Nikki Lyn E. Upfold

Qualitative study of pregnancy, childbirth and postnatal care experiences of Filipino immigrant women in Norway

Master's thesis in Public Health, specializing in Global Health
Supervisor: John-Arne Skolbekken
June 2020

Master'sthesis

NTNU
NorwegianUniversityofScienceandTechnology
FacultyofMedicineandHealthSciences
DepartmentofPublicHealthandNursing

NTNU
Norwegian University of
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ABSTRACT

Background: The last 50 years have seen a significant increase in both the childbearing age and diversity of women migrating to Norway. The Norwegian health care system may be well organized and equipped to diagnose and treat diseases common to native people, however it may not be prepared to meet the specific needs of particular immigrant groups. Maternal health care must be designed to meet the needs of all women in society in order to ensure fair access to services and address health inequalities. The migration of Filipinos to Norway has become more feminized, but studies on their experience in accessing maternal health care are scarce.

Knowing more about the experiences of Filipino immigrant women in accessing maternal health care can aid the Norwegian health care system to provide Filipino immigrant women with excellent quality care and improve their integration process in Norway.

Purpose: The purpose is to explore experiences of Filipino immigrant women of pregnancy, childbirth and postnatal care in Norway.

Design and methods: A qualitative study with a constructivist grounded theory approach. In total eighteen Filipino immigrant women living in Trondheim and Støren Norway, participated in four focus group discussions.

Conclusion: The core category was identified as *experiencing transitions*. Three key categories relating to experiences of Filipino immigrant women of pregnancy, childbirth and postnatal care in Norway emerged from the data. These were: Category I: Experiencing Norwegian maternal health care, Category II: Learning from negative experiences, and Category III: Achieving Social Integration.

Keywords: maternal health care, immigrants, qualitative research, Norway

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ABBREVIATIONS

WHO	World Health Organization
GT	Grounded Theory
UN	United Nations
NMHC	Norwegian Maternal Health Care
GP	General Practitioner
FGD	Focused Group Discussion

1 INTRODUCTION

Globally maternal mortality is inadmissibly high and more than 290, 000 women died as a result of pregnancy and childbirth complications (1). In 2017, recent report from WHO estimates that the global maternal mortality rate is 211 maternal deaths per 100 000 live births in (2). This means that approximately 810 women died each day from preventable causes related to pregnancy and childbirth (2). The main causes of almost 75% of all maternal deaths are severe bleeding, infections, high blood pressure during pregnancy, complications from delivery and unsafe abortion. The remainder are associated with non-obstetric causes such as cardiac diseases, diabetes, and infections like malaria (3). In 2018, it is reported that 2.6 million infants died in the first month of life and about 1 million newborns died within the first 24 hours (4). Infants who died within the first 28 days suffer from conditions and diseases associated with lack or inadequate maternal health care (2, 4). Research shows that global efforts and interventions in the health sector can save the lives of 1.6 million mothers and 10.2 million children by 2030 (5). Improving the health and increasing the survival rate of mothers and their children remains a global health challenge (6). Maternal and Infant mortality can occur anytime and anywhere, but it is more likely to occur in vulnerable groups in societies such as the migrant women (7, 8). Moreover, migration increases health vulnerability which is defined as the " the degree to which an individual is unable to anticipate, cope with, resist and recover from the impacts of diseases or epidemics (9). Pregnant migrant women need to cope with the stress of migration process, pregnancy and childbirth (10). Studies show diversity in pregnancy outcomes of migrant women. In Norway and Sweden migrant women and non-migrant women have similar pregnancy outcomes while in Italy and United Kingdom it is less favorable (11). Although studies vary and depends on the host country, characteristics of migrants and outcome of interest, it is significant to note that most of the research show poorer pregnancy outcomes for migrants (12). Societal factors that can influence these negative outcomes are low levels of education, socioeconomic position, and inadequate or lack of social support (8, 13, 14). The growing migrant population (90.7 million)` in Europe, including women of childbearing age, has put considerable pressure on EU countries to act and find solutions (15, 16). It is timely and relevant to develop EU health care system that meets the need of migrants especially women and children (15, 17).

In September 2000, The United Nations Millennium Declaration was signed and led world leaders to fight poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women (18). The event launched 8 Millennium Development Goals (MDGs) with its specific targets and indicators. Child and newborn mortality (MDG 4) and Maternal health (MDG 5) were closely interconnected. Providing adequate maternal health care during pregnancy, childbirth and postpartum periods significantly contributes to child survival as one-third of all child deaths occurred within the first month of life (19). In September 2015, the Sustainable Development Goals (SDGs) replaced the MDGs and were built on their legacy and achievements (20). The SDGs were composed of 17 Sustainable Development Goals, all interrelated and designed to achieve a healthier and more sustainable future for everyone (21).

The SDG 3 (Ensure lives and promote wellbeing for all at all ages) has implemented global action plan that aim to reduce maternal mortality ratio to less than 70 per 100 000 live births and neonatal mortality to 12 per 1000 live births by 2030. (22)

In addition, the WHO, UNICEF and partners from all stakeholder groups worked together and launched the Quality of Care Network in February 2017. The objective of this network is to support all pregnant women, newborns and children with good health care services therefore reducing maternal and newborn deaths by half (15).

1.1 Background

1.1.1 Maternal Health Care and Migration

According to WHO, maternal health refers to the health of women before and during pregnancy, childbirth and postpartum period (23) . It encompasses health care that include access to sexual and reproductive health services; nutritional advice; screening and management of communicable diseases and noncommunicable diseases; gender-based violence prevention and response; and risk detection and management (24). Utilization of integrated, evidence-based and cost-effective services for pregnant women in all stages of maternal health care is a key to reduce maternal mortality (25). In the preconception stage, studies show that health before conception can affect the outcome of pregnancy and also have long-term consequences for the mother and child (26). Having healthy lifestyle and behavior (healthy diet, exercise, avoiding smoking, illicit drug use and alcohol consumption) decreases risk of poor pregnancy outcomes (24, 27), . Parents

planning pregnancy should be screened for health problems that need to be diagnosed and managed to ensure healthiest possible start for their child (24). During pregnancy stage, women need to receive high-quality antenatal care that provides effective support, including social, cultural, emotional and psychological support, to pregnant women in a respectful way (28). During childbirth stage, WHO recommends intrapartum care, "which refers to organized care provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment and enables informed choice and continuous support during labor and childbirth" (29). Afterwards, in the postpartum stage, the care includes timely detection and management of potentially serious complications for the woman and child (30). Counseling on family planning, maternal health, nutrition, hygiene, breastfeeding, infant care and gender-based violence is also recommended in this period (31). Maternal health is a fundamental human right for all women, in all countries, societies and under all circumstances therefore, vulnerable women such as migrants and refugees must have equal access to adequate maternal health care (32, 33).

Migration is defined by WHO as "the movement of a person or a group of persons, either across an international border, or within a State. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, economic migrants, and persons moving for other purposes, including family reunification (34). There is no universally accepted definition of the term "migrant". However, the IOM defines it 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 causes for the movement are; or what the length of the stay is" (35). Several studies show that migration in itself has a negative effect on health (36-38) and migrant women have an increased risk for adverse pregnancy outcomes (11, 39).

1.1.2 Immigration in Norway

The United Nations has considered Norway the best country to live in for years (40) and it was also named the best performing advanced economy in 2018 (41). Norway welcomed 49,000 new immigrants in 2017 (42), and immigrants represent 18.2 % of the population (43). These new immigrants include 49.1% of free mobility immigrants, 5.8% of labor migrants, 29.2% of family members, and 15.9% of humanitarian migrants (42). In previous years, immigrants came primarily

from Africa , Asia and Western Europe, but in recent decades significant numbers of EU countries have moved to Eastern Europe (44). More than half of the immigrants in Norway are in within 20-44 year age group, compared to a third of the general population (44). This age group is within women's childbearing age (15-49)(45).

Increasing immigration stresses the urgent need for systemic steps to counter social inequalities and the additional challenges raised by the recent peak of migration (46). Addressing these challenges will be neither quick nor simple, but it is vital that governments and citizens recognize the continuing impact that migration will have on our social norms, values and institutions, as well as on our economies and well-being (42)

Today there are 23, 280 Filipino immigrants in Norway (47). In recent years, there is an increase in number of marriages between Filipinas and men from Norway and 80 per cent of migrants from the Philippines are women (47).

1.1.3 Maternal Health Care in Norway

The Norwegian health care system is built on the principle of equality and universal access (46, 48). Health care is financed by taxation, and all residents are covered by the National Insurance Sceme (Folketrygden, NIS). Hospitals in Norway are mostly public, state-owned and funded. Regional health authorities provide specialized health services, while primary public health care is administered by municipalities (49). A free, universal and comprehensive maternal health care is provided for all pregnant women in Norway (46).

Maternal health care is integrated into the municipal health service and is provided by the General practitioners (GP), midwives and health nurses (50). Midwives play an important role in the delivery of prenatal care because women have an opportunity to go to a midwife and/or General practitioners (GP) for prenatal check-ups (51).

In Norway, women have the right to receive information about health and healthcare services. It also includes information about treatment, diagnostics or examination. The women are also entitled to choose where to give birth. Although women were given the right to choose where to get care during childbirth, they themselves cannot choose the level of treatment. More specialized treatment requires referral from health professionals (52)

1.1.4 Maternal Health Care in the Philippines

In the Philippines, health care varies with private, public and barangay health centers; and majority of the national burden of health care is carried by the private health providers . The primary health care system consisted of rural health units that provided maternal and child health care, general outpatient and dental care , family planning and nutritional advice, disease control , health education , and environmental situation (53).

In 2017, pregnant women receiving prenatal care in the Philippines was reported at 93.8% (54).

Recently, the Philippine Department of Health launched a "National Safe Motherhood Program" with a vision of "For Filipino women to have full access to health services towards making their pregnancy and delivery safer". This program is committed to provide rational and responsive policy direction to its local government partners in the delivery of quality maternal and newborn health services with integrity and accountability using proven and innovative approaches.

1.2 Rationale

1.2.1 Rationale for study

The UN recognized that in order to achieve the vision of the 2030 Agenda and the Sustainable Development Goals, to leave no one behind, adequate attention must be given to the health needs of refugees and migrants (55). Currently there is limited research on pregnancy and childbirth experiences of Filipino immigrant women in Norway. To fill this gap, this study aims to explore Filipino immigrant women's experiences during pregnancy and childbirth in Norway and to describe barriers to maternity services from a qualitative perspective.

1.2.2 Objectives

The purpose of the study is to explore the experiences of Filipino immigrant women of pregnancy, childbirth and postnatal care in Norway

2 METHODS

The purpose of this study was to gain a deeper understanding of perceptions of Filipino immigrant women living in Norway on their experiences of pregnancy, childbirth and post-natal care. The principles of grounded theory analysis were used to analyze the data and developed a theoretical model of Filipino immigrant women's process of overcoming the challenges of pregnancy and childbirth. The model describes the process that these women use to overcome the challenges of pregnancy and childbirth. A qualitative, constructivist grounded theory approach was used in this study. This chapter discusses the methods.

2.1 Methodology

A qualitative study using FGDs was conducted with Filipino immigrant women who had pregnancy, childbirth and postnatal care experiences in Norway. For qualitative health research, focus groups are standard approaches used to gain information related to how people view and interpret their surroundings. The purpose of FGDs is to obtain data from a specific group of individuals rather than from a statistically representative sample of a broader population (56) .

Grounded theory was developed by sociologists Barney Glaser and Anselm Strauss in 1967 (1). This theory has provided a tool for researchers to study health phenomena from the perspective of those who experience them and made a remarkable breakthrough in nursing research (1). It aimed to construct a theory on important issues in people's lives, and this theory was based on empiric data rather than on existing literature (2). Glaser defined grounded theory as "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). While Charmaz defined it as, "an inductive methodology that provides systematic guidelines for gathering, synthesizing, analyzing, and conceptualizing qualitative data for the purpose of theory construction" (3). Several variations of grounded theory have evolved over time and from the divergences that have arisen, three main areas or methodological perspectives have been defined: classic; Straussian; and constructivist (4). (Singh & Estefan, 2018). These three methods had methodological similarities and differences between them. Similarities were the collection of data from natural settings, the use of theoretical sampling as an analytical tool, and the simultaneous

collection and analysis of data (Singh & Estefan, 2018). On the other hand, their differences were about the role of the researchers, the place of the literature review, the formulation of research questions, and the coding process (5).

Constructivist grounded theory (CGT) was created by Kathy Charmaz, a former graduate student of both Glaser and Strauss. Charmaz described CGT as " a contemporary revision of Glaser and Strauss's classic grounded theory. It assumes a relativist epistemology, sees knowledge as socially produced, acknowledges multiple standpoints of both the research participants and the grounded theorist, and takes a reflexive stance toward our actions, situations, and participants in the field setting and our analytic constructions of them (Charmaz 2009, p.129). CGT recognized that the existing prior knowledge, experience and insight of the researcher is key to this process and therefore rejects the Glaserian approach that calls for objectivity (Hunter et al., 2011).

I intended to use a methodological approach that will encourage active participation in the research process, enable flexibility and rigour in data gathering, promote creativity, enhance the conceptualization skill of the researcher, help provide depth and richness of data, and aid to develop a theory (6). In this regard, I considered using Charmaz's CGT suitable.

2.2 Sampling and Recruitment

Snowball and theoretical sampling methods were used in this study. I planned to obtain the sample in three different geographic locations (Trondheim, Bergen and Oslo) in Norway. However, due to time constraints a decision was made to limit the study to Trondheim and Støren. Thus, Filipino immigrant women living in Trondheim and Støren were recruited. Participants who agreed to participate in the study were screened by me to confirm eligibility. Two participants volunteered to join the study; however, both had childbirth experiences outside of Norway, therefore they did not meet the criteria to participate. The FGDs were conducted face to face in a location chosen by the participants, free of loud noises and distractions.

The recruitment of participants for this study began in October 2019. The data collection process took place from October 2019 to November 2019. I used my personal connections and social networks as starting point to gain access to possible participants. I also tried to get bigger network by going to malls and approaching Filipino immigrant women with children. Old and new contacts permitted me to connect with possible research participants. In addition, this strategy I

applied allowed me to use snowball sampling method and gained sufficient number of participants. Furthermore, in the third and fourth FGD I also applied theoretical sampling method.

A total of 18 Filipino immigrant women participated in this study. The Inclusion criteria included the following factors: should be a Filipino immigrant woman, must be 18 years old or older, mother language is Filipino/Tagalog, must have pregnancy and childbirth experiences in Norway. While the exclusion criteria were Filipino born and permanently residing in Norway.

2.3 Data Collection

Each FGD began with me introducing myself and discussing the purpose of the study, rights of the participants particularly the right to withdraw consent, and ground rules for the FGD. Examples of the ground rules discussed were voluntary participation, respect for the opinion of others, all responses are valid, speaking openly as they feel comfortable, and helping protect privacy by not discussing details of the FGD outside the group. Before the start of the FGD, written consent (Appendix) was obtained from each of the participants. All FGDs were voice recorded with the full knowledge and permission of the participants. A nonidentifying code was assigned to each participant. Notes written by me, about the participants, interview guide, demographic information and consent forms, were kept in a folder and stored in a locked cabinet in the my home. The recorder was kept in the same cabinet. At the conclusion of each FGD, the participants were thanked for their participation and asked if they have any questions or additional comments.

I transcribed and translated the data collected after each FGD. A copy of the focus group transcripts was sent to each participant for verification through private correspondence. Participants were asked to give feedbacks upon receiving the transcripts if there were any inaccuracy with the transcription and interpretation of the participants' statements by the researcher. Five participants responded and gave clarifications regarding their statements, which prompted me to make changes with the initial transcripts. After the necessary changes were made, I again sent a copy of transcripts to the participants involved.

Within two days, I received their approvals and no other changes were made. In this study an interview guide consisted of 10 open-ended questions, was used by me to maintain consistency for each FGD. The interview guide included questions on pregnancy and childbirth experience, evaluation of maternal healthcare services in Norway, similarities and differences of maternal

healthcare services between Norway and the Philippines, birth beliefs and practices in the Philippines, and lastly, family and social support.

The researcher collected demographic data from the participants using a list of eight questions (Appendix). Participants were between the ages of 25 and 48.

2.4 Data Analysis

The purpose of the data analysis in this qualitative study was to develop a theory. This study followed the process developed by Glaser and Strauss (1965) and adapted by Charmaz (2010). Using this method, I fostered my creativity, increased my potential to conceptualize, and helped me collect rich data from the participants. Figure 1 demonstrates the process that was followed and adapted by the researcher.

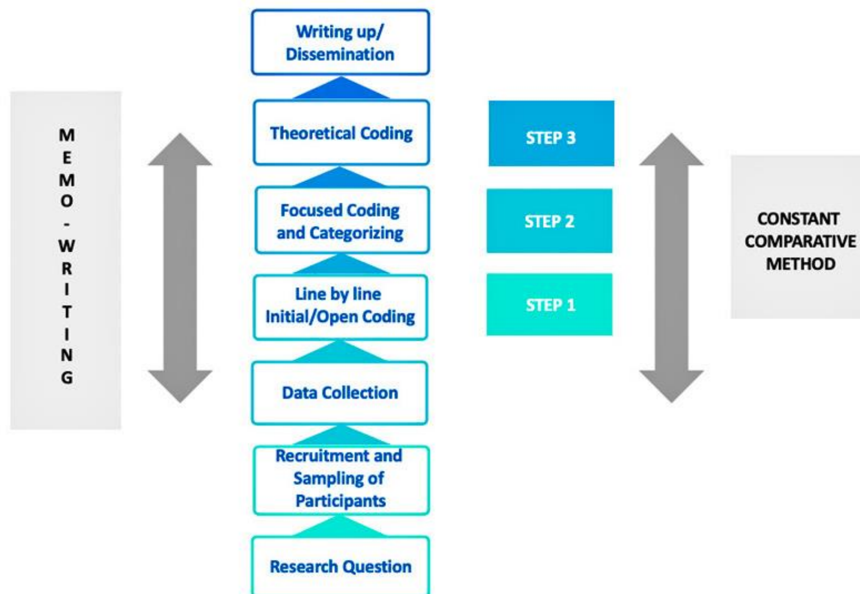

Figure 1: Grounded theory method. Adapted by N. Upfold (2019) from Constructing grounded theory: 2nd Edition by K. Chamaz, 2010.

I began transcribing the data from the first FGD in Filipino. Filipino transcripts were then translated into English by me, and then stored on a password protected external hard drive. The first step of data analysis started with reviewing the transcripts from the first FGD. Data was organized by creating a table with two columns labeled with the following headers: participants

response and initial codes. Initial coding was conducted using a line-by-line process. Data were coded with gerunds to help researcher detect processes and stick with the data (Charmaz 2014). Table 1 illustrates the process used in the initial/open coding. The data from each participant were compared and explored while remaining open to all possible ideas that will emerged. Completion of the initial/open coding and initial memo-writing elevated codes to tentative categories.

Figure 2: The process used in initial/open coding.

Focused coding was the second major step of the analysis. In this step, the codes were more directed, selective and conceptual than line-by-line coding (Charmaz 2006). I searched and chose the most frequent and significant codes among the initial codes. It involved comparing initial codes with data and distinguishing those code that have greater analytic power.

2.5 Ethical Considerations

The study was approved by the Norwegian University of Science and Technology and NSD (Appendix). As this study does not fall within the scope of the Health Research Act, the approval of the Regional Ethical Committee was not required. First, all study participants received written information about the research, and then prior to conducting the study a written consent was obtained from them. The information letter was translated into the Filipino language as well as explained in detail before the start of FGDs if it was necessary. Voluntary participation has been highlighted throughout the study. Before the FGD started, the researcher discussed the purpose of the study, the role of the participant in it, the publication of the results and participant's anonymity. A list of codes was established to remove the identifiers. In addition, the information collected through the FGDs was not transcribed in any way capable of identifying research participants. Information about participants were handled in a secure manner. Personal field notes, interview

guides, demographic information and consent forms were kept in a folder and stored in a locked cabinet in the researcher's home. The audio recorder was placed inside a locked cabinet in the researcher's office. Transcripts have been saved in an encrypted external hard drive. After completion of the master thesis, all information about the participants and audio recordings will be destroyed. The research was carried out among healthy participants who do not represent a "risk group"; therefore, it does not constitute a potential harm to the participants' well-being. Although the subject of the study was not considered to be a sensitive subject, the sensitivity was not ignored, as some women had an emotional pregnancy and childbirth experience. Distress protocol was studied by the researcher and implemented as necessary. Finally, empathy towards the concerns and issues of the participants was shown during and after the FGDs.

2.6 Researcher's Reflexivity

2.6.1 My role as a researcher, student nurse and Filipino immigrant

In my pursuit of my bachelor's degree in Nursing, I was exposed to the concept of maternal health care. Therefore, to some extent, my educational background has influenced this research study. A problem I faced during fieldwork happened when the FGDs were taking place. Participants would ask for my opinion or experience on the subject under discussion, and I would refrain from sharing my own experience so as not to influence the data.

The women would occasionally look at me and look for validation of what they were saying, and I, as a researcher, would not show as much response as possible in order not to affect the data. I felt guilty not being able to give them agreeable response; however, I tried to keep my position as neutral as I could.

It was easier for me to gain the trust and cooperation of the participants, because I was seen as a member of the group, a Filipino immigrant.

2.6.2 Preconceptions and prejudice

In the Philippines, I was a student nurse and had clinical duties in both public and private hospitals. Together with my classmates and clinical instructors, I took care of the mothers and their babies in the delivery ward. I was fairly exposed to the Philippine maternal health care system.

My greatest preconception was that quality maternal health care can only be achieved through private hospitals, and just like in the Philippines, the quality of care that the individual receives depends on the money they spend while accessing the health care system. However, the results in this study disproved my preconception and showed that all participants had access to good and free maternal health care in public hospitals in Norway

Furthermore, in the beginning I had the impression that during the postnatal phase the women can easily get help from the family of their husband. The findings have revealed a different scenario. Although some of the participants received support from their husband's family, they consider it to be limited and not sufficient. It was even more difficult for other women because there was no support from their husband's family.

3 FINDINGS

This study explores the experience of pregnancy, childbirth and postnatal care from the perspective of Filipino immigrant women living in Norway. Figure 3 illustrates the core category as well as its constituent categories and sub-categories. "Experiencing Transitions" sums up the entire experience of the pregnancy, childbirth and postnatal care of the participants in Norway. Participants shared their experience with NMHC, which has contributed greatly to their ability to deal with the changes they encountered during their pregnancy. Guidelines were followed in the delivery of the MHC services to the participants. Although care was standardized it was still very individualized and based on each participant's case. Information on negative experiences and how they had overcome them is instrumental for the health authorities to assist them in providing adequate health and social support to the Filipino immigrant women. Similarities and differences were observed in the coping strategies of the participants during their difficult experience. Finally, social integration and how the participants achieved it demonstrated that these women were open to change.

The following section presents the three main categories namely "experiencing NMHC", "learning from negative experiences" and "achieving social integration". Sub-categories under these three categories namely "appraising NMHC", "seeking adequate prenatal care", "receiving quality childbirth care", "obtaining satisfactory postnatal care", "developing self-reliance", "adjusting to changes", and "reconstructing traditional beliefs and practices from home country" will be presented. Noted differences on the NMHC experiences and overall assessment will also be discussed.

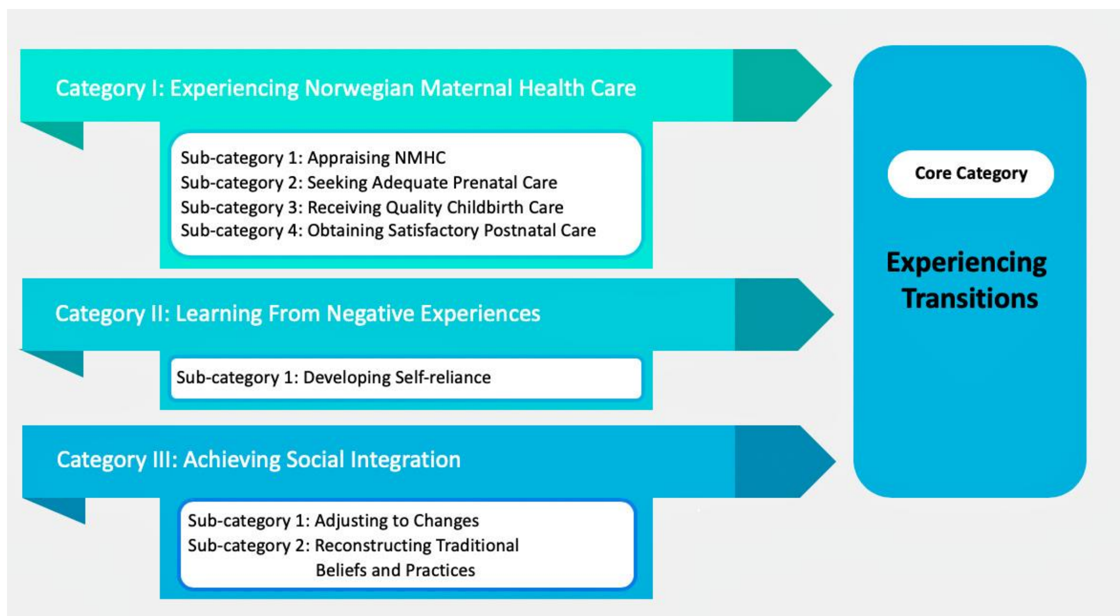

Figure3. The core category and its constituent categories and sub-categories.

3.1 Emergent Categories

3.1.1 Category I: Experiencing Norwegian Maternal Health Care (NMHC)

3.1.1.1 Sub-category 1: Appraising NMHC

Participants felt grateful for the free maternal health care they have received in Norway from their doctors and midwives. Health services mentioned by the participants were prenatal visits, ultrasound, health advice and support, hospital stay, cesarean, vacuum and normal assisted delivery, and receiving supplies (food, milk, medicine, clothes, and things for the mother and child) from the hospital. One factor that contributed to the feeling of being grateful was the knowledge or previous experience of paying for health services in their home country. The women felt lucky and were amazed that they don´t need to pay in Norway.

During prenatal visits, delivery, and postnatal care, participants observed that they were treated equally regardless of their immigration and job status. This experience was in contrast to their early assumptions that because they are foreigners there will be some inequality in the healthcare that they will receive. Several positive experiences during pregnancy were mentioned

such as having supportive and competent healthcare personnel, receiving adequate health information, being treated fairly by the health professionals, receiving effective treatment and medications, and being satisfied with the health service rendered in the hospital.

Additionally, it was mentioned that paying higher taxes in Norway was agreeable because Norway provides quality health care services. They also compared Norway in other developed countries like the USA and concluded that Norway was better in providing support for the children.

3.1.1.2 Sub-category 2: Seeking adequate Prenatal Care

The participants shared their expectation during the prenatal visits, they expected to received health information and instruction on how to care for themselves and their unborn babies. They also expected that NMHC will safeguard both their health and the health of their child. Their motivation to have a healthy pregnancy and baby made them attend the routine check-ups regularly. The participants first confirmed their pregnancy using a pregnancy test at home. Then they proceeded to contact their GP and arrange their first appointment. They had their first prenatal appointment approximately between 6 - 12 weeks of their pregnancy. Participants of recalled that the first questions asked by their GP was about the date of their last menstruation followed by the question about the symptoms of pregnancy they had experience.

Furthermore, the women shared that they were interviewed about their medical history (known hereditary diseases, previous pregnancies, and complications), the number of children, educational level, occupation, religion, and nationality. The participants recalled that their due date was calculated, blood and urine tests were also done. The GP/midwife inquired about their smoking and drinking habits. All participants were given their pregnancy health card during their first pregnancy checkup. They were also advised to bring this health card for all consultations and examinations throughout their pregnancy. Height, weight, and other relevant measurements (blood pressure, fetal heartbeat, uterus measurements) were taken and recorded in this health card. The initial visit was then followed by several prenatal appointments, including at least one ultrasound. One ultrasound was offered to the majority of mothers while some mothers who needed more than one ultrasound based on their health status received more. The GP determines when more than one ultrasound was required. The scheduled appointments gave them the perception that NMHC had a great way of monitoring their health and the health of their babies compared to their home country.

The participants mentioned that they had a supportive and competent doctor or midwife. The health personnel was respectful and genuine in providing prenatal care to the women. The positive conduct towards the women has helped them to trust NMHC and reduced their pregnancy and birth anxieties. However, it was stated by some participants that the time spent with the GP was limited and some of the women want to have a longer time during their checkup. The women were referred to their health station and advised to talk to a midwife for more information. The midwives were reported to be experts and have answered most of the participants' questions. They also provided the women with instructions on nutrition and exercise. Others had a different experience with their GP, and they claimed to be satisfied with the time and health advice allotted to them by their doctor. The women discussed that they were told of the importance of taking prenatal vitamins which contain folic acid during the first three months and that they had followed this advice from their GP. The reasons given by the participants on taking prenatal vitamins were to prevent birth abnormalities and miscarriage.

There was no restriction on doing regular activities such as exercise. They think that this was different from the practice in the Philippines wherein pregnant women were advised to be careful about doing their usual activities. In this stage, the doctor or midwife also identified any potential risks associated with the work of pregnant women that can affect their pregnancy. Once the potential risks were identified, their doctor advised them to temporarily stop working to safeguard their health and the health of their babies.

Noted differences on the participants' prenatal experiences

The participants varied on their choice of going to their GP or midwife. Majority of the participants accepted being referred to the midwife, while others stayed with their GP. There were also variations on the prenatal services received by the participants. Some participants had to have more frequent prenatal visits than others. Small size of the fetus and history of miscarriage from previous pregnancy prompted the health professionals to schedule more frequent prenatal visits (every 2 weeks) to these women. Another difference was the number of ultrasounds received by some of the participants. Majority of the women were given one ultrasound while others had more than one. The participants who became pregnant through IVF and those that had bleeding during pregnancy needed more monitoring and were received more than one ultrasound.

Overall assessment of prenatal services

Adequate prenatal care means the provision and uptake of prenatal services that are timely, sufficient and adequate. It is considered timely when the first visit occurs within the first three months of pregnancy, sufficient when there is attendance of at least four prenatal visits, and adequate when it has appropriate content. Appropriate content includes weight, height, blood pressure, general urine analysis; prescription of folic acid, and prescription of iron vitamins (8). The participants acknowledged adequate utilization of NMHC and agreed that they received adequate prenatal care in Norway.

"My first checkup was on the first week of February. I was 8 weeks pregnant. I did not have an obstetrician; I went to my regular doctor. They asked me if I want to have a midwife. I insisted to go to my general doctor because I'm impress with my general doctor. She was so supportive during my pregnancy. If you ask me about my doctor, I have praises for her…she is really good…she explains everything to me…how pregnancy works in Norway…things like that…so it was easy to be impress with her".

FGD 1:1

"I was satisfied. It was okay and very safe. I went to the doctor to verify my pregnancy after being positive in the home pregnancy test. They took my blood...they check and told me how many weeks pregnant I was. On my second checkup I recall they gave me a paper...it was a paper containing my gestational age, my weight...this helped to make sure that my baby was developing well...then they referred me to the midwife. The midwife contacted me and gave me an appointment to go to her. So instead of going to the doctor for checkup I went to the midwife. She advised me on what to expect during my pregnancy. We discussed my preparation, what to do...what to eat. It was a good experience. I was happy for her treatment of me. For me it did not matter if I was a cleaner or a doctor...I will get the same

FGD 2:4

3.1.1.3 Sub-category 3: Receiving quality Childbirth Care

All the participants gave birth in St. Olav´s Hospital. For most of the women, their labor started at home and progress slowly. These women came to the hospital too early and were asked to go home and return to the hospital when contractions were stronger and close together. Several

women refused to go back home and decided to stay in the hospital. Living far from the hospital was given as one of the grounds for refusal. Another reason given was fear of complications because of overdue pregnancy. On the other hand, some women were not asked to go home even though they were still in early labor. Staying in the hospital during early labor gave these women a sense of security.

Medications that help with cervix dilation and pain management were also provided to the respondents when necessary. Some women were glad to receive epidural during their labor and for them, it was very helpful. When it was time for birth, the women were assisted by the healthcare professionals during their normal delivery, and those that needed surgery had a cesarean delivery. While other women had vacuum-assisted delivery.

During their hospital stay, the respondents saw that Norway had better infrastructure and medical equipment, and this strengthened their belief that Norway had better public hospitals than in the Philippines. The women also noted the cleanliness and good ventilation in the hospital. It was described that hospital beds were hygienic and comfortable to use. In terms of the quality of care they received, the women claimed that they were handled equally and provided the same standard of care during their labor and delivery.

Moreover, the women were glad to be supported by skilled and polite medical and hospital staff. Almost all women had no complaints about the hospital routine and the change in hospital staff they had experienced. They described it to be smooth and acceptable. Most patient referrals were also viewed as fast and effective. The support from the midwives was continuous and commendable. The positive experience helped them gain confidence and security in the NMHC.

Noted differences on the participants' childbirth experiences

I found that some of the participants were asked to return home while others were admitted during their early labor.

One participant, who gave birth during Easter had a variation on the usual routine and that caused her to receive delayed treatment. Her experience will be further discussed in the category 2 section. Some participants mentioned that their doctor was open and gave them clear explanation of their condition during their delivery while others expressed that they were not given a clear explanation about what was happening. For the participants who were not given clear explanation, there were those who preferred not being told because they believed it would increase their anxiety

while others preferred the opposite. Stories on the women's complications will be tackled on category 2 section of this chapter.

Overall assessment of childbirth services

WHO defines quality of care as " the extent to which health care services provided to individuals and patient's populations improved desired health outcomes. In order to achieve this, health care needs to be safe, effective, timely, efficient, equitable, and people centered."

Even though some women had negative experience during childbirth they still perceived the overall experience to be positive. All participants declared that they received quality in-hospital care during childbirth.

" When I came there around 5 am…they told me I don't need to go home…Around 11 I said to myself just a little more endurance. But then it was already afternoon…my baby started getting weak inside…so the doctor decided…ah before that I told my husband that I am very tired I want to have CS …he said "let us wait for them to say it"… then they decided it was time for CS…" FGD1:2

"I had a cesarean delivery. During that time, there were many pregnant women scheduled for cesarean delivery. There was change in my schedule, they told me that I will have my surgery earlier than my scheduled time. I was awake during my cesarean delivery. They made me feel I can trust them, and I felt safe. I felt that I was in the hands of experts. They talked to me the same way as they talk to other patients. Other patients were Norwegians, while others also from other countries. We were treated equally. There was no special treatment. After delivery it was just me and my husband. I had a complication...I needed to receive blood transfusion. I received free treatment cesarean, food, for the baby milk, diaper, clothes and medications. FGD2:1

3.1.1.4 Sub-category 4: Obtaining satisfactory Postnatal Care

In the first 24 hours after birth, mothers reported that they had continuous access to care. The women and their newborn babies were monitored and checked for possible childbirth complications. As soon as complications were found they were treated. After childbirth, the mothers noted that the hospital was well equipped and provided them with a safe healing environment. Mothers were glad to be treated fairly irrespective of their nationality and economic

status by the hospital staff. The hospital and medical staff were described to be competent and attentive to their needs. They were also reported to be friendly and communicate with respect.

In addition to this, most women had experienced a smooth transition between the staff during shifting. The privacy of patients was protected by the provision of private rooms in the postnatal hotel. This postnatal hotel, with comfy and clean beds, allowed the husband or someone else to accompany the mothers after birth. Aside from this, the women appreciated that the nurse or midwife assisted them in cleaning their body after childbirth which made them comfortable. Meals were given to the mothers thus obviating the need to cook after birth. Some women wanted to stay in the hospital for longer than three days because it helped them concentrate on healing and caring for their infant, and not on household chores. They suggested that if possible, the hospital could consider giving the mothers the option of staying at the hotel for at least one week after birth. This will help mothers who feel they need more time to recover. On the other hand, some participants believed three days was enough for them and wanted to go home and settle as soon as possible in their homes.

Furthermore, the Norwegian hospital provided the participants with free basic items such as diapers and clothes for their newborn babies. Participants regarded these items as gifts from the hospital and the action added to their feeling of being grateful. Some first-time mothers commended feeling safe inside the hospital mainly because of the assistance they were given by the nurse or midwife in taking care of their newborns. They felt less confident and had little anxiety about caring for their newborns when they come home. It was noted that follow up care, breastfeeding support, and counseling for depression were provided by the midwives during the health worker's house visit or in the public health clinics. The respondents appreciated that NMHC prioritized the health and well-being of the newborns after birth.

Noted differences on the participants' postnatal experiences

It was reported that some of the mothers felt forced to shower after giving birth. While others were allowed to have a sponge bath. Their experience were further discussed on section category 3.

Overall assessment of postnatal services

During the postnatal period, the participants expressed that they had a positive experience with NMHC.

"After the delivery...if you need something you just call them...and they will come and assist you...I think it was good set up..." FGD1:4

"I can suggest that patients be allowed to stay for a week in the hospital...just like in the Philippines...It will help with the recovery...In my case I was very weak and needed to have enough assistance but they asked me to leave after 3 days of giving birth...I know it was because others need my room...But I still prefer it that way..." FGD2:2

3.1.2 Category II: Learning from negative experiences

3.1.2.1 Sub-category 1: Developing Self-reliance

The participants recounted having stressful or challenging experiences during their pregnancy. These adverse experiences ranged from the minor challenges like unsatisfied food cravings, and missing their family or friends, up to the major challenges such as, problems in communicating with their doctor, complications during and after birth, newborn complications, having less family and social support, and isolation and depression. In the first months of pregnancy, some women spoke about the difficulty of understanding their doctor and revealed that they were accompanied by their interpreter during their prenatal visits. Health information was explained to them in English by their husband or mother-in-law. The participants voiced that it would be better for immigrant women to have an interpreter especially for those who have less family support. It required more effort on the part of women to buy the food they prefer in the Asian store, which was located far from home, particularly after giving birth. Participants recounted that chatting online was helpful when they missed their family and friends.

Some of them narrated having complications during delivery or immediately after birth. Complications mentioned during delivery were labor did not progress, the cervix failed to dilate enough or in due time, the infant´s descent in the birth canal did not run smoothly, abnormal heart rate of the infant, and perineal tears that needed repair. Postnatal complications indicated were excessive bleeding, mother and newborn infections, incontinence, and depression. The participants

revealed that their complications were not explained clearly to them by their doctors. Some think that it was better this way and that it helped to lessen their anxiety. Others do not think so and prefer to have been told earlier and clearly about their complications. One participant who gave birth during a holiday experienced more difficulty in receiving care from her healthcare provider. The main reason was her doctor was not available during this time and according to the participant, fewer doctors were available to assist her. The help came but the participant needed to wait and endure pain longer than necessary.

During delivery, the participants gave their full trust and cooperation to the healthcare personnel. Most of them are grateful that they had skilled doctors and nurses who have saved their lives and their infants´ lives. In addition, moral support from their husbands helped them to survive the delivery process. When needed, medications, cesarean delivery, surgical repair of perineal tears, and blood transfusion have been performed and delivered promptly by health professionals. Having endured childbirth and some of its complications almost all the participants believed that their bodies were capable to survive another pregnancy and childbirth.

One of the difficulties women experienced after birth occurred when they returned to their homes. Several participants recalled that it was difficult because of the limited assistance they had received from their family and friends in Norway. Their family in the Philippines, particularly their female relatives, whose physical presence would have been very helpful, could only assist them by chatting online or by phone. Examples of support that their own family can provide were household help, assistance in taking care of the infant, and more effective moral support.

Several participants who had female relatives living in Norway reflected that having them around contributed to their physical and mental health. Partner support was discussed by the participants to be insufficient or limited because most of their partners have jobs. Other participants believed that since their spouse works in the morning they should rest at night. Several women temporarily received support from the family of their spouse when they visited and checked the newborn. Though it was temporary the women appreciated their efforts.

Friends in Norway also offered support like bringing cooked food and visiting the new mothers. This experience did not happen very often due to the limited availability of their friends who also had their own family and work to attend. In contrast, the participants stated their friends in the Philippines will have more time to visit them and provide moral support. For women, most people in the Philippines were less busy than people living in Norway. Some women revealed

feeling isolated and depressed. Chatting with friends or family and finding other ways to entertain themselves like watching movies and listening to music helped them overcome these negative emotions.

All participants concluded that the difficult experiences had led them to develop self-reliance. Having less family and social support promoted independence and increased their ability to care for themselves and their child. Furthermore, the experience increased their confidence that they could endure a similar situation in the future.

3.1.3 Category III: Achieving Social Integration

3.1.3.1 Sub-category 1: Adjusting to changes

During the focus group discussion, the women mentioned several changes that they had to make in their move to Norway. One major adjustment the respondents had was living away from their family and relatives. Some of them felt alone and they believe that the use of the internet and telephone although useful was not enough to replace the physical presence of their family. After some time, the women learned to overcome homesickness and feeling of isolation by not giving up and enduring the negative experience until it was better. Attending the Norwegian language course and learning Norwegian were among the adjustment they had to do. Some of the women were able to understand Norwegian before they became pregnant, eliminating the need for interpreters during their prenatal visits and delivery.

Another topic mentioned was about food. These women were used to eating warm Filipino food, mostly stews, soups, and rice. During their pregnancy, some women remembered having food cravings and missing their mother's cooking, but these cravings were left unsatisfied. Living in Norway, they needed to try and get used to Norwegian food which was more accessible to buy and requires less effort to cook.

Most of the women were able to gain new friends in Norway and these proved to be beneficial. Participants acknowledged that new friends provided support by visiting them and even bringing cooked food. While other women shared that their husband´s family offered support and were able to assist them others had a different experience. Several respondents expressed feeling alone and having no support from their husband's family. They narrated that the experience

changed them, and they became a stronger, independent, and self-sufficient woman after surviving it. It was important to note that the women were able to study, train, and find jobs in Norway. Also, the researcher observed that the women appeared to have adjusted well and looked happy to be living in Norway.

3.1.3.2 Sub-category 2: Reconstructing Traditional beliefs and practices

The Philippines have a wide range of traditional beliefs and practices about health and pregnancy. Such beliefs and practices differ and depend on the region or province from which an individual originates. The participants shared some of the beliefs and practices they were familiar with and revealed that they had followed some of them. According to some Filipino beliefs, cravings for food during pregnancy were common and these should be satisfied. Most women shared that they craved sour fruits like green mango and admitted that they believed that it was normal. While some women had fulfilled their food cravings, others were left unsatisfied. Dissatisfied women were often looking for foods that were only available in their home country or foods that were home-cooked by their own family in the Philippines. Another common practice associated with food was that new mothers should eat hot soup made of meat and vegetables to help promote lactation after childbirth. Nutritious foods were essential in producing nourishing milk for their infants.

Most of the discussions about traditional beliefs focused on the period after childbirth. Filipinos often classified food, medicine, and temperature/weather conditions according to their "hot" and "cold" properties and their effects on the body. They also claimed that abrupt changes in body temperature may be deemed harmful to health and that postpartum women should be protected from cold wind.

After birth, women must be kept warm and instructed not to drink cold drinks to avoid chills. They were also told to wear heavy clothing or to put on blankets to prevent the cold wind from entering their bodies. During this period, bathing was seen as a cause of illness and rheumatism in old age. The participants had various opinions about bathing or even showering right after birth. A small proportion of women thought it was normal and beneficial to them, and they felt very comfortable after the shower. On another hand, most of the women claimed they objected to taking a shower and insisted on having a sponge bath. It was important to note that there were women who said that they felt forced to shower immediately after birth by the health care worker and that

they were not given the option of a sponge or steam bath as an alternative. They also admitted lying to their health care worker about taking a shower after childbirth just to avoid it.

The concept of "relapse" which refers to extreme fatigue, weakness, and chronic headache associated with being active too soon after birth was also discussed. The women expressed that in Norway people do not believe in "relapse" and several participants were convinced that it does not exist. Some women, on the other hand, said that although they believe in the likelihood of suffering from "relapse," they cannot avoid the activities that could lead to this. Filipinos considered the postpartum period to be dangerous and women should be safe from the likely risk of developing hemorrhage, infection, and postpartum depression. Traditionally, a postpartum woman should rest completely and stay inside the house for 30 to 40 days. Doing housework was believed to be a predisposing factor to the exposure of the women to either water or cold wind, which may lead to developing arthritis and chronic aches. While recovering, her family or relatives will take care of her housework and cooking, and postpartum women will not be susceptible to "relapse", chronic body pain, or other health risks. In Norway, the participants expressed that because of the absence of their family and relatives they were required to do housework and cooked for themselves. Most of the women felt alone helpless and longed for the support of their family especially their mother during this time.

When the researcher asked the women if they felt free to practice their beliefs about pregnancy and childbirth from their home country, almost all of them responded that they felt free to practice their beliefs in Norway. On the other hand, some women stipulated that although they felt free, they also believed that not everything would be accepted. If it was harmful to them or their child, it will not be accepted in Norway.

4 DISCUSSION

The purpose of this master study has been to explore the experiences of pregnancy, childbirth and postnatal care of Filipino immigrant women living in Norway. The findings of the FGDs will be discussed against the theoretical background and recent studies in this chapter.

4.1 Category I: Experiencing Norwegian Maternal Health Care (NMHC)

4.1.1 Satisfaction

The findings in this study revealed the overall assessment of the participants about NMHC.

This study found that all participants were satisfied on the MHC that they have received in Norway. Migration background, a sociodemographic variable, affects women's satisfaction regarding maternal health care (57). I found that our findings were consistent with the study in Italy that showed that foreign women from non-western countries tend to be satisfied with maternal health services(58). Furthermore, in a study in Mozambiq, researcher found that participants from low middle-income countries like the Philippines, tend to have high level of satisfaction on maternal health care services offered in host country (58). In contrast, there were studies that showed opposite results, wherein immigrant women from non- western countries were dissatisfied with MHC from host country. Since there were no consistency in these findings about the impact of migration background further studies were needed to achieve consistency and find the reason behind the variations.

We found that all the participants were grateful for receiving free MHC in Norway. Immigrants tend to belong to the low-income group and not paying for health care increases their satisfaction of NMHC. According to Gurman and Becker (2008) women's perspectives on delivered health care services and their level of satisfaction with the health system are strongly influenced by their experiences in their home country (59). The experience or knowledge that maternal health care is not free in the Philippines could have cause their high satisfaction with NMHC.

4.1.2 Free Access and Utilization

The participants confirmed that they have free access to NMHC. This finding is consistent with the Norwegian Legislation granting all pregnant women in Norway free access to NMHC (46, 48).

Several studies suggest that free MHC increases access and utilization of maternal health services (2,3,4) (60-62). In 2019 a study conducted in Sierra Leone reported a 30% increase in institutional delivery rate after the government launched the free healthcare initiative for pregnant women (3). In contrast, some studies revealed that free MHC does not guarantee a high utilization rate. This was seen in the study done in Kenya that showed a low utilization rate despite the efforts made by the Kenyan government of implementing free maternal health care. Researchers in Kenya found that several factors play a role in the low utilization of services, such as lack of understanding of the role of MHC beyond the treatment of regular ailments and negative attitude of health workers (5).

Participants expectations about NMHC were met and this contributed to their being satisfied. Women in Nigeria had the same experience, they reported that their maternal expectations were met and reported a high satisfaction rating for MHC services (63).

4.1.3 Prenatal Care

In my study, I adapted the WHO definition of adequate prenatal care, which defines adequate prenatal care as the provision and uptake of prenatal services that begin during the first trimester of pregnancy, including at least four prenatal visits and with appropriate content (64). Appropriate content includes weight, height, blood pressure, general urine analysis; prescription of folic acid, and prescription of iron vitamins.

WHO states that prenatal care is a key component of maternal health care and that it is essential for all pregnant women (65). I found that although many studies suggest that prenatal care reduce neonatal morbidity and mortality (66-68), there is little evidence of its effectiveness in reducing maternal morbidity and mortality (69, 70). Nevertheless, I agree that prenatal care can help prevent maternal deaths by screening for actual and potential problems and by providing timely treatment for any complications that may arise(65, 71). It can also educate women to identify signs of danger and prompt them to seek appropriate care.

My findings found that in Norway, the participants were referred and encouraged by their GP to go to the midwife. Pregnant women, with low socio-economic status in Canada, had a different experience. Out of the 23 participants in this study only 10 were informed of the option of midwifery care by their physician. In this study, it was reported that some physicians did not respond positively when they were informed that their patient wants to pursue midwifery care (72).

The data shows that participants are seeking for midwifery care in order to be able to ask more questions and obtain more information about their pregnancy without time constraints. The findings echoed the experiences of pregnant women in Netherlands (73).

4.1.4 Childbirth and Postnatal Care

The data showed that some of the participants had birth complications. The use of maternal health care does not guarantee optimal birth outcomes for both the mother and child (74). Even though some women had complications during childbirth they still evaluated the care delivered to them as good.

The findings revealed that some of the women were asked to go home and return to the hospital when contractions were stronger and close together. Past research found that the longer a woman is in hospital the higher the risk for complications for her and her child (75). A recent research finding about effects of early versus late hospital admission mirrored this result. Researchers found that women who were admitted to labor early had a higher risk of delivery by cesarean section (76)

Similar to the women in Nepal (77) , the women in this study reported high satisfaction to childbirth and postnatal care. Factors that contributed to positive assessment of childbirth and postnatal care by the Nepali and Filipino women were cleanliness of the hospital, assurance of privacy, respect and courtesy of the care providers, receiving necessary medicine and supplies, and good healing environment.

4.2 Category II: Learning from negative experiences

The participants recounted having challenging experiences during their pregnancy. Difficulty understanding their GP during prenatal checkups were admitted by some of the women. Data emphasized the need for interpreter during health consultations. Patients in Norway have the right to receive information in the language that they understand, this applies to all women attending prenatal appointments and other health consultations (52). Several research findings stressed the need for interpreting services in the health care settings (78-80) .

Lack of sufficient explanation about health status and complications during delivery was disclosed by some of the participants. Most of the women who had complications wanted to be informed about their health status. There was a similarity between the experiences of the Filipino women and the women in Rwanda regarding insufficient health information. The study in Rwanda revealed that health care providers did not ensure that the women fully understand their health status and did not inform them about the anticipated progress (81) .

The participants shared the challenges they encountered during the postnatal period. Limited family and social support were common to immigrants and can trigger depression among the immigrant women (82). The women felt the need for family and friend support not just from the psychological point of view but also the practical point of view, like help with household chores. Similar findings were shown in the 2017 study conducted by Slomian (83)

4.3 Category III: Achieving Social Integration

By adjusting to changes the women in this study seem to achieve social integration in Norway. Studies showed that homesickness decreased after some years of migration (84), these was reflected by the experience of the Filipino immigrant women in Norway.

Language contribute to achieving social integration in a new society. It leads to acculturation to the culture of destination (85). The experiences of the women in this study support this statement. Learning the Norwegian language made it easier for some of the women to understand their health care providers. The findings could be supported by other research studies which reported that language barriers pose challenges in the health care delivery system (86).

Restructuring their traditional belief and practices from home country to accommodate new health care practices in Norway demonstrated willingness of the participants to adapt in a new culture.

4.4 Core Category: Experiencing Transitions

Pregnancy, childbirth and the postnatal period, just like other life events are accompanied by transitions. Transition is defined as " as a passage or movement from one state, condition or place to another and has universal properties and conditions which help to explain person-environment, in terms of developmental, situation, health illness, organizational processes, and outcomes" (87).

The transition to motherhood is an important developmental life event. It contributes to a woman's psychosocial development, which progress and leads to increase in an individual's adaptive functioning (Kegan, 1982; Rubin, 1994) . African-American women narrated that healthy transition of immigrant women to motherhood is facilitated by , support from partners and families, especially from the woman's mother and other significant women in her life, relevant information obtained from health care providers, advice from trusted sources, role models and answers to questions.

"Experiencing Transitions" sums up the entire experience of the pregnancy, childbirth, postnatal care of Filipino immigrant women in Norway. The category 1: experiencing Norwegian maternal health care was very instrumental in making it possible for these women to have had healthy transition to motherhood.

5 METHOD DISCUSSION

5.1 Strengths

The study benefited from the use of qualitative methodology and FGDs, which allowed me, as a researcher, to explore the perspective of the participants on the subject while allowing them to formulate their own views. In contrast to using quantitative method, in which the answers were based on established hypothesis, I had the opportunity to explore and gain new knowledge about the subject.

Strauss and Corbin (1990) defined qualitative research as "any type of research that produces findings not arrived at by statistical procedures or other means of quantification. It can refer to research about persons' lives, lived experiences, behaviors, emotions, and feelings as well as about organizational functioning, social movements, cultural phenomena, and interactions between nations." There are several advantages of using quality method (88). First, this method gives a rich and detailed description of the feelings , opinions and experiences of the participants (Denzin 1989); Second, through this method , the researcher discovers the inner experience of the participants and makes sense of how meanings are shaped through and in culture (Corbin & Strauss, 2008). Third, this method produces data that is subjective and detailed because the researcher interacts directly with the participants during the data collection process (88)

According to Kitzinger (2005), the focus group is an 'ideal' approach for examining individual stories, experiences, points of view, beliefs, needs and concerns. Similar to qualitative research, the methodology is significant in that it enables participants to develop their own questions and frameworks and to pursue their own needs and concerns in their own words and on their own terms. Recent studies have reported that FGDs provide a rich data from wide variety and of disciplines and contexts, brought about, in particular, by interaction between participants (89, 90)

The choice of method and the relevance of the method to the subject, can be considered to be the strength of the study. I, the researcher, being a member of the cultural group being studied, can be considered a strength because preconceptions from other cultures have been avoided and I have had an innate understanding of the relevant concepts (Boer H. (2006) (91) .

5.2 Limitations

My novice experience as a researcher can be considered a weakness of this study since qualitative research depends heavily on researcher expertise (92).

Presence of a recording device during the FGDs might had a significant effect on the data. Sarte (1969) and Paterson (1994) reported that interview participants may be affected by the presence or awareness of the researcher as part of the study. Participants realized that they were being listened to or watched, and that they might be judged, so they would try to present their experiences, opinions, actions and attitudes in a positive way. The effect of recording could be greater in group interviews where participants where ask to present their selves in the group. The effect of recording could be greater in group interviews where participants were asked to present themselves in a group.

This study was not generalizable due to the qualitative nature of the study. The study was also described as exploratory, as it dealt with a topic where there was limited knowledge, however I compared it against related theories and recent studies.

The used of grounded theory approach generated large amounts of data that was challenging to manage. Rigor, hard work and care in both the data collection and analysis was necessary for me to manage the data (93)

6 CONCLUSION

6.1 Summary

The purpose of this study was to explore immigrant Filipino women's experiences of pregnancy, childbirth and postnatal care in Norway. The study engaged directly into exploring the women's experiences using FGD's. The results of this research study can be used to help NMHC provide Filipino immigrant women and other immigrants with similar socio-cultural backgrounds with quality maternal health care that meets the women's needs and improve their social integration in Norway.

The discussion of the results is situated on the core category "experiencing transitions" that sums up the experiences of immigrant Filipino women of pregnancy, childbirth and postnatal care in Norway. The women have undergone several transitions related to their pregnancy and migration. Several topics were tackled by the FGDs. Detailed descriptions of the women's experiences showed both positive and negative experiences.

Experiences with maternal health care that had positive effect on the women should be maintained by the NMHC, while those that had negative effect could be reduce or eliminated. Favorable experiences reported were having skilled, respectful and competent health care providers; receiving useful and comprehensive prenatal health advice from the midwife; being in a safe and comfortable place during childbirth and postnatal care; receiving necessary treatment; and feeling of being well supported.

Significant unfavorable experiences were difficulty understanding their GP; being forced to shower after childbirth, insufficient health information on health status and treatment; and having childbirth complications.

After the research study, I developed a better understanding of Filipino immigrant's experiences of pregnancy, childbirth and postnatal care in Norway.

6.2 Further Research

The findings of this study suggest a need for more research on pregnancy, childbirth and postnatal care experiences among other ethnic minority groups. Future studies can be about childbirth complications among immigrant women in Norway. In addition, studies on effect of limited spousal support after childbirth can be investigated.

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APPENDIX A:

STUDY TITLE: "A QUALITATIVE STUDY OF PREGNANCY AND CHILDBIRTH EXPERIENCES OF FILIPINO IMMIGRANT WOMEN IN NORWAY"

INTERVIEW GUIDE

I. Pregnancy and Childbirth Experience

1. Describe your experience of maternity healthcare in Norway
2. How was the experience of childbirth in a Norwegian hospital?

II. Evaluation of Maternity Healthcare Services

3. What were your expectations for maternity healthcare services?
4. To what extent were they met?
5. How do you feel about the care that you received in Norway?
6. What is needed to further improve maternity healthcare in Norway?

III. Maternity Healthcare Services in the Philippines

7. What are the similarities and differences of maternal healthcare between Norway and the Philippines?

IV. Birth Traditions and Practices

8. What are the special practices and traditions related to pregnancy, childbirth and the postnatal period in the Philippines?
9. To what extent did you feel free to follow these practices and traditions in Norway?

V. Family and Social Support

10. How did family absence affect your experience of pregnancy and childbirt h?

TITLE: "A QUALITATIVE STUDY OF PREGNANCY AND CHILDBIRTH EXPERIENCES OF FILIPINO IMMIGRANT WOMEN IN NORWAY"

DEMOGRAPHIC QUESTIONNAIRE

Participant Study ID Number:________________ Date:________________

Sr. No	Questions	Answers
1.	Age	
2.	Education Level	
3.	Occupation	
4.	Immigration Status	a. Temporary Resident b. Family Immigration c. Permanent Resident d. Nationality Holder
5.	Marital Status	a. Single b. Married c. Cohabiting/living together d. Separated e. Divorced f. Widowed g. Other:___________________
6.	Number of children a. Born in Norway b. Born outside Norway	a. b.
7.	Living in Norway since	

APPENDIX B:

NSD's assessment

Project title

A qualitative study of pregnancy and childbirth experiences of Filipino immigrant women in Norway

Reference number

194200

Registered

02.10.2019 av Nikki Lyn Esnardo Upfold - nikkilu@stud.ntnu.no

Data controller (institution responsible for the project)

Norges teknisk-naturvitenskapelige universitet NTNU / Fakultet for medisin og helsevitenskap (MH) / Institutt for samfunnsmedisin og sykepleie

Project leader (academic employee/supervisor or PhD candidate)

John-Arne Skolbekken, john-arne.skolbekken@ntnu.no, tlf: 90012203

Type of project

Student project, Master's thesis

Contact information, student

Nikki Lyn Esnardo Upfold, nikkilu@stud.ntnu.no, tlf: 40594218

Project period

08.10.2019 - 30.06.2020

Status

04.10.2019 - Assessed

Assessment (1)

04.10.2019 - Assessed

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet 04.10.2019 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:
https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle særlige kategorier av personopplysninger om helse og alminnelige kategorier av personopplysninger frem til 30.06.2020

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 nr. 11 og art. 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse, som kan dokumenteres, og som den registrerte kan trekke tilbake.

Lovlig grunnlag for behandlingen vil dermed være den registrertes uttrykkelige samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a, jf. art. 9 nr. 2 bokstav a, jf. personopplysningsloven § 10, jf. § 9 (2).

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

Tlf. Personverntjenester: 55 58 21 17 (tast 1)

NTNU
Norwegian University of
Science and Technology