Master's thesis

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Childbirth experiences of Pakistani immigrant women in Norway

A descriptive phenomenological study

Master's thesis in Global Health
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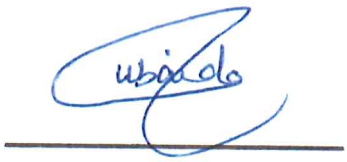
Declaration

I, Zubaida Waheed Butt, hereby declare that I am author of this work and the literature used from other researchers has been duly cited, and this work has not been submitted anywhere else.

Dated: 10-06-2020



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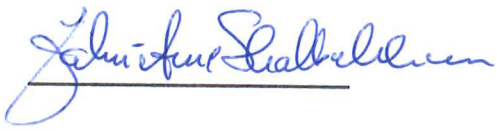

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Abstract

Objective: The objective of this study is to explore childbirth experiences of immigrant women from Pakistan.

Design: A descriptive phenomenological research design was used

Sample: Sample size for this study was 9 immigrant women from Pakistan.

Method: Individual interviews and focus group discussion were conducted, tape-recorded, transcribed, translated, and then analyzed following the Giorgi's descriptive phenomenological method.

Results: Three major themes emerged followed by several sub- themes. 1) Organizational structure and behavior (The first theme is related to Norwegian maternity healthcare system and health care providers how they influenced childbirth experience of participants. a) No out of pocket expenses, b) Experience with GP and Mid-wife, c) Number of Ultrasounds during pregnancy d) Admission in hospital for delivery, e) Estimation of baby's weight & Episiotomy, f) Post-delivery care and change in shift, g) Care of newborn and guidance for breast-feeding, h) Delay in procedures, 2) Communication Issue a) Language barrier, b) expression of pain c) undisclosed complications 3) Social Support (Final theme explains different types of social which was available or absent for the participants during pregnancy, delivery and postpartum) Informational Support, b) Instrumental support) c) Emotional support)

Conclusion: Pakistani immigrant women were partially satisfied with the Norwegian maternity healthcare system. Better informational and social support, and progressive communication with healthcare professionals can improve Pakistani immigrant women's childbirth experience in Norway.

Sammendrag

Bakgrunn: Fødsel er et universelt biologisk fenomen, som samtidig utføres under ulike kulturelle, sosiale, økonomiske og psykologiske betingelser for kvinner. Disse betingelsene påvirker deres fødselsopplevelse positivt eller negativt. Variasjon i fødsel på tvers av tid og kultur gjenspeiler dens sosiale konstruksjon. Studier viser betydelige forskjeller i fødselsresultater for innvandrerkvinner. Internasjonal migrasjon fortsetter å øke raskt. I 2017 bodde det mer enn 90 millioner innvandrere i Europa, inkludert Norge. Over 50% av innvandrerne var kvinner og mange var i fertil alder Innvandrerkvinner møter vanskeligheter med å tilpasse seg det nye miljøet spesielt i svangerskapsperioden og ved fødsel. For å forstå disse utfordringene er det derfor viktig å utforske innvandrerkvinners opplevelser ved fødsel. I løpet av 2016 sto innvandrerkvinner for 27% av alle fødsler i Norge. Innvandrere fra Pakistan utgjør den største innvandrergruppen i Norge. Denne studien ble utført for å utforske fødselsopplevelser hos pakistanske innvandrerkvinner i Norge.

Forskningsdesign: Et utvalg på 9 deltagere fra 3 forskjellige byer i Norge deltok i studien. Det ble gjennomført individuelle intervjuer og fokusgruppediskusjon for å samle inn data. Data ble analysert ved bruk av den beskrivende fenomenologiske metoden til Giorgi.

Resultater: Mangel på sosial støtte, kommunikasjonsspørsmål og organisasjonsstruktur og atferd i helsetjenesten for barsel var faktorer som påvirket fødselsopplevelsene til deltakerne i denne studien. Fravær av økonomiske kostnader, jordmødres kompetanse, kompetanse innen sying, stell av nyfødte og veiledning for amming ble satt stor pris på av deltakerne.

Konklusjon: Oppgaven konkluderte med at bedre informasjons- og sosial støtte og progressiv kommunikasjon med helsepersonell kan forbedre pakistanske innvandrerkvinners opplevelse av fødsel i Norge.

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I owe my deepest gratitude to my supervisor Professor John Arne Skolbekken for his constructive and valuable guidance throughout the research project. Thank you, John Arne, for guiding me with patience when I was such a beginner at everything. Thank you for your thoughtful feedback and your prompt response to my inquiries, no matter how naive they were. I was lucky to work under your kind supervision. Your way of teaching and dealing with the students has taught me lifelong lessons.

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Chapter 1

1. Introduction

Childbirth is a biological phenomenon which is universal whereas its social variations across time and cultures reflect its social construction (1). Childbirth has various cultural, social, economic, and psychological outcomes for women. Maternal confidence, support from partner, feelings of accomplishment are a few examples of positive childbirth outcomes (2). Maternal confidence refers to women's ability to performing new responsibilities. Whereas gestational diabetes, post-partum depression, increased financial burdens are some examples of possible negative outcomes for women (3). These outcomes may be different for women with an immigrant background. Some studies have reported similar or more positive birth outcomes for migrants (4). For example, in Canadian (5) and Swedish (6) (7) studies, similar levels of satisfaction with maternity care were found for immigrant and non-immigrant women. However, these outcomes may apply explicitly to migrants from 3rd world countries and may be accompanying with protective individual characteristics. On the contrary, many other studies revealed the issues of equity in birth outcomes for immigrants (8, 9).

A systematic review in immigrant-receiving countries in Europe explored the hazards for immigrants in outcomes in comparison with the natives. Immigrants had 43% higher risk for low birth weight, for preterm birth the risk was 24% higher, and 61% higher for congenital deformities (10). Apart from health outcome, considerable conflict in the traditions and beliefs of immigrant impacts the childbirth outcome negatively. Women tend to prefer their traditional beliefs and practices over the new environment. Some of childbirth related traditions in Muslim societies are

unusual for a western culture. For example, in Islamic culture, for the purpose of purity, it is customary practice to give bath to a new-born soon after birth. But for western cultures the reason to give bath for the purpose of purity of new-born might sound strange. Appropriate maternity care for immigrant women requires the incorporation of these beliefs and practices (11). In order to understand the cultural, social political and economic aspects of childbirth and how these aspects form the phenomena of pregnancy and childbirth, it is important to look at experiences of migrant women. And how these aspects shape the phenomena of pregnancy and childbirth.

Based on the personal observation and interest, lack of research studies on childbirth experiences of Pakistani immigrant women in Norway, and practicality for master thesis research project, the researcher carried out this study for the purpose to explore the childbirth experiences of Pakistani immigrant women in Norway.

1.1 Background

Prior to the 20th century, most births occurred at home. Women delivered in the comfort and familiarity of their own surroundings and suffered higher rates of infant mortality, maternal deaths, and subsequent ill health partly due to poor obstetrical care (12). From the turn of the century to the 1950s, birth became a medical event. The childbirths took place in an unfamiliar setting and role of women in their birth process started becoming passive. Nevertheless, in the mid-1970's wide variation in the birth process exists even within a single hospital, and, not surprisingly, the subjective childbirth experiences of women vary widely (13). In the late 20th century, childbirth has now become leading reason for hospitalization of women. Hospital-based maternity care has undergone marked changes in the 21st century (14). However, according to World Health

Organization's (WHO) statistics of the year 2017, approximately 810 women die every day from pregnancy and childbirth related causes. And 94% of all maternal deaths occur in low and lower middle-income countries. Moreover, maternal deaths caused by improperly performed procedures contribute to 13% of the maternal mortality rate worldwide (15). Urbanization, centralization of health care, and improved medical technology brought about greater safety for mothers and babies but imposed heavy social, psychological, and economical burdens globally (16). Next section of this chapter gives a brief view of childbirth as a global phenomenon.

1.2 Childbirth as a global phenomenon

Every year, approximately 140 million births occur globally. In order to improve childbirth outcomes, a considerable progress has been seen in labor practices to initiate, accelerate, terminate, regulate or monitor the physiological process of labor (17). This growing medicalization of childbirth processes negatively impacted women's childbirth experience by reducing her own capability to give birth. During various stages of pregnancy and childbirth, women experience a variety of feelings such as anxiety, uncertainty, fear, and other feelings such as happiness, fortuitous and possession etc. A positive childbirth experience is accomplished when women give birth to a healthy baby in a safe environment with respect to her sociocultural beliefs and expectations and get emotional support from a birth companion and skilled maternity healthcare professionals (18).

Childbirth experiences and practices vary among different societies worldwide. The policies and procedures of healthcare organizations influence the women's experiences of childbirth. WHO has released guidelines to health care systems on antenatal care for a positive pregnancy experience.

According to these recommendations, a positive childbirth experience is founded on the provision of the following services to pregnant women by health care systems.

A. Nutritional interventions

B. Maternal and fetal assessment

C. Preventive measures

D. Interventions for common physiological symptoms

E. Health systems interventions to improve the utilization and quality of ANC.

Each of the above-mentioned recommendations have further classifications. Some recommendations apply to all pregnant women whereas others are context specific. For example, dietary interventions and iron and folic acid supplements are recommended to all women irrespective of ethnic background or health status. Whereas calcium, zinc and vitamin A supplements are context specific. It is a responsibility of all health care systems to provide standard maternity health care services to all women including immigrants to achieve positive childbirth experience globally. (19).

1.3 Childbirth among immigrant women globally

International migration continues to grow rapidly (20). The United States of America have more than 50 million international migrants residing (21). And Saudi Arabia, Germany and the Russia have accommodated around 12 million, followed by the United Kingdom and Northern Ireland with 9 million international migrants (22). In the year 2017 the European region resided more than 90 million immigrants and above 50% of these immigrants were women, many of childbearing age (23). Maternity care needs and outcomes for migrant women are influenced by the process of migration. In several European countries, migrant women are responsible for approximately 20%

of all live births (24). Women's migration is generally driven by factors such as economic improvement, family reunion, and the seeking of refugee status. Migrant women may face stress due to resettlement that can affect their health and hormonal conditions, making them vulnerable to maternity health complications (25). Immigrant women in England experience maternity services as unresponsive to their healthcare needs due to lack of knowledge and discrimination which results in poor quality maternity care and putting women at risk of higher morbidity (26). In Canada, maternity care needs of immigrant women, such as social and emotional support, availability of practical information in culturally and linguistically appropriate form, have not been met effectively (27).

A study explored the experience of maternity service among first- and second-generation Pakistani women in the United Kingdom, though the study observed no clear intergenerational differences, it found that women with a limited or insufficient network or language barriers have additional needs (28). Negative experiences of Pakistani immigrant women in the US were uncovered in a study. Negative experiences included weakening of social networks, low socio-economic status, a healthcare system that was difficult to navigate (29). For example, new immigrants are often used to health systems that they belong to which might function differently than the U.S. health care system. Provision of care quality, differences in the prices and methods of payment, patient expectations, or doctor patient relationship were some of the aspects that immigrants found challenging to comprehend and adopt swiftly (30). So, familiarizing with the new health care system can also impact childbirth outcomes as the need for maternity services cannot always be planned.

The next section of this chapter describes the childbirth in Pakistan which is important to understand the differences between childbirth scenario in Pakistan and childbirth anywhere else.

1.4 Childbirth in Pakistan

The population of Pakistan is estimated to be 185 million and more than 60% of the people live in the countryside (31). One woman out of four do not have access to antenatal care (ANC). Above 50% of the childbirths are taking place at home assisted by skilled birth attendants (SBA). Despite having a large public-sector healthcare infrastructure, less can 20% of the childbirths in Pakistan take place at public health facilities (32). Leading reasons for poor maternal and newborn health outcomes consist of a number of organizational and socio-cultural barriers such as access, unaffordable cost, and quality-of-care and lack of healthcare professionals. Quality of care issues involve the clinical staff's technical incompetence to limited resources and compromised interpersonal care at healthcare facilities (33).

Caesarean-section, which is an important indicator of accessibility to the emergency obstetric care, is not always accessible to all women who had an immediate need with a strong medical indication (34). This is one of the reasons Pakistan is still responsible for more than half the global burden of maternal deaths (35). Most of the literature available about childbirth in Pakistan concerns higher rates of maternal and child mortality, however, a knowledge and practices study about maternal and new-born health gives an insight to the childbirth related traditions and practices in rural and semi urban population in Pakistan. According to this study, a pregnant woman usually approach antenatal care only if she is sick and, even then, not always. Common reasons for not getting formal ANC are; absence of complications; shyness to disclose pregnancy to family; fear of ultrasound

examinations by male staff, physically occupied with households, inadequate financial resources and presumed poor quality of care. During ANC at a public health center, iron supplements, tetanus toxoid injection, blood pressure, weight determination and physical examination are done at minor cost.

In Pakistan, large size of newborn is usually considered as healthy and a low weight baby is encouraged for easy delivery. Some women confine their diet during antenatal period to ease delivery, some cannot afford to eat while others eat less to avoid nausea. A concept of hygiene exists as mothers and father and SBA know that cleanliness is important, and germs can cause illness. However, an absence of hygiene practice is common during delivery process and care of newborn. It is believed that breast feeding provides resistance against illness to the newborn. Women feed their babies, but initiation of breastfeeding within one hour after birth, and exclusive breastfeeding for six months is not common. Most women breastfeed for two years, consistent with Islamic teaching, or until they are pregnant again. Mothers are advised to take rest and stay inside home until 40 days after delivery. They are given special food (hot milk, nuts, fats, and soups) during the postnatal period to overcome the weakness. Women are advised to drink less water in the early postnatal period because of the norm that intake of water after delivery water expands the stomach. The grandmother and other ladies in the family care for the mother and the baby. Fathers take the male babies to the doctor and to the barber for circumcision and head shaving. The traditional birth attendant visits the mother during postpartum period to examine the mother and give her required care (36). Childbirth statistics, maternal health care infrastructure and tradition in Pakistan can be entirely different from those practiced in Norway. Next section of this chapter gives an overview of childbirth in Norway.

1.5 Childbirth in Norway

In Norway, more than 50,000 children are born every year. “Pregnancy and childbirth” are well recognized as natural processes. Most of the antenatal care is organized by midwives with a focus on shared decision-making and avoiding needless check-ups (37). Normally, there are eight antenatal appointments including one regular ultrasound scan which is offered in the middle of second trimester of pregnancy. For women with low-risk pregnancy, not many medical tests are done, only a few blood tests early in pregnancy, measurement of fundal height and blood pressure is monitored regularly (38). In case of suspected pregnancy complications multiple ultrasound scans or medical tests can be done. The Caesarean Section ratio in Norway is relatively low in comparison with other Western countries (with 6.6% elective and 10.5% emergency CS). Three % of the women opt for homebirth (39) and for low-risk pregnancies, the main birth attendant during delivery is a midwife. It is also common practice that women get a support throughout the delivery process from a close relative or friend, mostly usually their husband (40). Physical support from husbands during pregnancy and child rearing is common in Norway. Female autonomy and individualism are popular local norms. The consultations with midwife or GP, medical tests and ultrasounds are free of charge. Moreover, delivery procedures and 3 to 5 days post-partum stay with meals is also free of cost (41).

The next section of this chapter elaborates how the Norwegian health system deal immigrants and what are childbirth statistics for immigrants in Norway.

1.6 Childbirth among immigrant women in Norway

By the year 2016, 27% of all births in Norway were to migrant women. Immigrant women in Norway have similar rights as local women for accessing healthcare during pregnancy and delivery. All pregnant women are entitled to free of cost consultation and maternity health care. Women are entitled to maternity benefits provided they have had a paid employment, and housewives or students are entitled to one-time cash benefit during pregnancy. Immigrant women have the facility to get an interpreter for their appointments with doctors and visits to the hospital (42). They can invite their parents or sibling for a period of three months up to nine months following the visit visa procedure as described (43). Despite all above mentioned facilities provided by the state, immigrant women in Norway were less positive about their childbirth experience (44). An increased risk of several adverse pregnancy outcomes, such as low birth weight, preterm birth, congenital malformations, and perinatal morbidity and mortality has been found for some migrant women in Norway (45).

Study on the childbirth experiences Lithuanian women in Norway have suggested significant variations in maternity care between Lithuanian and Norwegian cultures directly impact of Lithuanian women's childbirth experiences in Norway. The incompatibility of systems in terms of prenatal expectations, sociocultural values and reproductive politics were reported in the study by Lithuanian women (46). For example, the prenatal care in Lithuania is fundamentally shaped by obstetricians/gynecologists. And women in Lithuania are more satisfied with the maternity care received by obstetricians/gynecologists simply because they are regarded as more confident in their knowledge than family doctors (47), whereas in Norway prenatal care is provided by midwives and/or general practitioners (GP) (48).

Another study revealed poorer health outcomes for immigrant women after childbirth. For example, prevalence of gestational diabetes in immigrants from South Asia and North Africa was higher (more than twice) than the non-immigrant population. These outcomes persist irrespective of length of residence and generational change, which indicate the need of substantial policy to encourage equitable health outcomes. The study further proposes that routine health information on various aspects of integration should be available, including indicators of language and communication skills (49).

1.7 Childbirth for Pakistani Women in Norway

Norwegian-born children to immigrant parents from Pakistan made up the largest group of all Norwegian-born to immigrant parents, with 16 700 in YEAR (50). Migration of women from Pakistan to Norway is motivated by factors such as higher education and family reunion. During the processes of establishing life and family like many others, one challenge for immigrant pregnant women is to get familiar with the maternity health care system in the new society. They face the situation of being away from extended family during pregnancy and childbirth. Women having a poor family and social support tend to be more depressed (51). However, a study conducted in Oslo, Norway, revealed the prevalence of postpartum depression among Pakistani immigrant women, however, found the rate of postpartum depression to be lower when compared with the immigrant populations around the world. However, the risk factors were quite similar to the results from other studies. Moreover, there were few cultural differences in risk factors between ethnic Norwegians and Pakistani immigrants (52).

Millennium Development Goal five (10) is directly related to mother and child (53). As a developed country, Norway has achieved the Millennium Developmental Goals; however, the composition of the Norwegian society is getting diverse and childbirth issues and cultural competence within the field of women's health is significant. Data is needed to understand the significant issues that influence the childbirth experience of immigrant women in Norway.

1.8 Research question

Even though Pakistani Norwegians are the largest non-European minority group in Norway, only a few studies have been done so far on immigrant women from Pakistan regarding their childbirth experiences under Norwegian healthcare system. Maternity care practices in Norway are considerably different from those in Pakistan. Due to several factors, as mentioned above, immigrant women from Pakistan face difficulty while undergoing childbirth procedures under the Norwegian health care system which effect their childbirth outcomes. To provide excellent quality care, there is a need to explore the needs, perceptions, and expectations of immigrant s from Pakistan. As stated at the beginning of this chapter, the aim of this study is to gather empirical evidence on childbirth experience of Pakistani women, who represent one of the dominant immigrant groups in Norway. To achieve aim this study will explore the following research questions: What are the childbirth experiences of Pakistani immigrant women in Norway?

Next chapter of the thesis presents the materials and methods used to conduct the study.

Chapter 2

2. Methods and material

As the purpose of the research study was to explore the childbirth experiences of Pakistani immigrant women in Norway, a descriptive phenomenology (54) method in qualitative research was considered most suited as it is used in social sciences to explore and describe the lived experiences of individuals. The phenomenological method attempts to understand and interpret the meanings of experiences of human life. Childbirth experiences of immigrant women can be understood with respect to the context of the research study and specific time frame. According to Malterud selecting a theoretical framework for a research study is a constant and dynamic process, and it significantly affects the understanding and application of the findings to present them up into a research paper (55). An inductive approach was used in this study in order to discover themes and letting them emerge while interacting with data (56). Furthermore, Husserl's theory of phenomenology is used as a methodological starting point. To understand women's birth experiences through a phenomenological outlook, it is important to realize differences in the understanding of experiences of the phenomenon of childbirth between respondent and the investigator.

2.1 Study Design

There are no specific guidelines for choosing the accurate methodology, or analysis and evaluation for qualitative research (57). Methodology for the study needed to be the best suitable to reflect the birth experiences and identifying the dynamics of giving birth in an entirely different environment as a phenomenon of human life. The responses to the questions of this study could just not be limited to "yes" or "no". Methods of data collection and data analysis must be

comprehensive and complementary to each other. So, for the purpose of collecting qualitative data, a semi-structured interview strategy was chosen as it allows the researcher to ask informants a series of predetermined but open-ended questions which give the participants a chance to unfold the issues, they feel are important (58). Focus group discussion was also used for a group of participants that had similar educational background. This method allows interactive discussion between a group of preselected participants, led by a trained moderator, focusing on a specific set of problems (59). An interview guide (Appendix III) was prepared for both data collection techniques to highlight objectives of the research study and acquire knowledge about birth the experiences.

2.2 Sampling

A common rule for deciding upon sample size in a qualitative study is that the sample should be adequately large and varied to illuminate the objectives of the study (60). The concept of "saturation" has been widely used to determine the sample size in qualitative research. Saturation occurs when adding more participants to the study does not result in additional perspectives or information (61). However, the emerging concept of "information power" to decide the sample size seemed more appropriate for this study due to the smaller number of participants available and limited time frame for master's research project. The term information power means that a small sample size of participants can serve the purpose if the sample holds more relevant information (62). It further suggests that the sample size having sufficient information power depends on a) if the aim of the study is narrow or broad (b) sample specificity is dense or sparse, (c) an established theory has been applied or not (d) quality of dialogue is strong or weak, and (e) finally the strategy adopted for analysis is "case" or "cross case".

All above mentioned elements of information power were taken into consideration for this study. The aim of the study was quite narrow as it was conducted on the immigrants from Pakistan only. The sample specificity was tried to be sparse as all participants were Pakistani women who had a childbirth experience in Norway, not older than 5 years, and at the same time they exhibited some variation such as age, location and educational background. Established theory of descriptive phenomenology was applied in order to enlighten relations between various aspects of the empirical data. Quality of dialogue were stronger as FGD and interviews were interactive and focused. Lastly, analysis was based on narratives of the participants.

A sample of 9 Pakistani immigrant women, who gave birth in Norway, was taken from social network of researcher using a combination of convenience and snowball sampling. Information power was achieved because the sample included participants of different age group, locality and education level and most of the participants had more than one childbirth experience which provided variety of relevant information and huge data was gathered with limited sample of participants. Educational background of the participants is given in Table 1 below.

Table 1. Educational background of the participants

Participant No.	Education level
1.	Masters
2.	Masters
3.	Medical Doctor
4.	Medical Doctor
5.	Medical Doctor
6.	Medical Doctor
7.	Bachelors
8.	Bachelors
9.	Medical Doctor

Women remember their childbirth experiences clearly at 5 years of childbirth (63). So, inclusion criteria set for participants was Pakistani immigrant women in Norway who had childbirth experiences not older than 5 years. As the study is about immigrant women in Norway, so Pakistani women who were born in Norway were not including in study.

2.3 Recruitment Strategy

A general message about the research project was sent to the "WhatsApp" group of almost 59 women of Pakistani background, containing information about the research project. They were asked to send a personal message to the researcher with their email address, if they were willing to be part of the research project. The researcher received a positive response from 14 participants. A letter of information (Appendix I) was sent on the personal email of those 14 participants along with a basic information performa aimed to acquire demographic information of participants (Appendix IV). Eleven participants accepted the invitation and agreed to be part of the study. Three participants had to be excluded as their childbirth experience older than five years. A written consent was attained from all participant at the time of interview/ FGD (Appendix V). From the basic information about the participants, it came out that 6 out of 11 participants were medical doctors. It was decided that to make a focus group of 5 participants having similar educational background was feasible. A place and time at the participants' convenience were mutually decided. A night before, one of Focus Group participant excused for becoming part of FGD. So, the researcher had to conduct FGD with 4 participants.

2.4 Data Collection

Focus group discussion took place in October 2018 in Trondheim, whereas individual interviews were conducted in Trondheim and Oslo. During November 2018 to March 2019. A place of convenience of all participant was chosen. Interviews and FGD were conducted in Urdu which was the native language of all participants. Time duration for focus groups discussion was 3 hours 15 minutes and duration of individual interviews ranged between 25 to 35 minutes. FGD and interviews were audio recorded with the permission of participants.

2.5 Data Analysis

After completing the data collection process, all audio recordings were transcribed and translated from Urdu to English simultaneously by the researcher. Data were analyzed by following the five steps of Descriptive Phenomenological method of Giorgi. The first step was to undertake the phenomenological attitude. Being in the phenomenological attitude means that I had to put aside my preconceived notions and deal with the data without questioning its validity or and using my own knowledge and common-sense.

The second step in the data analysis required that I read the entire "naive description" to get a sense of the whole experience. The main idea was to read the "naive description" by being in the phenomenological attitude. which means that I had taken all the descriptions in the way participants experienced them within the particular timeframe and context.

Next step in the data analysis was the demarcation of "meaning units" within the narratives so that the data can be dealt with in practicable fragments. Since my descriptions was written in a software,

MS word, it was convenient for me to use another software to complete the 3rd step. I used QDA Miner Line software to help creating meaning units from the text. This process required honesty, focus and vigilance while reading and rereading the descriptions to avoid missing any information or expression and to ensure that the new meaning unit does not change the meaning of content.
In the fourth step I had to convert the meaning units into descriptive expressions which again was a task that needed complete attention. Selection of appropriate titles and fitting them in the relevant meaning units was an interesting process.

The final step in the process of data analysis was synthesis of the general structure from the selected titles for the experiences. It was important that all titles had linkage and that they can stand under the umbrella of general structure. After completing all these steps, I was ready to present my data for discussion.

2.6 Research Ethics

In order to get approval, an application was sent to NSD (Norwegian Centre for Research Data). Their approval is enclosed in Appendix 5. Through a letter of information (approved by NSD) all participants were informed about the purpose of this study and a written consent was taken from them before conducting the study. Information about participants was handled in a secure manner. Identifiers were removed and a list of codes was established. Personal information was stored separately from audio recording and transcripts. After completing the data collection process, the text was ready to be analyzed. Next chapter refers to the presentation of results along with discussion of each theme one by one.

Chapter 3

3. Results and Discussion

This section gives description of emerged themes and sub-themes followed by a short discussion of them as to avoid too long distance between them.

Table 3: Emerged themes and sub-themes

Sr. No.	Themes
1.	**Organizational Structure and behavior** 1. No out of pocket expenses 2. Experience with GP and Mid-wife 3. Number of Ultrasounds during pregnancy 4. Admission in hospital for delivery 5. Estimation of baby's weight & Episiotomy 6. Post-delivery care and change in shift 7. Care of newborn and guidance for breast-feeding
2.	**Communication Issues** 1. Language barrier 2. Expressions of pain 3. Undisclosed complications
3.	**Social Support** 1. Informational support 2. Instrumental support 3. Emotional support

3.1 Organizational Structure & behavior

Nowadays, among various personal and institutional factors that determine the childbirth experiences of women, the role of organization is of paramount importance. Here, the Norwegian

maternity health care system is the organization that provides maternity health care services to women throughout pregnancy and childbirth. Organizational behavior includes individuals and behavior of the organization itself. Women shared a combination of positive and negative experiences with the Norwegian health care system and providers. Delayed procedures, difficulties in admission in hospital for delivery, effect of change in shift on post-delivery care and number of ultrasounds provided had negative impact on women, whereas experience with midwives, care of the newborn, guidance for breast-feeding and no out of pocket expenses had a very positive impact on their childbirth experience.

The organizational structure and behavior of the hospital staff has a fundamental role in minimization of healthcare problems (64). Flaws in hospital management contribute significantly to morbidity and cost of healthcare (65). In the coming section of this chapter I will describe the factors relating to organizational structure and behavior and how these factors influenced the childbirth experience of the participants in this study followed by a discussion.

3.1.1 No out of pocket expense

Free maternity health care services in Norway had positive outcomes on the childbirth experiences, as feelings of gratitude for the government were expressed by the women. There were almost no out of pocket expenses for checkups, medical tests or ultrasounds throughout pregnancy and delivery. Moreover, during prolonged treatment of the newborn baby, there was no charge for parents to stay in hospital.

"We feel relieved as we never pay for any tests or treatments during pregnancy but buying good health care services in Pakistan depends on the pocket. It's not a problem for those who have money, but childbirth related medical expenses are a big problem for people who belong to lower middle class".

"I am pregnant again but this time, we are doing it in our own way. As hard as it is for my husband to pay kr. 1500 for each ultrasound, we had 3 kids on free health care and that experience was an experience enough. For extra in time care that I want I am willing to pay for it. So, I would say there are many good things in Norwegian health care system, but when they drop the ball it becomes weird".

A comparison was made with the maternity health care expenditures in Pakistan where childbirth is considered as a huge financial burden on the parents. On the other hand, provision of free maternity healthcare services was disregarded by a woman who had negative childbirth experiences. She was unhappy with her GP, and later she faced difficulty in getting admission to hospital which resulted in an unprepared delivery. Because of her previous poor experience, she was willing to pay for her antenatal care for in future.

Receiving health care services without any financial burden reduced the compressions of responsibilities that arise with addition to a family. Participants' acknowledgement for free maternity care in Norway can been seen from different angles. Health systems in some developed countries give coverage of maternity care which is restrictive to their citizens or for people who pay for health insurance. For example, many women in the U.S. skip needed medical care because

of costs, likely because of high out-of-pocket costs (66). However, in the UK and the Scandinavian countries maternity care is free for everyone, irrespective of financial or residential status (67). If a comparison is made with the maternity care system in Pakistan, there is an opportunity for everyone to choose public or private sector maternity care according to their financial situation. Public sector maternity care services are inexpensive, but quality of care is compromised. Whereas private sector gives better quality of care but financial burden. However, poorer childbirth outcomes in Pakistan with high maternal and child mortality, the flexibility of health care system seems insignificant (68).

3.1.2 Experience with GP and midwife

Feelings of satisfaction for interaction with a midwife during pregnancy were reported. Guidance and information provided by midwives was profoundly acknowledged. More care was given to women who were going through their first childbirth experience. The midwife's skill to change the position of the baby, from breach to normal with hands, saved a mother from an undesirable caesarean section.

"I got very good guidance from mid-wife and fastlege during pregnancy. At the time of my first pregnancy, whenever I had some problem, I used to discuss it with mid-wife. She always listened to me politely and presented easy solutions, so I was very happy with her."

"My fastlege was very annoying, he knew not but my mid-wife was very experienced and very kind. She used to have answers to all my questions and solution for all my pregnancy related problems"

GPs with experience in gynecology gave more satisfaction to women who were medical doctors. It was believed that GPs without experience in gynecology had limited knowledge about pregnancy related information. For example, a GP who had work experience in gynecology, was able explain the reason of smaller fundal height of women from Pakistani background. A *fundal height* measurement is typically done to determine if a baby is small for its gestational age. Fundal heights of Pakistani women were smaller than the ones written in the fundal height charts in Norway. He explained that Pakistani women might not lie in the fundal height charts made for Norwegian women, because statures of Pakistani women are smaller.

During the process of birth, the role of a midwife is important towards a normal birth and a positive birth experience. A trustful relationship between the woman and midwife is important for the emotional aspects related to the birth experience (69). Participants in this study expressed more satisfaction with a midwife compared to a GP. In the UK, Canada and New Zealand the role of the GP during antenatal care has been reduced. In other parts of the developed world like Australia, however, GPs continue to be high providers of antenatal care (70). In Norway, GPs mainly deal the women during the antenatal period but for most of women, services from a midwife are also available. Midwives have extensive knowledge and experience in dealing with the normal pregnancy and childbirth process. The Norwegian system function to maintain the naturality of the pregnancy and childbirth process, so until any complications occur, GPs and midwives are capable of dealing with pregnancy and childbirth (71). However, even though pregnancy proceeded normally, the study participants who could not get a midwife for some reason, and had to rely solemnly on their GP, felt more vulnerable during pregnancy.

3.1.3 Ultrasound scans during pregnancy

Presently, ultrasound scans during pregnancy are done to check the well-being of mother and child, however, the original medical purpose was to give a more certain estimate for the expected time of birth. It has since developed into a tool for monitoring the fetus's health and has acquired a meaning for the mother's mental well-being. For normal pregnancy, one ultrasound scan was done during week 17-18, whereas women who had complicated pregnancies could get multiple scans. One ultrasound during the whole pregnancy left feelings of uncertainty in women about their condition. Despite their repeated requests, a second ultrasound could not be done without the GPs referral. Based on the medical reasons, it was entirely the GP's decision to refer someone for a second ultrasound. Participants with a medical background got more anxious for having only one scan and they presumed that at least two ultrasound scans are recommended internationally during pregnancy. A woman who had background in gynecology shared that she was so unsatisfied with the Norwegian maternity healthcare guidelines for stage one of pregnancy that she went all the way to Pakistan to take all pregnancy related tests and ultrasound. A comparison was made with international protocol and the practice to do ultrasounds in Pakistan by women with medical background.

"I was working in gynecology before I came to Norway, so obviously my knowledge was fresh. I knew how gynecological procedures are done in Pakistan following international guidelines. I asked her (doctor) about having a dating ultrasound, as I knew that all over the world anomaly ultrasound is done at week 18 but before that dating ultrasound is done at week 12. But she said that in Norway, they have our own guidelines, and they follow them. They do only one ultrasound at week 18".

"I really wanted a second ultrasound during third trimester. I was not sure how was I doing being pregnant, how was my baby's growth. On each visit, I requested my GP to refer me for another ultrasound but every time he refused as my pregnancy was proceeding normal."

On the other hand, a second ultrasound was desired mostly for personal satisfaction. Women expressed that the activity of having ultrasound scan brings charm to the parents and specially for mothers it was visualization of her feelings being pregnant. Despite feeling of uncertainty during pregnancy, expectations for delivery in the hospital kept women positive and strong.

Pregnant women's views regarding one ultrasound during the whole pregnancy left feelings of uncertainty about their health condition. Based on their educational background, a difference behind the desire for a second ultrasound was observed. A second ultrasound was desired mostly for the women's personal satisfaction. For a pregnant woman, an ultrasound was more than a medical test while for GPs it had medical reason. According to one study, pregnant women see ultrasound as an event of meeting and connecting with her baby that was an important step towards motherhood (72). Another study on Syrian women revealed that ultrasound scans gave expectant mothers a reassurance that the baby was healthy, and their pregnancy was progressing normally (73). In another study of Nigerian women found that women demanded multiple ultrasounds to know about the sex and well-being of fetus (74). A study of Canadian women found that women's decision about ultrasound was influenced by numerous factors such as history of previous pregnancies and previous miscarriage and having a care provider etc. (75). All of above studies support the results of this study regarding women's demand for multiple, or at least two ultrasounds during pregnancy.

However, WHO recommends one ultrasound scan before 24 weeks of gestation to estimate gestational age, detect fetal abnormalities and improve the experience of pregnancy (76). The women expressed great satisfaction with the overall care they received during and after delivery of the baby. A second ultrasound during pregnancy has been a debate within Norway also, and very recently an ultrasound between week 11 to 13 has been introduced by the government on the condition that people who will request for it will have to pay for it (77). Early ultrasound has been available for a long time for the rich. The fee that is now demanded is making this procedure affordable for most women.

3.1.4 Admission in hospital for delivery

Women experiencing onset of labor, expect to be admitted and monitored upon reaching hospital. After week 38, GPs advised them to be in contact with the hospital after the onset of labor. Women could talk to a midwife on the phone around the clock and explain their condition. Based on the assessment of labor on phone, the midwife advised whether it was time to come to hospital or stay at home and wait until contractions get frequent. A stressful situation occurred when a woman, who reached hospital for delivery with contractions and a ruptured water bag was asked to return home and come again with more frequent contractions. Mothers who had first childbirth felt vulnerable in such a situation, particularly those who lived far from the hospital.

"My contractions were not coming with the interval that indicates the start of labor. I knew it being a doctor but may be for a person without medical background it might be difficult to understand the real pains and false pains. My water bag was already broken but still they sent me home. I think that they should have admitted me in hospital".

Although women with medical background were able to understand the process of labor and the intensity of contractions, but idea of staying home with a ruptured water bag was considered irrational. An unusual incident occurred in such situation, when a woman refused to go home and stayed in hospital against the will of her midwife. Being a medical doctor, she believed that in order to prevent the risk of infections to mother and newborn, the baby should be delivered within 24 hours after the water bag breaks. Next morning, she communicated her increasing pains to the midwife who did not believe her. She requested an epidural, but the midwife refused this, claiming that it was too early to have that. Angerly, she was left in the room with her husband. Then, within the next half hour, she delivered the baby. Later, the midwife and her colleague admitted that they were not expecting her to dilate so quickly.

"It was at night or next morning when my water bag broke at home. I talked to midwife on phone and she asked me to come to the hospital. I stayed one night in hospital, being doctor I knew that one is supposed to deliver the baby within 24 hours after the water bag broke. Staff at hospital was not ready to examine me. After I stayed 12 to 15 hours in hospital, midwives asked me to go back home. As a doctor I knew that I and my baby were prone to infections because water bag was broken so I refused to go".

For those who lived nearby or had mild labor symptoms it was not problematic to go back home and come again for delivery. Before the start of delivery process an examination or ultrasound in the hospital gave a feeling of satisfaction about the growth and wellbeing of the baby.

Admission in hospital for delivery was another matter for discussion. Grievances were expressed on situations where women were advised to go back home and come again for delivery. This situation became a trauma for a mother who delivered the baby in her husband's hands as delivery preparations were not done in hospital. This was one incident experienced by a study participant when her midwife could not make a correct estimation of delivery. Labor onset is generally defined as the onset of regular contractions that lead to progressive dilatation of the cervix and ultimately to delivery of the infant. According to the affected study participant, her midwife estimated delivery time based on the cervix dilation was 6 to 8 hours after the last examination and her baby came out within less than an hour. Being a medical doctor, she communicated her condition to midwife about having feelings of baby coming out soon. The midwife could not believe her, and the outcome was such an offhand event.

A study on patients experience in hospitals reported that every year, 14% of patients in Norwegian hospitals experience adverse events, which often have health-damaging consequences. And factors that came out in the study were 1) concerns or signs of complications; 2) lack of responsibility and error correction; and 3) lack of support, loyalty and learning opportunities (78). This might not be an issue for immigrant women only, as the academic literature highlights the mismanagement of pregnant women in hospitals globally (79). Another study discovered that the health-care staff repressed emotions, presence of pain in pregnant women and expected an attitude of submission that made the pregnancy a negative experience for women (80). From the hospital staff's perspective all women with first stage labor cannot be admitted due to the capacity of admission in hospitals.

3.1.5 Estimation of baby's weight and episiotomy

It is essential to obtain an accurate assessment of baby's weight before initiating a delivery process. In certain situations, misestimation of the baby's weight can lead to potential complications that arise from low or excessive birthweight during labor. One woman shared that just before delivery, she was informed that the size of her baby was very small. Her family history regarding size of babies at birth was taken. On the midwife's assumptions of the baby's weight, normal delivery was conducted without episiotomy. The baby was born with a normal weight but huge virginal tears to the mother.

"To their surprise, my baby's weight was 2.6 or 2.7 kg. Next day, the gynecologist told me that she was expecting it to be less than 2 kgs"

"Yes, I agree. Even after ultrasound examination, they say that baby is small, and it becomes a reason of stress for mothers"

Participants with a medical background believed that a routine episiotomy prevents huge vaginal tears in childbirth. They shared examples of many other Pakistani women, who gave birth in Norway, got huge vaginal tears due to lack of episiotomy. One woman who had work experience in gynecology in Pakistan, shared that it is a routine practice in Pakistan to do episiotomy for normal births. Women prefer episiotomy tear over natural tear as in some cases natural tears caused huge damage and prolonged recovery. One woman shared that stitching of her natural tears took over an hour in an operation theater under general anesthesia and her recovery period was over a year.

"*My midwife assessed that I did not need an episiotomy, but I got 3rd degree tears. I felt terrible for not recovering for the next year and half. And as result I fear normal delivery"*

However, experience with stiches after both, normal delivery, and cesarean section, was good. It was specifically mentioned by women that tears were very nicely stitched and remained pain free. Episiotomy is done in an effort to prevent soft tissue tearing during labor which may involve the anal sphincter and rectum (81). Until the last decade of the 19th century, nearly 61% of women received episiotomies during delivery as a standard of care, especially first-time mothers. But from the early 20th century, the rate of episiotomy decreased to 25% because of the emerging belief that episiotomy contributes to worse tearing than might occur naturally during childbirth (82). Moreover, other long- and short-term complications of episiotomy are infections, extension of the incision, increased blood loss and hematoma formation, pain, inflammation, dehiscence within the episiotomy region, sexual dysfunction, and increased costs (83). In the recent recommendation of WHO, routine episiotomy is not recommended, but selective episiotomy is recommended in obstetric emergencies, such as fetal distress requiring instrumental vaginal birth (84). In many countries including Pakistan, episiotomy is a routine practice at health facilities, whereas in Norway the rate of episiotomy is below twenty% (85). For some of the study participants a restrained practice of episiotomy in Norwegian hospitals had negative childbirth outcomes for Pakistani women who got 3rd or 4th degree vaginal tears. Considering the estimated size of the baby as small, midwives do not opt for episiotomy which result in serious complications such as severe perineal tears. In Asia, there is a traditional belief that women's perineum is shorter, less stretchy and more prone trauma than in other women. Multiple research studies done in USA

and Australia and Cambodia conducted on Asian women have revealed that Asian ethnicity can be a risk factor for severe perineal tears. The first study, based on an audit of a US medical procedures database, studied 34,048 vaginal deliveries and concluded that Asia ethnicity was an independent risk factor for severe vaginal lacerations (86). The other study was a prospective study of 6,595 women in Australia, concluded that women of Asian origin were twice as likely to have severe perineal trauma compared to non-Asian women (87). A study conducted in Cambodia found the reasons of practice of episiotomy on Asian women is explained by the fear of perineal tears and a common opinion that Asian women have a shorter and harder perineum (88).

According to the WHO's episiotomy guidelines, routine or liberal practice of episiotomy is not recommended except for certain situations. It is generally a midwife's or obstetrician's decision whether there is a need for episiotomy or not. If the weight of the baby is wrongly calculated as less than normal, the need of episiotomy might not be acknowledged. Women who give birth to higher birth weight infants, a known preventive factor is to make an episiotomy (89). Pakistani women in Norway got equivalent results after not having episiotomy. It is therefore important for health care professionals to consider physiological difference while dealing with diverse population.

3.1.6 Post-delivery care (hospital) and change in shift

Women expressed deep satisfaction for post-delivery care. They acclaimed that good care was given to the mothers after delivery. An independent room, in a hospital hotel, was allocated to women having normal delivery whereas women who delivered through caesarean section were kept in hospital as they required more care. During their stay in hospital after delivery, assistance

from nurses in taking them to the washroom, changing of clothes and giving medicine was highly appreciated. Mother and newborn stayed in hospital until the doctors were satisfied with their health.

"Care of the baby and my care after delivery was very good. After 2, 3 hours we were shifted to a hospital hotel. I stayed there for 3 days. I was alone at night as my husband used to go home, and I did not feel the need of any extra help. If the baby cried at night, she (nurse) took the baby and asked me to sleep. So, this care was really impressive".

However, change in shift of staff affected the post-delivery care at hospital. A woman shared her experience that when she delivered, it was the time for shift change. It was an extremely awkward situation when she was left uncovered on a bloody bed for almost an hour until the new staff came and sorted out the situation.

Change-of-shift report is the time when responsibility and accountability for the care of a patient is transferred from one nurse to another. Nurses work in complex environments that require a constant state of attention to multiple cues in order to maintain patient safety through surveillance (90). However, due to change in shift, continuity of care is interrupted (91). Most of the literature available on change of staff in hospital is with regard to transfer of information about patient between nurses. A delay lasting an hour in reaching to the patient who delivered was an incidence reported by one of the participants of this study. Such an incident had undoubtedly affected the childbirth experience. Despite this, the overall care and assistance given by nurses and midwives has been significantly acknowledged by all the participants.

3.1.7 Care of the newborn & guidance for breast feeding

Women strongly believed that the newborns were given the finest care at the hospital. A complete examination of newborns was done by a pediatrician within 24 hours after birth. Nurses help mothers in taking care of newborn so that they could sleep at night. Breast-feeding was emphasized by doctors in Norway and for this purpose, proper time and guidance was given to mothers who faced difficulty in breast-feeding their child. Newborns were kept in hospital until doctors got satisfied with their normal growth. One mother shared that despite having a normal delivery, she was kept in hospital as her newborn was in ICU.

"In Norway, care of newborns was very good here. Weight of the baby was monitored on a daily basis. Proper checkups of the newborn were done by pediatricians soon after birth"

"It's a blessing that in Norway, they take really good care of the newborn. I was not able to breast feed my baby. His weight was not increasing as expected. My midwife gave me some very practical tips on breast feeding and I was not discharged from hospital until my baby started gaining weight"

Nurses also guided parents about handling the newborn, and fathers were specially trained to change the diapers. All child related care at the hospital was talked about in a with very appreciative way by the participants.

Mothers confirm that breastfeeding counseling in the maternity health care clinics result in a better breastfeeding outcome. Lactation counselling is useful for mothers and infant's health, improving

initiation and breast-feeding rates (92). Antenatal counselling in healthcare setting motivates mothers for initiation of breastfeeding immediately after birth and practicing exclusive breastfeeding (93). A study in Norway on GP's knowledge and beliefs on breast-feeding revealed that GP's believed that counselling on breast feeding is very significant (94). Early initiation of breastfeeding and exclusive breastfeeding continuation increased when they were given training and counselling on breastfeeding (95). Many participants in this study confirmed that assistance by midwives improved their ability to breastfeed and ultimately had positive effect on the growth of their child. Beside above-mentioned factor, there were several communication issues between individual and healthcare organization that influenced childbirth experiences.

3.2 Communication Issues

A number of communication issues were reported by women during their childbirth experience. Non availability of pregnancy related material in Urdu or English language, women's difficulty in expressing labor pain in a locally expected expression lead to inadequate interactions with maternity health care providers. Moreover, women reported undisclosed delivery complications which resulted in delayed recovery.

3.2.1 Language barrier

Communication issues get more problematic as the woman proceeds towards birth. Women could communicate in English, but they were unable to express everything they wanted, and similarly, doctors also did not have a lot to say during appointments. The language barrier was more for medical women when they wanted to discuss everything using their medical background which created feelings of apprehension.

"I felt many times that she was unable to understand the medical terms I used while talking to her. I was not sure if it was a language issue or she did not know everything. We had communication problem as well because her English was not very good"

Women's relationship with their GP was assessed on the basis of how keenly he/she did the physical examinations. A detailed examination by the doctor was considered satisfactory but lack of verbal communication left women with a feeling of uncertainty. The interviews showed that the language barrier meant that many of the women did not receive the necessary information relating to childbirth and the postpartum period. This led the women to feel that they did not get the help they needed during labor.

"I had good relationship with the doctor during my first pregnancy. She used to examine me thoroughly. But she was not good at explaining things to me. I was confused initially but later around 7th month, I realized that whatever happened to me was a normal process".

"Also, here in Trondheim, there are no maternal groups for people who do not speak Norwegian. Nothing like this was available for even in English and it was strange for me understand in globalized world".

Lack of childbirth related material in English or Urdu was also a problem for women. Most of the material shared, such as informational leaflets, case history and assessment forms were in Norwegian

Due to the language barrier, women had to rely on sources of information from their social network which could be other people's experiences with health system. Immigrant women's experience of maternity care in Norway reported language as an important requirement for women to have their needs met (96). Thai migrants went through difficulties in accessing healthcare due to universal language barriers despite having the same rights to public healthcare as Norwegian citizens (97). Understanding health care system can be challenging for immigrants, as formal language is used in the official information which makes it difficult to understand (98). Language barrier has a big impact on doctor patient relationship. Language differences pose reciprocal barriers to pregnant women and physicians. Women felt inability to express all of their experiences while physicians cannot explain to them what they found during medical examination. Consequently, it added uncertainty to pregnant women.

The facility of an interpreter to reduce language barrier for patients is available in in Norway. And healthcare professionals are responsible for assessing if a patient need an interpreter, but patients can also ask the health service to arrange an interpreter. It was observed that none of the participant mentioned using or tried to acquire services of an interpreter during their visits to doctor and midwife. Health-care workers often do not use interpreters when the patient's Norwegian language skills are insufficient (99).

3.2.2 Expressions of pain

Midwives expected women to express their labor pains by screaming and shouting. It was believed that the right time for delivery was when women scream and shout with pain. An experience as shared above also, woman told her midwife that her pains were getting intense and she felt like delivering soon. But the midwife said that she was dramatizing, as she believed that delivery time would be 8 to 10 hours after the labor starts. This woman did not scream and cry so, midwives did

not believe when she told them about her pains. Eventually she delivered baby within an hour and later midwives wondered that why she didn't she expressed her pains loudly.

"When I told my midwife that my contractions are getting strong, she said you are dramatizing, it is just the beginning, actual time is when you start screaming and shouting. They actually said that".

Expression of labor pain varied among women. Some expressed it loudly while others expression was calmer and quieter. Midwives perceptions of the women's expression of pain made the situation worse for mothers. As they did not prepare for delivery it resulted in panic for them as well. Pain is a basic thing in human health which depends on expressions of subjective experience. Sociocultural factors greatly influence the perceptions and behavior regarding pain (100). Similarly, cultural differences exist in giving meaning to expression of and coping with pain (101). In the case of labor pain, when it increases, the women express it through crying and screaming (102). There are, however, substantial individual differences when it comes to tolerating labor pain as it can be highly individual experience and not all women express labor pain with screaming and shouting (103). Participant experienced that not expressing labor pain in the manner that midwives expect from women during last stages of labor, resulted in a failure to get attention of midwives.

3.2.3 Undisclosed complications

Women with a medical background expressed their concerns regarding undisclosed delivery complications by the doctors and midwives. All information regarding delivery complications was not communicated to the mother or her attendants. One woman suffered a hemorrhage during

delivery and the doctors did not tell her. After prolonged heavy bleeding she got unconscious. Later, when the gynecologist gave her papers, she came to know about her hemorrhage. Her complications had long term effects. Another informant faced a similar situation. Her normal delivery tear was verbally categorized as a 1st degree tear, but in her patient record it was a documented as a 3rd degree tear. The doctor's perspective on hiding such information is not known. Women who was a doctor shared that in Pakistan, it was a general rule for doctor to communicate all information and complications to all patients.

"On the second post-operative day, I pooped in my clothes, I could not control it. At that time, I realized that that I was not told what had actually happened with me during delivery. So, I called the nurse that I need to know what the doctors wrote in my journal. Next day my gynecologist who repaired the tears told me about the complication. So, it was only after I fussed and asked them to let me know what happened, why I can't control my muscles. They told this only because I asked. Even then, I remember, she told me that tear was degree A but eventually when I got the journal, I came to know so she told me one degree behind".

"And I think it was a blessing for me not to know that as my pregnancy was already very stressful".

The baby was born with a birth defect with one ear. Multiple scans during pregnancy could not reveal the problem. Mother was not sure that doctors deliberately hid it from her, or they could not pick up the defect in scans. For that mother, it was a blessing not knowing about her baby's defect

as her pregnancy was already very stressful and complicated. So, similar approach had different impact on different respondents.

In western societies immigrant patients experienced communication barriers with their physicians (104). In addition, patients experience anxiety and lack of confidence in health care because of negative happenstances with healthcare professionals mediated by language barriers (105).

Women's concerns about physicians over keeping the medical complications undisclosed could have several reasons. One reason for this medical confidentiality maybe human errors on the part of doctors (106). Doctors may withhold information due to personal preferences or physical and cognitive condition of the patient (107). Study participants experience of not getting enough information from doctor could be a matter of lack of communication or doctors had intentionally withheld the information due to patients' condition.

3.3 Social Support

By support, participants meant family support which included husband, parents, and especially mother's support. Support from the husband was considered essential during pregnancy, delivery and the post-partum period. During initial pregnancy, support by the husband was needed the most. Women who got husband's involvement in their pregnancy related concerns, did not need any other support. Whereas for others, who had absence of husband's support, pregnancy was expressed as a lonely journey.

"During my pregnancies and periods afterwards, no one from my family could reach me. But honestly, during pregnancy, delivery and post-partum I never felt alone because my husband was so much involved".

The need for their mother's support was felt most in the last trimester of pregnancy and during delivery and post-partum period. Women's mother's support, husband's mother's support, and support of both mothers (husband's mother and woman's mother) were the potential supports for the participants. Woman's mother's support during childbirth was considered purer and more effective compared to the husband's mother. Lack of mobility during the last trimester, urge to get motherly concern, trust for seeking help, and comfort level were the factors that made mother's support valuable for the participants.

"I think it's a blessing if you have your parents around at the time of delivery and after delivery, especially your mother".

"But in my second pregnancy which was way more complicated I did not even have baby blues. The only big difference was the presence of my mother in my second pregnancy. It was not that she was doing all the household chores. She took care of my children. I kept her as my safety net. But I remember during my first childbirth, my in-laws were here, I was 41 weeks pregnant, and they were concerned about traveling around".

Due to changing needs of these women during their childbirth process, different forms of support were desired. Physical support was needed more in the last trimester of pregnancy and after the

child was born. Emotional support, however, was needed more in early pregnancy and during delivery. And informational support was needed throughout pregnancy and after delivery specially for those who had first childbirth experience.

3.3.1 Informational Support

Informational support for expectant women was guidance or advice or answers to the questions about their problem during and after childbirth. Doctors, mi-wives, their own educational background, internet blogs, information from a close relative or colleague and personal experiences were sources of informational support for our respondents. Midwives and doctors were the most reliable sources for mothers, however, the women with medical background relied on their own knowledge and information from the close relatives with medical background and colleagues. Epidural, breastfeeding were commonly inquired questions. Guidance of mid-wives for breast feeding was considered very useful. Lack of information by GP about using supplements during pregnancy was criticized.

"And then I got it further going on as I used to go through pregnancy forums and birth plans. I read that epidural and episiotomy was recommended in certain situations".

"My first shock was that my first doctor did not give me pregnancy related supplement on my first visit, even she didn't ask me to take folic acid".

Women with a medical background expressed feelings of shock when their GP did not prescribe folic acid and supplements on her first appointment. However, GP with background in gynecology prescribed folic acid and supplement for women.

3.3.2 Emotional Support

The presence of someone around during difficult situations was considered as emotional support**.** Emotional support was needed in case of unusual circumstances such as unstable pregnancy, complicated delivery or post-partum depression or sickness of the newborn. It was expressed that their family's emotional support kept them motivated to deal with critical situations. For example, one participant from Oslo shared that her baby was born with complications during delivery. He got severely sick after birth and was admitted in the hospital for over a month. Doctors were unsure on the survival of the baby. This was devastating situation for the parents. She expressed that it was emotional support of my husband's family (parents and sibling) that kept me and my husband strong so that we could focus on our baby.

"And my husband's whole family (parents and sibling) lives in Oslo. So, I had good support from family during and after pregnancy. And for those difficult days when our newborn son was unwell, their (family's) moral support kept us strong"

Emotional support was also helpful in an uncertain situation during the delivery process. One of the participants shared her experience of a twin delivery when her mother was with her in delivery room. She said that she got panic when her first child was not breathing after birth. But the presence of her mother, who had experience of triplets, did not let her lose focus until the second baby was born.

"But my mother was there (in hospital during deliver) who had triplets, so she said, do not think about first baby, you are not done yet, focus on the other one."

3.3.3 Instrumental Support

Maternity health care services, financial support, personal care (providing expected essential diet) at home after delivery, help in household and care of children was instrumental support for women during pregnancy and after delivery. Women got financial support from their husband as most of women were housewives. Women acquired free maternity health care services from NMHCS during childbirth period.

> *"It is all free, we do not have to pay anything for whatever medical tests you need during pregnancy and childbirth."*

The practical help the women got, in household chores and care of children, was mostly from their own mother. Their mothers stayed from one month to three months. Women expressed feelings of contentment to have their mothers around during their childbirth experience.

> *"But in the last days of pregnancy I really felt that I need my mother's support. Because in last day mobility is affected the most, so it can be helpful if a family member is around for help. My mother arrived 15 days before my son's birth and she stayed with me for 2 months. It was a great help for me. So, I was blessed that from my mother, I got the care that is needed after delivery".*

Whereas women, who did not have any such help or had help from their mother in law, expressed difficulty in performing household chores, lack of care and lack of rest after delivery. They also felt the absence of the special diet which was traditionally recommended to women after delivery

in Pakistan. These women expressed facing more difficulty at the time of second childbirth due to lack of energy to do things for themselves.

"But the thing is that our household responsibilities and lack of family support does not allow to practice these for example rest or extra diet. May be at the time of first child, it was easy, but with an older child it was almost impossible as I did not have the energy or time"

Migrant women's needs go beyond their pregnancy and include psychosocial-emotional and economic support (108) Social support is believed to play a significant role in buffering the physical and emotional strain many pregnant women experience (109). A huge difference between motherhood in Pakistan and in Norway was found in terms of social support. In Pakistan, the family network is the main source of support and help for the women during pregnancy, childbirth, and the postpartum period. Women are mostly involved in childbirth related support for the mothers. The role of husbands is passive and limited to financial support. In Norway, they were far from their families and depended on their husbands and friends for support. Financial burden of childbirth was taken care of by the Norwegian government. The desired sources of help for immigrant women during pregnancy for women are mother, sisters or friends, and they might not be present in the new country (110).

Immigrant women's experiences of maternity-care suggests that pregnant women face several barriers like lack of information about healthcare services and insufficient support to access these services. Lack of relevant knowledge of pregnant women keeps them unprepared that enhances

the birth complications (111). The importance of various types of support changes with the changing needs of women as they move from pregnancy to labor and delivery, and then to the postpartum period. Informational support in the form of prenatal classes is related to decreased maternal physical complications during labor and delivery, and to improved physical and mental health postpartum (112). As for the present study participants, visits to their midwife during pregnancy were a greater and more practical source of information. Women who did not get access to a midwife had limited information and uncertainty. Health care providers are in a unique position to educate prospective parents about the importance of social support around the time of childbirth and may play a critical role in mobilizing support systems for new mothers.

As discussed earlier in the language barrier, availability of information regarding childbirth in the immigrant's mother language or at least in English would have a better impact on women irrespective of whether their education levels were graduate or above. Their duration of stay in Norway ranged between 2 to 8 years but most of them were unable to read Norwegian. During pregnancy, emotional and tangible support provided by the spouse and others is related to the expectant mother's mental well-being. Mothers who have the support of a companion during labor and delivery experience fewer childbirth complications and less postpartum depression. Postpartum mental health is related to both the emotional support and practical help (e.g. housework and child are activities) provided by the husband and others. In tough times, emotional support from family keeps women strong and driven.

Availability of instrumental support during pregnancy has positive outcomes on childbirth. The provision of instrumental support would be beneficial when the stressful event can be controlled

by adequate problem-solving responses. Study participants acclamation of not having any financial burden of childbirth, as maternity healthcare services were free of cost, support this argument. Furthermore, it was interesting that women preferred physical help from their own mother compared to their mother in law. Women who were able to bring their own mother did not get stressed and it was same for women whose husbands provided physical support as well as moral support. Mothers' postpartum mental health is related to both the emotional support and practical help (e.g. housework and childcare activities) provided by the husband and others.

Like many other studies, this study also explored some positive and negative experiences of immigrant women in Norway. Some of the findings from this study have already been explored by other studies conducted on the immigrants of Norway, however some new issues were also explored in this study. Demand for a second ultrasound has been a topic for debate not only by the immigrants but also by the natives. And recently, there has been a change in the policy and a second paid ultrasound has already been introduced by the government in public sector hospitals. Lack of informational support has been another issue discussed by the women. During the process of going through the relevant literature, I was surprised to see that most of the information, participants were missing, was available online. For example on www.helsedirektoratet.no and www.helsenorge.no, a detailed information related to pregnancy, birth and the postnatal period in Norway is available in English. For most of the study participant, English was suitable as language of communication. It was another surprise, despite considering language as a barrier during their interactions with GP, that none of the participants desired or tried to get the services of an interpreter which are available for free for all immigrants. Moreover, communication gaps between women and hospital staff including doctors, midwives, nurses created other problems like

undisclosed complication, delay in procedures and admission in hospital for delivery. Most of these issues seems issue of poor communication between health care providers and seekers. Health care providers also have to make effort to improve communication with immigrant women during pregnancy and to make their childbirth experience more positive.

Chapter 4

4. Strength & Limitations of the Study

The two major strength of this study is that only few studies have been conducted so far on the childbirth experiences of immigrant women from Pakistan. Achieving information power with a small sample size is another strength of this study. Major limitations of this study could be the selectivity of the sample size, as it mostly included the women from the social network of the researcher.

5.Conclusions

Pakistani immigrant women were partially satisfied with the Norwegian maternity healthcare system. Better informational and social support, progressive communication with healthcare professionals and better utilization of the resources that are already in place can improve Pakistani immigrant women's childbirth experience in Norway. Moreover, some of these problems may also be mended when and if the second-generation immigrants enter Norwegian health care as doctors and midwives.

References

1. Schneider Z. Pregnant women's experiences of models of care in some hospitals in Victoria. The Australian journal of advanced nursing : a quarterly publication of the Royal Australian Nursing Federation. 2002;19(3):32-8.
2. Karlström A, Nystedt A, Hildingsson I. The meaning of a very positive birth experience: focus groups discussions with women. BMC Pregnancy and Childbirth. 2015;15(1):251.
3. Behruzi R, Hatem M, Goulet L, Fraser W, Misago C. Understanding childbirth practices as an organizational cultural phenomenon: a conceptual framework. BMC Pregnancy and Childbirth. 2013;13(1):205.
4. Gagnon AJ, Zimbeck M, Zeitlin J, Alexander S, Blondel B, Buitendijk S, et al. Migration to western industrialised countries and perinatal health: a systematic review. Social science & medicine (1982). 2009;69(6):934-46.
5. Kingston D, Heaman M, Chalmers B, Kaczorowski J, O'Brien B, Lee L, et al. Comparison of Maternity Experiences of Canadian-Born and Recent and Non-Recent Immigrant Women: Findings From the Canadian Maternity Experiences Survey. Journal of Obstetrics and Gynaecology Canada. 2011;33(11):1105-15.
6. Hildingsson I, Rådestad I. Swedish women's satisfaction with medical and emotional aspects of antenatal care. Journal of advanced nursing. 2005;52(3):239-49.
7. Waldenström U, Rudman A, Hildingsson I. Intrapartum and postpartum care in Sweden: women's opinions and risk factors for not being satisfied. Acta obstetricia et gynecologica Scandinavica. 2006;85(5):551-60.
8. Gissler M, Alexander S, MacFarlane A, Small R, Stray-Pedersen B, Zeitlin J, et al. Stillbirths and infant deaths among migrants in industrialized countries. Acta obstetricia et gynecologica Scandinavica. 2009;88(2):134-48.
9. Hyman I, Dussault G. Negative Consequences of Acculturation on Health Behaviour, Social Support and Stress among Pregnant Southeast Asian Immigrant Women in Montreal: An Exploratory Study. Canadian Journal of Public Health. 2000;91(5):357-60.
10. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. Social Science & Medicine. 2009;68(3):452-61.

11. Urquia ML, Frank JW, Moineddin R, Glazier RH. Immigrants' duration of residence and adverse birth outcomes: a population-based study. BJOG. 2010;117(5):591-601.
12. Maternal mortality 2017 [Global Health Observatory (GHO) data]. Available from: https://www.who.int/gho/maternal_health/mortality/maternal/en/.
13. Norr KL, Block CR, Charles A, Meyering S, Meyers E. Explaining Pain and Enjoyment in Childbirth. Journal of Health and Social Behavior. 1977;18(3):260-75.
14. Kozhimannil KB, Shippee TP, Adegoke O, Vemig BA. Trends in hospital-based childbirth care: the role of health insurance. Am J Manag Care. 2013;19(4):e125-e32.
15. Maternal mortality 2017 [Global Health Observatory (GHO) data]. Available from: https://www.who.int/gho/maternal_health/mortality/maternal/en/.
16. Medicine Io. The Future of the Public's Health in the 21st Century. Washington, DC: The National Academies Press; 2003. 536 p.
17. Making childbirth a positive experience, New WHO guideline on intrapartum care 2018 Available from: https://www.who.int/reproductivehealth/intrapartum-care/en/.
18. Downe S, Finlayson K, Oladapo OT, Bonet M, Gülmezoglu AM. What matters to women during childbirth: A systematic qualitative review. PloS one. 2018;13(4):e0194906.
19. Intrapartum care for a positive childbirth experience, Transforming care of women and babies for improved health and well-being. Switzerland; 2018. Contract No.: (CC BY-NC-SA 3.0 IGO; ; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).
20. World Migration Report 2018, IOM, 2017. https://www.iom.int/sites/default/files/country/docs/china/r5_world_migration_report_2018_en.pdf
21. Scott HM, Havercamp SM. Systematic Review of Health Promotion Programs Focused on Behavioral Changes for People With Intellectual Disability. Intellectual and developmental disabilities. 2016;54(1):63-76.
22. International Migration Report. United Nations, New York; 2017.
23. Organization WH. Report on the health of refugees and migrants in the WHO European Region: no public health without refugee and migrant health. Europe; 2018.
24. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. BMC Pregnancy and Childbirth. 2014;14(1):152.

25. Jones A. A Silent but Mighty River: The Costs of Women's Economic Migration. Signs: Journal of Women in Culture and Society. 2008;33(4):761-9.
26. Ali N. Experiences of Maternity Services: Muslim Women's Perspectives 2004.
27. Denise LS. Immigrant and Refugee Women. Anthropology in Action. 2007;14(1-2):52-62.
28. Bakken KS, Skjeldal OH, Stray-Pedersen B. Obstetric Outcomes of First- and Second-Generation Pakistani Immigrants: A Comparison Study at a Low-Risk Maternity Ward in Norway. Journal of Immigrant and Minority Health. 2017;19(1):33-40.
29. Bustamante AV, Van der Wees PJ. Integrating immigrants into the U.S. health system. Virtual Mentor [Internet]. 2012 2012/04//; 14(4):[318-23 pp.]. Available from: http://europepmc.org/abstract/MED/23352068 https://doi.org/10.1001/virtualmentor.2012.14.4.stas1-1204.
30 Bustamante AV, Van der Wees PJ. Integrating immigrants into the U.S. health system. Virtual Mentor [Internet]. 2012 2012/04//; 14(4):[318-23 pp.]. Available from: http://europepmc.org/abstract/MED/23352068 https://doi.org/10.1001/virtualmentor.2012.14.4.stas1-1204
31. Hameed W, Avan BI. Women's experiences of mistreatment during childbirth: A comparative view of home- and facility-based births in Pakistan. PloS one. 2018;13(3):e0194601.
32. Mahmood MA. Improving maternal and neonatal health : measuring the impact of the PAIMAN Project in ten districts in Pakistan. Islamabad: USAID : PAIMAN; 2010.
33. Mumtaz Z, Salway S, Bhatti A, Shanner L, Zaman S, Laing L, et al. Improving maternal health in Pakistan: toward a deeper understanding of the social determinants of poor women's access to maternal health services. Am J Public Health. 2014;104 Suppl 1(Suppl 1):S17-S24.
34. Mumtaz S, Bahk J, Khang Y-H. Rising trends and inequalities in cesarean section rates in Pakistan: Evidence from Pakistan Demographic and Health Surveys, 1990-2013. PloS one. 2017;12(10):e0186563-e.
35. Trends in maternal mortality: 1990 to 2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva 27, Switzerland; 2015.

36. Khadduri R, Marsh DR, Rasmussen B, Bari A, Nazir R, Darmstadt GL. Household knowledge and practices of newborn and maternal health in Haripur district, Pakistan. Journal of Perinatology. 2008;28(3):182-7.
37. Number of live births in Norway from 2009 to 2019 Norway2020 [Available from: https://www.statista.com/statistics/611719/number-of-births-in-norway/.
38. Preis H, Benyamini Y, Eberhard-Gran M, Garthus-Niegel S. Childbirth preferences and related fears - comparison between Norway and Israel. BMC Pregnancy and Childbirth. 2018;18(1):362.
39. Zeitlin J, Mohangoo AD, Delnord M, Cuttini M. The second European Perinatal Health Report: documenting changes over 6 years in the health of mothers and babies in Europe. Journal of epidemiology and community health. 2013;67(12):983-5.
40. Vangen S, Stoltenberg C, Holan S, Moe N, Magnus P, Harris JR, et al. Outcome of Pregnancy Among Immigrant Women With Diabetes. Diabetes Care. 2003;26(2):327.
41. (Helsedirektoratet) NDoH. Pregnancy and maternity care in Norway 2017 [Available from: https://helsenorge.no/other-languages/english/pregnancy-and-maternity-care.
42. Organisation and management of the Ministry of Health and Care Services 2018 [Available from:https://www.regjeringen.no/en/dep/hod/organisation-and-management-of-the-ministry-of-health-and-care-services/etater-og-virksomheter-under-helse--og-omsorgsdepartementet/Subordinate-institutions/the-directorate-for-health-and-social-af/id213297/.
43. Immigration NDo. Visit Norway Oslo2020 [Available from: https://www.udi.no/en/want-to-apply/visit-and-holiday/.
44. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. BMC Pregnancy and Childbirth. 2014;14(1):152.
45. Jolita Greblikaite VV, Zivile Ziukaite. Family farms in Lithuania: Problems and challenges. Ekonomia Społeczna. 2017;1:64-71.
46. Zemaite K. Birth experiences among Lithuanian immigrant women in Norway. Oslo: University of Oslo; 2013.
47. Zemaite K. Birth experiences among Lithuanian immigrant women in Norway. Oslo: University of Oslo; 2013.

48. Norum J, Heyd A, Hjelseth B, Svee T, Mürer FA, Erlandsen R, et al. Quality of obstetric care in the sparsely populated sub-arctic area of Norway 2009–2011. BMC Pregnancy and Childbirth. 2013;13(1):175.
49. Bjerke SE, Vangen S, Nordhagen R, Ytterdahl T, Magnus P, Stray-Pedersen B. Postpartum depression among Pakistani women in Norway: prevalence and risk factors. The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstet. 2008;21(12):889-94.
50. Norway Statistics, Immigrants and Norwegian-born to immigrant parents, 1 January 2017 2017 [Available from: https://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2017-03-02.
51. Norway Statistics. Immigrants and Norwegian-born to immigrant parents, 1 January 2017 2017 [Available from: https://www.ssb.no/en/befolkning/statistikker/innvbef/aar/2017-03-02.
52. Bjerke SE, Vangen S, Nordhagen R, Ytterdahl T, Magnus P, Stray-Pedersen B. Postpartum depression among Pakistani women in Norway: prevalence and risk factors. The journal of maternal-fetal & neonatal medicine : the official journal of the European Association of Perinatal Medicine, the Federation of Asia and Oceania Perinatal Societies, the International Society of Perinatal Obstet. 2008;21(12):889-94.
53. United Nations, MDG Acceleration and Beyond 2015. 2013.
54. Giorgi A. The Descriptive Phenomenological Method in Psychology: A Modified Husserlian Approach: Duquesne University Press; 2009.
55. Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scandinavian journal of public health. 2012;40(8):795-805.
56. Goddard W, Melville S. Research methodology : an introduction. 2001.
57. Willig C, editor Introducing qualitative research in psychology : adventures in theory and method2008.
58. DeJonckheere M, Vaughn LM. Semistructured interviewing in primary care research: a balance of relationship and rigour. Fam Med Community Health. 2019;7(2):e000057-e.

59. Nyumba TO, Wilson KA, Derrick CJ, Mukherjee N. The use of focus group discussion methodology: Insights from two decades of application in conservation. Methods in Ecology and Evolution. 2018;9:20-32.
60. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qualitative health research. 2016;26(13):1753-60.
61. Glaser BG, Strauss AL, Strutzel E. The Discovery of Grounded Theory; Strategies for Qualitative Research. Nursing Research. 1968;17(4).
62. Malterud K, Siersma VD, Guassora AD. Sample Size in Qualitative Interview Studies: Guided by Information Power. Qualitative health research. 2016;26(13):1753-60.
63. Takehara K, Noguchi M, Shimane T, Misago C. A longitudinal study of women's memories of their childbirth experiences at five years postpartum. BMC pregnancy and childbirth. 2014;14:221-.
64. Cunningham TR, Geller ES. Advances in Patient Safety
Organizational Behavior Management in Health Care: Applications for Large-Scale Improvements in Patient Safety. In: Henriksen K, Battles JB, Keyes MA, Grady ML, editors. Advances in Patient Safety: New Directions and Alternative Approaches (Vol 2: Culture and Redesign). Rockville (MD): Agency for Healthcare Research and Quality (US); 2008.
65. Upperman JS, Staley P, Friend K, Neches W, Kazimer D, Benes J, et al. The impact of hospitalwide computerized physician order entry on medical errors in a pediatric hospital. Journal of pediatric surgery. 2005;40(1):57-9.
66. Munira Z. Gunja RT, Shanoor Seervai, Sara R. Collins. What Is the Status of Women’s Health and Health Care in the U.S. Compared to Ten Other Countries? New York: The Commonwealth Fund; 2018.
67. Barker K. The social care and health systems of nine countries. London; 2013.
68. Khan A, Zaman S. Costs of vaginal delivery and Caesarean section at a tertiary level public hospital in Islamabad, Pakistan. BMC Pregnancy and Childbirth. 2010;10(1):2.
69. Dahlberg U, Aune I. The woman's birth experience−The effect of interpersonal relationships and continuity of care. Midwifery. 2013;29(4):407-15.
70. Wong CG, Julie; Pan, Ying; Henderson, Joan; Britt, Helena. Antenatal care in Australian general practice. Australian Family Physician. 2016;45(8).

71. Norwegian Directorate for Health and Social Affairs [Available from: https://helsenorge.no/.
72. Westerneng M, Diepeveen M, Witteveen AB, Westerman MJ, van der Horst HE, van Baar AL, et al. Experiences of pregnant women with a third trimester routine ultrasound - a qualitative study. BMC Pregnancy and Childbirth. 2019;19(1):319.
73. Bashour H, Hafez R, Abdulsalam A. Syrian Women's Perceptions and Experiences of Ultrasound Screening in Pregnancy: Implications for Antenatal Policy. Reproductive Health Matters. 2005;13(25):147-54.
74. Okeke TC, Ugwu EO, Ikeako LC, Adiri CO, Ezenyeaku CC, Ekwuazi KE, et al. Falls among pregnant women in Enugu, Southeast Nigeria. Nigerian journal of clinical practice. 2014;17(3):292-5.
75. Abdullah P, Landy CK, McCague H, Macpherson A, Tamim H. Factors associated with the timing of the first prenatal ultrasound in Canada. BMC Pregnancy and Childbirth. 2019;19(1):164.
76. WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016.
77. Lauvrak V. Tidlig ultralyd i svangerskapsomsorgen. Oslo: Nasjonalt kunnskapssenter for helsetjenesten; 2012.
78. Hågensen G, Nilsen G, Mehus G, Henriksen N. The struggle against perceived negligence. A qualitative study of patients' experiences of adverse events in Norwegian hospitals. BMC Health Services Research. 2018;18(1):302.
79. Bohren MA, Vogel JP, Tunçalp Ö, Fawole B, Titiloye MA, Olutayo AO, et al. Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. Reproductive Health. 2017;14(1):9.
80. Mejía Merino CM, Faneyra Zapata L, Molina Berrio DP, Arango Urrea JD. Dehumanization during Delivery: Meanings and Experiences of Women Cared for in the Medellín Public Network. Investigación y Educación en Enfermería. 2018;36.
81. Practice Bulletin No. 165: Prevention and Management of Obstetric Lacerations at V aginal Delivery. Obstetrics and gynecology. 2016;128(1):e1-e15.
82. Horsager-Boehrer R. Why episiotomy during labor can hurt more than help 2017 [Available from: https://utswmed.org/medblog/episiotomy-perineum-tearing/.

83. Gün İ, Doğan B, Özdamar Ö. Long- and short-term complications of episiotomy. Turk J Obstet Gynecol. 2016;13(3):144-8.
84. WHO recommendation on episiotomy policy. Geneva: World Health Organization; 201.
85. Blondel B, Alexander S, Bjarnadóttir RI, Gissler M, Langhoff-Roos J, Novak-Antolič Ž, et al. Variations in rates of severe perineal tears and episiotomies in 20 European countries: a study based on routine national data in Euro-Peristat Project. Acta obstetricia et gynecologica Scandinavica. 2016;95(7):746-54.
86. Schantz C, Sim KL, Ly EM, Barennes H, Sudaroth S, Goyet S. Reasons for routine episiotomy: A mixed-methods study in a large maternity hospital in Phnom Penh, Cambodia. Reproductive Health Matters. 2015;23(45):68-77.
87. Dahlen HG, Ryan M, Homer CS, Cooke M. An Australian prospective cohort study of risk factors for severe perineal trauma during childbirth. Midwifery. 2007;23(2):196-203.
88. Schantz C, Sim KL, Ly EM, Barennes H, Sudaroth S, Goyet S. Reasons for routine episiotomy: A mixed-methods study in a large maternity hospital in Phnom Penh, Cambodia. Reproductive Health Matters. 2015;23(45):68-77.
89. Kleitman V, Feldman R, Walfisch A, Toledano R, Sheiner E. Recurrent shoulder dystocia: is it predictable? Archives of gynecology and obstetrics. 2016;294(6):1161-6.
90. Rhudy LM, Johnson MR, Krecke CA, Keigley DS, Schnell SJ, Maxson PM, et al. Change-of-Shift Nursing Handoff Interruptions: Implications for Evidence-Based Practice. Worldviews on evidence-based nursing. 2019;16(5):362-70.
91. Grimshaw J, Hatch D, Willard M, Abraham S. A Qualitative Study of the Change-of-Shift Report at the Patients’ Bedside. The Health Care Manager. 2016;35(4).
92. Sindhu Thomas DNM, Dr Prabha K Dasila. Effect of Antenatal Lactation Counselling on Knowledge and Breastfeeding Practices among Mothers. International Journal of Health Sciences and Research. 2018;8(2):138-48.
93. Biks GA, Tariku A, Tessema GA. Effects of antenatal care and institutional delivery on exclusive breastfeeding practice in northwest Ethiopia: a nested case‑control study. International Breastfeeding Journal. 2015;10(1):30.
94. Svendby HR, Løland BF, Omtvedt M, Holmsen ST, Lagerløv P. Norwegian general practitioners' knowledge and beliefs about breastfeeding, and their self-rated ability as breastfeeding counsellor. Scandinavian journal of primary health care. 2016;34(2):122-9.

95. Zainab Taha AAH, Ludmilla Wikkeling-Scott, Dimitrios Papandreou. Risk Factors Associated with Initiation of Breastfeeding among Mothers with Low Birth Weight Babies: A Cross-sectional Multicenter Study in Abu Dhabi, United Arab Emirates. Macedonian Journal of Medical Sciences. 2020;8:38-44.
96. Bakken KS, Stray-Pedersen B. Emergency cesarean section among women in Robson groups one and three: A comparison study of immigrant and Norwegian women giving birth in a low-risk maternity hospital in Norway. Health Care for Women International. 2019;40(7-9):761-75.
97. Tschirhart N, Diaz E, Ottersen T. Accessing public healthcare in Oslo, Norway: the experiences of Thai immigrant masseuses. BMC Health Services Research. 2019;19(1):722.
98. Straiton ML, Myhre S. Learning to navigate the healthcare system in a new country: a qualitative study. Scandinavian journal of primary health care. 2017;35(4):352-9.
99. Mapping the use of interpreters in community health services [Kartlegging av tolkebruk i kommunehelsetjenesten], Norwegian Directorate of Health, 2013.
99. McCaffery M. What is the role of nondrug methods in the nursing care of patients with acute pain? Pain management nursing : official journal of the American Society of Pain Management Nurses. 2002;3(3):77-80.
100. Callister LC, Khalaf I, Semenic S, Kartchner R, Vehvilainen-Julkunen K. The pain of childbirth: perceptions of culturally diverse women. Pain Management Nursing. 2003;4(4):145-54.
101. Kelly Yu-Hsin Liao MH, Qian Lu, Angie LeRoy. Cultural diff erences in pain experience among four ethnic groups: A qualitative pilot study. Journal of Behavioral Health. 2016;5(2):75-81.
102. Aziato L, Acheampong AK, Umoar KL. Labour pain experiences and perceptions: a qualitative study among post-partum women in Ghana. BMC Pregnancy and Childbirth. 2017;17(1):73.
103. Jangland E, Gunningberg L, Carlsson M. Patients' and relatives' complaints about encounters and communication in health care: evidence for quality improvement. Patient education and counseling. 2009;75(2):199-204.

104. Salim Ahmed SL, Nusrat Shommu, Nahid Rumana, Tanvir Turin. Experiences of communication barriers between physicians and immigrant patients: A systematic review and thematic synthesis. Patient Experience Journal. 2017;4(1):122-40.
105. Palmboom GG, Willems DL, Janssen NBAT, de Haes JCJM. Doctor's views on disclosing or withholding information on low risks of complication. J Med Ethics. 2007;33(2):67-70.
106. Palmboom GG, Willems DL, Janssen NBAT, de Haes JCJM. Doctor's views on disclosing or withholding information on low risks of complication. J Med Ethics. 2007;33(2):67-70.
107. Fair F, Raben L, Watson H, Vivilaki V, van den Muijsenbergh M, Soltani H, et al. Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review. PloS one. 2020;15(2):e0228378-e.
108. Maharlouei N. The Importance of Social Support During Pregnancy. Women's Helath Bulletin. 2016;3(1):1.
109. Bauer HM, Rodriguez MA, Quiroga SS, Flores-Ortiz YG. Barriers to health care for abused Latina and Asian immigrant women. Journal of health care for the poor and underserved. 2000;11(1):33-44.
110. Yuan X, Hu H, Zhang M, Long W, Liu J, Jiang J, et al. Iron deficiency in late pregnancy and its associations with birth outcomes in Chinese pregnant women: a retrospective cohort study. Nutrition & Metabolism. 2019;16(1):30.
111. Gjerdingen DK, Froberg DG, Fontaine P. The effects of social support on women's health during pregnancy, labor and delivery, and the postpartum period. Family medicine. 1991;23(5):370-5.

APPENDICES

Appendix 1

PARTICIPANT INFORMATION SHEET TEMPLATE FOR ADULTS

NTNU
Norwegian University of Science and Technology

INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

EXPERIENCES OF PAKISTANI WOMEN HAVING CESAREAN SECNTION COMPARE TO THOSE WHO HAD A NORMAL DELIVERY

You are invited to participate in a research project. This study is conducted to explore experiences of Pakistani women who have given birth via caesarean section or normal delivery in any hospital in Norway. You are selected as a participant for this study because you meet the selection criteria set for this study. This study is conducted under the Department of Public Health and Nursing, NTNU, Trondheim Campus.

WHAT IS THE STUDY ABOUT?

The study will collect and record personal information about your childbirth experiences in hospitals of Norway. Questions will be asked about your expectations, experiences and opinions regarding their dealing with hospital during childbirth by Individual interviews and group discussions.

POSSIBLE BENEFITS AND EXPECTED DISADVANTAGES OF TAKING PART

Your valuable participation in the study would help the researcher explore various factors that are associated with childbirth experiences of women from Pakistan. The information obtained from your interviews would be analyzed and conclusions would be suggested to the Norwegian health care department for better understanding and improved care of Pakistani women going to give birth in hospitals. Any sensitive information that would become part of this study would be kept secret and confidentiality will be maintained. There are no apparent disadvantages of participating in the study.

VOLUNTARY PARTICIPATION AND THE POSSIBLITY TO WITHDRAW CONSEN

Participation in the study is voluntary. If you wish to take part, you will need to sign the declaration of consent on the last page. You can, at any given time and without reason withdraw your consent. This will not have any consequences for any future treatment. If you decide to withdraw participation in the project, you can demand that your tests and personal health data be deleted, unless however, the personal health data and tests have already been analyzed or used in scientific publications. If you at a later point, wish to withdraw consent or have questions regarding the project, you can contact

Zubaida Waheed Butt  004799895568,  zubaidawaheedbutt@gmail.com

WHAT WILL HAPPEN TO YOUR HEALTH INFORMATION?

The information that is recorded about you will only be used as described in the purpose of the study. You have the right to access which information is recorded about you and the right to stipulate that any error in the information that is recorded is corrected.

All information will be processed and used without your name or personal identification number, or any other information that is directly identifiable to you.

Zubaida Waheed Butt has the responsibility for the daily operations/running of the Research Project and that any information about you will be handled in a secure manner. Information about you will be anonymized or deleted a maximum of 5 years after the project has ended.

APPROVAL

The Project is approved by NSD *(Ref: 60676 / 3 / LAR)*.

Appendix II

Consent Form

consent for participating in the research project

I AM WILLING TO PARTICIPATE IN THE RESEARCH PROJECT

City/Town and date	Participant's Signature
	Participant's Name (in BLOCK LETTERS)

I confirm that I have given information about the research project [*You can include this sentence if you wish, only in the instances where the information is given face to face.*]

Place and date	Signature
	Role in the research project

Appendix III

INTERVIEW GUIDE **DATE:**

1) **Pregnancy**
    1. How was your experience with antenatal care in Norway?
2) **Childbirth and Post-partum period**
    2. What were your expectations for childbirth in Norway?
    3. How was the experience of delivery in a Norwegian hospital?
3) **Opinion about Norwegian Maternity Health Care System / Hospitals**
    4. What do you think of the Norwegian Maternity Health Care System?
    5. What do you think could have improved your experiences during your pregnancy, delivery and postpartum period?
4) **Pregnancy, Childbirth and Post-partum period in Pakistan**
    6. How is it different to give birth in Pakistan?
    7. How different is Maternity Health Care system in Pakistan as compare to Norway?
5) **Birth Traditions and Practices**
    8. What are the special practices and traditions related to pregnancy, delivery and post-partum period in Pakistan?
    9. How free you were to practice your traditional beliefs during pregnancy, delivery and post-partum period in Norway?
6) **Family and Social Networks**
    10. How important is the support of family during pregnancy, delivery and post-partum period?

Appendix 1V

PERSONAL INFORMATION OF PARTICIPANT

Sr. No. _____ **Date: _____**

Sr. No	Questions	Answers
1.	Name	
2.	Age	
3.	Education Level	
4.	Occupation	
5	Immigration Status	a) Temporary Resident b) Family Immigration c) Permanent Resident d) Nationality Holder
6.	Number of children a) Born in Norway b) Born outside Norway	 a) b)
7.	Living in Norway since	
8.	Method of Childbirth Child 1 _____ Child 2 _____ Child 3 _____ Child 4_____	a) Normal delivery b) Cesarean Section

Appendix V

NSD Approval

John- Arne Skolbekken
Postbok 8905
7491 TRONDHEIM

Vår dato: 11.06.2018 Vår ref: 60676 / 3 / LAR Deres dato: Deres ref:

Tilrådning fra NSD Personvernombudet for forskning § 7-27

Personvernombudet for forskning viser til meldeskjema mottatt 07.05.2018 for prosjektet:

60676	*A Qualitative Study Of Childbirth Experiences Of Pakistani Immigrant Women In Norway*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*John- Arne Skolbekken*
Student	*ZUbaida Waheed Butt*

Vurdering

Etter gjennomgang av opplysningene i meldeskjemaet og øvrig dokumentasjon finner vi at prosjektet er unntatt konsesjonsplikt og at personopplysningene som blir samlet inn i dette prosjektet er regulert av § 7-27 i personopplysningsforskriften. På den neste siden er vår vurdering av prosjektopplegget slik det er meldt til oss. Du kan nå gå i gang med å behandle personopplysninger.

Vilkår for vår anbefaling

Vår anbefaling forutsetter at du gjennomfører prosjektet i tråd med:

- opplysningene gitt i meldeskjemaet og øvrig dokumentasjon
- vår prosjektvurdering, se side 2
- eventuell korrespondanse med oss

Meld fra hvis du gjør vesentlige endringer i prosjektet

Dersom prosjektet endrer seg, kan det være nødvendig å sende inn endringsmelding. På våre nettsider finner du svar på hvilke endringer du må melde, samt endringsskjema.

Opplysninger om prosjektet blir lagt ut på våre nettsider og i Meldingsarkivet

Vi har lagt ut opplysninger om prosjektet på nettsidene våre. Alle våre institusjoner har også tilgang til egne prosjekter i Meldingsarkivet.

Vi tar kontakt om status for behandling av personopplysninger ved prosjektslutt

Ved prosjektslutt 31.07.2019 vil vi ta kontakt for å avklare status for behandlingen av personopplysninger.

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Se våre nettsider eller ta kontakt dersom du har spørsmål. Vi ønsker lykke til med prosjektet!

Vennlig hilsen

Marianne Høgetveit Myhren

Lasse André Raa

Kontaktperson: Lasse André Raa tlf: 55 58 20 59 / Lasse.Raa@nsd.no
Vedlegg: Prosjektvurdering
Kopi: ZUbaida Waheed Butt, zubaidawaheedbutt@gmail.com

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 60676

PURPOSE
To explore the experiences of immigrant women from Pakistan who had childbirth in Norway.

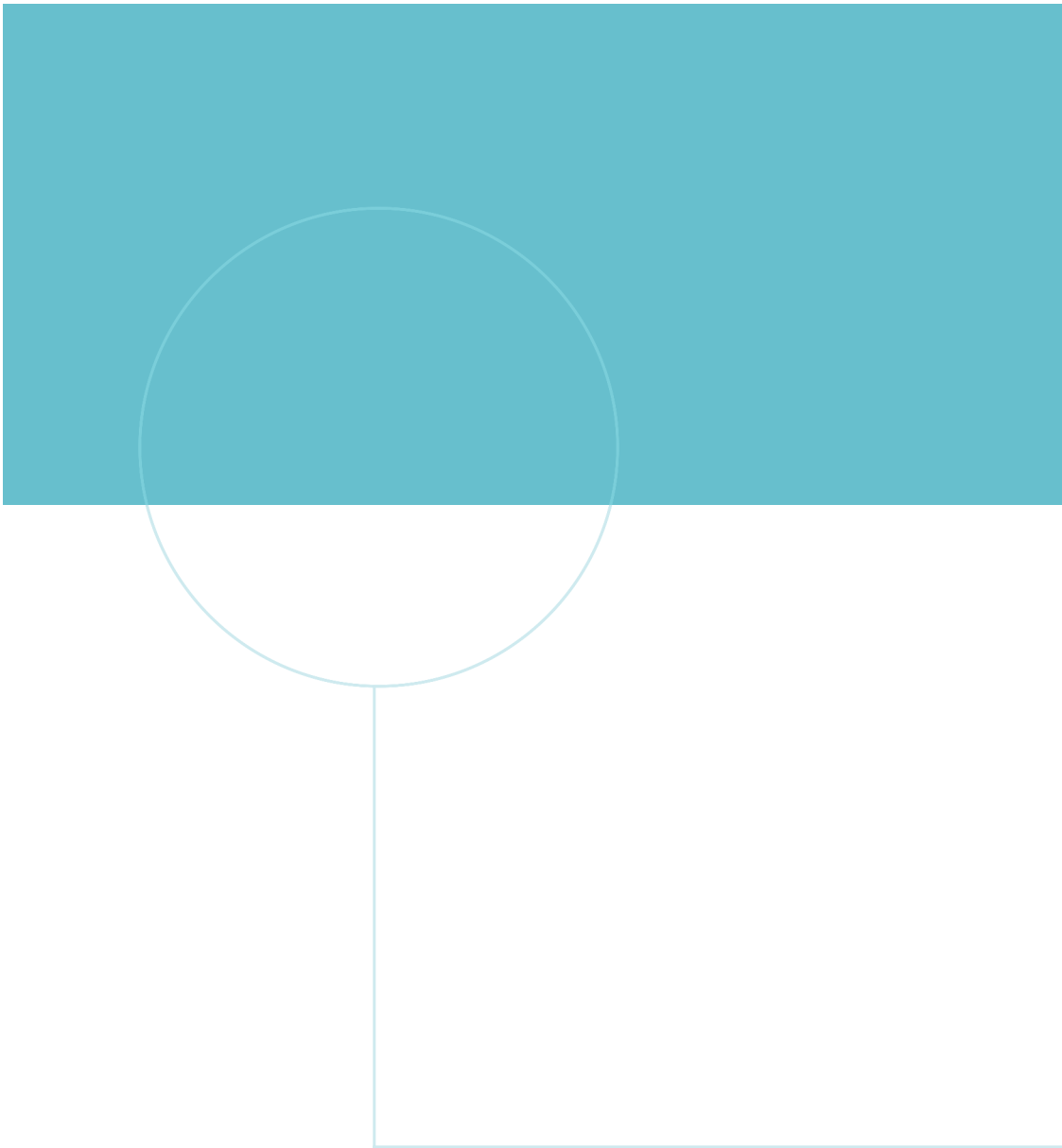
SAMPLE
Immigrant women from Pakistan who gave birth to a child in Norway.

INFORMATION AND CONSENT
According to your notification form, the sample will receive written information and will give their consent to participate. The information letter we have received is mainly well formulated. However, a project end date must be specified (31.07.2019).

SENSITIVE INFORMATION
It is the Data Protection Official's view that there will be registered sensitive information about health as well as ethnic origin or political/philosophical/religious beliefs. This means that the researcher must be even more careful with regards to use of the data, both when it comes to ethical issues, data collection and information security during the project.

DATA SECURITY
The Data Protection Official presupposes that you will process all data according to the NTNU internal guidelines/routines for information security.

PROJECT END
The estimated end date of the project is 31.07.2019. According to your notification form/information letter you intend to anonymise the collected data by this date. Making the data anonymous entails processing it in such a way that no individuals can be identified. This is done by:
- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable personal data (i.e. an identifying combination of background variables, such as residence/work place, age and gender)
- deleting digital audio



NTNU

Norwegian University of
Science and Technology