of the other midwives interviewed in this study.

The potential implications of these challenges, beyond negative consequences on workplace dissatisfaction, also can include poorer patient satisfaction and poor overall quality of care. While the challenges outlined in this chapter have the potential to affect all women who interact with the Norwegian maternity service, patients who are more socially and structurally vulnerable, who often need more time and resources from their health providers, will suffer disproportionately more. As Chapter 5 will discuss, pregnant migrant women are considered to be one of the most structurally vulnerable groups, and due to social, economic, and cultural factors require additional attention, compassion, and often resources from medical providers.

While Norway has excellent maternal and neonatal health statistics, it is additionally important to center the work lives of the providers, and ensure that they feel supported and satisfied within their job. The theory of labor welfare emphasizes that employees who are happier and healthier within their labor conditions are more productive and perform at higher standards (Arena, 2014, p.97). The Norwegian Working Environment Act (Arbeidsmiljøloven), emphasizes that employers must assess for factors that impact employee health and wellbeing, and address any factors within the workplace that may negatively impact employees (Arbeidsmiljøloven, 2022). This legal framework, which centers the theory of labor welfare, was developed to protect the health and happiness of employees. However, from the results of this study, there are several critical structural factors that are significantly impacting the mental wellbeing of midwives, as well as patient satisfaction. Future research is indicated to evaluate potential interventions or policy changes that could lead to improvement in Norwegian midwives' wellbeing at work.

Evaluating the satisfaction of midwives who work within the Norwegian maternity service sets an important baseline for midwives' perceived capacity to provide care to patients who would especially benefit from the highly individualized midwifery framework of care. As the remainder of this thesis will show, recently-arrived migrant women experience vulnerability during their pregnancies, and have been shown to often need additional support and coordination of resources

during their interactions with the Norwegian maternity service. With increased medicalization of birth, staffing shortages, and decreased capacity for midwives to operate within their frameworks, midwives are appearing to be experiencing tighter restrictions on their ability to provide care that centers the needs of each individual patient. While the implications of these challenges will impact all women who become pregnant and give birth in Norway, patients need additional support, particularly women with a migration background, will suffer these effects disproportionately.

CHAPTER FIVE: CONSTRUCTING VULNERABILITY

5.0 INTRODUCTION

One of the core concepts I wished to explore in this project was "structural vulnerability," and how the midwives I interviewed integrated the concept into their priorities, decisions, and interactions. Official health guidelines recommend that care provision should be individualized based on their patients' unique situation, but I was interested in how these providers construct vulnerability and how they incorporate it into their practice. Watts and Bohle (1993, p.45) described three coordinates of vulnerability: (1) the risk of exposure to stress and crisis, (2) the risk of poorer capacity to adapt to stress and crisis, and (3) the risk of severe consequences of and limited resilience against stress and crisis. Vulnerability in discourse can be conceptualized as an individual or community at risk, but can also be used to convey relative powerlessness or precarity (Whittle, et al. 2020, p.5). Additionally, having vulnerability or becoming vulnerable can produce social devaluation, social exclusion, and contempt from others (Delor & Hubert, 2000, p.1560). Building upon the concept of "vulnerability," "structural vulnerability" is a concept that relates to how social, political, and economic structures and institutions can cause the inequitable distribution of poor health outcomes (Bourgois, 2017, p.299).

Migrant women are considered to be especially structurally vulnerable, as a result of a variety of individual intersecting identities, like race, socioeconomic status, gender, education, and social position in society. These identities, when combined with temporary or irregular states of vulnerability that may occur over a life course, like migration, language proficiency, violence, and pregnancy, can place this population at significant risk for poor health. Past literature has indicated that migrant women in Norway are vulnerable to disproportionately worse obstetric and neonatal outcomes compared to ethnic Norwegian women, across nearly every metric, from gestational diabetes (Holan, et al. 2008, p.128), to emergency cesarean section (Bakken, Skjeldal, & Stray-Pedersen, 2015, p.4), to stillbirth (Skeie, et al. 2003, p.1013). In addition to poorer health outcomes, women with a migration background additionally are at higher risk of receiving sub-optimal care, including under-utilization of translation services by providers (Kale & Syed, 2010, p.190), challenges with navigating the Norwegian health system (Bains, et al. 2021, p.5), and experiences of discrimination or bias from providers (Glavin & Sæteren, 2016, p.5).

The prior chapter discussed the daily professional conditions described by the midwives in order to parse out what challenges are related to their work-lives, and what challenges are specific to this population. Prior to discussing the perceived challenges in providing migrant-friendly maternity

care, I want to discuss how the interviewed midwives consider and evaluate the care their patients need. In this chapter, I explore the perspectives of the interviewed midwives as they discuss what "vulnerability" means to them, who they perceive to be vulnerable, and what accommodations, if any, they make for patients they recognize as vulnerable. The majority of this analysis draws from the responses of the six midwives who participated in the second set of interviews, since "vulnerability" was one of the main concepts that I incorporated into the second interview guide. With that being said, a couple of the other midwives from the previous interviews also discussed vulnerability either on their own or through the prompting of the interviewer, so I also included their perspectives as well. As this chapter will show, the midwives who were interviewed had a complex understanding of the concept of vulnerability, both on structural and temporal levels, and revealed the ways in which they adapt or bring external resources into their care.

5.1 OSCILLATIONS IN VULNERABILITY

In the very first interview of my very first qualitative research study, I had the pleasure of sitting down with Signe, a health station midwife who has worked for many years in an area of Oslo that has been historically a popular area for settlement across several waves of migration. As we sat in a meeting room in her health station over a cup of hot coffee, she opened the discussion of vulnerability in a way that I did not expect. When I asked her what the concept of vulnerability meant to her, without much hesitation she said:

> *Well first of all I think being pregnant you are vulnerable. So, in a way we are all vulnerable as well, I guess. (Signe, Health Station Midwife)*

I was surprised by this comment, because I was initially expecting her to provide a response that was more specific to migrant health, given the context of the study and some of the discussions we had in the interview prior to this section of questioning. Past literature has placed several aspects of health and disease, like HIV infection, elderly age, obesity or malnutrition, or heart disease, as factors that both create vulnerable periods in individuals' lives as well as increase vulnerability for other health conditions (Flaskerud & Winslow, 1998, p.71-75), discourse has not necessarily framed pregnancy in the same way (Briscoe, Lavender & McGowan, 2016, p. 2). Across the life cycle, vulnerability can be experienced as a process or a journey, with oscillations in the level of vulnerability dependent on a combination of individual circumstance and societal factors (Zarowsky, Haddad, & Nguyen, 2012, p.6). In their article, "A concept analysis of women's vulnerability during pregnancy, birth, and the postnatal period," Briscoe, Lavender, and McGowan (2016, p.2339) introduce a conceptual model

that describes pregnancy as a state of vulnerability for all women that either increases or decreases in response to stimuli of barrier (lack of access to pregnancy information, lack of dignity, lack of trust) or repair (good patient-provider relationships, high self-esteem, partner support). This framework discusses how vulnerability can be resolved or reduced by correct recognition of barriers and appropriate reparative measures by health workers (Briscoe, Lavendar, & McGowan, 2016, p.2337). Signe opened the discussion of vulnerability in the same way as the framework proposed by Briscoe, Lavender, and McGowan, placing pregnancy first as a state of vulnerability for all of her patients, before introducing the compounding barriers and factors that increase vulnerability for her patients.

> *Well first of all I think being pregnant you are vulnerable. So, in a way we are all vulnerable as well, I guess. And coming here, is for most people a vulnerable situation. And I add to that if you are new to the country… I mean if you have things in your history that make connecting with other people difficult, meeting people in power difficult… (Signe, Health Station Midwife)*

Placing the vulnerability of pregnancy first, ahead of other structural, health, or social factors, was a perspective that was shared by a few other midwives in subsequent interviews:

> *When a woman becomes pregnant, they are vulnerable from the first day that they become pregnant. Especially when you are not in your home country, you feel a little bit extra vulnerable. (Sara, Health Station Midwife)*

One of the maternity ward midwives, Emilie, discussed her location in the health system as a professional who possesses power and influence over her patients. In her discussion of vulnerability, she shared how she understands the position she has as somebody who has a direct relationship to the health of her patients. From her perspective, labor and delivery is a significant period of vulnerability for her patients, and is a period of time where many women feel fear or insecurity. As a result, she feels it is her professional responsibility to be a resource and a guide.

> *All the ladies I meet are vulnerable. I have a power in my profession when I meet them, when they are in pain and they are scared. They are in a very scared place. Even if they are very well prepared, they are vulnerable during birth, and I have to use my power, my professional power, my women's knowledge and everything, in a humble way. (Emilie, Maternity ward Midwife)*

While many of the midwives later moved into discussions of structural causes of vulnerability, I was particularly interested in how these midwives did not initially jump into essentializing or framing migrant women as inherently vulnerable. Instead, vulnerability for their patients, migration

background or not, was constructed as transient or varied depending on the complexity of their current circumstances. As Line, a health station midwife, reflected: "*I think for me, it's not who you are but more the factors around you that's affecting you and your vulnerability.*"

This conceptualization of vulnerability is in line with many of the critiques against structural vulnerability – that constructing certain groups as intrinsically vulnerable at all times as a result of powerful and immovable structures may implicitly reproduce oppressive ideologies that may block efforts of resilience, and can inadvertently further stigmatization (Brown, 2011, p.315). Kaye, et al. (2014, p.267) proposes that an individual oscillates between vulnerability and resilience in reaction to external stressors. How the individual moves between vulnerability and resilience is as a result of bodily capital, or the resources associated with health, beauty, and productivity; and social capital, the resources associated with social norms, networks, and structures (Kaye, et al. 2014, p.267). This suggests that the boundaries of and experience of vulnerability are not as rigid as some conceptualizations of vulnerability have suggested.

5.2 PERCEIVED FACTORS OF VULNERABILITY

Pregnancy was introduced by these three midwives as the first factor of vulnerability that women across all backgrounds have the potential to enter into – vulnerable in that pregnancy is a stage in health that demands additional care, resources, and support. These three midwives, Line, Signe, and Sara, then went on to discuss additional layers of vulnerability that may impact care and needs. As previously mentioned, Signe added that the process of migration, and the period of time as a "newcomer" (which within the MiPreg study we have defined as residence for less than or equal to five years) produce additional layers of vulnerability that superimpose that of pregnancy. Sara, a health station midwife who was not born in Norway, additionally layered migration and unfamiliarity with the country as important factors of vulnerability related to pregnancy. She also added that having challenges with speaking a common language within the health space can produce feelings of vulnerability and fear in migrant women. One of the midwives, who works with many undocumented women, discussed extensively how a lack of temporary or permanent legal status in Norway can produce large barriers in accessing care, producing additional vulnerability for women who are pregnant.

Other midwives discussed additional factors that superimposed layers of vulnerability onto patients specifically with a migration background. Themes of language, communication, and understanding were very common amongst the interviews. Communication barriers increase patient

risk for poor health outcomes (Latimer, Robertiello, & Squires, 2019, p.20) and low understanding of pregnancy information (Bains, et al. 2021, p.6). Ingrid, a maternity ward midwife, reflected on this theme often throughout her interview, because she placed special importance on the individual relationships she developed with her patients.

> *I think vulnerability for me means if you are not fully able to unhindered make decisions about your own health and healthcare, which I think is difficult [to do] if you don't understand the system and don't understand the language (Ingrid, Maternity ward Midwife)*

Ingrid raised an important concern regarding vulnerability, where she framed understanding and personal agency as important factors that impact a woman's vulnerability during the perinatal period. Language, communication, and understanding barriers impact a patient's ability to provide free and informed consent, and leave them vulnerable to coercion and harm in the healthcare setting. (Forrow & Kotrimas, 2017, p.855). I discuss more extensively the specific challenges associated with language and communication in Chapter 6, since it was the most significant challenge raised by the midwives across every interview.

The midwives additionally discussed psychosocial wellbeing to be another factor that they consider while assessing the vulnerability of their patients. Many of the midwives discussed how they consistently ask their patients about their social world, including their relationship with their partner, how they feel about their pregnancy, who they have in their world, and how socially integrated into Norwegian life they feel. One midwife, Kjersti, discussed how she perceives patients without family or other women to be vulnerable.

> *What I have experienced is that they feel vulnerable when they don't have their family around, like when they can't have their mothers or their sisters or the women that are close to them. (Kjersti, Maternity ward Midwife)*

A few of the other midwives discussed how they perceive patients who suffer from mental illness or distress to experience increased vulnerability during pregnancy. Line discussed how she has experienced that pregnant migrant women are more vulnerable to postpartum depression but are inconsistently assessed for the condition. She additionally discussed how she readily incorporates psychological support services like social workers and psychologist referrals or response teams for patients with a history of mental illness, because she perceives this group to need additional support during pregnancy. Oline, another health station midwife, also discussed how she perceives women with a background of psychiatric illness and alcohol use to be in need of additional resources during

pregnancy. The midwives further discuss how they coordinate psychosocial support resources for their patients with a migration background in Chapter 7 of this thesis.

Several of the midwives discussed how the vulnerabilities of migrant women are very specific to individual circumstance, and constructed vulnerability on the basis of possessing "resources," which based on context I interpreted to mean material-need resources, social capital, and knowledge. Terese, a health station midwife, who shared her perspective, as well as a story about an individual patient, deconstructs the idea that migrant women are inherently vulnerable.

> *But it's not a homogenous group, is it? So that it becomes very individual how we meet them. And some have a lot of resources... I had one who has only been in Norway for 10 years, but who has a good education. Comes from Somalia, works 100%. This is the first time that she is pregnant, but she can and has read a lot. So there it is – and has already done as much research as other ethnic Norwegians have not done, right. So you have the whole spectrum, also. (Terese, Health Station Midwife)*

This perspective was shared by Irene, a maternity ward midwife, who also framed vulnerability as interconnected with access to resources. In her experience, she noted that women with poorer resources and poor self-advocacy had later initiation of antenatal care and poorer quality of care during their pregnancies. In this discussion, she framed migrant women as generally resource-poor in comparison to ethnic Norwegian women, but also stated that low-resource Norwegian women have similar challenges:

> *I probably think that there is a difference in the treatment that a minority woman gets, and a women with a lot of resources and who knows and plays on the right buttons. I certainly think… that you might wait longer to get started. That is, that is differential treatment! You should be careful to say [this], but I mean it. I believe that there is a difference in treatment between minority women and resourceful women. This does not mean, it is more about resources, the same applies, for example, to women with few resources who are ethnic Norwegians. They can also experience the same thing. Women who demand little and do not have enough resources they unfortunately fall further behind in the queue. (Irene, Maternity Ward Midwife)*

Irene and Terese's discussion of "resources" can be examined through the lens of "structural vulnerability." Whittle, et al. (2020, p.12-16) discusses how material-need insecurity can be associated with stigma inside and outside of the health system, structural disempowerment, and experiences of worsening health status. For women who are either materially, socially, or intellectually "resource-poor," as a result of structural factors like race, class, socioeconomic status, education, and citizenship, the health system can become a conduit for structural disempowerment

through poorer experiences of quality of care, delayed access to care, poorer health knowledge, and worse health outcomes.

The midwives shared many unique perspectives about how they conceptualize vulnerability within the patients they serve. Some drew a picture of vulnerability over a life course, regarding how a woman can experience different levels of vulnerability through her life based on how she interacts with various circumstances like migration, pregnancy, and birth. Others identified structural factors, like legal immigration status, psychosocial wellbeing, resource insecurity, health knowledge, and language proficiency. It was clear that for those interviewed, assessing individual patient need based on vulnerability was central to their practice, and was a concept that they regularly integrate into how they triage and assess their patients.

5.3 MAPPING VULNERABILITY

During our discussions of vulnerability, I asked the midwives to reflect on how they assess the relative vulnerability of their patients. While collective knowledge of structural vulnerability should be a really important goal for health providers, in my opinion it is even more important for concepts of vulnerability to be integrated into patient assessment and care in a way that can be used consistently across patients. As a healthcare worker in the United States, I have been exposed to hospitals and clinics who have adopted standardized vulnerability assessment tools to be used during clinical encounters as a quick way to evaluate which additional resources might be necessary to integrate into patient care. Bourgois, et al. (2018, p.10) advocates for the integration of an assessment tool for structural vulnerability as a stepping stone to "structural competency" in the U.S. healthcare context, when combined with clinical curriculum in provider-patient rapport, social medicine, history taking, and ethics. Given the level of attention that the midwives displayed in laying out specific groups and experiences that produced experiences of vulnerability, I expected some type of triaging or assessment tool that they had integrated into their daily practice. All of the midwives denied utilizing standardized assessment tools in their practice. However, across all of the discussions, the midwives instead shared that they assessed vulnerability through patient interviewing.

Oline, a health station midwife, introduced her assessment of vulnerability as a "mapping" process – where, based on the needs, she adds additional appointments or extra time to ask questions about her patient's life – her work, finances, family, friends, husband, medical history, diet experiences of violence, mental health and wellbeing, education, and existing health knowledge. Some midwives described these interviews to be an extended process where a patient's life was

mapped over several visits. Others reported that they performed this interview only in the first visit. These interviews were described to be integrated into other routine maternity care tasks, like pregnancy education and assessment of vital signs.

My first participant, Signe, had a wealth of information to share on this subject, and walked me through how she assesses vulnerability and made decisions about adding in external resources:

> *When I talk to someone I will find out whether she can, in what degree she is addressing her own needs and… about her life situation. I mean, there are so many different ways of being vulnerable…. Some of the women are really strong but they are in a vulnerable situation and the vulnerability might not need anything else… that I would give her some extra time, maybe, because it takes a little more time for her to express her needs or what she is wondering about.*
>
> *We always talk about… I mean not so much about living, how they live physically, but both are they working, are they at home, are they providing for others, and all of this about violence… and then I also ask about [her] childhood. And then general violence I always talk about whether they are in a violent relationship now, but also if they have also had any experiences with violence in the past or growing up. So hopefully it is a lot covered. (Signe, Health Station Midwife)*

In addition, one health station midwife, Kari, discussed how she incorporates patient self-assessments of vulnerability into her care. That is, if a woman contacts her health station and indicates that she has assessed her own needs and is requesting extra care and support, Kari will take that assessment at face value and will make efforts prioritize that patient accordingly: "*I usually tell everyone that if they think they need it, then they can send me a message when they get home and I will try to make it happen. The woman is involved in the assessment of the need."*

The midwifery model care is one that is highly individualized, patient centered, and aides women in developing embodied connections to their physiological changes during pregnancy (Berg, Ólafsdóttir, & Lundgren, 2012, p.2). Through the use of in-depth interviewing, the development of relationships over the course of a woman's pregnancy, and integrating external resources into care, the midwives who I interviewed have shown to consider the concept of vulnerability in their assessments.

However, a limitation of this study is that every midwife that volunteered for participation has described a personal interest and a wealth of experience in migrant-centered care. Through the interviews, each midwife displayed different ways of making their practice "their own" – that is, through differing communication styles, interview techniques, how they support their patients, and more. All of the midwives but one denied having had discussions during their midwifery education

or professional training about vulnerable populations, migrant health, or cross-cultural competency. As a result, it is difficult to know how consistently comprehensive these interviews are for assessing the various factors of vulnerability across different patient populations, and for midwives with less professional interest in these topics, it is unknown whether these interviews occur at all. While all of the interviewed midwives denied using any clinical vulnerability assessment tools, one study found that the surveyed Norwegian community midwives surveyed utilize some assessment tools like the Edinburgh Postnatal Depression Scale (EPDS), Tolerance, Worried, Eye-opener, Amnesi, and K/Cut down (TWEAK) for alcohol use, and Motivational Interviewing (MI) with domestic violence emphasis (Espejord, et al. 2022, p.5). This study also found that use of these assessments increased amongst the population after receiving training on the tools (Espejord, et al. 2022, p.5). Future studies are needed to evaluate whether other more comprehensive vulnerability assessment tools would be beneficial or accepted by midwives within the Norwegian maternity care system.

5.4 PRIORITIZATION OF VULNERABILITY AND ADAPTATIONS TO CARE

As discussed in the previous chapter, it appears that there are often periods of time where the maternity system is overwhelmed with a high volume of patients needing antenatal care, and during these periods there is a need to either delay initiation of antenatal care, or to triage patients away to receive care from their general practitioners (GP). During these periods, in order to decide who needs care and at what time, a couple of the midwives shared that they evaluate the vulnerability of their patients and make decisions based on what they find. Oline, a health station midwife, shared how performing this triage of care is difficult but essential, given the resource restrictions:

> *Yes, because then it really hurts someone else then – that you prioritize those who need it the most. That is the kind of philosophy we must have…. There are some who go to a GP, and they can do this even if they have a GP. But, as long as they don't have a GP, they must come to us. So then we have to take care of them. (Oline, Health Station Midwife)*

The midwives who shared this experience explained that they make efforts to prioritize first-time mothers and mothers with a migration background, given that they perceive these groups to need extra time for assessment and antenatal education. It was also common for midwives to prioritize those without assigned GPs, which are assigned to individuals with legal residence for periods longer than six months. Those on temporary visas, who have experienced delays in receiving their Norwegian birth number (national identity number), or who are undocumented, are not entitled to a GP and thus have no other option than to seek maternity care through the health stations or the

specialized clinic for undocumented migrants in Oslo. One midwife, Kari shared that she believes assessment for vulnerability is subjective across different midwives, which may create differences in who is prioritized for accessing care from the health station, and when they are called in:

> *In principle, according to the guidelines, everyone should have access to maternity care from a midwife, but we have not been able to do that and we still do not. But what we have done is that we have tried to prioritize first-time mothers and other vulnerable people. Whether one is vulnerable depends on one's own assessment. (Kari, Health Station Midwife)*

In addition to vulnerability dictating prioritization in antenatal care, the midwives I interviewed additionally discussed how they personally adapted their care to address the needs of women they perceived to be vulnerable. The most common response across the midwives included adapting their schedules through adding extra appointments or increasing appointment lengths. This was common for those who needed a professional interpreter, but was also for those who the midwives perceived to need more time to answer questions that they may have, or needed more information about pregnancy, Norway, or their health. Some of the midwives shared that they felt they had the capacity and flexibility to adjust their schedule in this way, while others felt that this was not always possible. This was a consistent finding across both health station midwives and maternity ward midwives. Kjersti, a postnatal ward midwife who also works in the maternity ward, discussed how she makes an effort to give more one-on-one care to women in labor who she perceives to be vulnerable, particularly those from a migration background, in order to build trust and security during childbirth, since she identified higher anxiety and communication problems from this group. As reflected by Kjersti:

> *…[For] immigrant women, I used to stay in the room all the time, maybe for eight hours straight, just to make sure they feel safe. Because I think if they feel safe and secure and seen, the delivery will go more like normal… The difference is that I tend to say to all of the other midwives, "I need to stay here. Take me out if there is an emergency, only. I need to stay with this woman because I think she needs extra care," because of the situation. You never know what they have been through. (Kjersti, Maternity Ward Midwife)*

The next way that several of the midwives discussed adjusting their care was through the ready integration of social support services, whether it be social workers, psychologists, NAV (the Norwegian Labor and Welfare Administration), and child welfare services. A couple of the health station midwives shared that the health stations have recently integrated some social services resources into their staff. Kari reported that her health station has one day a week when NAV social workers answer questions or help women and their families with filling out applications. This resource arose because many of the midwives in her health station were reporting that they were helping their

patients with NAV and UDI (the Norwegian Immigration Authorities) paperwork. It is unclear how many of the health stations have this offer, but at least one other midwife working in another Oslo health station reported still helping her patients with this paperwork in addition to her other responsibilities. Oline shared that her health station, and some others have an in-house family support team that has family therapists and psychologists available for referral. One of the midwives, who works in the Oslo center for paperless migrants, reported that they have available psychologists for referral, which she readily does if she recognizes the need or if her patients share a history of mental illness. Several of the maternity ward midwives reported that their wards have acute psychiatric team who are available at any time.

An additional important resource that all of the midwives cited to be useful to address the specific vulnerabilities of migrant women especially were the multicultural doulas. This program, started in 2017 at the Oslo University Hospital, aims to strengthen the quality of care and social support needs of women with a migration background, through the assignment of a doula who shares their language and culture. This program is only available to women who are vulnerable as a result of a limited social network, residence of less than five years in Norway, and poor Norwegian language proficiency. The role of the doula is to be a support person for the migrant woman through her pregnancy and birth. The doula helps the woman navigate the Norwegian maternity system, acts as a cultural bridge and advocate between the women and their providers, and supports the psychosocial wellbeing of the patient by promoting continuity, trust, and safety. One midwife, who has worked with many multicultural doulas, discussed why she felt the integration of the doulas was so important in providing high quality care for vulnerable women.

> *From [my work] as a midwife… [I had] the feeling that I didn't do a good job because I felt that I couldn't give them the confidence and trust that the women who were giving birth trusted in me, because there was this missing link with communication. Even if we use translators it's not the same thing…For me being a part of a labour or being a midwife is a lot of non-verbal communication, you use a lot of body language, but it's also a lot of the cultural perspective. How do you use massage as a tool of pain relief?, How is it acceptable? (Health Station Midwife)*

Every midwife who reflected on the multicultural doulas, which were nine of the thirteen participants, stated that the introduction of the doula project has been overwhelmingly positive. One midwife reported that the program is "worth its weight in gold," because of the "support," "security," and "network" that may have otherwise not existed for the patients who were able to access the service. Several midwives, especially those in the maternity ward contexts, reported that they readily

incorporate the doulas into their team, and lean on them as they get to know their patients and social and cultural worlds. Every midwife who mentioned the doulas expressed desires for expansion of the program, more training of doulas and less strict entry requirements for doula assignment. As Ingrid, a maternity ward midwife, shared: "*I think that the "flerkulturell doula" or the multicultural doula, which is a free service, is a really good thing and I wish that every immigrant woman who hasn't been her long or doesn't speak the language, I wish that everyone would have this opportunity."*

The midwives' responses indicate that they adapt their care to accommodate the needs of patients they perceived to be vulnerable and in need of additional support, through the use of extending or adding appointment times, or through integrating additional resources available to them through the maternity system, like social workers, psychologists, and multicultural doulas.

5.5 ABOVE AND BEYOND THE CALL OF DUTY

In addition to integrating aspects of the social services into their care as needed, the midwives also discussed how for migrant women, they also make extraordinary efforts to support patients who they perceive as vulnerable, often "above and beyond" their job responsibilities. This story starts with Kjersti, a midwife who was working primarily in the postpartum ward of her hospital at the time of the interview, who discussed several examples of ways that she supports the psychosocial wellbeing of her patients. Throughout her interview, she constantly reinforced her desire to make her patients "feel safe and seen," through spending extra quality time and listening openly to their perspectives and worries: "*I feel like a psychiatrist though. I talk a lot and I sit at the bed, and make sure that they can feel safe."*

Kjersti also discussed how she will encourage her patients with a migration background to have family or other women in their network to visit them in the postnatal ward, because, as she stated:

> *It is very important…to have a woman nearby when they are giving birth, or at least in the postnatal phase. That they learn a lot from the other women in their community, and I can see when women come in and they sit after birth- the mothers are blossoming… [The women] care in a way that we cannot give them in a way. I think that that's very important to them, to feel stronger and that they have women close to them, at least. (Kjersti, Maternity Ward Midwife)*

For women who she has identified as having a limited social network, Kjersti reported that she will place them in rooms with another new mother, to help foster new friendships or to have somebody to talk to who is not a healthcare professional. She reported that this was often a successful intervention

that seemed to help her patients with limited social network. Kjersti was an excellent example of a midwife who adapted her care beyond her typical responsibilities in order to ensure that her patients were getting the care that she felt they needed. She was not alone. Several of the midwives discussed small or large ways that they went "above and beyond," sometimes outside of protocol, in their care. Five of the midwives shared that they regularly give their personal phone number to their more vulnerable patients so that they can reach them outside of work hours or appointments, especially those without GPs. One midwife reported that she regularly gives her personal phone number to patients who had difficult or traumatic birth experiences, so that she can follow up on them and their health and wellbeing after they are discharged from the hospital.

More than half of the midwives reported performing off-hours home visitation or even having patients come to their own home. One midwife discussed occasionally performing home births through separate employment in a private practice. Several of these midwives performed home visits for emergency lactation support, for infants who were not feeding or if the mothers were in pain. One midwife discussed how performing home visits or inviting patients to her home was a really positive way to aid migrant women with breastfeeding in a calmer and non-clinical environment. This opportunity also allows her to connect and support her patients in their needs after birth, to promote continuity of care:

> *Sometimes, yes, I have made some home visits *laughs* Yes. And that's because I specialize in breastfeeding issues, and many immigrant women have issues, actually, with breastfeeding. So I do go home and I think that is a very nice thing to do, because I learn a lot myself also. I grow on it. Sometimes, it's just a little short visit that is required – just a change in position for the baby is required, or the breast, it's not much.*
>
> *To sit in peace and quiet and to not be at the hospital with this pressure and all of that, with all the things you should be doing hanging over your head, it is much easier for me. It is very nice to go home for the home visits. If I know that they are not far from me, I just say, "If you want, you can come." Some families have actually come to my place, and we do this breastfeeding education. I have made these PowerPoints and I just explain to them. And that is so nice. (Maternity Ward Midwife)*

The last way that one of the midwives reported going "above and beyond" in their job duties in order to address the needs of their patients who were experiencing vulnerability as a result of a low social network, was through creating opportunities for mothers with a migration background to meet each other. In her antenatal or postpartum responsibilities, she shared that she would ask patients with the same country background if they would like to come to appointments together. She perceived these group visits as a positive intervention for those who were interested in meeting others who were going

through similar circumstances – pregnancy, migration, navigating the culture and structures of Norway, and learning Norwegian.

Throughout the interviews, it was clear that the midwives who work in the Norwegian maternity system reflect deeply and routinely on the vulnerabilities of women who come into their care. In our discussions, the midwives framed their conceptualization of vulnerability as a dynamic process that involves both structural factors and individual circumstance. The midwives additionally shared how they employ the midwifery model of care provision, which centers care that is tailored to patient's individual needs and promotes psychosocial wellbeing, in order to adapt their assessments, referrals, and interventions to meet where they identify the patient to need additional support. For many of the midwives, vulnerability assessments were used to prioritize certain patients for care and resources. Several of the midwives shared situations where they adapted their care beyond their typical responsibilities, in some ways that might be not permitted by their employment institutions. The results of this line of questioning during the interviews suggests that the participating midwives have the motivation to support and empower their patients on an individual basis. However, as the previous chapter described, many of the interviewed midwives reported decreased capacity to provide their patients the patient-centered care within the midwifery framework. The midwives who discussed vulnerability identified several factors that increased their patients' vulnerability, including pregnancy itself, migration, recent arrival to Norway, limited social network, mental disorder, and language. All of the midwives who discussed vulnerability framed recently-arrived women with a migration background as a patient group that especially experiences vulnerability while undergoing their pregnancies in Norway.

CHAPTER SIX: MISINTERPRETATIONS AND MISCOMMUNICATIONS

6.0 INTRODUCTION

With increasing movement of persons across borders, a significant challenge for modern healthcare providers is the development of the skillset to communicate across cultural and linguistic barriers. Even when common languages are spoken or interpreters are utilized, miscommunications can occur as meanings and interpretations change across cultural boundaries. For example, in the United States, the use of direct eye contact during conversation shows confidence and trustworthiness, while in Japan can be considered deeply uncomfortable and disrespectful (Hattori, 1987, p.111). This difference in basic conversational behavior is believed to reflect the societal structures of each country respectively, with the United States' foundation in equality and individuality and Japan's foundation in collectivism and social hierarchy (Hattori, 1987, p.111). For health workers who operate in multicultural settings, it is important to develop and utilize skills to recognize and adapt their care across these boundaries to ensure high quality of care. In the health care setting, clear communication is essential to developing accurate diagnoses, performing assessments and procedures, building patient-provider rapport, and understanding patient needs and symptoms (Johnson, 2004, p. 1-2). Ethically, clear communication is necessary to ensure that patients can provide informed consent freely, and thus to reduce risks of undue harm.

Past studies have shown that medical providers face several challenges to communication while working in multicultural settings, most often concerning access to qualified interpretation services. Akhavan (2012, p.4) described how midwives working in Scandinavia consistently have challenges in accessing interpreters, finding high-quality interpreters, developing trust with patients with other cultural and linguistic backgrounds, and difficulty communicating certain reproductive health concepts cross-culturally. The midwifery model of care is highly individualized and patient centered, and depends on both verbal and non-verbal communication (Berg, Ólafsdóttir, & Lundgren, 2012, p.2). As such, barriers to communication can greatly impact quality of care provision and patient satisfaction. The midwives who participated in this study were asked to reflect upon the most significant challenges that they experience while providing maternity care to women with a migration background, and all 13 midwives reported challenges with language and communication. The following chapter will follow the two main themes brought up in the interviews: accessing interpretation and the use of alternative interpretation methods, and health education and understanding of health information. The chapter will finish by discussing how the multicultural doula program has been an important resource to bridge these barriers.

6.1 BARRIERS TO USE OF QUALIFIED INTERPRETATION AND ALTERNATIVE INTERPRETATION USE

Every midwife who was interviewed for this study spent a significant amount of time outlining the challenges they have experienced while navigating the use of interpretation services. The main challenges outlined were accessing the service, integrating the translator into their care, finding the appropriate translator for their patient needs, and determining at which points in their care translation services were indicated. While all persons accessing health care in Norway who do not speak Norwegian have a right to interpretation, the participants of this study indicated that decision-making around use of the service is complicated and vastly underutilized. Prior to 2022, the legal framework surrounding the right to qualified interpretation did not mandate the use of qualified translation, rather framed it as a consideration (Lovdata, 2020). On January 1st, 2022, after the completion of the interviews for this study, new legislation came into effect that demands the utilization of interpretation services for those who need them and provides further guidance to ensure interpretation quality (Lovdata, 2022), so the effects of these updated policies warrant further investigation.

Midwifery as a profession centers the ability to build trust with patients through the provision of supportive and individualized care, centering the concepts of patient respect and autonomy (Giarratano, 2003, p.1). Essential to this framework is the ability to have verbal and non-verbal exchanges between the patient and her midwife, where she can express her expectations and needs, and the midwife can guide and support. Patients who had challenges meeting their providers in a common language reported lower satisfaction with care (Brach, Fraser, Paez, 2005, p.1), are less likely to try to access care (*Ibid.*), and have increased risk for adverse medical events (Cohen, et al. 2005, p.579). As this section will describe, the interviewed midwives working in the Norwegian maternity service have reported a general underutilization of interpretation services in comparison to the needs of their patients.

In the Norwegian health service, every patient who does not speak proficient Norwegian has the right to qualified interpretation for their medical appointments and procedures. In order to become a qualified interpreter in Norway, one must undergo a series of state qualifying and authorizing examinations, or undergo a Bachelor's course in order to ensure high quality of interpretation (Integrerings og mangfoldsdirektoratet, 2022). Interpreters must additionally pass several additional courses for interpreting in the public sector, which include important concepts like confidentiality and sensitivity (Integrerings og mangfoldsdirektoratet, 2022). Qualified interpreters can be accessed

through private and public interpretation services, and based on the responses from the study participants, which service is used varies by institution.

Challenges in accessing qualified interpretation services were shared across midwives working in both the health stations and maternity wards, however through the interviews it became apparent that the utilization of qualified interpretation was much poorer in the labor and delivery setting. The first barrier to the use of interpretation services that especially impacted midwives in the maternity ward was the limited availability of in-person interpretation. It is commonly understood that childbirth, aside from scheduled cesarean section and induction, is an event that occurs spontaneously, and thus cannot be planned in advance. As a result, advance booking of a translator is often impossible or delayed by many hours. According to the participants, interpretation services, both on the telephone and in-person, are only available during typical working hours (Monday through Friday, 8am to 5pm), meaning that these services are often only available if the birth also occurs within these working hours. Due to the barriers in accessing a qualified interpreter in the maternity wards, many midwives reported that they rarely call for interpretation in their practice. Instead, several of the maternity ward midwives have shared that they rely heavily on family members or friends for interpretation during labor and delivery. Emilie, a maternity ward midwife, discussed with frustration how finding a translator within these work-hours constraints is very difficult:

> *We would like to. We would like to. But the translation, the people who work in the translation, they have work hours. And they go to bed {laughs}…Often when [the women] come, they have had some consultations at the health stations, and they wrote down the translator's number on the birth papers. But often when we call, they can't between then and then, call me tomorrow at eight, but the birth is now! It is difficult, especially at the delivery ward. (Emilie, Maternity Ward Midwife)*

As such, physical interpretation has been shown to be most highly utilized by midwives with the ability to plan in advance of appointments. From the discussions during this study, those who work in the postpartum ward, antenatal care appointments, ultrasound, and home-visits have higher physical interpretation usage and satisfaction with interpretation than those in the maternity ward, as a result of concurrent work schedules.

Many of the midwives reported taking special consideration in finding the "right interpreter" to improve patient comfort during visits and promote trust between patient and interpreter. They achieved this through seeking interpreters that fit certain demographics like gender, ethnicity, and past experience translating in the medical field. Seeking specialized interpreters was a method in which the interviewed providers used to both promote trust and receptiveness of services in their

patients, and to empower their patients over their own health. One of the more common accommodations the midwives reported was seeking female interpreters, especially for patients with social or religious preferences that would prohibit the use of a male interpreter. Some of the midwives shared that they always request female interpreters when interpretation is necessary, regardless of the religious or social preference of the patient, given the potential for discussion of intimate topics related to women's sexuality and health. Others specifically sought female interpreters for appointments where they planned to discuss sensitive subjects or perform examinations or procedures. This practice, however, was reported to narrow the number of available interpreters at any given time, which can result in lower utilization of interpretation during appointments and birth.

Several midwives have also reported instances where the interpreter spoke a different dialect of the requested language, resulting in inadequate or loss of interpretation during the appointment or birth. Similarly, some midwives have noted that the use of physical translators has on some occasions introduced conflict from social tensions carrying over from issues within their home country. Emilie, a maternity ward midwife, commented:

> *The translation part is difficult. It is difficult because we don't know enough about their culture, their language, their subcultures, and all of the culture conflicts they have in their own country… It needs to be the right person to translate… I have had experiences that, where I had the translator in the room, and they just kicked them out. (Emilie, Maternity Ward Midwife)*

Some of the midwives also reported poor experiences with hired qualified translators, where they felt that the interpretation was inaccurate, or the interpreter was unprofessional. The midwives shared that they have utilized internal workplace avenues for reporting poor interpretation quality and professional misconduct. The midwives who shared this experience reported feeling a loss of control over the information being shared, as well as negative impacts on their connection with their patients, as expressed by Oline:

> *There are different qualities of interpreters too, so you do not know exactly what the interpreter conveys. So those are the kinds of misunderstandings. The interpreter can talk a lot about what is being said. So, what are you saying, really? It would have been interesting to know. It is not always possible to know exactly what was passed on either. You lose a little control, it is not all good then either. (Oline, Health Station Midwife)*

Additionally, one maternity ward midwife expressed that a barrier for her use of physical interpretation in childbirth is the perception that the translator may not have training or experience in medical interpretation, which may make the translator and women uncomfortable during labor and

delivery. This was an experience shared by some of the other midwives, where they expressed wishes for translators with specific training in maternity care. Linnea, a maternity ward midwife, shared:

> *We do not have any good procedures for [using a translator] at birth…we do not have anything… maybe I missed it… that a plan could have been made with an interpreter who might be used to being involved in childbirth… so then there may have to be someone who has received some more education around this. (Linnea, Maternity Ward Midwife)*

Midwives working across both contexts have shared that they commonly utilize partners and family members for interpretation, rather than using a professional interpretation service. Often, this is at the preference of the women, who may feel more comfortable to have only those she trusts in her appointments. The use of family members as interpreters is discouraged in both institutional policies and by the Norwegian Health Directorate for several reasons (Stortinget, 2020). It has been discouraged to use family members for interpretation because they may not have the clinical knowledge or vocabulary necessary to provide precise translation, which decreases the quality of the interpretation (Ho, 2008, p.225) and could potentially lead to medical errors (Basu, Costa, & Jain, 2017, p.248). Additionally, the use of family members may raise ethical concerns regarding patient autonomy if the family member were to deliberately mistranslate information, and their use could potentially violate the patient's right to privacy and confidentiality (Ho, 2008, p.225). Deliberate mistranslation can additionally mislead providers about potentially important conditions or symptoms (Ho, 2008, p.225). One of the midwives, Emilie, has felt particularly frustrated regarding her personal challenges in accessing qualified interpretation services in birth, and reported that as a result, she has often used family members or partners to translate for lack of another option. To address these concerns regarding quality of interpretation from family members, she closely monitors the family members and intervenes when she suspects mistranslation:

> *And if you do the information through the partners, I am not sure exactly what they say. I can be straight. I can tell the partners, "Tell. Her. Word. By. Word." If I feel… because sometimes you feel they don't say what you communicate, you know? They kind of change it, mix it. Different. So, that's hard. But in my experience, if you have time, have patience, you can do it in a good way. (Emilie, Maternity Ward Midwife).*

Conversely, some midwives, especially those who work in the antenatal care context, have indicated that the use of family interpretation can provide an adequate stop-gap in situations where they did not know a translator was needed, emergencies, or if the interpreter appointment falls through. Some of the midwives shared that if this occurs, they will make efforts in subsequent appointments to book

interpretation for this patient. One midwife, Irene, who currently provides primarily ultrasounds, stated that professional interpreters are not often booked for her appointments, so she often has to use family or partners:

> *When I am working in the maternity clinic for ultrasound, especially when I have an immigrant woman, I think that there is a lot I have to tell them. So I hope that they have with them an interpreter if they do not speak Norwegian well. The partner is often used as an interpreter, and it is certainly better than nothing. (Irene, Maternity Ward Midwife)*

The midwives also discussed challenges with deciding when it is most appropriate to call for interpretation, especially those who work in the wards. Childbirth is often framed as an acute medical event, but for most patients it spans several hours, and for some, a couple of days. Throughout the phases of birth, from cervical dilation and effacement, to delivery of the baby, to delivery of the placenta, there are stages that are active, requiring a lot of communication between the mother and the health personnel, and times where the mother rests without health providers present. How the laboring woman proceeds through these stages is unpredictable, making it almost impossible to book a translator in advance. Some shared that they will make an effort to use telephone interpretation at one point during each stage, while others have stated that they only considered using interpretation during emergent situations. Several of the midwives reported never or rarely attempting to utilize a translator during any of the births they have attended, a point emphasized by Signe:

> *I think it is also the nature of labor, because when are you going to book the translator? Are you going to have the translator for the whole labor, or are you going to have them for just one hour in the beginning to talk things through and explain what she can do and cannot do? It is very difficult, so I cannot recall having a translator in a laboring situation, actually. (Signe, Health Station Midwife, recalling past work in Labor Ward)*

In situations where the woman or her partner have some Norwegian proficiency, the interviewed midwives shared that the suggestion of the use of an interpreter was an uncomfortable experience. Learning a new language can take months to years, and is highly dependent on individual and social factors. For those who may be more established in the country with higher Norwegian proficiency, the suggestion of the use of a translator can feel unnecessary, or even embarrassing, for the patient. The midwives have also shared experiences where the suggestion of a translator has hurt the pride of the patient or her family. Oline, a health station midwife, related her experiences with this challenge:

> *I try to explain to the husband, that you should not be responsible for conveying information to your wife, because it gets in the way. It is not that you are bad at Norwegian, but I need*

to know that she gets all of the information that I give. I have a couple where he was very offended when I said that we had to have an interpreter next time: 'did you not think I speak Norwegian somehow, I speak good Norwegian.' It has nothing to do with it, you just don't need to have that responsibility. But he was very angry. It was not okay for me to ask for an interpreter. (Oline, Health Station Midwife)

Despite the reported widespread use of family members for interpretation during appointments and childbirth, many of the midwives discussed how they separate the patient from the family member and book qualified interpretation ahead of assessments for topics, like domestic violence, rape, mental health, and abortion, that may be socially, culturally, or religiously charged. They prefer to do this in order to protect their patients' privacy and allow the opportunity for their patients to speak freely without external influence from their partner or family. As Oline explained, "*We try to get [the women] in once without the man so that we can talk about 'violence,' map their mental health – what they have been exposed to, experiences they have had along the way, various traumas they have."*

Some of the midwives also reported that they use providers or non-medical staff for interpretation when no other option was available. One midwife, Kjersti, shared that she has asked non-medical staff in the hospital to interpret for her patients in acute situations, even though it is against policy, when she was unable to access a translator:

Sometimes, we have used the person who washes the floor there. It's so embarrassing. Like, 'Can you just come in here?' That's not allowed either, because you have to take these courses… We can't wait, this is an emergency… Because maybe the woman who works in the kitchen or washes the floor, they are women, they have children. I can see they are caring people, so I just use them sometimes and I don't tell anyone. (Kjersti, Maternity Ward Midwife).

While the use of other medical staff who come from other countries or have proficiency in other languages can be highly beneficial, since they are available, have existing medical knowledge, and have a duty to confidentiality. However, to some, this can be seen as an inappropriate use of medical resources. One maternity ward midwife, Emilie, discussed that some providers that she works with often prefer to not translate for their patients, because they are not compensated for the money they save the health service from not contracting a qualified translator:

We do that in the hospital, we have a lot of different midwives from a lot of different countries, and we use them as translators. Poland, Iran, Somalia, Russia… So we use the staff… It's not a good thing either all the time. Well, the staff don't get paid for it… when negotiating a pay raise. They don't get compensated for it when it is a big resource for us. (Emilie, Maternity Ward Midwife).

From the responses, it was indicated that the maternity wards have lower utilization of qualified interpretation services. Aside from the challenges in accessing interpretation within the unpredictable nature of childbirth, several of the midwives interviewed felt that the underutilization of interpretation services is as much an issue of the professional culture within the maternity ward providers as it is an issue of accessibility. Several cited it to be uncomfortable to have interpretation present during birth, either by phone or physically, and that the use of the interpreter made it harder to connect with their patients. Many described having an additional interpreter in the room as unnatural, strange, or invasive. Others shared perceptions that interpretation was not needed or necessary during childbirth, and that they instead relied on the clinical presentation and non-verbal cues to determine patient condition and comfort. Several of the maternity ward midwives shared beliefs that interpretation services would never be easily integrated into labor and delivery care, such as Linnea:

> *Having an interpreter present at birth is not common for us either. I do not think that it will ever be used either – not for birth. In the postpartum ward it is common. It is common to order an interpreter who comes then. But it is not always done there either. It depends on busyness, capacity. But it is something they are also entitled to, so it is a bit difficult… You are often left with the fact that you have not done a good enough job really. (Linnea, Maternity Ward Midwife).*

In addition to the several challenges in the utilization of interpretation services, several of the midwives shared that managers and leadership in their wards and health stations have attempted to limit the use of qualified interpretation as a result of the financial expenditure associated with interpreter use. Every midwife who shared this experience additionally reported discomfort, fear, or frustration with these requests, because they felt it negatively impacted the quality of care they could provide and infringed on patient rights. As Kari, a health station midwife, noted:

> *…we have received feedback from the manager that we spend too many resources on interpreters. If they ask us to use less interpreters, it would be quite scary, because we use an interpreter when there is a need for it and it is incredibly important to work with them. I cannot start consultations without an interpreter where an interpreter is needed. (Kari, Health Station Midwife)*

The experience of management attempting to limit the use of qualified interpretation was shared by providers across the different sides of the maternity service, suggesting that policy reform is indicated to address cost and expand general accessibility to interpretation services.

These discussions regarding challenges in the use of interpretation have been where the interviewed midwives have shared the most expressions of frustration, pain, and embarrassment.

Midwifery as a profession and a care framework depends on the ability to connect and empathize with the women they serve, and the foundation of these connections comes through careful interviewing, psychosocial support, and open communication (Giarratano, 2003, p.1), all of which are highly dependent on the capacity for verbal communication. This frustration was well described by Oline, a health station midwife: "*It hurts so much to stand there on the side as a midwife, and not be able to get informed. It is a cruel situation as a midwife, it's so frustrating."*

The implications of limited access to information or the inability to communicate with their midwives means that migrant women without English or Norwegian proficiency have additional challenges in communicating how they feel, not only regarding feelings of anxiety or fear, but also potentially more serious symptoms like pain, dizziness, nausea, or lightheadedness. Additionally, reduced access to interpretation increases the likelihood of poor understanding of important pregnancy information and removes the woman's agency over her own medical decisions. To address these challenges in accessing appropriate and qualified interpretation, it is clear that a multilevel approach is needed. First, the new 2022 policy that mandates the use of qualified interpretation for any patient who needs it must be adopted to the best of health providers' abilities. Second, the health and interpretation service authorities must re-examine their interpretation policies to address the cost, availability, and working hours of interpreters. Incentivization programs may be necessary to encourage higher enrollment in interpretation training programs. Finally, efforts need to be made by the Norwegian health authorities to offer health information and information on the rights to interpretation on official platforms like Helsenorge in languages representative of the resident migrant populations of Norway.

> *It is my opinion that if you are a Norwegian woman you will get full information every minute of every hour of your whole birth, but if you're a migrant woman you will get small bits and pieces. (Ingrid, Maternity Ward Midwife)*

6.2 MEETING WOMEN WHERE THEY ARE: PATIENT EDUCATION AND UNDERSTANDING OF HEALTH INFORMATION

One of the most important roles that midwives adopt in their profession is that of patient education. In their position, both in the antenatal and labor and delivery care contexts, they are conduits of critically important health information that determines the management and progression of their pregnancies. For many women with a migration background, midwives are the main point of contact that aides in orienting the women to the culture, structure, and approach of the Norwegian maternity system. As such, beyond the ability to communicate information across linguistic barriers, midwives

have the additional challenge of translating key health and social concepts to a diverse group of individuals with varying levels of education, health literacy, and experience with pregnancy. Insufficient understanding of health information can lead to poorer management of own health, lower engagement with the health system, higher hospitalization and mortality rates, and increased health care costs (Jayasinghe, et al. 2016, p.2). In Norway, recently-arrived women have been found to have poorer understanding of important pregnancy information (Bains, et al. 2021, p.7), suggesting that there is a need for strengthening of interpretation and patient education programs across the Norwegian maternity services.

All of the midwives interviewed for this study shared that patient education was an important part of their daily routine. Many of the midwives, particularly those who work in the health stations, have noted that it can be challenging to meet patients at their individual existing knowledge around pregnancy, and as a result feel responsible for educating them in important reproductive health topics. The midwives who discussed this noted a wide diversity of existing health knowledge, with many migrant women coming from backgrounds where reproductive health and pregnancy were openly discussed in families and communities, and many who did not. Kjersti, a maternity ward midwife, shared:

> *They don't know much about birthing, how the process is, through the pregnancy, what happens. You know, the knowledge about how to actually become pregnant, what's happening in their [bodies]… The knowledge about the whole process, I think. And then they are giving birth, and they don't know what's happening. (Kjersti, Maternity Ward Midwife)*

Several of the midwives who work in the maternity wards shared that they have encountered many instances where patients would arrive in labor with poor understanding about their own pregnancies and health. Two of them discussed how they felt that these patients, most of whom were coming from a migration background, did not receive early enough attendance to their pregnancies, and thus less opportunity for an exchange of information. As one of the midwives noted:

> *I think a lot could have been done if they got better follow-up during the pregnancy. They should have been informed from very early in the pregnancy that they should go to the midwife…Because then I think they are better prepared and are more informed about reasons to get in touch along the way, should problems arise. And that they are better prepared for how things work in Norwegian hospitals and maternity wards and what is normal and not normal. (Nora, Maternity Ward Midwife)*

Several of the health station midwives shared challenges with maintaining sufficient patient attendance to antenatal care appointments, and cited a variety of reasons why women with a migration

background can have additional barriers in accessing the maternity care system. Some of these barriers included access to transportation, finding time to come with their partner or family member, being able to take time off of work, coming from health systems with a lower number of required antenatal care visits, and existing knowledge from past pregnancies. More concerningly, one midwife, Nora, discussed how she has observed that some health stations do not have enough resources to meet the capacity of pregnant mothers seeking care, so during especially busy times of the year, some women do not have their first appointment with the midwife until their second trimester:

> *The problem is the health stations are so full, that people are not called in for the first check-up until week 24, 28, 32, sometimes. And then you are way too far into the pregnancy and have missed many of the weeks where there is a high risk something can go wrong. (Nora, Maternity Ward Midwife)*

This was noted by a couple of the other health station midwives, who also described having to ask some women to wait to start their antenatal care appointments later, but they also shared that they made special efforts to prioritize first-time mothers and migrant women. With that being said, it is concerning that there are reported periods where women do not get called for their first appointment until the end of their first trimester or early in their second. Delaying care and access to information could potentially result in delayed intervention on potentially concerning symptoms and behaviors. While Norwegian women or well-established migrant women can alternatively access care through their general practitioner, women with low understanding of the Norwegian health system, as well as undocumented women or those without permanent residence status may not have access to this option.

Within the health stations, though, there are several midwives who were interviewed for this study who, even amongst time and resource constraints, thought deeply about the special needs of women who come from a migration background. Through their interviews, they displayed that they think critically about their position as providers and educators, and the power that they have in this position to influence the lives and health of the patients they serve. Many of them expressed desire for additional training and resources to be able to further facilitate patient education for those coming from a culturally different background.

The midwives interviewed for this study shared the common topics of discussion during antenatal care visits, including the changes her body will go through; information regarding her diet, exercise and intimacy; ways to support her psychosocial wellbeing; and dangerous symptoms to look out for. When it comes close to time for birth, the midwives also provide information that prepares them for birth and the postpartum period – the signs of labor, breastfeeding, body changes during the

postpartum period, and transitioning to motherhood. For some migrant women with limited knowledge about sexual and reproductive health topics, their interactions with the Norwegian maternity system may be among their first experiences learning this information. These patient education topics are integrated into the midwives' clinical responsibilities, and the amount of time spent on these topics is highly individualized based on each patient's existing knowledge and the midwife's approach. Some of the midwives encountered additional challenges in discussing topics that may differ cross-culturally, like diet and activity level. Many of the health station midwives who were interviewed discussed how they will extend the length of their visits, or add additional visits for women who have poor understanding of health information, to ensure that they have enough time to cover all important topics and address any questions they may have. They additionally reported adding extra time to appointments if interpretation services are needed, as explained by Kari, a health station midwife:

> *...If a newcomer arrives, and you set aside an hour for the first time, there can be very little time. If you are going to apply for a place to give birth, take blood samples, have an interpreter, inform about the Norwegian system, take information and fill in a health card, it will be a lot. So what we do then is that we use that hour and we set up an hour faster than one would have done otherwise. (Kari, Health Station Midwife)*

In addition to adding extra time for appointments and making efforts to meet patients where their educational needs are, three of the midwives also discussed using educational aides. One of the midwives during our interview showed me a series of medical models she uses to supplement the conversations she has in her appointments. She had a pelvis model that showed female external and internal reproductive anatomy, a demonstration model for IUD insertion, and a model that showed fetal growth through pregnancy, among others. She added that the use of these models was met with positive responses from the women she works with. She also discussed how she would search through the internet to find supplementary videos in other languages about pregnancy and birth that she could show her patients. Two other midwives also discussed incorporating videos from YouTube into their pregnancy, birth, and lactation conversations. However, one midwife, Signe expressed challenges finding videos that were consistent with Norwegian standards, and raised concern regarding the content she was sharing:

> *There are not so many…. I mean, there are resources on YouTube, or whatever, but you don't get to check some of the times. For example, sometimes I want to find a film about the start of the birth in Urdu – I wouldn't be able to check the content and if it is relatable to*

Norwegian standards. I found some Danish, but it would be nice to have a bit more of that. (Signe, Health Station Midwife)

Several of the midwives expressed that they wished they had educational materials produced within the Norwegian standards, translated into several languages, that could help supplement these conversations with migrant women. One midwife referenced videos from *Ammehjelpen,* a Norwegian free online information resource for breastfeeding, which she reported that she regularly incorporates into her post-partum discussions. Another midwife, Signe, also discussed how her health station provides an information sheet that is given to the patient during their first appointment, but appeared ambivalent about its efficacy as an educational tool, which is why she searches for other supplements elsewhere.

We also have like a standard form that is in quite a few languages that is made by the health authorities, but it is written only. So, it's like a leaflet that you get after the first consultation, so I always bring that out. But it says a lot about the Norwegian system and how things are working when you are pregnant, where you can go, and also a little bit about birth and labor. (Signe, Health Station Midwife)

From these discussions within the interviews, it became clear that the approach to patient education was not standard, and that the midwives had to be resourceful in collecting and vetting materials that they would share with their patients. While the midwives who discussed patient education within this study exhibited creativity and compassion in their individual approach to this topic, it also became clear that they needed more community and institutional support in providing multilingual supplemental materials in accordance with the Norwegian standards.

Despite the care that many of the interviewed midwives shared that they take to make sure their patients are informed about their pregnancies, some of them identified additional challenges that impacted their patients' ability to understand the information. One health station midwife, Kari, shared that she had a difficult time communicating nuanced information cross-linguistically, even when an interpreter is used or if they are both speaking English:

I do not often think that the interpreter is really the barrier either, but it may be more that she has already made an assessment, that she has perceived something as dangerous or not dangerous. Since I have worked elsewhere and tried to learn other languages, I think that the nuances in what you manage to communicate can be very limiting. Even in relation to English, a lot is lost, even though it may be a common language. (Kari, Health Station Midwife)

As mentioned in the previous section of this chapter, the use of verbal communication is a key aspect of health care provision, and there are several reported challenges associated with the use of interpretation services. But there are additional challenges in communicating cross-linguistically, given that so much of the use of language is culturally bound. Common challenges in cross-linguistic and cross-cultural communication for health providers include encountering differences in communication styles, difference in illness and health perspectives, and differing expectations for the clinical encounter (Hudelson, 2005, p.313-314). For most providers, it is difficult to know how information they are providing will be received, a challenge that becomes even more salient across cultural boundaries. One midwife reflected on how she struggles with ensuring that her patients are receiving the information that she needs to provide when her patients have differing priorities or expectations for the antenatal care appointments:

> *You see that she comes with these worries all the time, but obviously there's something more to these worries. What is it? And you can't sort of get past it. Or, at the same time you are sitting with them thinking, "You should prepare them for birth, for breastfeeding, for the postnatal period, how is she going to cope with the child, is she connecting to the child, is she feeling the child, does she know what to do if she doesn't feel the child?" I mean, there are so many things that you should also give her information about, and then her worries are sort of blocking her capacity to get the information, I think. (Signe, Health Station Midwife)*

Another midwife, Heidi, also shared this tension between meeting the expectations of their patients with the midwives' desire to share important pregnancy information. From her perspective, managing cultural barriers required her to become more flexible and attentive to how priorities, expectations, and expressions of symptoms vary cross-culturally:

> *So, you have to adapt all the way. So, the challenges are the language and the ability to formulate information and be able to be sure that they have received it, but also understand what is important to them and what their ailments are, because they have their way of expressing it. There can often be many physical ailments and you do not always know exactly what is important to them and what is an expression of something else. So, I spend a lot of time on it and try to get to know them so that I can meet them where they are. (Heidi, Health Station Midwife)*

This approach of highly individualizing one's own approach to care was a common theme throughout the interviews with the midwives. While this is a key value of the midwifery profession, the midwives interviewed shared how they adjust their care to accommodate communication barriers, and that they make extra time to try to understand their patients' needs. Past research has indicated that improving

cross-cultural communication in the health system requires the development of interpersonal relationships between the patient and the provider, through open and respectful negotiation, in order to understand the expectations, background, and motivations that each party brings (Betancourt, Green, & Carrillo, 2018, p.31). The midwives interviewed for this study have discussed how they adapt their communication styles to accommodate linguistic and comprehension barriers- by increasing consultation time or frequency, integrating multiple education mediums into discussions, and careful interviewing. Some of the interviewed midwives expressed the desire for strengthening or increasing available resources on the community and institutional levels to supplement their care visits, so that patients with poor understanding of pregnancy information might have additional avenues to obtain this information beyond the midwives. Additionally, further research is needed to further understand the resource scarcity and decision-making process behind delaying the initiation of antenatal care in some health stations, because delayed or inconsistent access to care can additionally impact patient understanding of health information. While this small subset of a large group of professionals in Norway likely represents a group that has a higher investment in health and care of migrant women than the average midwife, it is also my opinion that the patient-centered model of the midwifery profession produces an adaptable ethos of care that is better prepared to address the specific vulnerabilities of women with a migration background. With that being said, of the midwives interviewed in the second portion of the study, only one reported receiving formal training, either through their employment or in their midwifery education, on cultural competency or effective multicultural communication. Most of them, however, expressed the desire for continuing education on these topics.

6.3 MULTICULTURAL DOULA PROGRAM

As discussed in Chapter 5, one of the resources most of the midwives reported to be most helpful in the provision of care across cultural and linguistic barriers were the multicultural doulas. This program was aimed to target the most vulnerable groups who interact with the maternity service – recently-arrived migrant women who have poor Norwegian language proficiency and limited social networks in Norway. Past literature from a similar program in Sweden has found that the use of multicultural doula support has not only improved migrant patients' perceptions of satisfaction and support in the maternity service (Helena, et al. 2021, p.3), but has been an important resource for midwives to help bridge cultural and informational divides (Akhavan & Lundgren, 2012, p.83).

There is currently no published literature detailing Norwegian midwives' perceptions about the multicultural doula program.

The midwives interviewed in this study shared how the multicultural doula program has been an essential resource to mediate interactions where there exists a large linguistic and cultural divides that impact the midwives' ability to connect with their patients' needs. One midwife shared how the multicultural doulas were meant to help bridge communication and expectation gaps, by both explaining to patients the Norwegian approach to pregnancy and birth, and explaining to providers how patients might perceive certain aspects of care. All of the midwives who discussed the multicultural doulas not only found them to be extremely useful mediators in their practice, but also a significant support resource for their patients. One midwife, Ingrid, a maternity ward midwife, shared how the doulas have helped her to deconstruct some of the biases she has that impact her care for women with a migration background, particularly around pain management:

> *I think that culture and religion can crash a bit between Norwegian and migrant women. I believe that Norwegians we have this opinion that migrant women from different cultures have a different way of expressing pain, so they will verbalize pain in very big ways even though they are not in that much pain. So, I think that migrant women are more at risk of not being believed even though they actually are in a lot of pain and the labour is far advanced… Even though I don't want to have that opinion myself I do. I have grown up in Norway and practiced in Norwegian healthcare and I am not immune to influences of opinions…So I think that the "flerkulturell doula" or the multicultural doula, which is a free service, is a really good thing. (Ingrid, Maternity Ward Midwife)*

One challenge associated with the multicultural doula project, as reported by the midwives, was the heavy use of the doulas for interpretation assistance, especially in the birth context. Haugaard, et al. (2020, p.5) discussed how interviewed multicultural doulas working in Norway reported that they were often expected by medical staff to serve as translators, due to the inability or oversight to call for a professional interpreter. Multicultural doulas are not professionally trained in medical interpretation, and are explicitly told that it is not their role in pregnancy and birth. However, from the interviews, several of the midwives have reported that they consider the multicultural doulas as an alternative interpretation source, much like the use of family members or friends. One midwife, Emilie, discussed how she uses the multicultural doulas as interpreters in order to get to know her patients and their needs, rather than for medical interpretation:

> *They don't want the translation part in their job description, I think, but it comes naturally. [The women] know the doulas, if there is a good relationship between the lady and the doula,*

> *they talk. They talk together and they translate it, if they talk to each other like that. And we do that, in our expertise, to get to know people. (Emilie, Maternity Ward Midwife)*

Emilie did make the delineation between the use of the doulas as translation to get to know the patient, rather than for determining a patient's medical history or explaining clinical procedure. She shared that she will hire a professional interpreter for postpartum discussions and for discussion of intimate or sensitive information, like HIV status. Other midwives who worked in the maternity wards indicated that they view the multicultural doulas as a viable alternative to a professional interpreter.

Every midwife who discussed the multicultural doulas stated that they wished for expansion of the program to cover more of their patients with a migration background. One midwife, Kjersti, wished that her hospital had multicultural doulas either hired in permanent positions in the ward, or as consultants, where they could call and ask questions about certain cultural practices or interactions, like circumcision:

> *[I hope] that we educate more doulas, because I think that is so much needed. Just to have someone who knows the system and the culture and how they give birth in that specific area or region or country. That she is present. Maybe the doula can have three or four women that they take care of, maybe if she is hired by the hospital? Because that would be so much help for us… Like two or three doulas every day. Oh my god that would have been so nice!...[Or] maybe like one with more expertise in the circumcision that would be available for us to call a number and ask, "does this look right? Can we cut it open like this? How do we sew this back? What do we do?" (Kjersti, Maternity Ward Midwife)*

From the interviews, the multicultural doula program has been shown to be an exceptionally useful tool for the midwives in providing migrant-friendly care in the Norwegian maternity service. For many of the midwives, the doulas served as a cultural mediator that advocated the needs of the women they worked with. All of the midwives who discussed this program expressed desire for expansion of the program, and more communication about the roles of the doulas in the maternity service, regarding interpretation and birth support. Further studies are indicated to discuss how this program is impacting maternal and neonatal outcomes for migrant women who receive assistance from a doula.

CHAPTER SEVEN: MIDWIVES AS AGENTS OF SOCIAL SUPPORT

7.0 INTRODUCTION

The process of migration and resettlement is associated with many stressors related to cultural adaptation and navigation of new systems. However, migration is not a static process, and each migrant brings with them their own subset of vulnerabilities and methods of resilience, depending on their prior experiences and the available resources in their new country. Aside from challenges with language and communication, as discussed in the previous chapter, past research has shown that migrants who have arrived to Norway often have limited social networks (Bains, et al. 2021, p.8); difficulty navigating Norwegian social welfare services, like unemployment and child benefit financial assistance, kindergarten placement, and parental benefit (Egge, Kvellestad, & Glavin, 2018, p.15; Bains, et al. 2021, p.5; Glavin & Sæteren, 2016, p.6); and challenges understanding the structure of the Norwegian healthcare system (Bains, et al. 2021, p.5). As an important profession within the Norwegian maternity system, midwives operate as a conduit for conveying critically important information regarding pregnancy management, infant care, and psychosocial wellbeing, as well as important structural and cultural aspects of life in Norway (Bains et al. 2021, p.5).

The midwives interviewed in this study identified several common challenges that they observed pregnant migrant women experience while adjusting to life in Norway. Many of these challenges were specifically related to women who had recently arrived to Norway within the last five years. The three main categories of challenges the midwives highlighted were related to migrant women's social networks, challenges with understanding and navigating the Norwegian healthcare system, and difficulties navigating social welfare services. Orr (2004, p.842) discusses how social support can be defined as "emotional, instrumental, or financial aid from one's social relationships," and how it can also include informational support. Many of the midwives indicated that within their roles as health providers and often as the first or only Norwegian contact for those with limited social network, that they often take on the responsibility of providing this social support, by guiding their patients through life in Norway. In their positions, the midwives interviewed in this study promote their patients' wellbeing by connecting and supporting their patients' needs on individual, interpersonal, community, and organizational levels. As discussed in Chapter 6, Norwegian midwives approach their assessments of their patients' vulnerabilities and resiliencies as a "mapping process," to understand at which locations in their lives their patients need additional support. This chapter will evaluate how the midwives

identify the individual needs of their patients, and how through their own care or through referral to external resources, they work to provide social support to women with a migration background. This chapter ends with a discussion of additional challenges that one midwife, Line, who works with undocumented migrants in Oslo, has identified in caring for this specific group. While this population faces similar challenges as other migrant groups, she identified several additional care challenges specific to undocumented migrants, due to their social precarity and mistrust in the health system.

7.1 SOCIAL NETWORK

An important challenge that many midwives discussed was caring for patients with limited social networks. Recently-arrived women are more at risk for losing existing networks when they migrate, and having limited social networks in their new country (Bains, et al. 2021, p.11). As a result, this group can experience struggles in adapting to the new social and cultural environments, which can increase psychological distress (Bains, et al. 2021, p.11). This effect may decrease with time to build more robust networks, but pregnant women with limited social networks are at a higher risk for several adverse obstetric outcomes, including postpartum depression (Dennis, Merry, & Gagnon, 2017, p.419), preterm birth (Sørbye, et al. 2019, p.5), and low weight for gestational age (Orr, 2004, p.847). Conversely, having increased social support, from family, friends, or community members, is associated with positive pregnancy outcomes (Orr, 2004, p. 847). Having established social networks facilitates health system navigation, provides an alternative source for interpretation of health concepts, and supports psychological health. Many women who seek care in the Norwegian maternity service have described developing very close relationships with their midwives throughout their pregnancies, describing the quality of their relationship to be akin to that of a sister or a friend (Egge, Kvellestad, & Glavin, 2018, p.12). In addition to their clinical responsibilities of safely monitoring the progression of their patients' pregnancies, midwives play a substantial supportive role in the psychosocial wellbeing of their patients and operate as a social locus for those with limited networks.

Many of the midwives interviewed for this study reflected on the impact that the social network of their patients with a migration background has on their wellbeing during their pregnancies. One midwife, Signe, discussed how for some women with a migration background, pregnancy can be a stressor that causes women to isolate themselves from others, for concern for their health and as a result of limited social network:

Some women don't want to be active at all, they are very scared. They think that sex can be dangerous or to walk outside the house when it is icy on the ground, that she might fall. So, they limit themselves a lot. I have had women who don't go out without their husband, for example, and then when the husband is working a lot, then she becomes very limited, and she becomes lonely. Sometimes you want to go home to their houses and just take them out for a walk, because it is not good for them. They are new in the country, they don't have a network or anyone, and they just sit at home. (Signe, Health Station Midwife)

Signe went on to discuss how it was a common phenomenon for women from several countries to limit their physical activity during both pregnancy and after birth, especially in the winter when there is ice on the streets and sidewalks. Decreased physical activity during pregnancy was a phenomenon also mentioned by four other midwives, where it was framed within the context of times where they encountered other birthing frameworks that emphasize lower physical activity during pregnancy. This is in contrast to the Norwegian approach to pregnancy and post-partum care, that encourages relatively higher physical activity. Signe further discussed how she wished to implement a community program, where she would make walking groups with pregnant migrant women and health station staff, in order to help the women expand their social networks and to give them a safe space to be active.

One theme that emerged was how some migrant women with limited social networks in Norway will seek out the guidance and support of other women, particularly other women from their home country, during their pregnancies. One maternity ward midwife, Kjersti, shared the story of a recently-arrived woman with low social network giving birth in Oslo:

This other night, there was this woman from Pakistan. She was all alone here; she arrived a year ago in 2020. She had just given birth to her third child, and she had given birth to two in Pakistan and her third here by cesarean. She could not do the language at all… she had asked her the woman who [owned] her apartment, who was from the same country. But they were not friends. It was just somebody who spoke the language, just that was the thing in common…

It also tells me that women from the same country and the same culture, they are there for each other. And of course, she would come… [She] cared for her in a way that was so, so nice to see. They just know what they need, culturally. (Kjersti, Maternity Ward Midwife).

This example of a woman with a limited social network beyond her partner, building her circle of support from other women to aid her through her pregnancy, is a consistent finding with relevant literature, which has shown that the development of close friendships with women that they trust can be an important source of emotional support and information-sharing (Dunn, Pirie, & Hellerstedt, 2003, p.359). The midwives also discussed how extended family members within Norway can play a

similar role in providing emotional support and information sharing for women with a migration background. One midwife reflected strong interpersonal networks of extended family, especially for migrant women who came to Norway via family reunification, can be a really important source about pregnancy information and the Norwegian health system. She reported that strong family ties are a factor that she specifically seeks to map while evaluating her patients' needs during pregnancy:

> *That is also part of what we map, the network around. Always ask about it. "Do you have a network?" "Do you have someone you can ask?" "Do you have someone who has given birth in Norway before?" "Do you have someone who can explain what happens when you are pregnant?" There are of course some who do not have it, but the main impression is that [some] have a lot [of people] to ask. In-laws, extended family. I just had one in [control], and she had lots of cousins and they lived in a big family. So that's how the transfer of competence happens, I think. (Terese, Health Station Midwife)*

With that being said, some of the midwives also shared that family members can also negatively influence patient-provider relationships and health seeking behavior, with partners and extended families also as potential sources of stress. Additionally, some midwives also noted that the current generation appear to have less familial support than women who arrived in the previous generation. This may in part be a result of stricter Norwegian immigration policy in the last decade, particularly with regards to family immigration (Hagelund, 2020, p.14). As noted by Kjersti:

> *Before that, it was this big family tradition with a bigger family and everyone lived together as a whole. The mothers would help their daughters with their children and the upbringing. But now it's very many people who are very lonely, who don't have much network. (Kjersti, Maternity Ward Midwife)*

A few of the midwives discussed how they have noticed migrant women have more established social networks with increased amount of time in the country, higher Norwegian language proficiency, and more cultural integration. This was mentioned by several of the midwives in the context of the ethnic Somali population in Norway, who as a result of several civil wars in the 1970s, 1980s, and 1990s arrived in Norway as refugees. They are still the largest African migration group residing in Norway (Statistisk Sentralbyrå, 2022), and in 2016 were also the largest non-European migrant group (Statistisk Sentralbyrå, 2016). There have been two to three generations of Somali-Norwegians since the first arrivals, with social integration improving with each generation as children attend Norwegian schools and adults gaining Norwegian employment. This group still encounters several challenges in the Norwegian maternity service, however the midwives who discussed this group in the study

specifically mentioned how they noticed that ethnic Somali women have stronger social networks than other migrant groups.

The midwives discussed how they provide social support to migrants with low social network. One maternity ward midwife shared that she personally calls or asks health stations to follow up on women with a limited social network who had a difficult birth experience. Another health station midwife shared that she routinely gives her personal phone number to recently-arrived women so that she can answer any questions they have at any time. All of the health station midwives interviewed stated that they add additional appointments and extend appointment lengths for women with fewer social resources. Most of the maternity ward midwives stated that they give extra attention and support to women who arrive in labor and alone, even when time or resources may make this difficult. Kjersti reflected on this challenge:

> *I have to take extra care of them. So, it's not like… I feel like a psychiatrist though. I talk a lot and I sit at the bed, and make sure that they can feel safe. Also in younger women, they feel really unsafe, they speak another language, they are in another culture that they are not used to. They are used to having their whole family and now they are alone. (Kjersti, Maternity Ward Midwife)*

Kjersti, also often works in the postpartum ward, and shared how she intentionally places women who birthed alone together in rooms in the ward to help build their social network with new motherhood, and facilitate conversations between them. She shared: "*Sometimes I just go in there and say, "she's also a mother, you both gave birth at the same time, isn't that interesting? Don't you want to know? Don't you want to talk and share some experiences?"*

Kjersti was one of several midwives who either discussed how they attempted to assist with building social networks among their patients, or shared how they wished that more resources to do so were in place. Many of the midwives discussed a desire for the implementation of group antenatal, birth, and lactation courses for women with a migration background. Currently, there are very few education courses of this type available in languages other than Norwegian and English. However, for a few of the health station midwives, birth preparation courses could be an opportunity for women with limited social networks to meet other pregnant women who speak their same language or come from their same background to meet and build relationships, as Signe discussed:

> *If we were able to make group sessions and had time for that and the resources, I think it would be very nice to have, because then you can get a translator and you could get more of a social setting as well. A lot of the problems these women face is that they don't have the*

network… A lot of them are very isolated, and the pregnancy can be a very good time to address that and meet other women. (Signe, Health Station Midwife)

Group courses not only have the benefit of aiding in building social networks for migrant women, but there also exists some evidence that these courses can have positive impact on the understanding of the information that is being taught (Lee & Holroyd, 2009, p.367; Stamler, 1998, p.943). Participation in group preparation courses additionally have been shown to reduce the risk of post-partum distress and improve self-confidence after birth (Matthey, et al. 2004, p.120). As such, further intervention research is needed to determine whether this would be a feasible addition to the Norwegian maternity system to aide in the patient education and psychosocial support of women with a migration background.

7.2 HEALTH SYSTEM NAVIGATION

Past literature has indicated that women with a migration background have difficulty understanding the structure of the Norwegian maternity system and the services they have the right to access (Bains, et al. 2021, p.5). Women, irrespective of legal residency status, have a right to comprehensive maternity care, as well as essential and emergency services. Goth, Berg & Hakman (2010, p.30) found that migrants overutilize emergency services while under-using primary care services, in part due to a lack of knowledge about the primary care system's purpose as a gatekeeper to specialist care. Using the emergency services inappropriately in the perinatal health context can result in unforeseen costs for care irrespective of legal status. Possessing legal documentation subsidizes or eliminates costs associated with maternity care, while undocumented migrants must often cover costs associated with birth and ultrasound. It is difficult to find information regarding the Norwegian maternity system's structure and individual rights to care in languages other than Norwegian or English on the Norwegian national or local health authorities' digital platforms. Unforeseen costs and confusion about where to go can influence health seeking behavior, by delaying or avoiding care, and negatively impact trust in the system. Potential facilitators of understanding the maternity service offer can include existing social networks within Norway, health system information translated into languages that reflect existing migrant populations in Norway, and guidance from providers within the system.

While pregnant, it is important for women to know which providers are supervising their care and what role they take, which providers cover other non-pregnancy related health needs, where to go in case an emergent symptom arises, and who to call to ask questions. However, for those who are interacting with a health system that they did not grow up in, there may be several aspects of the

structure, roles of providers, and management strategies that may feel unfamiliar. Most of the midwives interviewed for this study reported that many women with a migration background have challenges in understanding and navigating the Norwegian maternity service. Several of them shared that they commonly encounter patients who have little to no knowledge of the maternity system nor their rights to healthcare. Oline, a health station midwife, expressed: "*There is something wrong with our system. Many of them do not know the system as well as the others and do not know their rights"*

In response to patients with limited knowledge of the health system, many of the midwives indicated that they take it upon themselves to supplement the insufficient knowledge, either informally, via conversation, or through supplementary materials like pamphlets or websites. A couple of the midwives shared that they adopt the role of a "guide" for women who have limited resources, limited social network, and limited knowledge of the structures and culture of Norway. The information that they share, as well as which parts of the health system address different symptoms and problems, is critically important to providing high quality maternity care to those who have recently arrived in Norway:

> *I mean you also become her guide to the system in a way. And normally she is very new to everything, even just talking about how things happen here can take a lot of time just to explain, who am I? What am I going to do during the whole pregnancy? What does the hospital do? Where can she make contact if she has a problem? I mean, all of those type of things that are more established if it is a Norwegian woman knowing the system, so it is much more time consuming. (Signe, Health Station Midwife)*

From the interviews, it appears that how midwives approach the issue of poor understanding of the Norwegian maternity services is highly dependent on individual interest and approach to care. In our discussions, it was very clear that across the providers, there were substantial differences in individual approach to care, mindset about work, and values, all of which impacts how the midwives address challenges within their workplace and with patients. A few of the midwives identified poor understanding of the maternity service as a challenge, but were so busy in their daily work-lives to be able to address it or provide information. Another midwife, Ingrid, shared that health providers are not provided with enough training to explain how the system works to those who need guidance:

> *Yeah, and the Norwegian healthcare system is quite difficult to understand. It's not intuitive at all. I used a long time understand how it worked… and you know the nurses and midwives we don't get very much education about how the healthcare system is built up and all the little details. (Ingrid, Maternity Ward Midwife)*

However, most of the midwives shared that they regularly use verbal communication to both assess level of knowledge about the Norwegian maternity system and to provide information about where to go if certain symptoms arise. Two midwives, Signe and Oline, shared that they make sure that their patients are informed by using a combination of a standard form, which is translated into several languages that has basic information on the system and how pregnancy in Norway typically progresses, and several conversations where they ensure that their patients have sufficient understanding. As Oline explained:

> *But we usually get them informed well, when we are able to communicate – about how the plan is and what they can expect in relation to follow-up, that you apply for a place of birth, that you go to that and that hospital, and if there is something during pregnancy, they can call directly there. But it is to get them directly to the hospital if, for example, there is less life one day in the stomach. So, I print [the form] a few times during pregnancy for them. (Oline, Health Station Midwife)*

From our discussions in the interviews, it became apparent that for many migrant women, especially those who have recently arrived or have limited social or economic resources, the midwives in the Norwegian maternity system are an important resource for information and guidance. For some women, like those who have not lived in the country long or have had a good health status, becoming pregnant may be their first interaction with the Norwegian healthcare system. However, due to the appointment lengths, communication problems, and individual midwife approach or interest, it is my opinion that there is variation in how much information is shared or understood regarding this topic. There is additionally insufficient information on the Norwegian Health Directorate, Helsenorge, or Oslo Municipality websites in languages other than Norwegian or (occasionally) English for individuals to perform their own research. Some interventions appear to have been implemented to support this challenge, like the use of pamphlets in some of the health stations. Goth, Berg & Hakman (2010, p.30) argues that a way to improve understanding of the Norwegian health system for recently-arrived migrants is to incorporate an immediate dissemination of materials with this information, translated into the person's mother tongue, immediately after the migrants' registered arrival. However, this intervention leaves out those who live in Norway unregistered. With that being said, interventions that promote better understanding of the Norwegian health system to those who have recently arrived in Norway must be implemented beyond the individual provider level, and instead target community, organizational, and policy levels.

7.3 COORDINATION OF SOCIAL SERVICES

In addition to challenges with navigating the Norwegian maternity services, the midwives also indicated that recently-arrived migrant women experience challenges and frustration with understanding many of the social systems in place, like the immigration service (UDI), the Norwegian Labor and Welfare Administration (NAV), or the child welfare service (Bufdir). This is consistent with past research, which has found that migrant women have reported difficulty navigating social welfare services like unemployment assistance, child benefit financial assistance, applying for kindergarten, and parental benefits (Bains, et al. 2021, p.5; Glavin & Sæteren, 2018, p.15). Additionally, past research has indicated that benefits and assistance from NAV are distributed preferentially, based perceptions of deservingness and dependence (Synnes, 2021, p. 169; Volckmar-Eeg & Vassenden, 2022, p.166). This practice is likely to carry into other social welfare programs, further mystifying processes that are already confusing to those unfamiliar with these systems. While migrant populations are extremely diverse and some individuals may need or use these services more than others, all newcomers to Norway experience confusion and frustration at one point or another as they try to become familiar with the social systems and their structures.

Past studies have found that midwives, particularly those who work in the health stations, regularly integrate discussions of social welfare schemes into their appointments (Egge, Kvellestad, & Glavin, 2018, p.15). This also became apparent through the course of my own interviews with the midwives who participated in this study, however several of the midwives indicated that they often feel that they do not have the knowledge or time to provide this information during appointments. One health station midwife, Oline, shared that many of her patients with a migration background have the expectations that midwives will give advice and guide them through these processes:

> I *think it is difficult that they come from a different system than us. To me, it's our natural system, and so should explain to them how things work here… And I want to find out if you need anything extra… The Norwegian system really, the NAV system. If they do not have a social security number, GP… there is so much they bring that they would like to have fixed, and I cannot fix it. That is often the frustration. I have to explain that I have no influence on it. There's an awful lot I cannot do, and then they might think that when they come to me, I can fix quite a lot for them, and then I can't really fix that much for them. I can take care of that pregnancy there and then, and guide them a bit in the system, but I can't help them so much with the practical then. (Oline, Health Station Midwife)*

A couple of the midwives shared that in the past, they used to work with patients on their applications or helping with scheduling appointments and phone calls with the different agencies. However, within the last couple of years, in response to requests from the midwives, a few of the health stations have

retained social workers to assist with inquiries and applications. All of the health station midwives who have this service have shared that they are extremely grateful for this addition. As Kari emphasized:

> *In recent years, we have had an expanded open health center with a social worker, which we can refer to, so it definitely helps. So, every Friday, there are two social workers from NAV and a family substitute who speak several languages. It is more adapted as a social service and has a very low threshold. You can come and get help to fill in everything from applications for a kindergarten place to parental benefits, so it has relieved us of something completely enormous. (Kari, Health Station Midwife)*

The midwives have additionally discussed how they incorporate local organizations, programs, and other services into their care. Several of the midwives in the health stations and maternity wards discussed coordinating care and advice through the Asylum Reception Centers (Asylmottak) for asylum seeking patients awaiting decisions from UDI. Additionally, the midwives shared that they regularly coordinate with several aspects of the District Psychiatry Center, a specialist part of the Norwegian Health Service, whether it be meeting with a psychologist or acute referrals the emergency room or specialist psychiatric teams.

One midwife, Kari, discussed how after birth, she refers parents to the "Home Start" family contact program, a municipality-funded offer for parents who need additional assistance at home, including emotional support, information and advice, home visitation, and relief when they are feeling overwhelmed. There are 12 offices, located in several of the Oslo neighborhoods:

> *The family substitute also helps a lot. If a family is struggling a lot and has many children or the mother is depressed, then we can connect her also she can come to the family maybe once a week and relieve the parents for a few hours for example. (Kari, Health Station Midwife)*

In their position, midwives are viewed as an important resource and guide to understanding the structures and culture of Norway. While the midwives have shared that while they understand and regularly incorporate other institutional bodies to supplement their care, they emphasized that they do not have the training, knowledge, or time to be able to help beyond issues immediately related to pregnancy. For example, one health station midwife discussed how on home visits she cannot offer assistance when she encounters cramped or poor living conditions unless the conditions are impacting the mother and child, at which point she calls child welfare services. Through the course of the interviews, it became apparent that the midwives experience that women with a migration background lean on the midwives to assist them with navigating the Norwegian social services. However, due to

time and resource constraints within their daily professional responsibilities, the midwives have shared that instead of entirely taking these responsibilities upon themselves, they support their patients through referrals to the various support resources and programs available to them through the maternity service.

7.4 CHALLENGES FOR UNDOCUMENTED WOMEN

Many of these structural challenges – limited social networks and support, poor understanding of and access to the health system, and challenges with social welfare programs – become especially exacerbated for irregular or undocumented migrant women in Norway. Within the Norwegian context, existing without legal documentation prohibits individuals from accessing the formal labor market, limits rights to most of the healthcare service, reduces access to social and welfare support systems, and makes them vulnerable to removal or deportation from the country (Bendixsen, 2020, p.481). In the course of this study, I was fortunate to interview with a midwife who works directly with undocumented migrants in one of the Health Centres for Paperless Migrants (Helsesenteret for Papirløse), NGO-funded health centers run in a partnership between the Kirkens Bymisjon and the Norwegian branch of the Red Cross. Through her participation, I was able to illuminate some of the additional challenges that migrants without legal documentation, as well as the midwives who care for them, face while pregnant and interacting with the Norwegian maternity system.

De Genova (2002, p.422) discusses how undocumented migrant persons, blend into the social fabrics of migrant communities, but experience fluctuating experiences of "illegality" when in situations where they are more likely to interact with the state. The Norwegian maternity system, a state apparatus as a subsect of the Norwegian health system, is an entity experienced differentially by migrants who do not have legal documentation in Norway than those who do. For example, those without a Norwegian national identity number, or have only a temporary number (known as a D-number), generally do not have access to care from a general practitioner, thus must receive antenatal care from health stations. Additionally, those without legal documentation are responsible to pay costs associated with some aspects of their care, including any emergency care they receive, costs associated with birth, and ultrasonography. This population also struggles to trust the Norwegian health system, for fear of discovery and deportation, which impacts health seeking behavior and midwife-patient interactions (Kvamme, & Voldner, 2021, p.288). Challenges with this population exist on individual, community, and organizational levels, and require significant attention and care

from health providers. However, literature detailing the experiences of this population are vastly underreported in Norwegian scholarship.

My discussion with this midwife revealed several of these challenges, however further studies are needed to further illuminate, from the patient's perspective, the barriers and facilitators of maternity system access for undocumented migrant women. Through our discussion, it became apparent that migrants existing without legal documentation become among the most socially, financially, and informationally vulnerable, especially during pregnancy, and thus often require the most time and coordination of resources from the midwives in the Norwegian maternity system. Their challenges in accessing care, even from a system that they have the right to access, illuminates in sharp contrast many of the structural problems that exist within the Norwegian maternity service that impact the health of the migrant population as a whole.

The first major challenge this midwife shared in relation to undocumented migrants, like that of other migrant women, is an issue of accessing and navigating the Norwegian health system. She shared her role as a coordinator between women who approach the Health Centre because they do not have a right to the general practitioner, and health stations who will later supervise her patient's care. She lamented undocumented migrants who live in rural areas, or outside of Oslo and Bergen, who are unable to use the Health Centre locations to access care of any kind. A surprising difficulty that she shared in her position was needing to convince health station staff to take on undocumented migrants who need maternity care. This likely arises out of confusion about who has overall responsibility for women with a migration background – the midwives at the Health Centre or the midwives at the health stations. Ultimately, health station midwives, as members of the public health service have overall supervision responsibility, but some are not aware of this. This used to be a regular problem that has mostly resolved. However, there are still some midwives who try to refuse taking over care for migrant women, in response to which this midwife shared that she has to be especially firm while advocating for her patients with these providers. This sentiment sometimes carries into health station maternity appointments, where this midwife reported that undocumented pregnant women have told her that they feel misunderstood, ignored, or not given enough time with the midwives. She shared: "*It's not been so many years since the health stations said, 'no we don't take the pregnant,' or 'it's not our job,' but yes, it is and why shouldn't it be? Sometimes we still get a phone to say that, 'No, you should take her' or 'She comes to you.'*"

In addition to challenges in accessing maternity care in the Norwegian health system, Line shared how many undocumented women experience financial difficulties in accessing antenatal,

labor, and postpartum care. She mentioned that undocumented patients experience inconsistent billing practices after birth and ultrasound – where some receive bills for certain services while others do not. Additionally, this midwife reported that many women experience high costs associated with accessing family planning resources before or after pregnancy, particularly IUDs, which makes patients vulnerable to unwanted pregnancies. For those who receive bills but cannot pay, she noted that undocumented patients, many of whom are low-income due to unemployment or employment outside the formal labor sector, become less willing to come to future appointments and services for fear of the financial costs. For those who travel far to receive care or assistance at the Health Centre, these costs are compounded by high cost of transportation and lost employment hours:

> *To pay for an ultrasound that is actually free for everybody else, but then for you it's not free. I think that we have a system in Norway that is free of charge when you are pregnant and also when you are seeking abortion care, but not for everybody. In theory yes, but in practice no. (Health Station Midwife)*

This midwife also discussed how many undocumented migrants have limited social networks. Past research has found challenges related to maintaining contact with their patients due to housing insecurity and deportation (Kvamme & Voldner, 2021, p.288). She echoed this sentiment, sharing that for some of her undocumented patients, communication and attendance to their maternity visits can be inconsistent. As a result of inconsistent attendance of appointments, this midwife stated that undocumented women often have poorer understanding of important pregnancy information.

> *Sometimes the girls are difficult to get a hold of. Sometimes, I can have one patient that I had tried to call and then she doesn't answer. So then I think, "maybe she has gone out of the country," ... That's also difficult because you can get girls that come to ask for advice and then they are getting transported out in two weeks. (Health Station Midwife)*

This midwife attributed these challenges in establishing and maintaining contact with pregnant undocumented migrant women to be as a result of a lack of awareness of rights to maternity care, and limited or no access to digital resources. She also shared that she has observed many undocumented women who desire more social contacts and social support. She framed her undocumented patients as "excluded from society" and "being on the outside." De Genova (2002, p.422) describes how the concept of 'illegality' can become an embodied process in the daily lives of those who live without documentation, producing alternative social patterns and concealment. However, in these alternative patterns and concealment, irregular migrant populations have been shown to be incredibly resourceful, using means of information gathering and support in unconventional and industrious

ways (Sigona, 2012, p.51). My study only focused on the challenges the midwives could identify in providing care to women of migrant background, so this midwife did not provide information regarding undocumented migrants' resiliencies during pregnancy. Further research is needed to illuminate the ways in which irregular migrants seek support and information outside of the health system. This midwife expressed wishes to supplement and strengthen the resiliencies of undocumented migrant women through expansions of activities through the NGO partnerships with the Centre. She suggested group programming for undocumented migrant families for psychosocial support, Norwegian language practice, and information about Norwegian life and culture.

While undocumented migrants, due to their experience of "illegality" (De Genova, 2002, p.422), are prohibited from accessing Norwegian social and welfare services, this midwife discussed how in her position she works to help supplement her patients' needs. In her position at the Health Centre, she regularly utilizes local NGOs and individual connections in order to provide additional social support to her patients, like clothing, food, and sanitary products. She shared that many of her patients arrive to appointments with poor understanding of the health and social systems and what they can and cannot access. The most common support resource she coordinates for her patients is psychological care, which she regularly connects patients with during pregnancy if they have a history of violence or symptoms of emotional distress. However, due to the Health Centre's reliance on volunteers, it is challenging for patients to receive care from the same psychologist across appointments. She additionally coordinates with NGOs that focus on child health to support the needs of the families after the child is born. Finally, for those who are awaiting their cases with UDI or need help understanding what assistance they have the right to receive from NAV, the Health Centre additionally has a social worker who is available to advise, which she refers patients to regularly.

As discussed earlier, these challenges undocumented women experience in the maternity service associated with limited social network and poor understanding of and accessibility to the Norwegian health and social welfare services, are further compounded by experiences of social exclusion and "illegality." Further studies are needed to understand the policies and practices the Norwegian health service uses to bill for services for those not included in the Norwegian National Insurance Scheme, as well as the maternal and neonatal health outcomes for undocumented women who receive maternity care in Norway. Future interventions to aid the health and wellbeing of pregnant undocumented migrant women need to use multilevel approaches to support their complicated fabric of vulnerability and promote more equitable experiences in the Norwegian maternity service.

CHAPTER EIGHT: STRAIN UNDER COVID-19

8.0 INTRODUCTION

Given this study's location in time, I felt it was essential to incorporate an additional discussion of the impacts that the ongoing COVID-19 pandemic had on the provision of migrant-centered care. As a health provider myself, I personally experienced how many of the necessary infection control measures introduced new layers of physical and emotional distance between patients and providers. The introduction of personal protective equipment like masks, safety glasses, and gowns made the nuances of verbal and nonverbal communication more difficult to discern. It became more difficult to assess and support patients when we were also told to maintain physical distance from them. Many of my patients shared that they were afraid to call for an ambulance or go to a hospital for fear of infection.

Norway, compared to the rest of the world, was spared much of the devastation that the pandemic wrought, due to many factors, including high accessibility to and acceptance of the COVID-19 vaccines, as well as careful implementation of infection-control measures like stay-at-home orders, border closures, and mask mandates. Of the 1.43 million cases, only 3,141 patients have died (Reuters, 2022) a triumph compared to the statistics of my home country, the United States, who of 81.5 million cases just surpassed 1 million deaths (New York Times, 2022). Recent research has also illuminated how vulnerability to COVID-19 infection, morbidity, and mortality has followed lines of social vulnerability, with migrant populations found to be especially impacted during the pandemic. In Norway, migrants disproportionately experienced higher infection rates, hospital admissions, intensive care treatments, and deaths compared to their population size during the pandemic (Diaz, et al. 2021, p.2). The higher burden of disease within migrant populations in Europe has been theorized to be a result of a compilation of several structural factors, including reduced access to the health system leading to delayed testing (Fabiani, et al. 2021, p.40), belonging to a minority ethnic group (Rostila, et al. 2021, p.1515; Aldridge, et al. 2022, p.4), and lower social economic status and crowded housing (Rostila, et al. 2021, p.1516). Additionally, COVID-19 restrictions produced additional health and social inequities for vulnerable populations, called the "double burden of COVID-19" (Jervelund & Eikemo, 2021, p.2). Unemployment, food insecurity, social isolation, and psychological distress were ways in which migrant persons differentially experienced the pandemic (Diaz, et al., 2021, p.3).

Recent studies have indicated that the COVID-19 pandemic has severely impacted maternity services around the world. Many maternity services have experienced scaling back of perinatal care and the increased use of several obstetric interventions during the pandemic (Rice & Williams, 2021, p.4-6). Additionally, there have been limitations in the use of typical support personnel to help during pregnancy and birth, like social workers, family members, in-person translators. This, combined with social distancing and stay-at-home mandates have produced feelings of isolation and anxiety during pregnancy (Linden, et al. 2021, p.4). Research has also found that pregnant women are more likely to experience COVID-19 vaccine hesitancy due to vague and inconsistent information regarding vaccine safety (Gencer, et al. 2022, p.319), despite the increased risks for adverse complications from COVID-19 infection during pregnancy, as well as increased risk for complications during pregnancy (Hapshy, et al. 2021, p.1479). The literature has also indicated that the COVID-19 pandemic has changed how patients seek care. Masroor (2020, p.2) discusses how patients have avoided the health system or delayed seeking care for fear of infection. To reduce spread, many services have implemented telemedicine in lieu of in-person appointments. The Norwegian maternity service was severely impacted by the social-distancing and stay-at-home orders, with temporary health station closures, movement of many antenatal care visits to telemedicine or phone appointments, and a pause on home visits after birth (Asefa, et al. 2021, p.5).

Up until this point, there is no existing literature that discusses how the pandemic affected women with a migration background seeking care in the Norwegian maternity service, nor how the pandemic affected the professional lives of midwives. However, given the strains on the Norwegian midwifery profession, it appears that the additional challenges introduced by the COVID-19 pandemic impacted the maternity service to a significant degree. Six of the thirteen midwives were asked about how COVID-19 impacted their profession and how their patients with a migration background were affected.

8.1 DECREASED ACCESS TO CARE AND PAUSING OF SEVERAL MATERNITY SERVICE OFFERINGS

All of the midwives reflected on how the introduction of several infection control guidelines affected the care they provided, as well as the way their patients interacted with the Norwegian maternity system. The midwives reported that, especially during the earlier days of the pandemic when much was unknown about COVID-19, patients felt fearful of interacting with the health services. Some of the midwives reported that during the first year of the pandemic, they experienced more patient

absenteeism to appointments. Another midwife shared that she noticed pregnancy surveillance drop due to her patients' fear of becoming infected on public transportation.

While guidance varied health station by health station, the midwives additionally reported changes in services offered during the COVID-19 pandemic due to infection control guidelines. Namely, home visits after birth, birth preparation courses, and breastfeeding preparation courses were all temporarily paused. One midwife, Signe shared how she wasn't permitted to go on home visits unless it was absolutely necessary: "*We also couldn't go to people's house for a very long time, or very limited at least. We did go for some, but it had to be very sort of good reason. Not for everyone, only for those who had, like, really bad experiences or the child was really small…"*

This especially impacted women with a migration background, for whom many of these offerings provided immense benefit in not only providing essential information for pregnancy and new parenthood, but also the opportunity to connect with other women. The home visits were also an important opportunity for midwives to evaluate the woman's psychosocial wellbeing after birth, and to see how the mother is coping with the new child. Pausing the home visits offering meant that this important follow-up was lost. One study out of the UK found that up to 20% of women develop mental health symptoms either during pregnancy or within the first year after birth, and approximately one quarter of maternal deaths between 6 weeks and one year after childbirth are related to mental illness (RCOG, 2017). The uncertainty of the COVID-19 pandemic and the effects of home confinement during stay-at-home measures had negative impacts on mental well-being for individuals around the world (Ammar, et al. 2020, p.8). Migrant women have a higher risk of experiencing mental illness during the perinatal period (Anderson, et al. 2017, p.454-457), due to risk factors like uncertain migration status, loss of cultural traditions, lack of social support, and low socioeconomic status (Schmied, et al. 2017, p.8-13). Additionally, migrant women have been shown to have higher hesitancy in seeking help from the health system (Watson, et al. 2019, p.9). These additional layers of mental health vulnerability that migrant women experience in the perinatal period were likely exacerbated during the COVID-19 pandemic. The implications of this vulnerability, combined with the temporary loss of several maternity service offerings that not only provided essential information and oversight, but also supported patients' psychosocial wellbeing, need to be further investigated.

Additionally, within the first year of the pandemic, many of the midwives reported changes in how maternity appointments were organized and performed. Some of the midwives reported the movement of maternity appointments to digital formats (teleconferencing, phone calls) in their health stations. Line, a health station midwife, expressed concern for patients, particularly undocumented

individuals, who had limited digital skills or consistent access to a telephone to have appointments in this format. Another midwife, Kjersti, reported that in the clinic where she works part time, she had many patients who wished for in-person follow-up. Many of the mothers were extremely anxious, and she shared that she was constantly in the position to turn people away unless they had concerning symptoms needing specialist follow-up. Kjersti further discussed:

> *Yeah, we had to tighten in, actually, because there were so many who wanted to come. So we did consultations by phone, and there were more of those kind of consultations, where we had to calm them down. Ask them, "Okay, is the baby thriving? Is it peeing? Did it poo?" Things that we are worried about, that they would get information from the healthcare station that they didn't understand. Only the situations or the cases where we were uncertain, like "Okay, this is not good" or "We have to do a checkup", [we would] involve a pediatrician or an obstetrician to see the mothers… But we had to tighten that. A lot of phone calls during Covid. (Kjersti, Maternity Ward Midwife)*

Another midwife, Signe, reported how during the pandemic, her in-person appointments were shortened to only fifteen minutes in length. Halting and shortening in-person visitations especially impacted women with a migration background, especially those who have recently arrived in Norway, who needed additional time for interpreter use or for orientation to the Norwegian health services. Past research has shown that migrant women often need more support during pregnancy, including information about pregnancy and the health system's structure, assistance with interpretation, and psychosocial support (Fair, et al. 2020, p.16), so these measures negatively impacted the midwives' ability to address these vulnerabilities. Fortunately, the health stations returned to near-full capacity by summer of 2021, with a return of in-person follow-up in the maternity service. However, the effects of the loss of certain services and decreased follow-up had on maternal and neonatal health outcomes are yet to be seen in Norwegian scholarship.

8.2 SOCIAL ISOLATION AND DECREASED SOCIAL SUPPORT

A common theme that all of the midwives reported during our conversations about the impact the pandemic had on pregnant migrant women was increased social isolation. One study from Greece found that there was a decrease in antenatal wellbeing during lockdown (Stavridou, et al. 2020, p.616). Many in the pandemic, especially during strict stay-at-home orders and the promotion of social distancing, felt increased loneliness and social isolation. However, these effects were likely greater for recently-arrived migrant women who, past literature has shown, are more likely to experience small or limited social networks (Bains, et al. 2021, p.5) in their host country.

One of the midwives, Signe, discussed how she noticed that her patients with a migration background were especially anxious during the pandemic, and that many of them were afraid to come to appointments or leave the house. Because most workplaces closed for many months, and the ability to socialize with those outside the household was restricted, it was nearly impossible for migrant women to strengthen or develop social networks. She additionally shared how a major source of stress for her migrant patients during the pandemic was concern for the health and wellbeing of family back at home.

Additionally, restrictions placed during the pandemic that restricted family members of the patients from attending appointments was reported to be a significant source of distress for patients with a migration background. Most importantly, patients' partners were only permitted to attend one antenatal care visit, and for a period of time were restricted from attending the births. Signe, a health station midwife, shared how during this period, partners felt left out and uninformed. This led to partners feeling unprepared for the child's arrival, and insecure about how best to support the birthing parent, as pointed out by Signe:

> *We didn't allow partners to come for checkups, only one time during the pregnancy. So that was very limited, and they also couldn't come for the ultrasound at the hospital, so a lot of people felt that all of the men or the partners were left out… [And in the postnatal period,] men, they were not prepared and in shock and not having anyone to talk to. (Signe, Health Station Midwife)*

This was also a challenge described by Emilie, a maternity ward midwife, who shared how she was unable to access in-person interpretation services during the pandemic and could not use the patient's partner in situations where interpretation was needed. She shared that she did have several births with the partners present over Skype, but this was really challenging to do for several of her migrant patients and thus they had to give birth alone. She reflected on how not having the partners present for birth created larger information gaps between non-Norwegian speaking patients and health personnel, and how restricting the fathers or family members from birth removed an important resource of support for her migrant patients. Ingrid also reflected these challenges, sharing how in the postpartum wards, her patients had a harder time recovering after birth because the partners or family members could not be present to assist with the neonate's care.

One midwife, Kjersti, argued that in some ways, however, that the restrictions on family members in the postpartum wards was helpful for helping the new mothers connect with their babies without the added stress of external individuals.

> *In a way, it has been more for the women, I think, better? Because they connect more to the baby, they don't think about all the visitors that will come and they don't have to take a shower then make themselves presentable for the world. Because the covid made them stay in their room, get to know their babies, the breastfeeding is going well. (Kjersti, Maternity Ward Midwife)*

She went on to say how the restrictions on family visitation during the pandemic also helped her in her work, because she had more time to devote to patient care, and without the external distractions it was easier understand her patient's needs: "*Everything has been better. And for us, also, a much better environment to work in without all of the visitors, the fathers, and yeah. It has been nice, actually, to have time."*

Finally, one midwife, Emilie, shared how the use of the masking and personal protective equipment made it more difficult to communicate with her patient, because she was unable to read or convey facial expressions or provide physical comfort (a hug, hand on the shoulder, etc.). She shared that she felt like she was unable to comfort her patients during childbirth in the same way that she could before the pandemic.

The midwives in this study shared how their patients with a migration background experienced increased social isolation and anxiety during the pandemic. Due to restrictions placed for infection control, migrant patients were also cut off from important sources of social and emotional support – their family and partners – during their antenatal care appointments and birth. Additionally, due to pausing or limitation of offerings in the maternity service, there were fewer opportunities for midwives to aid in the provision of psychosocial support. Further research is indicated to collect and report first-hand experiences from migrant women residing in Norway who report emotional distress during their pregnancies during the pandemic. Additionally, the long-term effects of emotional distress during this period, within this population have yet to be determined. However, given the specific vulnerability to mental illness during pregnancy that women with a migration background possess, coupled with their decreased access to the Norwegian maternity service during the pandemic, this population needs to be prioritized in future mental health studies in Norway.

8.3 INCREASED WORKLOAD

Another theme that three of the midwives shared was how the COVID-19 pandemic has increased their workload. In addition to their clinical responsibilities, many of the midwives reported an increase in the number of tasks they had to perform related to infection control, with a decreased number of staff. Prior to the pandemic, an increased workload with decreased staff was shown to be a major

cause of burnout amongst midwives (Lukasse & Henriksen, 2019, p.1563). One study in Turkey found that midwives were shown to have almost twice the prevalence of depression of nurses, and the contributing factors were determined to be emotional exhaustion and higher perceived stress (Yörük & Güler, 2020, p.396). It has been reported that the effects of the COVID-19 pandemic have exacerbated existing issues midwives perceive within their positions (Catling, et al. 2022, p.2).

Signe a health station midwife, shared how her workload drastically increased during the pandemic, and how that, coupled with the uncertainty about guidelines due to rapid changes in recommendations, created increased worry and stress within her midwife cohort. Additionally, her health station recommended shortening appointment lengths to fifteen minutes in duration, which she found to be very challenging. With all of these added stressors in her job, she was left with the feeling that the quality of care she could provide was worse:

> *I think the biggest problem in the beginning was that we were expected to do the same job, but do everything else as well… I mean, a lot of the healthcare workers here were also worried, some for themselves, some for family members… but we were expected to do the same job but clean in between. I mean, you expect the quality of the care to be the same, but I don't think that's possible. And also at the same time, you keep the consultations short, so at the beginning we were only meant to spend 15 minutes with a woman… so [there were] a lot of things like that that caused a lot of discussion here. (Signe, Health Station Midwife)*

The perception of increased workload with decreased availability in staff during the first year of the pandemic was also felt by those who work in the maternity wards. Ingrid, who works in a maternity ward, shared how during the pandemic, she had to take on additional responsibilities that were normally covered by other staff, like bioengineer, food delivery, cleaning, and patient transport, due to employee illness, staffing shortages, and restrictions on external into the ward. Emilie, another maternity ward midwife, shared that they faced additional staffing strain due to isolation precautions for COVID positive patients:

> *When you do have the COVID that always [requires] two persons for every one lady. You have to put one in the room, and you can't leave the room, and then you have a server that needs to give her everything she needs, give the messages out. Those two normally have two or three ladies, so we are almost always understaffed. And the budget is… we are understaffed… Our guidelines for one to one? That's not possible. (Emilie, Maternity Ward Midwife)*

Poor staffing levels was a theme that emerged throughout the study, both in the midwives' reflections prior to the pandemic, and further exacerbated by the effects of the pandemic. The consequences of poor staffing levels for migrant women can be dire. If communication problems exist, and

interpretation services are unavailable, midwives have a reduced capacity to take the extra time needed to assess their patients' needs. Reduced clinical oversight can have impacts in quality of care and patient satisfaction, and increases risk for adverse events. Migrant women have already been established as having higher risk for medical intervention (Jatta, et al. 2021, p.6; Sørbye, et al. 2014, p.81), which was likely exacerbated when coupled with the increased use of medical intervention throughout the pandemic (Rice & Williams, 2021, p.4-6). The majority of the maternity ward midwives worked in hospital settings with migrant women representing a large proportion of their patient population, and reported that COVID-19 infection amongst migrant laboring mothers was and continues to be high. Further research is indicated to examine the effect of the Norwegian maternity service's staffing challenges and increased workload during the COVID-19 pandemic on migrant women's obstetrical outcomes.

8.4 VACCINE HESITANCY

The last challenge that the majority of the midwives reported during the COVID-19 pandemic was the guidance around COVID-19 vaccination for their patients. COVID-19 infection during pregnancy increases risk for adverse pregnancy and birth outcomes, as well as increases risk for maternal mortality (Ellington, et al. 2020, p.772). Vaccination against COVID-19 has overwhelming evidence of preventing severe infection across most of the population, including those who are pregnant (Dagan, et al. 2021, p.1694). However, one study surveying vaccine willingness across several European countries found that a high proportion of surveyed pregnant women in Norway, 44.9%, would not take the COVID-19 vaccine during pregnancy (Ceulemans, et al. 2021, p.6). Despite data indicating its safety, persistent hesitancy against COVID-19 vaccination during pregnancy has been established as an issue that is expanding existing disparities in maternal mortality and morbidity along lines of race and ethnicity (Kharbanda & Vazquez-Benitez, 2022, p.1451). Contributors to vaccine hesitancy include low levels of self-reported knowledge about the vaccines, younger age, and essential worker status (Simmons, et al. 2022, p.2759). One study found that while 94% of Norwegian-born individuals surveyed had received at least one vaccine against COVID-19, only 73% of foreign-born individuals and 82% of children born to immigrant parents had received at least one dose (Kraft, et al. 2022, p.3). This study had a significant variation in data however, with individuals from eastern European countries, like Latvia, Bulgaria, Poland, and Lithuania, had only 44-47% coverage of at least one dose, while other groups had high uptake, like Vietnam, Sri Lanka, and India, who had 88-93% coverage (Kraft, et al. 2022, p.3). Studies investigating COVID-19 vaccination

hesitancy amongst migrant populations is currently sparse, however is considered to be a major area of concern in global health communities (Crawshaw, et al. 2021, p.1). One study in Canada found that migrant populations had two times the odds of having COVID-19 vaccine hesitancy compared to Canadian-born peers, due to concerns about vaccine safety, side effects and mistrust in vaccines (Lin, 2022, p.7-10). In another global study, undocumented migrant populations were found to have high accessibility to COVID-19 vaccination (86.4%), but only 41.1% wanted it (Page, et al. 2022, p.5).

The midwives shared frustration regarding the changing vaccination guidelines for pregnant women throughout the pandemic. One of the midwives, Signe discussed how due to vague guidance regarding the vaccine's safety for pregnant patients, there was a high degree of variation across health providers about whether or not it would be recommended. This resulted in patients experiencing different recommendations from different providers, producing confusion and mistrust. She shared that she was grateful when the guidelines became more clearly stated:

> *In the beginning, the guidelines were very vague, and made a lot of people wonder. Women got a lot of different advice from their doctors, and it was very much up to the family doctor to say, "okay, this is good for you, this is not." So, we saw that it was very differently practiced, so when the advice came for everyone to get the vaccine, I think that was very good, because then there was no doubt anymore… (Signe, Health Station Midwife)*

Ingrid, a maternity ward midwife, shared her frustrations about the lack of clarity in the guidelines, sharing that she felt that there was too much responsibility put on patients for determining the risks and benefits of the COVID-19 vaccine, and that providers were not providing enough information or support to help patients make their decision. She also reported feeling frustrated with the health authorities for the lack of guidance:

> *Yeah, and the decision was put on them, that you could "take the vaccine if you want to, I don't yet recommend it but maybe if you want to" and how can you put that responsibility on a woman's shoulder? That she may kill herself and her baby either way? It's an impossible decision to make. So, I wish that they would have taken a more forceful decision that "we don't know enough and then we will not recommend it" until you do know enough and then you recommend it. (Ingrid, Maternity Ward Midwife)*

Signe also shared that regarding the COVID-19 vaccinations, the patients were more influenced to take or not take the vaccine depending on providers' personal perspectives, rather than evidence-based data regarding the vaccines' safety.

> *People are very much focused on the, "what do you actually think." A lot of people were scared when that advice first came, whether you should [take the vaccine]… I think a lot of women are scared to take the vaccine and they want to discuss it, even though the advice is much more clear. (Signe, Health Station Midwife)*

All of the midwives reported that many of their patients have felt hesitant about taking the COVID-19 vaccine, and reported that their migrant patients appear to be more hesitant. One maternity ward midwife, Emilie, who I interviewed eleven months after the vaccines became available in Norway, stated that she had not met a single patient with a migration background who had taken the vaccine. Signe reported that she has had many patients, both migrant and Norwegian, who are not willing to take the COVID-19 vaccination during pregnancy, even after the guidance recommending the vaccine became clear.

Migrant women are especially vulnerable to COVID-19 infection, morbidity, and mortality during pregnancy, yet appear to feel increased hesitancy regarding COVID-19 vaccination. This challenge is further compounded by inconsistent or vague guidance from providers in the maternity service, which has produced further mistrust in the vaccine's safety. Further studies are indicated to elucidate causes for hesitancy amongst this group, and identify possible interventions to improve vaccine uptake.

CONCLUSION

Through the course of this thesis, it was my intention to center the voices of midwives working in the greater Oslo area and the challenges they perceive while providing care to women with a migration background. As I sat in the interviews and when I sifted through pages of transcriptions, I found myself to be enamored with the candor, sincerity, and consideration that the interviewed midwives brought to our conversations. Through hearing and reading their stories, I was able to glimpse into not only the daily realities of their professional lives, but also into their experiences and perspectives – their approaches to care, their feelings about their work, and areas of tension or difficulty. The thirteen midwives who participated in this study revealed many of the challenges that they experience in their daily professional lives while caring for recently-arrived women with a migration background. Through the course of their interviews, the midwives led me through their professional challenges, how they construct and act upon vulnerability, challenges that migrant women experience while interacting with the maternity system, and how they adjust their care to accommodate their needs.

Prior to discussing the needs of recently-arrived migrant women, Chapter Four outlined the labor conditions for midwives working in the Norwegian maternity service. It is important to understand the professional context the midwives work within in order to understand their capacity for providing care to socially vulnerable patients, like women with a migration background. In this chapter, the midwives share how they love their profession and their patients, but are facing increasing workloads with insufficient staffing, increasing fragmentation between the various sections of providers in the maternity service, and devaluation of the midwifery framework of care. These experiences are occurring against the backdrop of an increasing trend of medicalization of birth in Norway, with the centralization of the country's maternity service, closure of midwife-led maternity wards, and an increased emphasis on medical surveillance and intervention during pregnancy as the gold standard of care. As a result, midwives are facing an existential threat to the future of their profession, where their capacities and autonomy as providers are shrinking and more and more midwives are experiencing burnout globally. Women with a migration background, who experience increased vulnerability for poor maternal and neonatal health outcomes in the Norwegian maternity service, and who benefit immensely from the individualized and patient-centered model of midwifery care, have and will continue to suffer the rippling effects of these labor condition challenges.

In Chapter 5, the midwives and I discussed the concept of "vulnerability." It was my aim to discover how the midwives constructed and assessed for vulnerability in their patients, and how they acted upon vulnerability once it was identified. In their discussions, the midwives shared how they perceived vulnerability to be both a static and dynamic process, where it oscillates over an individual's life course, dependent on both structural factors and individual circumstances. The midwives identified several factors that produce vulnerability within their patients, including pregnancy, recent arrival to Norway, language barriers, limited social networks, education, and mental disorders. In their practice, the midwives shared how they will assess for vulnerability through patient interviewing, where they "map" their patients' lives to evaluate for the need of additional support resources and personnel. The midwives also discussed how the concept of vulnerability has been integrated into how they prioritize patients seeking care, within the current reality where many women in Oslo are turned away from receiving care from midwives. Most of the interviewed midwives finished their discussions by sharing how for patients they identified to be vulnerable, they made extra accommodations and coordinated additional resources to ensure that they received the support and information that they needed. For some of the midwives, their efforts to make these accommodations went beyond their professional responsibilities, and for some, against institutional policy and procedure. Through their discussions, it was clear that the interviewed midwives, even against the professional landscape of increased workload and decreased staffing and capacity, regularly incorporate the concept of "vulnerability" into their assessments and approaches to care to address the needs of structurally vulnerable patients.

Chapters 6 and 7 discuss the main challenges that the midwives perceive while providing care to women with a migration background. Chapter 6 discussed challenges in communication, both in interpretation and communication of health information. The most significant challenge, which was highlighted by every single midwife in the study, was access to and use of qualified interpretation. The midwives shared many barriers to accessing qualified interpreters, including narrow windows of in-person interpreter availability, matching the correct dialect, seeking female interpreters, supervisory pressures, and desiring interpreters with experience in maternity care. The midwives also related challenges in integrating interpreters into their care, including when to call, short appointment lengths, patients' pride, developing trust, and three-way communication. As a result of many of these barriers and challenges, there appears to be a significant under-utilization of qualified interpretation across the maternity service, but particularly in the maternity wards. Instead, midwives have reported that they lean on patients' friends and family members, or other medical

staff despite their lack of qualifications for interpretation, due to their accessibility. In addition to challenges in interpretation, the midwives also remarked on challenges in communicating health information across linguistic and cultural differences. Several of the midwives perceived migrant women to often have poor understanding of health information, so as a result the interviewed midwives discussed ways they inform patients about important topics related to pregnancy, birth, postpartum, and infant care. The midwives reported that resources to assist with the education of these topics are sparse and widely unavailable in languages other than English and Norwegian. Additionally, the midwives reported challenges in negotiating the discussions of sensitive topics in consultations with patients with differing communication styles, cultural background, and difference in health perspectives. Most of the midwives reported that the multicultural doula program was an important resource to bridge these challenges, however the doulas are often expected to operate as interpreters. The midwives shared a desire for additional educational materials in accordance with Norwegian standards of care for facilitating these interactions. The midwives expressed a desire for additional education or training in cross-cultural communication to facilitate these interactions, as well as an expansion of the reach of the multicultural doula program.

Chapter 7 uncovered social and institutional challenges that that the midwives perceived that pregnant women experience during recent migration to Norway. They reflected on how many recently-arrived women with a migration background experience loneliness and limited social networks during their pregnancies. The midwives expressed the desire for an increased capacity for group antenatal, birth preparation, and lactation courses with more language options, as well as walking groups, in order to give expecting mothers the opportunity to meet each other and grow their network. Larger social networks can be a facilitator for health and social system navigation, and can be an important resource of information sharing and psychosocial support. In addition to low social networks, the midwives discussed challenges that women with a migration background experience in understanding and navigating the Norwegian health and social support systems. In their roles, the midwives often are in the position as a guide to these systems, answering questions about where to go, coordinating referrals to mental health or family support programs, and even at times assisting with forms and applications. Several of the midwives shared the perspective that guiding patients through these systems, especially the social support systems, is an expectation beyond their responsibilities and training. A couple of the health stations have integrated support personnel, like social workers and psychologists, in order to support patients with these needs. One midwife also discussed how undocumented migrant women experience additional challenges while

seeking maternity care in Norway, including unforeseen costs of care, mistrust of the health system and providers, social isolation and exclusion, and barriers to accessing many support programs. She described the importance of non-governmental or charity organizations to support many of the vulnerabilities undocumented migrant women experience during pregnancy and parenthood. Literature describing the experiences of irregular migrant women seeking maternity care in Norway is exceedingly sparse, but deeply needed, to better understand the needs of this population. To address the needs of women with a migration background in the maternity service, I suggest an expansion of social service support personnel within the health stations, especially within health stations with higher proportions of migrant patients, in order to further offset these responsibilities off of the midwives. Additionally, it is my opinion that much of this information could be demystified if the digital platforms for UDI, NAV, Helsenorge, Bufdir, and the municipalities had their information available in languages that match the resident populations of Norway.

Finally, in Chapter 8, I discussed how the strain of the COVID-19 pandemic was perceived as by the midwives as a breaking point for the maternity service. The midwives reported temporary cessation of several essential services, including in-person appointments, and home visitation, leaving more women, particularly women with a migration background, without adequate clinical follow-up or psychosocial support. Additionally, the midwives discussed how the infection control restrictions impacted the ways their patients experienced the maternity services. They shared additional isolation for their migrant patients, with partners being barred from most maternity appointments and briefly, birth; decreased capacity for midwives to assess for psychosocial wellbeing; and challenges in providing comfort and picking up on non-verbal communication through social distancing and personal protective equipment. The midwives shared how during the pandemic they experienced drastically increased workloads with decreased staff and support personnel, which they perceived to ultimately impact their overall quality of care provision. Finally, the midwives shared the experience of increased vaccination hesitancy amongst their patients, particularly those with a migration background. While in Norway, the COVID-19 restrictions have been lifted, these reports from the midwives still have salience in illuminating in sharp relief the existing gaps in the Norwegian maternity service, and how these gaps are specifically affecting women with a migration background.

The participating midwives have emphasized that they need support – more personnel, more autonomy, more continuity of care – to facilitate the care of their patients. While especially equipped within the patient-centered, empowering midwifery model of care, the midwives have

shared experiences of devaluation in their profession as a result of the encroaching threat of biomedicine and centralization in the Norwegian maternity services. In addition, the midwives shared how for women with a migration background, there are few resources provided by or in partnership with the Norwegian maternity service to aid in the many layers of vulnerability that the women experience during their pregnancies. They reported many instances where their efforts to meet the needs of their migrant patients came from their own initiatives, not from any formal policies or programs, and often occurred at detriment to their own time, energy, and/or mental health. The wished for training in their midwifery educations on topics like cross-cultural competency and migrant-centered care. Without the training or initiative, it is difficult to ascertain whether the manners in which these interviewed midwives adjusted their care to meet the individual needs of their migrant patients is common practice across midwives in the entire Norwegian maternity service. However, given the increasing population of persons with a migration background crossing Norway's borders, it is critical that the Norwegian maternity service examines their approach to the care of migrant women. Adjustments to the training of and resources available to providers, as well as overall improvement to the maternity service's labor conditions, are indicated to improve recently-arrived migrant women's obstetrical and neonatal outcomes, increase satisfaction in the maternity service, and aide in their transition to life in Norway during this vulnerable period.

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Appendices

Appendix A: MiPreg Study Interview Guide (Translated to English)

Phase 1: Information

I/we are (name, institution, researcher)

We would like to talk to you because you have agreed to participate in the MiPreg study. The study is a research project that aims to improve pregnancy and maternity care for recently-immigrated women in Oslo. An important part of the study is to improve knowledge about how newly-arrived pregnant women experience and experience the follow-up of pregnancy.

We would like to ask you some questions to understand your experiences as a midwife in meeting with newly-arrived migrants at the health station. Our goal is to map different experiences with, and any challenges you as midwives have, in your encounters with these women. We also want to ask you some questions about how you experience communication with this patient group and how you think that women's previous migration experiences, cultural background, and life situation affect your daily work with maternity care.

We also want to emphasize that there are no right or wrong answers to the questions we ask – we are primarily interested in your experiences, thoughts, and perspectives.

The conversation will be recorded to simplify the analysis process and will be stored in Oslo University Hospital's secure data server, which only the researchers in the study have access to and will be immediately deleted from the admissions unit. The audio recording will then be transcribed and anonymized and stored in the same server. The files will be deleted within 5 years after the project is completed.

Is there anything that is unclear? Do you have any questions?

Phase 2: Background Questions

1. How old are you?
2. What is your professional background?
3. How long have you worked with maternity care?

Phase 3: Introductory Questions

Phase 3, Part 1:

Now I will/we will ask you more questions related to your everyday work and your work experiences with pregnancy follow-up for newly-arrived migrants

1. Can you tell me a little about your daily work life? What is a typical workday or work week like?

    Probe 1: How many surveys/conversations do you have every day?

    Probe 2: How much time is set aside for each survey/conversation?

    Probe 3: Is there time set aside for home visits for women who have given birth?

2. How do you cope with the increased number of immigrants here at this health center?

    Probe 4: Is this something you are talking about?

    Probe 5: Are there enough resources set aside to meet them?

    Probe 6: How do you organize maternity care now that you have a larger proportion of immigrant women?

3. On a weekly basis, how many migrant women do you assume that come for examination/interview?
4. How many of these do you assume have recently arrived (less than five years)?
5. Are there any special challenges associated with this group of pregnant women?

    Probe 7: For example, in relation to time set aside, the need for an interpreter, clarification of linguistic misunderstandings, other medical needs / challenges beyond pregnancy.

6. Do you feel that you have enough resources to tackle these challenges?
7. Do you feel that enough time has been allocated to each individual woman and any companions?

Phase 3, Part 2

Maternity Care

1. Do you feel that you have enough time to convey information in a good way to the women (newly arrived migrants)?
2. Do you yourself feel that you have the opportunity to meet the women's wishes and needs?

3. Are there certain wishes and needs that you experience as incompatible with either Norwegian health practice or not affordable in terms of time and resource use?
4. Do you think that you have enough time for each individual, and if not – how much extra time do you think should ideally be set aside for each woman?
5. How do you experience the communication with the women?
6. Is there often a need for an interpreter? To what degree?

    Probe 8: Who/which agencies do you use as an interpreter?

    Probe 9: Are you satisfied with the interpretation services? Does the service cover the languages the women speak?

    Probe 10: If no to the question: Do you have any thoughts on how the services can be improved?

    Probe 11: How do you experience the use of an interpreter/telephone interpreter? Does it affect the flow and communication between you and the woman?
7. Do you yourself feel that you are able to convey important information about the pregnancy and the mother/child's health to the woman?
8. Is there anything in the maternity care for this specific group of women that you think is important to put the spotlight on or change?

Phase 3, Part 3

Cultural Aspects/Health Practices

1. Do you think it is important for good maternity care that you take into account and have an understanding of the woman's own cultural practices related to maternity care and birth?
2. As a follow-up to this: to what extent are you trying to capture the woman's own past experiences? And do you think this is important in the maternity care that you offer?
3. To what extent do you think you have the capacity to talk about or follow up when the women express fear for their own- or the child's health, or are in a difficult life situation?
4. Do you sometimes feel that the woman's own knowledge of practices to take care of her own and the child's health sometimes conflicts with your own knowledge and experience?

    Probe 12: Do you have any examples of situations where you have experienced this?

    Probe 13: How do you handle such a situation?

    Probe 14: Do you feel that you have enough knowledge related to this topic?

Phase 3, Part 4

Needs/Barriers/Measures

1. Are there any factors you think could have contributed positively to the maternity care for newly-arrived pregnant migrant women?
2. Are there any barriers or important factors that come into play in your own daily work with maternity care for this group of women?
3. What do you think is most important for maintaining or improving maternity care for this group of women?

Phase 4: Summarizing

1. Is there anything that you would like to add?

Thank you so much for your contribution!

Appendix B: Midwife Study Interview Guide

Interview Guide for Midwife Interviews (English):

Section 1: Personal/Professional Background

1. How old are you?
2. Can you tell me a bit about yourself and your professional background?

- Aim for or follow up on: age, national origin, education, experience in healthcare, experience in maternity care

Section 2: Workplace

3. Can you describe a typical workday or work week?

- Aim for or follow up on: number of consultations, staffing, length of a workday, other responsibilities

4. Can you describe a typical maternity consultation?
5. How do these consultations change when you have somebody with a migration background?

- Aim for or follow up on: length of visit, social interactions, family, health topics discussed, social welfare schemes

6. If you could guess, how many migrant women do you see on a weekly basis? How many of which have arrived recently (in the last five years)?

Section 3: Vulnerability

7. What does the term 'vulnerability' mean to you?
8. How do you assess vulnerability in your patients?

- Aim for or follow up on: any discussions of formal guidelines they must follow or mandated discussions they might have in order to assess vulnerability (ex. Domestic violence, need for state financial assistance, etc.)

Section 4: Care Challenges

9. What challenges do you run into while providing care to migrant women?
10. Have you ever had an experience where you struggled with a language barrier, and how did you cope?
11. Have you ever had an experience where you have had to help your patients with navigating immigration authorities or social welfare programs?
12. Do you find you need to allocate more time to discuss health concepts to migrant women, like nutrition, physical activity, signs of emergency, etc.?

13. Do you notice that there are differences between Norwegian-born women and migrant women in the types of knowledge they have about their pregnancy?
14. How do you have conversations with patients about health practices around pregnancy hat are different than what is recommended in Norway?

Section 5: Resource Allocation and Efficacy

15. What resources are available to you to facilitate clinical visits with migrant women?
16. What resources did you wish you had available to you to assist with some of the challenges mentioned?
17. Have there been times where you have had to go "above and beyond" your job description for women with a migration background?

Section 6: COVID-19

18. How has your work changed in the context of the COVID-19 pandemic?
19. Have you noticed a difference in how newly-arrived migrant women are interacting with the maternity care system right now with the COVID-19 pandemic?
20. Are there any ways that migrant women may be experiencing the pandemic differently than non-migrant women?

- Aim for or follow up on: housing, finances, social welfare assistance, social distancing, social network, etc.

Appendix C: Consent Form for Midwife Study

MiPreg Oslo universitetssykehus

Request for Participation in Research Project

MiPreg Midwife Study:

Challenges Faced by Midwives in Maternity Service Provision to Recently-Arrived Migrant Women in Norway

Background information

Many of the women who are new to Norway will become pregnant and give birth to children during the first years after arrival. Our researcher team is interested in the perspectives of Norwegian midwives on the challenges that they face while providing maternity care to recently-arrived immigrants. We want to hear what they have to say about antenatal and maternity care in Oslo.

Midwives are central to the Norwegian pregnancy care system, who often follow pregnant women throughout their antenatal and delivery care. Many the women they provide care for are women with migrant backgrounds. Previous studies have shown that migrant women and their newborns are more at risk for complications during pregnancy than the rest of the population. Many factors can play into this. Though critical to understanding this problem, prior research has not investigated the perspectives of midwives on potential difficulties or resources needs while providing maternity care to migrant women.

The MiPreg Study will listen to what you have to say about your encounters with migrant women while conducting your daily responsibilities in the health centers and delivery wards. We will ask questions that will help us learn more about your professional background, daily job responsibilities, your care visits with migrant women, and your assessment of resources allocated to you. We will investigate concepts like vulnerability, language, translation of health information and concepts, and relationships between patients and providers. The ultimate objective of our study is to improve antenatal and postpartum care for women who are new to Norway, and to improve the working lives of Norwegian midwives.

What does the study involve?

You will be recruited by the leaders of the study based on your location of work, either in the health station or in the delivery ward. You will be asked if you would like to participate in the interview. We know nothing about you other than your occupation as a midwife. We will not be given access to your health or professional records. We will not retain any information about your location of work, or any information that would be able to identify you.

A member of our research team will be asking you questions about these and similar topics:

- Which country you grew up in, your age, the languages you speak, and your professional background.

- Your daily professional responsibilities and activities as a midwife, your consultations with migrant women, and how many migrant women you see a week.

- What vulnerability as a concept means to you, and whether you assess women for vulnerability factors while providing care.

- What challenges arise while providing care to migrant women, like language, length of visits, family members, differences in pregnancy care practices, and translation of core concepts in the Norwegian approach to pregnancy.

- What resources are available to you to facilitate clinical visits, and what resources you might wish you had.

The interview will take place either at your workplace or in your home if you prefer. The language of interview can occur in either English or Norwegian, depending on your comfort. You can choose not to answer any questions you find unpleasant. The study will not influence your professional status.

The interview takes an average of 1 hour. The conversation will be recorded digitally then written down as notes. The digital recording is deleted immediately after the notes are taken, then stored on a secure server on the University of Oslo's Sensitive Data Service (TSD).

Possible advantages and disadvantages

You will not benefit in any special way by participating in the study, but the knowledge we gain will help other midwives, and pregnant immigrant women in the future.

Could we contact you again later?

We would like to invite you to participate in the analysis of the information we collect from you and others like you. We would like to contact you after the interview to invite you to learn and comment on our key findings.

What happens with the information you give us?

All the information we obtain about you will be treated as confidential. That means it will be impossible to identify you because your name, workplace, and all other information is anonymized. Only the persons associated with this study will have access to this information. It will not be possible to identify you after the results of the study are published.

You have the right to review/see this information, and any incorrect information will be corrected if you tell us to do so. You can request to have the information deleted from our records the moment you withdraw from the study. The information will be deleted 10 years after the project is completed.

Voluntary participation

Participation in the study is voluntary. You may withdraw at any time without giving us a reason for why you want to withdraw. Your decision to participate in the study will have no influence on employment status. According to Section 50 of the Norwegian Health Research Act, participants in this kind of study are protected by the Norwegian Patient Injury Act (Patient Injury Compensation Scheme).

If you wish to participate, please sign the Declaration Form below.

If you wish to withdraw from the study at a later time, you simply need to send an e-mail to the Principal Investigator for this study, Dr Ingvil Sørbye, at this e-mail: isorbye@ous-hf.no or contact us by telephone. 23 07 00 00.

Consent to Participation in the Study

"Challenges Faced by Midwives in Maternity Service Provision to Recently-Arrived Migrant Women in Norway"

I am willing to participate in the study:

_____ Date:_____ Signature of participant

Confirmation that the participant has been informed about all aspects of participation:

_____ Date:_____ Signature, representative of research team

Appendix D: Midwife Study Information Sheet

MiPreg Oslo universitetssykehus

A Call for Participation in Research Study

MiPreg Midwife Study:

Challenges Faced by Midwives in Maternity Service Provision to Recently-Arrived Migrant Women in Norway

Project Information:

We are looking for midwives who are willing to participate in our project! We are interested in speaking to midwives who *have experience caring for pregnant migrant women* in health stations and delivery wards in Oslo, Norway. We will ask you questions about your professional responsibilities as a midwife, your appointments with migrant women, and difficulties you may have while providing care for migrant women. We hope that the results found from this study will help improve the working lives of other midwives and the health outcomes of pregnant immigrant women in the future.

What will the study involve?

If you volunteer to participate in the study, you will be invited to an interview that will be about one hour in duration. These interviews will take place either at your place of work or in your home if you prefer. The language of the interview will be in either English or Norwegian. You can choose to not answer any questions that you do not feel comfortable answering. After the interview, if you would like, you are invited to participate in the analysis of the study by reading our key findings and letting us know your thoughts.

Your Privacy

Your privacy is incredibly important to our study. We want you to feel comfortable sharing your experiences without it impacting your social life or employment. This study will not have any access to your health or professional records. We will not retain or report any information about your place of work, or information that could identify you.

The interview will be recorded digitally then written down as notes. The digital recording is deleted immediately after the notes are taken, then stored on a secure server on the University of Oslo's Sensitive Data Service (TSD). The only people who have access to the server are those stated below.

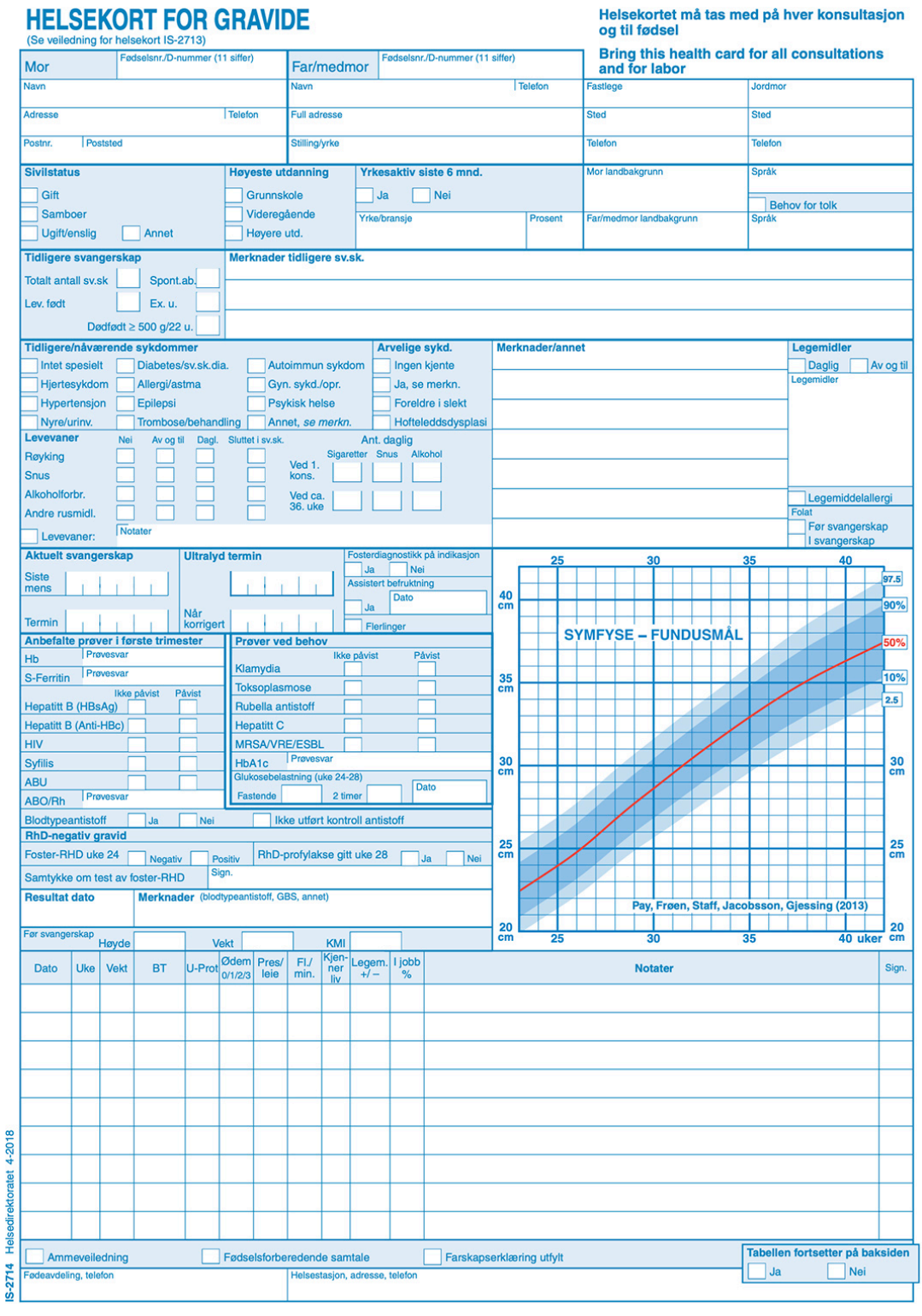
If you are interested, please contact:

Mackenzie Kay, Universitetet i Oslo Telephone: +4790679077
Email: mackenzie.kay@studmed.uio.no

Project Supervisors:

Johanne Sundby, MD, PhD – Universitetet i Oslo
Benedikte Linkskog, PhD – OsloMet
Sukhjeet Bains, MD, PhD – Universitetet i Oslo, Oslo Universitetssykehus

Appendix E*: Helsekort for Gravide,* "Maternal Health Card"



HELSEKORT FOR GRAVIDE

(Se veiledning for helsekort IS-2713)

Helsekortet må tas med på hver konsultasjon og til fødsel

Bring this health card for all consultations and for labor

Mor | Fødselsnr./D-nummer (11 siffer) | Far/medmor | Fødselsnr./D-nummer (11 siffer)

Navn | Telefon | Adresse | Telefon | Postnr. | Poststed | Full adresse | Stilling/yrke

Fastlege | Jordmor | Sted | Sted | Telefon | Telefon

Sivilstatus: Gift; Samboer; Ugift/enslig; Annet

Høyeste utdanning: Grunnskole; Videregående; Høyere utd.

Yrkesaktiv siste 6 mnd.: Ja; Nei | Yrke/bransje | Prosent

Mor landbakgrunn | Språk | Behov for tolk | Far/medmor landbakgrunn | Språk

Tidligere svangerskap: Totalt antall sv.sk | Spont.ab. | Lev. født | Ex. u. | Dødfødt ≥ 500 g/22 u.

Merknader tidligere sv.sk.

Tidligere/nåværende sykdommer: Intet spesielt; Diabetes/sv.sk.dia.; Autoimmun sykdom; Hjertesykdom; Allergi/astma; Gyn. sykd./opr.; Hypertensjon; Epilepsi; Psykisk helse; Nyre/urinv.; Trombose/behandling; Annet, *se merkn.*

Arvelige sykd.: Ingen kjente; Ja, se merkn.; Foreldre i slekt; Hofteleddsdysplasi

Merknader/annet

Legemidler: Daglig; Av og til; Legemidler; Legemiddelallergi

Levevaner

	Nei	Av og til	Dagl.	Sluttet i sv.sk.	Ant. daglig: Sigaretter	Snus	Alkohol
Røyking					Ved 1. kons.		
Snus							
Alkoholforbr.					Ved ca. 36. uke		
Andre rusmidl.							

Levevaner: | Notater

Folat: Før svangerskap; I svangerskap

Aktuelt svangerskap: Siste mens | Termin

Ultralyd termin: Når korrigert

Fosterdiagnostikk på indikasjon: Ja; Nei

Assistert befruktning: Ja | Dato

Flerlinger

Anbefalte prøver i første trimester

	Prøvesvar / Ikke påvist	Påvist
Hb	Prøvesvar	
S-Ferritin	Prøvesvar	
Hepatitt B (HBsAg)		
Hepatitt B (Anti-HBc)		
HIV		
Syfilis		
ABU		
ABO/Rh	Prøvesvar	

Prøver ved behov

	Ikke påvist	Påvist
Klamydia		
Toksoplasmose		
Rubella antistoff		
Hepatitt C		
MRSA/VRE/ESBL		
HbA1c	Prøvesvar	

Glukosebelastning (uke 24-28): Fastende | 2 timer | Dato

Blodtypeantistoff: Ja; Nei | Ikke utført kontroll antistoff

RhD-negativ gravid

Foster-RHD uke 24: Negativ; Positiv | RhD-profylakse gitt uke 28: Ja; Nei

Samtykke om test av foster-RHD | Sign.

Resultat dato | **Merknader** (blodtypeantistoff, GBS, annet)

Før svangerskap: Høyde | Vekt | KMI

Dato	Uke	Vekt	BT	U-Prot	Ødem 0/1/2/3	Pres/ leie	Fl./ min.	Kjen-ner liv	Legem. +/ –	I jobb %	Notater	Sign.

Ammeveiledning; Fødselsforberedende samtale; Farskapserklæring utfylt

Tabellen fortsetter på baksiden: Ja; Nei

Fødeavdeling, telefon | Helsestasjon, adresse, telefon

IS-2714 Helsedirektoratet 4-2018

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Appendix F: Quotes from Norwegian Transcripts, Translated and Original

(Page 49, Heidi)

There are an incredible number of pregnant women who call all the time, and want to be on our lists. So we have to be careful to be able to do a good job. That we prioritize correctly, and set aside enough time for those who need it… No, we do not have [enough coverage]. There are over 1000 births a year, but we have been on a little over 500 home visits, so it is part of the remaining 500 who have not received. (Heidi, Health Station Midwife)

> *Det er jo utrolig mange gravide som ringer hele tiden, og ønsker seg inn på listene våre. Så vi må jo passe på for å kunne gjøre en god jobb. At vi prioriterer riktig, og setter av nok tid til de som trenger det... Nei det har vi vel ikke. Det er jo over 1000 fødsler i året, men vi har vært på litt over 500 hjemmebesøk, så det er jo en del av resterende 500 som ikke har fått.*

(Page 52, Oline)

Yes, it is a bit complicated. You have us, there is the GP, and then there is the hospital – and there is no common computer system. We each sit on our toes, and then the poor pregnant person becomes the primary person who will tell [the providers] everything – and that is so unprofessional. It's so stressful, and you get so tired of it, and then you do not feel completely safe and taken care of either when health professionals ask, "what has happened before," somehow. (Oline, Health Station Midwife)

> *Ja, det er litt komplisert – du har oss, så er det fastlege og så er det sykehuset – og så er det ingen som har felles datasystem. Vi sitter på hver vår tue, og så blir den stakkars gravide primærpersonen som skal fortelle alt – og det er jo også uproft. Det er jo så belastende, og du blir så lei av der, og så føler du deg ikke helt trygg og ivaretatt heller når helsepersonell spør 'hva har skjedd før' liksom.*

(Page 58, Oline)

I face challenges, of course I do, but I feel…. I have colleagues, right? So I can ask a little, and then we can discuss a little, then we can find out things together. (Oline, Health Station Midwife)

> *Jeg møter på utfordringer, selvfølgelig gjør jeg det, men jeg føler jo... jeg har jo kolleger, ikke sant? Så jeg kan spørre litt, så kan vi drøfte litt, så kan vi finne ut av ting sammen.*

(Page 66, Terese)

But it's not a homogenous group, is it? So that it becomes very individual how we meet them. And some have a lot of resources... I had one who has only been in Norway for 10 years, but who has a good education. Comes from Somalia, works 100%. This is the first time that she

is pregnant, but she can and has read a lot. So there it is – and has already done as much research as other ethnic Norwegians have not done, right. So you have the whole spectrum, also. (Terese, Health Station Midwife)

> *Men det er jo ikke en homogen gruppe, ikke sant? Sånn at det er blir veldig – allikevel selvsagt veldig individuelt hvordan vi møter dem. Og noen har masse ressurser... hadde jeg ei som bare har vært i Norge i 10 år, men som har god utdannelse. Kommer fra Somalia, jobber 100%. Det er første gang hun er gravid, men kan og har lest seg opp veldig mye. Så det er det – og har allerede gjort så mye undersøkelse som de fleste andre etnisk norske ikke har gjort, ikke sant. Så man har helle spekteret, altså.*

(Page 66, Irene)

I probably think that there is a difference in the treatment that a minority woman gets, and a woman with a lot of resources and who knows and plays on the right buttons. I certainly think… that you might wait longer to get started. That is, that is differential treatment! You should be careful to say [this], but I mean it. I believe that there is a difference in treatment between minority women and resourceful women. This does not mean, it is more about resources, the same applies, for example, to women with few resources who are ethnic Norwegians. They can also experience the same thing. Women who demand little and do not have enough resources they unfortunately fall further behind in the queue. (Irene, Maternity Ward Midwife)

> *Det som vi ser er at, jeg tror nok at det er en forskjell på behandlingen som en minoritetskvinne får, og en kvinne med mye ressurser og som vet og spille på de riktig knappene. Det tror jeg helt sikkert, og det tror jeg gjelder mange ting, at man kanskje avventer lenger med å sette i gang, man - altså at det er forskjellsbehandling skal man være forsiktig med å si, men jeg mener det. Jeg mener at det er en forskjellsbehandling på minoritetskvinner og ressurssterke kvinner. Det betyr ikke, altså det går mer på ressurser, det samme gjelder for eksempel på kvinner med lite ressurser som er etnisk norske. De kan også oppleve det samme. Kvinner som krever lite og som ikke har nok med ressurser, de kommer dessverre lenger bak i køen.*

(Page 69, Oline)

Yes, because then it really hurts someone else then – that you prioritize those who need it the most. That is the kind of philosophy we must have…. There are some who go to a GP, and they can do this even if they have a GP. But, as long as they don't have a GP, they must come to us. So then we have to take care of them. (Oline, Health Station Midwife)

> *Ja, for da går det vel egentlig ut over noen andre da – at man prioritere de som trenger det mest. Det er jo en sånn filosofi vi må ha egentlig... Ja, det er en del som går til fastlegen, og det kan jo det her gjøre også hvis de har en fastlege. Men, så lenge de ikke har fastlege, så må de jo komme til oss. Så da er det vi som må ta oss av dem.*

(Page 70, Kari)

In principle, according to the guidelines, everyone should have access to maternity care from a midwife, but we have not been able to do that and we still do not. But what we have done is that we have tried to prioritize first-time mothers and other vulnerable people. Whether one is vulnerable depends on one's own assessment. (Kari, Health Station Midwife)

> *Ja i utgangspunktet i følge retningslinjene skal alle ha tilgang til barselomsorg fra jordmor, men vi har jo ikke klart å gjøre det og det gjør vi fortsatt ikke. Men det vi har gjort er at vi har prøvd å prioritere førstegangsfødende og andre sårbare. Hvorvidt man er sårbar kommer jo an på egen vurdering.*

(Page 78, Oline)

There are different qualities of interpreters too, so you do not know exactly what the interpreter conveys. So those are the kinds of misunderstandings. The interpreter can talk a lot about what is being said. So, what are you saying, really? It would have been interesting to know. It is not always possible to know exactly what was passed on either. You lose a little control, it is not all good then either. (Oline, Health Station Midwife)

> *Det er jo ulik kvalitet på tolker og, så du vet ikke helt hva tolken formidler. Så det er sånne typer misforståelser. Den tolken kan jo prate mye om det som bli sagt. Så, hva forteller du egentlig? Så det hadde vært interessant å vite. Det er ikke alltid man helt veit hva som blir videreformidla heller. Man mister litt kontrollen, det er ikke helt godt det heller da.*

(Page 79, Linnea)

We do not have any good procedures for [using a translator] at birth…we do not have anything… maybe I missed it… that a plan could have been made with an interpreter who might be used to being involved in childbirth… so then there may have to be someone who has received some more education around this. (Linnea, Maternity Ward Midwife)

> Vi ikke har noe gode prosedyrer på det med fødsel…vi har ikke noe….det savner jeg kanskje….at det kunne vært laget et opplegg med en tolk som kanskje kan bli vant til å være med i fødsel... så da må det kanskje være noen som har fått noe mer utdanning rundt dette.

(Page 80, Irene)

When I am working in the maternity clinic for ultrasound, especially when I have an immigrant woman, I think that there is a lot I have to tell them. So I hope that they have with them an interpreter if they do not speak Norwegian well. The partner is often used as an interpreter, and it is certainly better than nothing. (Irene, Maternity Ward Midwife)

> *Når jeg er på svangerskapspoliklinikk for ultralyd, særlig når jeg får inn innvandrerkvinner, så synes jeg det er mye jeg har å fortelle til dem. Så jeg håper de har med seg tolk hvis de*

ikke snakker ganske godt norsk. Partner brukes nok ofte som tolk, og det er absolutt bedre enn ingenting.

(Page 80-81, Oline)

I try to explain to the husband, that you should not be responsible for conveying information to your wife, because it gets in the way. It is not that you are bad at Norwegian, but I need to know that she gets all of the information that I give. I have a couple where he was very offended when I said that we had to have an interpreter next time: 'did you not think I speak Norwegian somehow, I speak good Norwegian.' It has nothing to do with it, you just don't need to have that responsibility. But he was very angry. It was not okay for me to ask for an interpreter. (Oline, Health Station Midwife)

Jeg prøver å forklare til mannen, at du skal ikke ha ansvar for å formidle lite liv til kona di, fordi det blir for mye på en måte. Det er ikke det at du er dårlig i norsk, men jeg trenger å vite at hun får all informasjonen som jeg gir. Jeg har et par der han ble veldig fornærma da jeg sa at vi måtte ha tolk neste gang: 'syntes du ikke at jeg snakker norsk liksom, jeg snakker da godt norsk'. Det har ingenting med det å gjøre, det er bare at du skal slippe det ansvaret. Men han var ordentlig hissig. Det var ikke greit at jeg ba om en tolk.

(Page 82, Linnea)

Having an interpreter present at birth is not common for us either. I do not think that it will ever be used either – not for birth. In the postpartum ward it is common. It is common to order an interpreter who comes then. But it is not always done there either. It depends on busyness, capacity. But it is something they are also entitled to, so it is a bit difficult… You are often left with the fact that you have not done a good enough job really. (Linnea, Maternity Ward Midwife).

Hvis en tolk skal være med på fødsel, så er ikke det vanlig for oss heller. Det tror jeg aldri heller blir brukt – ikke fødsel. På barselavdelingen er det vanlig. Der er det vanlig at vi bestiller en tolk som kommer da. Men det er ikke alltid det blir gjort det heller da. Det kommer an på travelhet, kapasitet. Men det er jo noe de også har krav på, så det er litt vanskelig… Det er ofte man sitter igjen med at man ikke har gjort en god nok jobb egentlig.

(Page 82, Kari)

…we have received feedback from the manager that we spend too many resources on interpreters. If they ask us to use less interpreters, it would be quite scary, because we use an interpreter when there is a need for it and it is incredibly important to work with them. I cannot start consultations without an interpreter where an interpreter is needed. (Kari, Health Station Midwife)

… Har vi fått tilbakemelding på fra lederen at vi bruker for mye ressurser på tolk. Dersom de ber oss bruke mindre tolk, er jo det ganske skummelt, for vi bruker jo tolk når vi mener

at det er behov for det og det er jo ufattelig viktig med tolk. Jeg kan jo ikke begynne konsultasjoner uten tolk der det er nødvendig med tolk.

(Page 84, Nora)

I think a lot could have been done if they got better follow-up during the pregnancy. They should have been informed from very early in the pregnancy that they should go to the midwife…Because then I think they are better prepared and are more informed about reasons to get in touch along the way, should problems arise. And that they are better prepared for how things work in Norwegian hospitals and maternity wards and what is normal and not normal. (Nora, Maternity Ward Midwife)

Jeg tror jo mye kunne vært gjort hvis de fikk bedre oppfølging i svangerskapet. At de burde vært informert fra veldig tidlig i svangerskapet at de bør gå til jordmor... For da tror jeg at de er bedre forberedt og er mer informert om årsaker til å ta kontakt underveis, skulle det oppstå problemer. Og at de er bedre forberedt på hvordan det fingerer på norske sykehus og fødeavdelinger og hva som er normalt og ikke normalt.

(Page 85, Nora)

The problem is the health stations are so full, that people are not called in for the first check-up until week 24, 28, 32, sometimes. And then you are way too far into the pregnancy and have missed many of the weeks where there is a high risk something can go wrong. (Nora, Maternity Ward Midwife)

Men så er samtidig problemet at helsestasjonene er så fulle, at folk ikke blir kalt inn til førstekontrollen før uke 24, 28, altså 32, noen ganger. Og da er du på en måte allerede langt ut i det svangerskapet og har kanskje vært gjennom mange av de ukene hvor det er en høy risiko for at noe kan gå galt.

(Page 86, Kari)

...If a newcomer arrives, and you set aside an hour for the first time, there can be very little time. If you are going to apply for a place to give birth, take blood samples, have an interpreter, inform about the Norwegian system, take information and fill in a health card, it will be a lot. So what we do then is that we use that hour and we set up an hour faster than one would have done otherwise. (Kari, Health Station Midwife)

...Hvis det kommer en nyankommet, og man setter av en time første gang så kan det bli veldig knapt med tid. Hvis du både skal søke fødeplass, ta blodprøver, ha tolk, informere om det norske systemet, ta opplysninger og fylle ut helsekort, så blir det veldig mye. Så det som det hender at vi gjør da er at vi bruker den timen og setter vi opp en time fortere enn man ville ha gjort ellers.

(Page 87, Kari)

I do not often think that the interpreter is really the barrier either, but it may be more that she has already made an assessment, that she has perceived something as dangerous or not dangerous. Since I have worked elsewhere and tried to learn other languages, I think that the nuances in what you manage to communicate can be very limiting. Even in relation to English, a lot is lost, even though it may be a common language. (Kari, Health Station Midwife)

> *Jeg syns ikke så ofte at tolken egentlig er barrieren heller, men det kan være mer at hun har gjort en vurdering allerede, at hun har tolket noe som farlig eller ikke farlig. I og med at jeg har jobbet andre steder og prøvd å lære meg andre språk, så tenker jeg at de nyansene i det man klarer å meddele kan jo være veldig begrensende. Til og med i forhold til engelsk så er det jo mye som blir borte, selv om det kan være et felles språk.*

(Page 88, Heidi)

So you have to adapt all the way. So the challenges are the language and the ability to formulate information and be able to be sure that they have received it, but also understand what is important to them and what their ailments are, because they have their way of expressing it. There can often be many physical ailments and you do not always know exactly what is important to them and what is an expression of something else. So I spend a lot of time on it and try to get to know them so that I can meet them where they are. (Heidi, Health Station Midwife)

> *Så man må tilpasse seg hele veien. Så utfordringene må jo være språk og det og få formulert informasjon og kunne være sikker på at de har mottatt den, men også forstå hva som er viktig for dem og hva som er deres plager, for de har jo sin måte å uttrykke det på. Det kan jo ofte være mange fysiske plager også vet man jo ikke alltid helt hva som er viktig for dem og hva som er et uttrykk for noe annet. Så jeg bruker mye tid på det og prøver å bli kjent med de, slik at de jeg kan møte de der hvor de er.*

(Page 95, Terese)

That is also part of what we map, the network around. Always ask about it. "Do you have a network?" "Do you have someone you can ask?" "Do you have someone who has given birth in Norway before?" "Do you have someone who can explain what happens when you are pregnant?" There are of course some who do not have it, but the main impression is that [some] have a lot [of people] to ask. In-laws, extended family. I just had one in [control], and she had lots of cousins and they lived in a big family. So that's how the transfer of competence happens, I think. (Terese, Health Station Midwife)

> *Og det er jo også en del av det vi kartlegger, nettverket rundt. Pleier alltid å spørre om det. Har du nettverk, har du noen du kan spørre, har du noen som har født i Norge før, har du noen som kan forklare hva som skjer når du er gravid, og ja. Så har jeg - ja, det er jo selvsagt noen som ikke har det, men hovedinntrykket er at de har mange å spørre.*

Svigerfamilie, storfamilie. Jeg hadde nettopp ei inne, og hun hadde masse fettere og kusiner og de levde i en storfamilie. Så det er sånn kompetanseoverføringen skjer, tror jeg.

(Page 99, Oline)

But we usually get them informed well, when we are able to communicate – about how the plan is and what they can expect in relation to follow-up, that you apply for a place of birth, that you go to that and that hospital, and if there is something during pregnancy, they can call directly there. But it is to get them directly to the hospital if, for example, there is less life one day in the stomach. So I print [the form] a few times during pregnancy [for them.] (Oline, Health Station Midwife)

Men, vi pleier å få orientert de greit, når vi klarer å kommunisere - om hvordan opplegget er og hva de kan forvente i forhold til oppfølging, at man søker en fødeplass, at man skal på det og det sykehuset, og hvis det er noe i svangerskapet, så kan de ringe direkte dit. Men det er det å få dem direkte til sykehuset hvis det for eksempel er mindre liv en dag i magen. Så den prenter jeg inn ganske mange ganger i løpet av et svangerskap.

(Page 100, Oline)

I *think it is difficult that they come from a different system than us. To me, it's our natural system, and so should explain to them how things work here… And I want to find out if you need anything extra… The Norwegian system really, the NAV system. If they do not have a social security number, GP… there is so much they bring that they would like to have fixed, and I cannot fix it. That is often the frustration. I have to explain that I have no influence on it. There's an awful lot I cannot do, and then they might think that when they come to me I can fix quite a lot for them, and then I can't really fix that much for them. I can take care of that pregnancy there and then, and guide them a bit in the system, but I can't help them so much with the practical then. (Oline, Health Station Midwife)*

Jeg syntes jo det er vanskelig det at de kommer fra et annet system enn oss. For meg er det naturlig systemet vårt, og så skulle forklare til dem hvordan ting fungerer her... Og jeg vil finne ut hvis du trenger noe ekstra... Det norske systemet egentlig, NAV systemet; hvis de ikke har personnummer, fastlege… det er så mye de kommer med som de gjerne skulle ha fiksa, og så kan ikke jeg fikse det. Det er ofte det som er frustrasjonen. Få forklart dem at jeg ikke har noe påvirkning på det. Det er fryktelig mye jeg ikke kan gjøre, og så tenker de kanskje at når de kommer til meg så kan jeg fiksa ganske mye for dem, og så kan jeg egentlig ikke fikse så mye for dem. Jeg kan ta meg av det svangerskapet der og da, og geleide de litt i systemet, men jeg kan jo ikke hjelpe dem så mye med det praktiske da.

(Page 101, Kari)

In recent years, we have had an expanded open health center with a social worker, which we can refer to, so it definitely helps. So, every Friday, there are two social workers from NAV and a family substitute who speak several languages. It is more adapted as a social

service and has a very low threshold. You can come and get help to fill in everything from applications for a kindergarten place to parental benefits, so it has relieved us of something completely enormous. (Kari, Health Station Midwife)

> *I de siste årene så har vi jo hatt en utvidet åpen helsestasjon med sosionom, som vi kan henvise til, så det hjelper jo absolutt. Så hver fredag er det to sosionomer fra NAV og en familievikar som snakker flere språk, og det er mer tilpasset som en sosial tjeneste og som har veldig lavterskel. Du kan komme og få hjelp til å fylle ut alt fra søknader om barnehageplass til foreldrepenger, så det har jo avlastet oss noe helt enormt.*

(Page 101, Kari)

The family substitute also helps a lot. If a family is struggling a lot and has many children or the mother is depressed, then we can connect her also she can come to the family maybe once a week and relieve the parents for a few hours for example. (Kari, Health Station Midwife)

> *Og familievikaren hjelper jo også mye. Dersom en familie sliter veldig og har mange barn eller moren er deprimert, så kan vi koble på henne også kan hun komme til familien kanskje en gang i uka og avlaste foreldrene i noen timer for eksempel. Vi har jo også «home-start» som vi henviser en del til.*

Appendix G: Ethical Clearance from Oslo University Hospital Data Protection Officer

Oslo universitetssykehus

Oslo universitetssykehus HF

Postadresse:
Trondheimsveien 235
0514 Oslo

Sentralbord:
02770

Org.nr:
NO 993 467 049 MVA

www.oslo-universitetssykehus.no

PERSONVERNOMBUDETS UTTALELSE

Til: Mackenzie Kay

Fra: Personvernombudet ved Oslo universitetssykehus

Dato: 01.09.2021

Saksnummer:21/17793

Personvernombudets uttalelse til innsamling og behandling av personopplysninger for forskning i prosjektet:

Challenges Faced by Midwives in Maternity Service Provision to Newly Arrived Migrant Women in Norway

Personvernombudet har vurdert det til at den planlagte databehandlingen av personopplysninger tilfredsstiller de krav som stilles i helse- og personvernlovgivningen.

Personvernombudet har ingen innvendinger til at den planlagte databehandlingen av personopplysninger kan igangsettes under forutsetning av følgende:

1. Forskningsansvarlig / databehandlingsansvarlig er OUS
2. Behandling av personopplysningene / helseopplysninger i studien skjer i samsvar med og innenfor det formål som er oppgitt i meldingen.
3. Studien er godkjent av aktuelle avdelingsledere ved OUS.
4. Prosjektet er forelagt NSD.
5. Studien er frivillig og samtykkebasert.
6. Data lagres avidentifisert. Kryssliste som kobler avidentifiserte data med personopplysninger lagres separat og avlåst.
7. Data slettes eller anonymiseres etter prosjektslutt.
8. Dersom formålet, utvalget av inkluderte eller databehandlingen endres må personvernombudet gis forhåndsinformasjon om dette.

Med hilsen

Tor Åsmund Martinsen

Tor Åsmund Martinsen
Personvernombud