PhD in Sociology no. 57 - 2022

How Universal Is Universal Health Care?

A Policy Analysis of the Provision of Maternal Health Care for Immigrant Women in Norway

Lydia Mehrara

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ISBN: 978-82-92958-55-1

Print: Trykkeriet Nord

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Dedicated to Farkhondeh, Manouchehr, and Sam

Acknowledgements

This dissertation is a product of years of hard work and dedication. The journey towards its completion has encompassed many challenges and many more triumphs and contentment. First and foremost, I would like to extend my appreciation to Nord University and the Faculty of Social Sciences for the opportunity to pursue my doctoral degree in a field I am passionate about. I am also grateful to my study participants, without whom my study would not have been possible. Thank you for offering me your trust and sharing your time, insight, and experiences with me.

Thank you to Professor Trude Gjernes, for challenging me throughout the different stages of my doctoral dissertation process as my primary supervisor. Your knowledge about medical sociology, your attention to detail, and your continuous encouragement for my involvement in various interdisciplinary contexts has supported my academic and professional growth. I would also like to acknowledge Professor Cecilie Høj Anvik, who offered her guidance as my supervisor in the first year of my PhD program. I am especially grateful to Dr. Susan Young, who has provided me with ongoing unwavering support and guidance throughout my PhD program as a secondary supervisor. Your mentorship since 2016 has been truly invaluable, and I am grateful for your time, enthusiasm, insight, and most of all, your persistence and patience.

During my postgraduate journey, I have been fortunate enough to meet and work alongside many accomplished and brilliant professionals and colleagues. Many thanks to Xóchitl Castañeda and her team at the University of California Berkeley School of Public Health for welcoming me as a visiting scholar in the summer of 2019 and for offering me an intellectually intriguing and unique learning experience. This gratitude also extends to the PROFRES national research school in Norway for the opportunity to be a part of an interdisciplinary research network and program since 2018.

I would like to acknowledge my community of friends and colleagues who accompanied me though this journey, sharing joy, laughter, advice, and friendship through trying times. Some of these wonderful people include Kirill Gurvich, Ensieh Roud, Valeria Nyu, Linn-Marie Lillehaug Pedersen, Cordula Karich, Kathinka Fossum Evertsen, Pål Csaszni Halvorsen, Ann-Torill Tørrisplass, Maja Nilssen, and Anne Kamilla Lund, from Nord University.

I am profoundly grateful for my parents, Farkhondeh and Manouchehr, as well as my younger brother, Sam, for giving me unconditional love, and support throughout my many life

endeavors as well as the encouragement to pursue and complete a doctoral degree. Thank you for keeping me grounded and centered. Mom and Dad, I attribute the best parts of who I am to you as you have taught me the importance of hard work, dedication, authenticity and kindness. Sam, being your older sister has been one of the greatest joys of my life, and growing up with you has brought me so much happiness, love, and friendship. Your vibrant energy and outlook on life has always encouraged me to aim high, challenge myself, and be the best version of myself. I look forward to continuing to be your role model and biggest cheerleader as you embark on your post-secondary education and many other amazing life adventures. Special thanks to Arezo and Samrand and my cousins Diana and Anita for being my second family, opening their home to me when I first moved to Norway, and for supporting me in pursuit of this career.

Finally, to Rui, thank you for all the love and happiness you bring to my life and for your support, empathy, and care during this challenging process. You offer me motivation in times of need and give me hope and a sense of peace.

Lydia Mehrara
November 2021, Bodø, Norway

Abstract

This dissertation critically examines the intersection of immigration and Norway's universal welfare ideology within the context of migrant maternal health, questioning how universal or appropriate universal health care is in the face of growing diversity. The main objective of the research project was to explore the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women. This overarching issue was examined from different perspectives across four independent research articles, which were brought together under six foundational chapters of discussion. This two-part synthesis comprises the doctoral dissertation.

This is a qualitative sociological study, utilizing multiple qualitative methods including interviews, participant observations, and documents analyzed across four articles. This enabled the development of different perspectives on the research question by engaging with different data sources. Each of the four articles contained in this dissertation consequently acts as a building block in the critical examination of Norway's universal health policy. The first article presents a social policy analysis of the Norwegian maternal health care system, which carves out the foundations for the project; the second article is a theoretical discussion on universalism offering a critical reflection on the shifting definition of universalism within the context of the Norwegian democratic welfare state and the concept of equity; the third article examines the experiences of immigrant women with navigating and negotiating the Norwegian maternal health care system; and finally, the fourth article presents a critical analysis of primary maternal and child health care providers' experiences of working with immigrant women from a socio-political perspective.

Together the findings of these articles suggest that the decentralized approach to addressing challenges linked to diversity in the health care system are reduced from national issues to local and regional issues. Thus, handling diversity and ensuring equity in Norway's standardized maternal health care system is made the responsibility of front-line practitioners, or street-level bureaucrats, like nurses and midwives. This decentralized approach to migrant maternal health care does not question the monocultural approach to dealing with diversity; therefore, it leads to the replication of cultural indifference at the practice level, despite the local or individual intentions of practitioners to meet and respond to the needs of immigrant women. Hence, individual and local responses to nation-wide issues can lead to inequality of opportunity and access. In speaking to the system as a whole, the findings of this study identify

that the policy position demonstrates universalism as inherently normative, whereby diversity is marginalized. This trickles down to how migrant women are recognized and met in this system at the practice level. The effects produced by this decentralized system on the service users is conforming, requiring them to accept a generalized provision, and needs to be addressed at its roots by questioning the underpinning assumptions of Norway’s universal policy.

In conclusion, this dissertation argues that universalism and its egalitarian ethos are utopic, and that given the monocultural underpinnings of Norway’s universal welfare policy, inequality will be replicated by the system as long as diversity is handled in a decentralized fashion. The future of Norwegian universalism requires the adoption of a multicultural focus and the embeddedness of cultural diversity in its socio-political ideology of redistribution principles. The risk of forgoing this while Norwegian society continues to diversify will lead to cleavages and more stark representations of inequality in society, with a growing trend towards privatized services.

This study makes an important contribution to the intersecting fields of migration, public health, public policy, social work, and medical sociology.

Sammendrag

Denne avhandlingen er en kritisk undersøkelse av interseksjonen mellom immigrasjon og Norges universelle velferdsideologi, innenfor konteksten av mødrehelse hos innvandrere. Den stiller spørsmål om hvor universelle eller passende universelle helsetilbud er i møte med økende mangfold. Hovedmålet med forskningsprosjektet er å utforske følgene av Norges desentraliserte tilnærming til innvandrerkvinners behov knyttet til mødrehelse. Dette overordnede temaet undersøkes fra ulike perspektiver gjennom fire forskningsartikler som sammenholdes i seks diskusjonskapitler, og til sammen utgjør disse doktorgradsavhandlingens to deler.

Avhandlingen er en kvalitativ, sosiologisk studie som bruker flere kvalitative metoder, inkludert intervju, deltakende observasjon og dokumenter, som analyseres i fire artikler. Bruken av ulike metoder har gjort det mulig å utvikle forskjellige perspektiver på forskningsspørsmålet, ved å bruke ulike datakilder. Hver av avhandlingens fire artikler utgjør dermed en byggestein i den kritiske undersøkelsen av Norges universelle helsepolitikk. Den første artikkelen presenterer en sosialpolitisk analyse av det norske systemet for mødrehelse, som setter premissene for prosjektet. Den andre artikkelen er en teoretisk diskusjon om universalisme, og innebærer en kritisk refleksjon over skiftende definisjoner av universalisme innenfor konteksten av den norske demokratiske velferdsstaten og konseptet om likhet. Den tredje artikkelen undersøker innvandrerkvinners erfaringer med å manøvrere og forhandle med det norske systemet for mødrehelse. Den fjerde og siste artikkelen presenterer en kritisk analyse av erfaringene tjenesteytere i førstelinjen for mødre- og barnehelse har med å jobbe med innvandrerkvinner, ut fra et sosiopolitisk perspektiv.

Til sammen tyder funnene i artiklene på at den desentraliserte tilnærmingen til utfordringer knyttet til mangfold i helsevesenet, blir redusert fra et nasjonalt til et lokalt og regionalt anliggende. Slik blir ansvaret for å håndtere mangfold og sikre likhet, tillagt førstelinjearbeidere eller bakkebyråkrater som sykepleiere og jordmødre. Den desentraliserte tilnærmingen til mødrehelse for innvandrere stiller ikke spørsmål ved den monokulturelle tilnærmingen til håndtering av mangfold; derfor medfører den en reproduksjon av kulturell likegyldighet på praksisnivået, til tross for lokale eller individuelle intensjoner blant praksisutøvere om å møte og svare på innvandrerkvinners behov.

Dermed kan individuelle og lokale svar på nasjonale spørsmål føre til ulikheter i muligheter og tilgang. På systemnivå viser denne studiens funn at den desentraliserte tilnærmingen anskueliggjør universalisme som iboende normativ, noe som også medfører at mangfold marginaliseres. Dette får konsekvenser for hvilken anerkjennelse innvandrerkvinner blir møtt med i dette systemet på praksisnivået. Effektene det desentraliserte systemet får for brukerne, er karakterisert av konformitet, og krever at de godtar et generalisert tilbud. Disse effektene må belyses ved å stille spørsmål ved de underliggende antakelsene som ligger til grunn for Norges universelle politikk.

I avhandlingen argumenteres det for at universalismen og dens egalitære etos er utopiske, og at gitt det monokulturelle fundamentet til Norges universelle helsepolitikk, vil ulikhet bli reprodusert av systemet så fremt mangfold blir håndtert desentralisert. Den norske universalismens framtid fordrer et nytt, multikulturelt fokus, og at kulturelt mangfold integreres i dens sosiopolitiske ideologi om prinsipper for omfordeling. Risikoen ved å gi avkall på en slik multikulturell politikk samtidig som det norske samfunnet blir stadig mer mangfoldig, vil medføre større ulikhet i samfunnet, med økt privatisering av tjenester.

Denne studien gir et viktig bidrag til de kryssende feltene migrasjon, folkehelse, offentlig politikk, sosialt arbeid og medisinsk sosiologi.

List of Articles

1) Mehrara, L., & Young, S. (2020). Health equity and universal provision in Norway: A case study. *Nordic Journal of Social Research, 11*(1), 39–65. https://doi.org/10.7577/njsr.2638

2) Mehrara, L. (2020). Seeking the ideal of universalism within Norway's social reality. *Social Inclusion 8*(1), 133–144. http://dx.doi.org/10.17645/si.v8i1.2535

3) Mehrara, L., Gjernes, T., Young, S. Immigrant women's experiences with maternal health care in Norway. Under Review at *International Journal of Qualitative Studies on Health and Well-being.*[1]

4) Mehrara, L. More than health care: Midwives and public health nurses working with immigrant women in Norway. Under review at *Journal of Comparative Social Work.*

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[1] Mehrara, L., Olaug Gjernes, T. K., & Young, S. (2022). Immigrant women's experiences with Norwegian maternal health services: implications for policy and practice. *International Journal of Qualitative Studies on Health and Well-being*, *17*(1), 2066256. https://doi.org/10.1080/17482631.2022.2066256

Contents

Tables and Figures

Abbreviations

NMHS: Norwegian Maternal Health Services

TEGRA: Health program for migrant women- short for "inTEGRAtion"

WPR: "What's the problem represented to be?" framework

Part I: Foundation

Chapter 1: Introduction

My interest in research on the field of migrant health stems from both my personal life and my academic background. As an immigrant in multiple settings, I have witnessed and experienced some of the challenges associated with migration and integration into a new society, from a young age to the present day, with each subsequent move across continents and borders. This has shaped, and has been shaped simultaneously, by my journey in academia, from Global Health to Social Work, and now Sociology. I have been interested in and curious about the lives of other immigrants, particularly women, and how they face the challenges of immigration at different stages of life, particularly while pregnant or with young children. The initial idea for investigating the intersections of policy and immigrant maternal health was sparked during a social work internship in Sweden, where I met a young pregnant girl staying at a center for unaccompanied asylum-seeking minors. I had many questions about how she would cope with all the challenges on her way to motherhood in a foreign country with a different system, language, culture, and so on, and without any familial support. Upon doing some investigation, I soon realized the limitations in the scope of research in this field and of health inequalities among immigrant women in Scandinavia, where equality and quality of life are highly esteemed. I therefore committed myself to exploring the issue of maternal health care for migrant women through a policy and practice perspective. This began as a graduate research project in Norway and continued as the investigative topic for my doctoral dissertation.

This chapter provides the contextual overview as well as the structure of this dissertation, which is constructed to answer the following research question: *What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?*

1.1 Background

Norway has a generous welfare system, extending to its health sector in the form of universal health coverage. The assumption underlying this method of provision across the population is that through equal, undifferentiated opportunity or universal access, inequality can be remedied. However, in recent years, this assumption of universalism has been challenged by diversity, particularly that of ethno-cultural[2] diversity brought on by a relatively new and

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[2] The term ethnocultural refers to "an ethnic identity supported by cultural practice, tradition, and society and to a group of people who believe they are ethnically or culturally distinct from other groups or both" (p. 65) Hall, L. E. (2004). Dictionary of multicultural psychology: Issues, terms, and concepts. Sage. https://doi.org/10.4135/9781452204437 .

growing segment of the Norwegian population, immigrants. [3] These challenges are reflected in the indicators of poorer health outcomes among Norway's migrant[4] population in comparison to its local population (Attanapola, 2013). One particular example of this disparity is evident in maternal health and birth outcomes of immigrant women, who, on average, have higher rates of birth complications, miscarriages, and other adverse birth outcomes (Bakken, 2016; Vik et al., 2019).

Although immigration has benefits for a host nation, it can also pose many new challenges for its health care and welfare systems, as is the case in Norway. This is because while social service provisions, including health care, can be efficient at targeting and treating the needs of the native population in a host country, they may not be prepared to address the specific needs of some migrant populations. This, therefore, leads to inadvertent disparities among indicators of well-being, such as health, between these two population groups. In Norway, with universalism remaining the core principle of its health policy, the challenges associated with growing ethno-cultural diversity as a result of increasing immigration, are demanding universal health care to be suitable for and accessible beyond a statutory right to people who are not ethnic Norwegians and who come from many different cultural and linguistic groups.

As immigration in Norway increases, there is a growing focus on the specific health care needs of migrant populations and the consequences of meeting these needs. This is a relatively recent field of research. Among the considerations in addressing the health needs of immigrants is the decentralized nature of the distribution of health services, with governance and the provision of many services devolving to municipalities. In order to optimize health care delivery, local governments are given the autonomy to redistribute health services, within the frame of national guidelines established by the Norwegian Directorate of Health, in ways that best meet the needs of their respective populations. In this dissertation, I challenge this strategy as problematic, and in the following contextual subsection I position my argument against it. This will be followed by the aim and structure of this dissertation.

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[3] Immigrants refers to: "persons born abroad with two foreign-born parents and four foreign born grandparents" SSB. Persons with immigrant background. Statistisk sentralbyrå- Statistics Norway. https://www.ssb.no/ajax/ordforklaring?key=225102&sprak=en.

[4] Migrants, officially referred to as persons with immigrant backgrounds, are: "persons born abroad with two foreign-born parents and four foreign born grandparents, in addition to persons born in Norway with two foreign-born parents and four foreign-born grandparents" ibid..

1.2 Contextual Setting

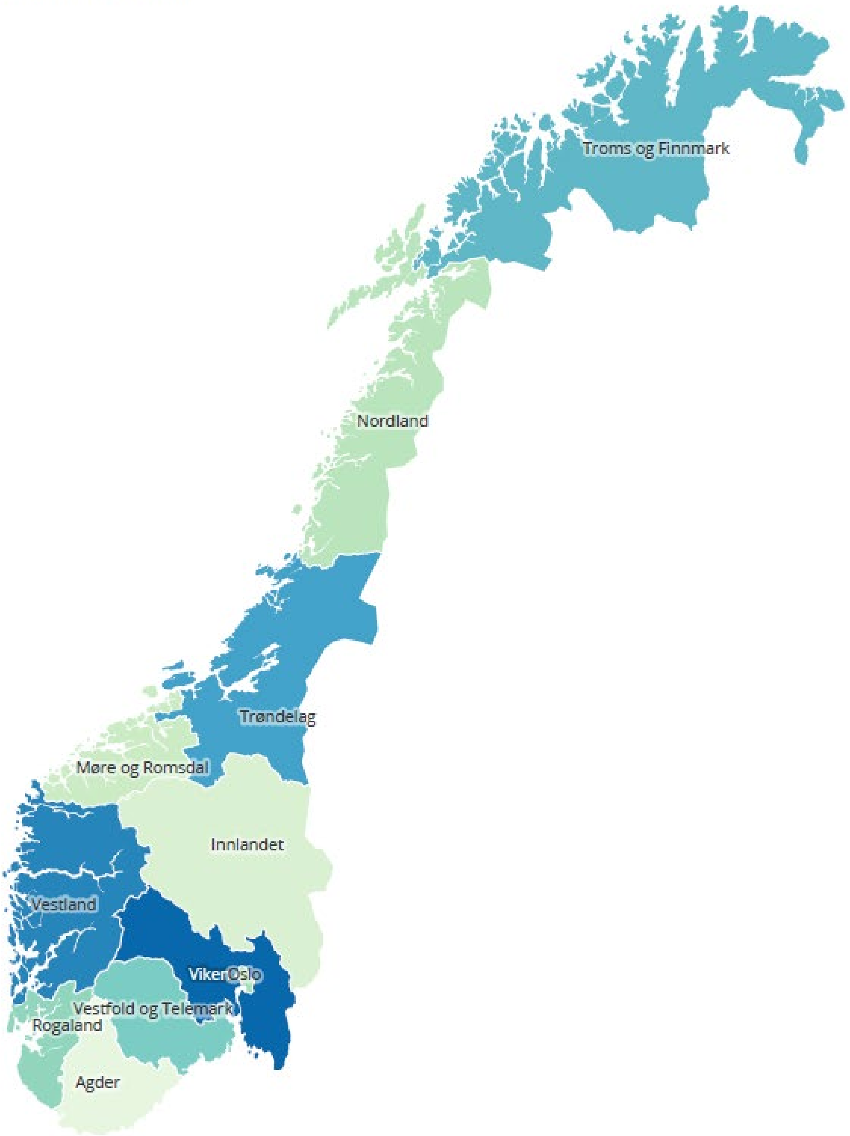
To contextualize this study, this section briefly problematizes migrant maternal health care in Norway as a pertinent area of study. I provide a description of Norway's immigrant population and its characteristics, followed by the organization of the maternal health care system and the issue of discretionary response. This section is followed by the aims, research questions, and structure of this dissertation.

1.2.1 Immigration and Immigrants in Norway

Norway has a population of 5 402 171 as of 2021 (SSB, 2021g). Immigrants constitute a growing percentage of the Norwegian population. In 2021, people with immigrant backgrounds constituted 18.5% of Norway's population (SSB, 2021a). The majority of this population are immigrants from Asia, Africa, Latin America, and other "non-western" countries (SSB, 2021a). In 2021, The top three source countries for migrants in Norway were Poland, Lithuania, and Somalia respectively (SSB, 2021b). Norway is a large country that has been divided into eleven counties with different geographic, economic, and demographic characteristics (Regjeringen, 2019) (Figure 1).

Figure 1

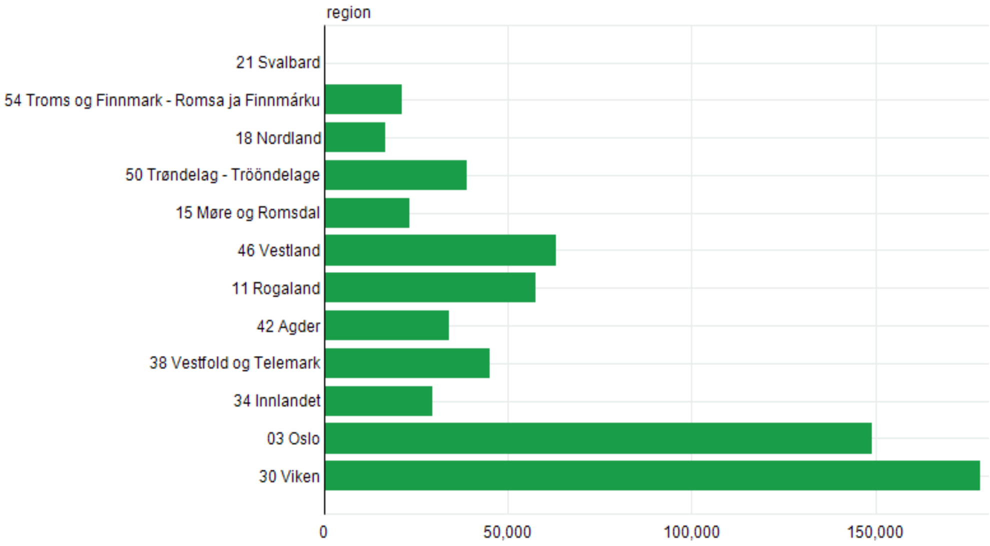
Map of Norway's 11 Counties as of 2020 (Regjeringen, 2019)



Following the general settlement patterns in Norway, the population of persons with immigrant backgrounds, and consequently immigrant women of childbearing age, is concentrated in the southeast and southwest parts of the country in the counties of Viken, Oslo, Rogaland, and Vestland, as indicated in Figure 2. This constitutes one rationale for my choice of locations for data collection.

Figure 2

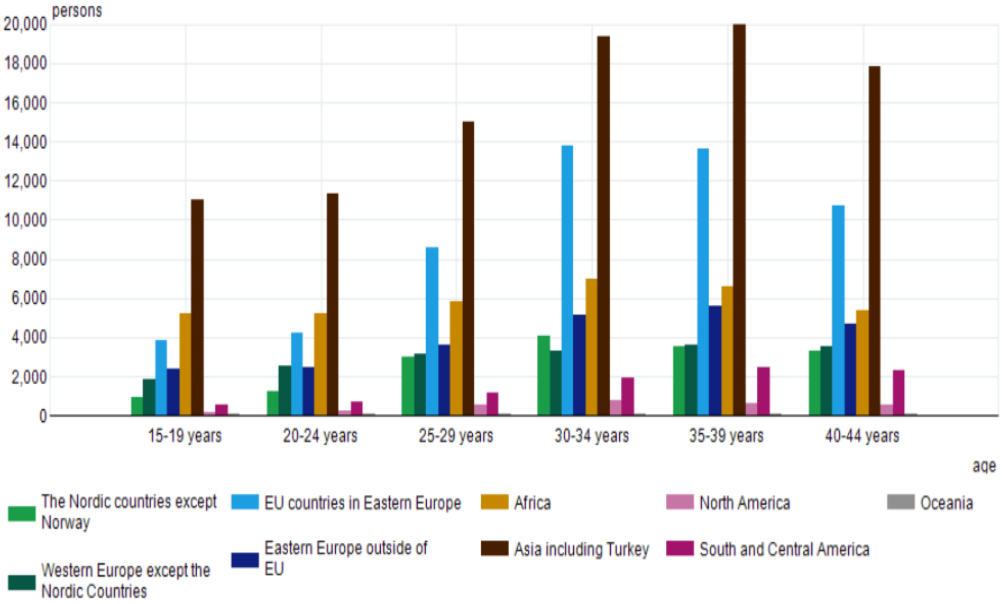
Female Population with Immigrant Background by County of Residence (SSB, 2021h)



Migrants in Norway are generally young, with the majority between 20 and 44 years of age (SSB, 2021c). Women of childbearing age (15–45) make up 255,234 of the total migrant population in 2020, which is over 25% of the migrant population and nearly 5% of the total population of Norway (SSB, 2021d). Immigrant women have a higher birth rate than Norwegian women. In 2020, 52,979 live births were recorded in Norway (SSB, 2021f), 27% of which were by immigrant women (SSB, 2021i). Migrant women may, therefore, have frequent encounters with the maternal health care system. Given that many of these women come from countries where health care systems and maternal health care are very different from those in Norway, as indicated in Figure 3, their encounters with the Norwegian maternal health care system become an important area of investigation.

Figure 3

Females of Childbearing Age (15–44) with Immigrant Background by World Region (SSB, 2021e)



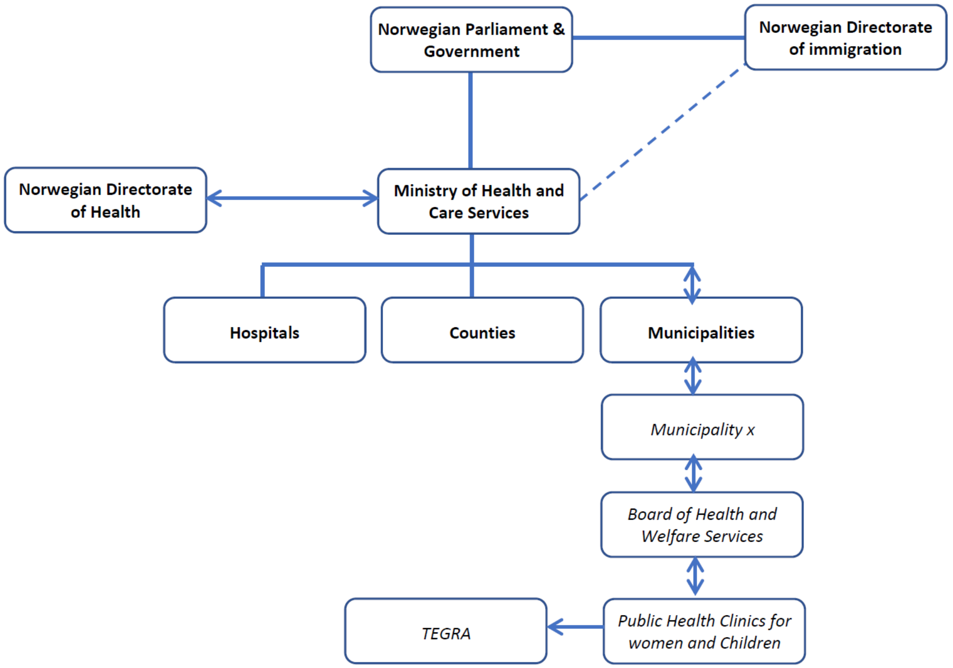
1.2.2 Health Governance and Organization of Maternal Health Care in Norway

Maternity care in Norway is provided at two levels: at the secondary level by specialized doctors and midwives at hospitals, and at the primary level by midwives at public health clinics and general practitioners. As the governance and regulation of health care provision is decentralized in Norway, the state retains responsibility for public hospitals, while local governments are in charge of most other health care services. This structure is rooted in the long history of local governments' autonomy from the state in Norway (Borge, 2010). Local governments are, therefore, responsible for and have discretion, within the bounds of national guidelines, in the distribution of health services. Given that the primary level of maternity care is under municipal jurisdiction, provisions can be tailored to best meet the needs of the local populations.

Since migrant maternal health has not been problematized in Norwegian health policy as is explored in the first article (Mehrara & Young, 2020), some municipalities with a high population of migrants have devised discretionary initiatives in response to locally recognized challenges related to migrant maternal health. One municipality with a high population of migrants, for example, operates a pre- and post-natal workshop for immigrant women, named TEGRA which is short for “inTEGRAtion”, in order to provide this group with better opportunities to utilize the Norwegian maternal health care system. This program is important in the development of this dissertation and is discussed at various points. Figure 4 illustrates the decentralized governance of maternal health care in Norway and the placement of TEGRA as an extension to the standard service provision structure.

Figure 4

Organization of Municipal Maternal Health Services in Norway (as cited in Mehrara, 2020)



1.2.3 Discretionary Response

Given the different patterns of migrant settlement across the country, the availability and scope of these initiatives vary from place to place. This has limited such targeted health initiatives to immigrants in migrant-dense areas. Such discretionary practice responses to the needs of immigrant women – in other words, the challenges of ethno-cultural diversity – may have implications for Norway's social democratic values of egalitarianism. This is because migrant maternal health is not a regional issue but a national one, and though local responses have been an effective way of acutely addressing this issue, it requires a national response.

This doctoral project raises a series of questions challenging the idea of Nordic exceptionalism by interrogating the notions of equality and equity within Norway's universal health policy. It identifies this system's implications for maternal health care and outlines the experiences of maternal health care providers and immigrant service users in different regions of Norway. Finally, this project reflects on the response of the Norwegian welfare state to cultural diversity resulting from a growing immigrant population.

1.3 Aim and Significance

This doctoral project explores the equity and equality debate within the context of universalism from a sociological perspective by focusing on maternal health services for immigrant women as a representation of this dynamic. Both macro (system) and micro (individual) dimensions are explored. The aim is to investigate whether and how different levels of government in Norway are responding to the maternal health challenges and needs of migrant women, and what the local effects of these are on migrant service users and primary maternal and child health care providers. The significance of this study lies in its contribution to knowledge in the cross-disciplinary fields of policy, sociology of health, immigration, and maternal health care. Furthermore, this research contributes to sparking a discussion on how health practice and policy can inform one another in responding to the challenges resulting from ethno-cultural diversity in Norway, in order to ultimately enhance service delivery to immigrant women.

1.4 Research Questions

The overarching research question in this dissertation is as follows:

What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?

This is investigated through five constructive subsidiary questions, analyzed across four articles in the order presented below.

Article 1

1. *How does Norwegian health policy provide maternal health services to migrant women?*
2. *How have these policies enabled accessibility and acceptability of maternal health services to migrant women?*

Article 2

III. *How much inequality in policy instruments can a universalist state tolerate in its pursuit of equity?*

Article 3

IV. *How do immigrant women experience and navigate the Norwegian maternal health care system during pregnancy and birth?*

Article 4

V. *What are the implications of cultural diversity for health care practice in a universal system?*

1.5 Structure of the Dissertation

This dissertation consists of four distinct yet related articles, which contribute to the investigation of the principal research question from different angles. The dissertation is organized into two parts. The first part comprises of six foundational chapters, which bring the research articles together; the second part presents the four scientific articles. The first chapter provides a brief introduction and background to the study. The second chapter contextualizes the study, providing a historical perspective and reviewing existing literature on immigration and health. The third chapter outlines the overarching conceptual and theoretical frameworks for the dissertation, which provide the analytical basis for the discussion of the research articles. Following this, the fourth chapter provides the methodological frame for the dissertation, including research design, data collection and processing, philosophical considerations, and a reflexive discussion on researcher positionality. After these substantive chapters, the fifth chapter provides a summary of each article and an overview of all four in Table 4, which is followed by an in-depth discussion and conclusion in the sixth chapter, where the contributions of the dissertation are highlighted.

Chapter 2: Literature and Contextual Review

The effect of immigration in relation to health is twofold, affecting both the health care system and the health of immigrants. This chapter presents the "state of the art" foundation for this dissertation. Although each of the four articles contextualizes the background for this study, this chapter acts as an encompassing discussion, addressing the details and parallel discussions bringing together the contextual underpinnings for this research project, its aims, and its significance. Therefore, the chapter serves as more than a summary, supplementing a more rounded discussion of what is known, where the gaps in knowledge are, and why and how this dissertation contributes to knowledge on the intersection of immigration and Norway's universal health care system.

The chapter argues that immigration creates new challenges for both the health care system of a host nation and the immigrants themselves. Both are connected to Norway's universal policy system. Subsequently, it covers an overview of the intersections of political history, social policy, and migrant health. It begins with the history of the welfare state and public health insurance in Norway. The discussion around the inception of Norway's welfare state is embedded in both the Nordic (Denmark, Sweden, Norway, Finland, and Iceland) and Scandinavian (Denmark, Sweden, and Norway) contexts; the terms "Nordic" and "Scandinavian" are not synonymous, but both are mentioned here as both include Norway. Next, the chapter outlines the impact of immigration on the health care system and the health of immigrants, conceptualizing immigration as an intersecting determinant of health. These arguments are essential in describing why and how this presents an important topic for study and for carving out the significance and contribution of this research project, which are presented in the chapter summary.

2.1 Inception of Universalism

How did universalism in its current form emerge in Norway, and why did the provision of social services independent of social class become a mechanism for class compromise? This section provides an overview of the expansion of social insurance schemes and the inception of universalism as a principle of redistribution in Norwegian social policy. This is important for understanding the historical underpinnings of the Norwegian universal health insurance scheme today and demonstrates the importance of studying immigrant maternal health care in Norway.

2.1.1 Welfare State and Social Insurance

The welfare state, with all its indeterminate usages (Kuhnle, 1978), is a relatively recent European creation, dating back to the last quarter of the 19th century (Castles et al., 2010), a period marked by great political, economic, and societal transformations. These events catalyzed changes in European societies and their needs, subsequently leading to an evolution in the role of the state from protecting the nation from war, to protecting society and responding to its new post-war social needs (Castles et al., 2010).

Similarly, the concept of social policy as the social protection of society, however enacted, is fairly new.[5] Bismarckian theories on insurance and social policy as a form of nation-building during the 1880s in Germany established the foundations for the development of the German welfare state and triggered the expansion of social protection policies, such as social insurance, in other countries. Over time, and around the turn of the 20th century, these policies expanded to incorporate pension plans, old-age protection, unemployment protection, industrial accident insurance, sickness insurance, and family allowances across most post-industrial western countries, including Norway (Kuhnle & Sander, 2010). However, Bismarck was not the inventor of state-organized social insurance. Prior to the German legislation of social insurance in 1883, many small-scale forms of insurance for workers and the poor existed across western Europe. As noted by (Anttonen & Sipilä, 2012, p. 17) “the idea of equal treatment was exceptional,” with different groups attracting different benefits. Norway for example, had “poor law legislation,” and had occupational risk insurance for miners (by 1842) and for seamen (by 1860) (Kuhnle, 1978, p. 13). Nevertheless, it was the growth of industrialization towards the latter part of the 19th century that set the hallmark of state legislation in social insurance and protection. Though insurance on a broad scale was nonexistent, most industrializing or industrialized countries in Western Europe enacted worker accident insurance. In Norway, compulsory worker accident insurance paid by the employer was implemented in 1894 (Kuhnle, 1978, p. 24). This was followed by proposals for other forms of insurance, including sickness insurance, which was accepted in 1909 (Kuhnle, 1978, p. 27). These early social insurance programs were not universal, limited often to industrial workers or based on means-tested schemes, which excluded many. However, they did gradually expand with the establishment of

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[5] The definition of social policy is debated. In this study, social policy refers to “publicly provided, or regulated, core programmes such as income maintenance (or social security), housing, health and social services,” (p.71) which is how the concept is defined within academic discourse by Clasen, J. (2013). Defining comparative social policy. In P. Kennett (Ed.), A handbook of comparative social policy (2 ed., pp. 71–83). Edward Elgar Publishing. https://doi.org/https://doi.org/10.4337/9781782546535.00012

the "welfare state" after World War II, marking the evolution of state policy for the benefit of society.

The notion of welfare policy, or policies, was not formally introduced until the mid-20th century. In 1942, a report by Sir William Beveridge was published in the United Kingdom (The National Archives), which became fundamental in shaping post-WWII reform and the creation of the British welfare state. Commonly known as the Beveridge Report of 1942, it emphasized the need for a comprehensive social insurance scheme that would protect citizens from "cradle to grave" from the "five giant evils" of society – want, disease, ignorance, squalor, and idleness (The National Archives) – and for social provisions that would transcend class. The expansion of welfare accelerated after WWII between 1947 and the 1960s in many western countries (Castles et al., 2010). With the common need to eliminate poverty and increase the participation of their citizens in society, other countries in Europe and the west, including Norway, adopted many aspects of the Beveridge Report. However, given socio-political and economic differences, adoptions of reforms in enacting social provisions, and their timings, differed markedly.

2.1.2 Universalism in Scandinavia

It is interesting to consider why and how the concept of universalism was embraced in the Nordic countries, who were neither the pioneers of this concept (Stefánsson, 2012) nor as wealthy or progressive as some other European nations of the time. The welfare models, as we know them today, were therefore not developed *ab initio*. This is also true of the Nordic model renowned for its generosity and success. Kautto (2010) points out that though there may be a misconception that the Nordic model was created from a "common preconceived master plan" (p. 588), rather as evident from the history of social insurance initiatives, it was "the result of processes of political evolution rather than intelligent design" (p. 588).

Why was universalism adopted in Norway? The events of the 20th century brought about a growing need for social planning. This meant that the fighting of "poverty went hand in hand with state institution building for social and economic growth as well as political democracy" (Kuhnle & Hort, 2004, p. 1). This development coincided with the economic boost from discovery of oil in the North Sea in the 1960s. As a result, the role of the state, and consequently, the size of the public sector, expanded by "broad-based popular social movements" (Kuhnle & Hort, 2004, p. 1) to include not only more comprehensive and inclusive social insurance policies but also education and public health programs. Thus, it was not until 1956 that means testing schemes in Norway were progressively replaced by more inclusive national programs, marking the beginning of universal schemes that covered all citizens and were independent of social class (Kuhnle & Hort, 2004, p. 7). This became the hallmark of Nordic universalism, whereby welfare services became mechanisms for class compromise and transcended divisions of social class. Additionally, as Bendixen et al. (2017) expand:

> …rather than being characterized by a tension or contradiction between citizen and the state, Scandinavian societies are characterized by high levels of trust in the state. The state in Scandinavia is to a considerable extent regarded as an extension of a political community, the legitimacy of which rests on the perception of broad participation and popular control. (2017, p. 7)

Why was universalism a successful model of social welfare in Norway? Kuhnle and Hort (2004) argue that the many initiatives of social insurance in Nordic countries before and after the beginning of the 20th century paved the path for the adoption of universalism. The application of the principle was successful because of the strong "idealistic and pragmatic ideas promoted and partly implemented" (Kuhnle & Hort, 2004, p. 9) in these early schemes. These were also supplemented by pertinent issues for the Nordic states, such as community building; risk exposure; human dignity i.e. the Universal Declaration of Human Rights in 1948; and economic and bureaucratic efficiency, effectively eliminating means testing for social provisions (Kuhnle & Hort, 2004). Kautto (2010), however, defines three socio-structural conditions that were predeterminants for a unique incubation environment for universalism to expand in Scandinavia. These shaped the particular development of the welfare state in Scandinavia, which was different from that of the rest of Europe, and enabled "universalism to become such an integral part of its policies" (p. 588). These factors were the political, demographic, and cultural climates of the time. Additionally, the high prevalence of social and institutional trust in these societies, as discussed by Rothstein and Stolle (2008), set the precedence for the inception and development of the universal welfare models in Scandinavia.

According to Kautto (2010), the first major consideration in this developmental trajectory was the separation of power from the Church to the State, and the ensuing transfer of welfare responsibilities to the state. Another key factor was the demographics of the population that paved the way for universalistic solutions (Kautto, 2010). Farmers comprised a significant majority of the population, and thus they maintained a powerful stance in politics. This made farmers "one cornerstone of the Scandinavian tri-polar class structure, together with the working and upper classes" (Kautto, 2010, p. 588); as such, they pushed for "ideas of citizenship and equal rights" (Kautto, 2010, p. 589), extending social policies otherwise limited to "workers" in other countries to the public.

Finally, and most importantly, despite some inter-Nordic migration, the Nordic countries remained by and large culturally, ethnically, religiously, and to some extent, linguistically homogenous. These circumstances, combined with a common history of social policy development, increased the likelihood of the successful adoption of universal ideas, equality, and collective public responsibility, compared to other more fragmented and socially mixed societies. Universalism in Scandinavia was justified because it supported national cohesion or unity and increased the functional capacity of citizens. Hence, the success of universalism in Norwegian welfare policy is historically nestled in Scandinavian socio-cultural and political ideologies. The expansion of egalitarian ideologies in parallel to Norwegian nation-building in the 19th century led to the inception of public health insurance.

2.1.3 Public Health Insurance in Norway

The foundations for universal public health were also lain by the formation of other types of insurance in parallel to the development of the Norwegian welfare state. However, before its development into a public benefit and its adoption as a right, health care in Norway had a very different history. Only sporadic small-scale health promotion programs existed across the country prior to 1860, when the first Public Health Law was passed: "the 1860 law enabled proactive public health policies in Norwegian communes but in general did not specifically compel them… consequently, the actual practice of public health varied a great deal throughout the country" (Hubbard, 2006, p. 115). Furthermore, like other forms of state-supported interventions in Norway at the time, public health care interventions targeted the poor through means testing schemes, with the result that state-employed doctors provided necessary medical services to the needy at little to no cost (Kuhnle & Hort, 2004). The state legislature around this intervention and the scale of the operation, which was limited by resources, left many inhabitants uncovered and without access. Nevertheless, the Public Health Law of 1860 marked the first steps towards universalizing public health care in Norway (Kuhnle & Hort, 2004). In what followed, sickness insurance was implemented in 1909 and covered a fraction of the country's active work force; however, this did not become a universal benefit for several decades due to war and the associated economic depressions. It was the health reforms after WWII, influenced by the visions of then Health Director Karl Evang on social medicine, that sparked changes in legislation around health care (Hubbard, 2006). These events resulted in the adoption of universal health solutions and eventually in the ratification of the universal sickness benefit in 1956, marking a new era of universal public health in Norway.

2.1.4 Maternity Care and the Feminist Tradition of the Norwegian Welfare State

The history of maternity care is interwoven with the era of industrialization in Europe, the evolution of egalitarian ideas in society, the expansion of equality from rich and poor to the sexes to include gender as well as social standing, women's suffrage, and surely the birth of the Norwegian welfare state in the 19th and 20th centuries.

As Peterson (2013) maintains, "even though industrialization was relatively small and mainly confined to the cities of Kristiania and Bergen, it was instrumental in helping form new social classes, and with them new social tensions" (p. 38). Industrialization in Norway was slower in comparison to industrial giants like Germany. This allowed Norway to take a gradual approach to the adoption of other countries' industrial regulations and workers' insurance policies, in an attempt to avoid the same problems of industrialization. Regulations included the enactment of maternity leave for the growing number of women working in factories, mainly as an aspect of population policy (Peterson, 2013). In Norway's 1892 Factory Law, a six-week postpartum prohibition on the return to work was introduced in the name of protecting women workers and their newborns (Peterson, 2013); this formed the basis for Norway's maternity leave. This law did not work in favor of working-class women, who relied on their jobs for survival, and thus it became a battleground for feminist groups in policy reforms that took place in the years that followed. The combined efforts of the Norwegian Women's Rights Association (Norsk Kvinnesaksforening, n.d), organized in 1884, and the national midwives' association (Den norske jordmorforening, n.d), established in 1908, led to feminist movements that reformed both maternity leave policies and maternity care. As Peterson says, "In the decades to come, more Norwegian women would be covered under maternity legislation. Feminists, midwives and working women would work to expand the definition of maternity protections. Maternity would quickly become a condition that warranted not only regulation, but also compensation" (Peterson, 2013, p. 88). By the end of the 19th century, childbirth had become institutionalized, ceasing to be an intimate personal event and becoming the state's domain, requiring its protection. These women's movements were essential in the early universalization of maternity care by trained midwives to all women, regardless of their ability to pay, and were furthermore catalysts for discussions that shaped the development of the Norwegian welfare state's policies on women's and children's health and rights. As such, "…notions of women-friendliness and state feminism were coined in 'the golden period of Scandinavian gender equality policies'" and consequently, "gender equality has increasingly been presented as a summarizing symbol of the welfare state model" since the 1970s (Bendixen et al., 2017, p. 18). The role of women in shaping the Norwegian welfare state through advocacy for women's rights was, therefore, significant.

2.2 Diversity as a Challenge to Egalitarian Socio-Political Ideology

Given the history of universalism and the factors responsible for its success in Scandinavia, cultural diversity poses a challenge to the pillars of the egalitarian ideology that grew from below at the community level through the coming together of working-class civic society. Cultural diversity is a form of heterogeneity, which opposes the sense of national homogeneity that modernized Norway and led to the inception of its welfare state. Furthermore, this type of diversity brings forth new challenges for equality that were not historically considered, leading inevitably to newly forming grey areas in universal social policy, and thus, to pockets of inequity in society. As Bendixen et al. (2017) suggest, "intersectionality" is warranted because of the "new socio-economic and political conditions that are a result of increased immigration and globalization" (p. 18). Eriksen (2017) argues:

> In the current, historically unprecedented situation where ethnic minorities, including immigrants as well as indigenous groups and 'national minorities', demand both equality and the right to difference, it has become evident time and time again that the welfare state is geared toward dealing with inequality, as regard gender, class and regional inequalities, but has few tools available for handling cultural diversity as anything but a social problem to be resolved through a stronger emphasis on equality as well as equity. (2017, p. vii).

Similarly, when it comes to maternal health care for immigrant women, the current system lacks an intersectional awareness of the needs and experiences that women from different socio-cultural backgrounds bring with them.

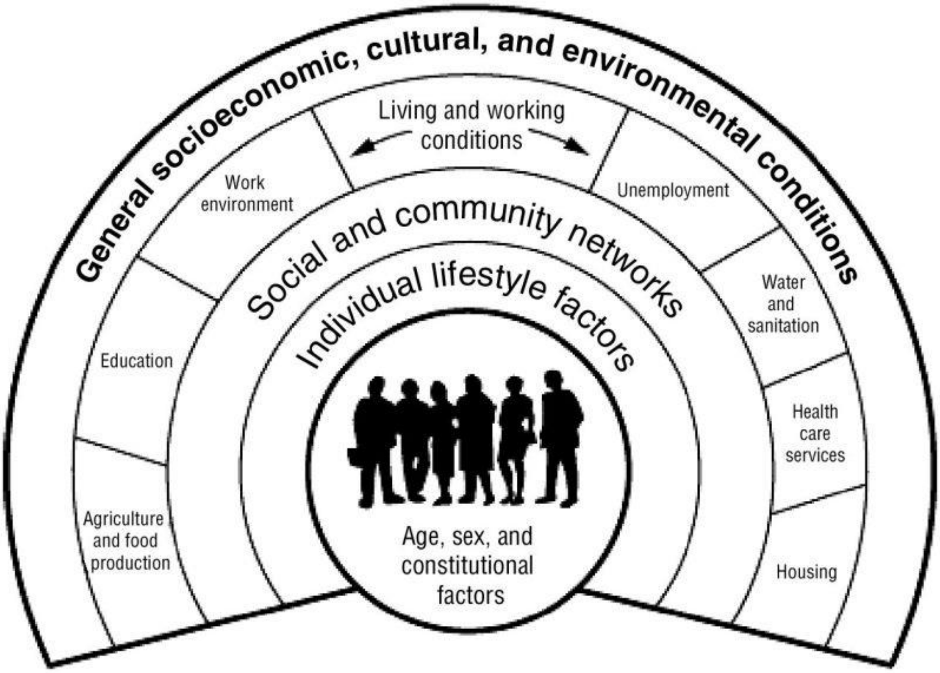
2.2.1 Immigration as an Intersecting Determinant of Health

Immigrants may face certain barriers in utilizing a universal health care system to their benefit. These barriers could be linked to socio-economic factors, which are most often a focus for policy, such as in Norway (Ringard et al., 2013), but they could also be linked to factors directly associated with being an immigrant. Cultural differences, for example, can lead to different help-seeking behaviors, different expectations of the health care system, and/or different ways of interacting with it. Navigating a new health care system can also pose many challenges; these could be related to the extent of immigrants' knowledge about the new health care system, health literacy, networks, communication barriers, and so on. Finally, other forms of social and cultural capital can influence immigrants' limited usage of a health care system to which they may be, unknowingly, legally entitled. Multiple studies from Europe, and a growing body from Scandinavia and especially Norway in more recent years – for example, Herrero-Arias et al. (2020); Mbanya et al. (2019); Næss (2019) – explore these issues in connection to immigrants' health. These have been integrated into the four research articles.

Immigration must, therefore, be framed as a determinant of immigrants' health in the host country. This is because immigration can affect the utilization, experience, and health outcomes of immigrants in a multitude of ways. However, this determinant, in comparison to the traditional model of the "social determinants of health" by Dahlgren and Whitehead (1991), illustrated in Figure 5, is not a static category in the social-ecological model. It is a relative factor present at all levels, affecting immigrants – a heterogeneous group within themselves – differently. Hence, immigration is an intersecting determinant of health traversing all levels of this ecological model. This concept has also been proposed by others in the field of migrant health (Castañeda et al., 2015; Davies et al., 2006; International Organization for Migration, 2017; Reeske & Razum, 2011).

Figure 5

Social-Ecological Model for Social Determinants of Health (Dahlgren & Whitehead, 1991)



2.3 Summary and Contribution

This chapter provides the contextual foundation for the research question guiding this dissertation: *What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?*, and why and how this presents as an important topic for study in the Norwegian context. In summary, immigration on the one hand, is a source of diversity in the Norwegian welfare state, which has implications for the functioning of its egalitarian ideologies of equality and equity. As such, immigration poses new challenges for the Norwegian universal health care system. On the other hand, immigration in itself is also a determinant of health for those who come to Norway, and it affects their utilization of the universal health care system that is meant to provide an equal opportunity to all. Research in the arena of diversity and universalism, especially on immigrant women's health in Norway, is growing. This is an indication that diversity is an area of interest for both the health care system and the health of immigrants and, as such, points to the importance of this field and the need for attention at both the policy and practice levels of health care. This dissertation is, therefore, not a novel discovery but an important contribution to this interdisciplinary discussion by way of illustrating the implications of universal health policy in Norway for maternal health care for immigrant women from a policy, practice, and user-experience perspective.

Chapter 3: Theory

According to Reed, “facts provide an ‘example of’ a theory, whereas theory provides ‘a new way to view’ the facts” (2011, p. 22).

Thus far, the first two chapters have presented the contextual foundation for the overarching research question in this dissertation: *What are the implications of Norway’s decentralized approach to addressing the maternal health needs of immigrant women?* In doing so, I argued for the significance of this study in contributing to the discourse of universalist policy and its consequent implications for diversity. Universalist policy and practice are explored in detail across the four articles in this dissertation from a theoretical perspective and through identifying theories to explain the data. They subsequently constitute different components of this greater research project, which work in synergy when brought together under a larger theoretical framework in answering the central research question. This chapter describes the theoretical framework. I begin by explaining the three-layer overarching theoretical framework that brings the articles together as one summative discussion, and I end with reflections on engagement with theory and a chapter summary.

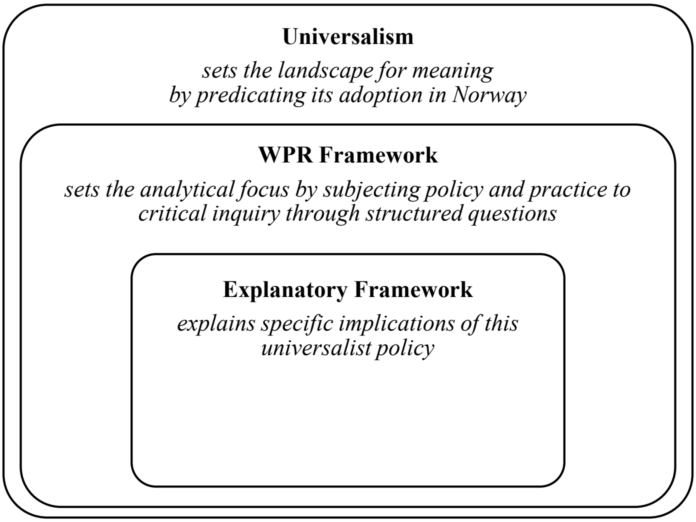
3.1 Overarching Theoretical Framework

The discussion in each article denotes an autonomous but connected theoretical perspective and separate arguments; however, the four articles are all contained within a discourse on universalism. The overarching theoretical framework serves to capture the analytical essence of this dissertation from a broader perspective by facilitating the correlation of the specific arguments across the four articles.

Universalism is the overarching theory and main concept across this PhD, as I am analyzing its applications and implications in policy and practice through the examination of maternal health care for immigrant women. In this way, universalism sets the landscape for this research. Carol Bacchi’s “What’s the problem represented to be?” (WPR) framework (2009) is applied as an intermediate analytical framework to identify the inherent issues in the conceptualization and application of universalism in Norwegian health policy, which shape the provision of maternal health services to immigrant women. The issues articulated through the application of Bacchi’s analytical framework are then explored more specifically using a series of content-specific middle-range theories across the articles, which in this overarching theoretical framework I group as the explanatory framework. These content-specific theories illustrate the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women from different perspectives. Figure 6 illustrates this layered overarching theoretical framework. This layered process of interpretation is what Reed (2011) likens to the painting of a landscape, in which various theories representing various brushstrokes color or reconstruct the meanings contained in the landscape to ultimately present a detailed and multifaceted larger picture.

Figure 6

Overarching Theoretical Framework of Dissertation



3.1.1 Universalism

Universalism is the first layer of this framework as it is an integral concept throughout this dissertation. It both frames the study as a whole and permeates all four of its components (the articles). Universalism is mainly a concept associated with a welfare ideology of distribution; consequently, it is a policy position rather than an independent theoretical construct. However, this policy position derives from a human rights ideology linked to equality. As such, universalism has claim to being a theory in its own right, which is also how it is conceptualized in this study.

Universalism as a theory represents the landscape analogy, as coined by Reed (2011), in this dissertation. It describes both a policy principle centered on equality, and also a principle for practice. Seeing universalism as a policy and practice concept, I illustrate the normativity of universalist principles in implementation; seeing it as a theoretical concept, I discuss how it should work and what the practical implementations lead to, which in this case, is to ensure services are available to everyone.

As a policy position in Norway, universalist welfare policy assumes the normative position that equal access results in equal outcome. However, this is a problematic assumption because normativity paints over difference. The state recognizes the challenges of this idealistic assumption; hence, it has adopted a decentralized system of governance, which applies to health care organization and distribution. Acknowledging that equality in outcomes may not result from equality in opportunity (Anttonen & Sipilä, 2012; Carey et al., 2015; Mehrara, 2020; Mehrara & Young, 2020), this decentralized approach gives a degree of discretion to local governments to target universal provision, within the bounds of national guidelines, in ways that best meet the needs of their populations. In this way, the assumption is that a decentralized system can amend inequality. This functional position can address some of these effects at a local level, while at the same time, potentially reinforcing the normative position of universalism. The resulting effects of this form of amendment can nurture a conforming outlook towards acceptance of the norm. This is because ethno-cultural diversity becomes characterized as a local issue rather than a national one; immigrants, who may not be able to benefit equally from services they are entitled to, become recipients of the local politics of distribution within the already existing normative system. In other words, there is no compromise in meeting the needs of a culturally diverse population half-way; hence, it is an assimilative approach, in which immigrants are expected to meet the system instead. This is addressed in the first two articles.

Although maternal health provisions are a gender-specific service for females within the universal health system, they remain normative in how they are provided because they are based on the same universal principles. As such this service also remains unobservant of other forms of diversity beyond gender, such as culture and class, which I explore in this dissertation in article three. The consequence of this form of governance and the response to cultural diversity within the context of maternity care has been that municipalities with high immigrant populations may have discretionary responses to the targeting of health services. The effects of this are reported in the four contained articles.

Universalism as a theory and concept frames this dissertation and is presented as a thread of discussion throughout the four research articles, which analyze its effects from different perspectives. Consequently, universalism as a common denominator forms the first layer of the overarching theoretical framework (Figure 6). The contextual perspectives for the articles on Norway's universal maternal health care are informed by Carol Bacchi's (2009) framework for policy analysis.

3.1.2 Analytical Framework

Carol Bacchi's "What's the problem represented to be?" (WPR) is a methodology and framework developed in 1999 for analyzing policy. WPR is "a tool for investigating a variety of social issues and responses to those issues" (Bacchi, 2012, p. 1). The fundamental aim of WPR is to interrogate the ways in which "problems" are (re)presented in policy through "a mode of critical inquiry which simultaneously engages to contemporary poststructuralist accounts of power, subjects and social change" (Bacchi, 2012, p. 1). The WPR framework consists of six guiding questions (Table 1), designed to critically tease out and investigate the implicit problem representations in public policy. More specifically, this framework targets the examination of public policies by analyzing their "conceptual premises," "genealogy," and the effects of problematizations in discursive, subjective, and lived contexts (Bacchi 2009). Each question in the WPR framework requires an in-depth investigation that chronologically and cumulatively offers a comprehensive and multidimensional analysis.

Bacchi's WPR critical policy analysis framework is used as an analytical framework in this dissertation, which helps articulate the normative issues of universalism in a critical manner. WPR is applied to this dissertation as a mediating theoretical framework, linking the overarching theory of universalism to the specific content theories in the explanatory framework. It does this by articulating how Norway's universal health system functions, how it is responding to the maternal health needs of immigrant women, and with what effects. The findings that resulted from the application of this framework subsequently informed the questions addressed throughout the research articles. In this way, WPR mediates the connection of universalism to the more specific content analyzed in the articles; hence, it links the layers of the overarching theoretical framework together and enables a comprehensive analytic discussion in the last chapter around the main research question: *What are implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?*

Table 1

WPR Framework - Adapted from Bacchi (2009)

1	What's the problem represented to be in a specific policy or policy proposal?
2	What presuppositions or assumptions underpin this representation of the 'problem'?
3	How has this representation of the 'problem' come about?
4	What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?
5	What effects are produced by this representation of the 'problem'?
6	How/where has this representation of the 'problem' been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?

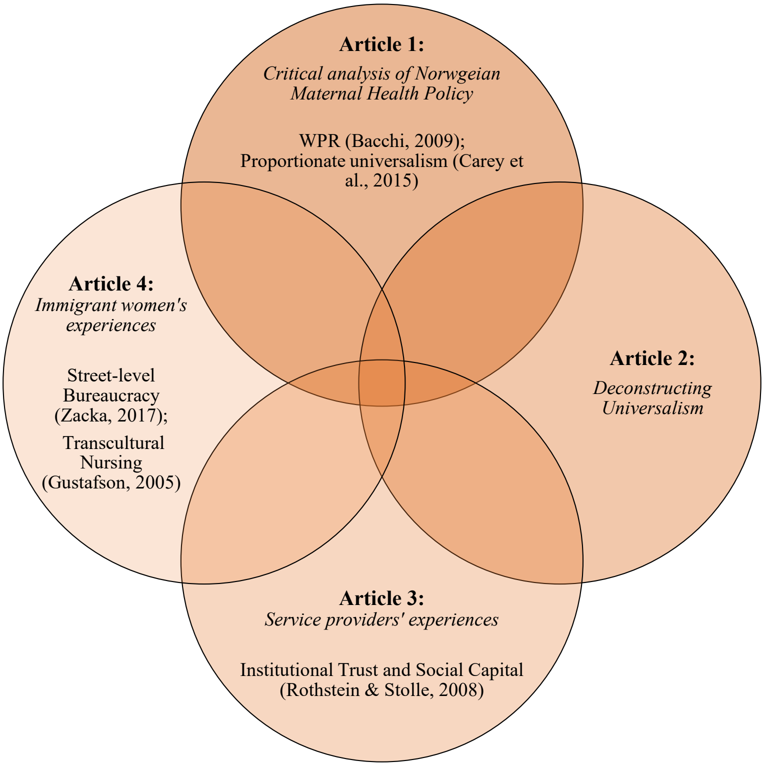
3.1.3 Explanatory Framework

Reed (2011) states, "we do not expect theory to reference the social world in the same concrete manner that we expect evidence to reference the social world. Indeed, the whole point of theory is to be abstract and conceptual" (p. 20). This is not a weakness of theory, however. The abstract nature of theory acts to reconsider interpretations of factual evidence, broadening and deepening the construction of knowledge beyond the evidential frame. The application of theory to phenomena for in-depth interpretation beyond its direct reference is what Reed (2011) refers to as re-signification. This is the purpose of the explanatory framework – to offer interpretations of the implications of Norway's universal maternal health policy beyond what the data directly represent. Additionally, and perhaps in some contradiction to Reed's conceptualization of theory as abstract, other writers consider that an additional purpose of theory is to provide a direction for intervention. In this construction, theory is for practice (to explain what *is*) and theory of practice (to state *what should be done*) (Young et al., 2014). Since this policy analysis dissertation aims to achieve more than an abstract problematization of the issue, the practical contributions of this explanatory framework, described in this chapter, are presented as policy directions in the final chapter.

The innermost layer of the overarching theoretical framework is the explanatory framework, which consists of several auxiliary concepts that act to illustrate the effects produced and represented by universalism. Each of the four articles engages with content-specific middle-range theories to analyze its respective research questions. Together, the articles offer different but connected analytical perspectives on the implications of Norwegian universalism. These key concepts, therefore, compose the explanatory framework. This explanatory framework serves as a means for elaborating the implications of universalism at the dissertation level in the final chapter. Linking this back with Reed's (2011) analogy of the landscape of meaning, the explanatory framework, like a series of finer brushes that paint the issues arising from the WPR analysis, expand understandings of universalism. To explain this explanatory framework, I present a brief description of the key concepts in each article and reflect on their function and contribution to the debate on universalism. Figure 7 illustrates the key conceptual premises in this project.

Figure 7

Explanatory Framework



Carol Bacchi: Critical Policy Analysis

The first article applies Bacchi's (2009) "What's the problem represented to be?" (WPR) framework as a critical policy analysis framework for investigating Norway's health policy with regard to maternal health provisions for immigrant women. As explained in section 3.1.2, this framework works to deconstruct policy in order to uncover its silences or implicit policy discourses, otherwise referred to as problem representations. The six questions in this framework were applied to the critical analysis of Norwegian health policy and the provision of maternal health services to immigrant women, examining whether this universal health policy addresses ethno-cultural diversity. This resulted in the teasing out of the underpinnings of Norwegian health policy and, in doing so, offering an overview of the health system, its governance and its provisions in connection to maternal health services to migrant women in Stavanger.

The first question of the WPR framework described the "problem" formulation and showed from the policy data how maternal health services for migrant women, from a universalist position, is not considered to be a problem, itself a normative positioning. The second question is embedded in Foucault's archeology (Bacchi, 2012) and refers to assumptions underpinning the "problem," which in the first article were shown to be related to the universalist assumption that universal provision results in equal access. The third question is embedded in Foucault's genealogy (Bacchi, 2012) and refers to the history of the "problem" formulation, which is described in relation to how a targeted health program for immigrant women evolved. The fourth question asks policy analysts to consider the "problem" differently and identify what is missing from the current formulation of the problem. The analysis refers again to the way in which universalism is normative and tends not to identify specific groups. Examples from the case study presented in the first article underscore knowledge about services, language differences, and cultural expectations of service users as challenges to the outreach of service providers in attracting target groups to grass-roots targeted health initiatives more challenging. The fifth question asks analysts to reflect on the effects of problem representation on the discursive, subjective, and lived experiences which the article identifies as linked to issues of normativity and cultural sensitivity. The final question asks what could be done differently. This is when proportionate universalism by Carey et al. (2015) is suggested as a policy opportunity to address the principle of equity in parallel to equality in service provision by offering selective provisions targeting the needs of specific groups, like immigrant women, within a universal system.

Engaging with Bacchi’s framework in this article was fundamental for this dissertation because the questions that arose from its findings shaped the subsequent articles in this dissertation. In this way, it informs both the topics addressed and the data collected for the second, third, and fourth articles, and links all of them to universalism. This is why WPR serves as the analytic layer in the overarching theoretical framework, as described in section 3.1.2. Moreover, WPR is also part of the explanatory framework because it offers critical knowledge on the Norwegian universal health system and its response to diversity. Table 2 details how Bacchi’s WPR framework is linked to the other articles in this dissertation, and how it maintains the analytic focus on universalism throughout this project.

Table 2
Bacchi's WPR Framework as a Medium between the Articles and Universalism

	WPR questions	**Connection to article(s)**
1	What’s the problem represented to be in a specific policy or policy proposal?	Article 2 offers a theoretical discussion of why diversity is a problem for universalism by teasing out the challenges of it as a concept both theoretically in policy and in practice.
2	What presuppositions or assumptions underpin this representation of the ‘problem’?	Article 2 elaborates on this by exploring the historical dimension and conception of universalism in Norway.
3	How has this representation of the ‘problem’ come about?	This is discussed throughout articles 2, 3, and 4 as a discussion on growing diversity and different health needs and expectations within a normative universal health system.
4	What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought about differently?	This is illustrated in articles 3 and 4 as a discussion on the implications of Norway’s universal health system for service users and practitioners underscoring the issue of equity and equality.
5	What effects are produced by this representation of the ‘problem’?	*Discursive*: Article 2 examines the discourse; articles 3 and 4 illustrate the effects on and of diversity. *Subjective*: Different expectations of service provision (article 3) and cultural blindness (article 4). *Lived*: Institutional trust enhanced or eroded (article 3) cultural blindness of service providers in article 4. In summary, equal access does not lead to equal outcomes.
6	How/where has this representation of the ‘problem’ been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced?	Article 2 conceptualizes “targeted universalism” as a solution to current universalist policy, while article 4 illustrates how local actors are approaching this problem at the community level in the absence of culturally cognizant health policy.

Universalism

Rothstein (1998), defines universalism as a policy principle in the distribution of welfare services that covers “the entire citizenry” (p. 20) without any means testing. Building on the findings of the first article, and the question elicited by the concept of proportionate universalism, the second article expands on the paradox of equality and equity by asking how much diversity can be tolerated in a universal system. The second article presents an extended theoretical discussion on universalism as both a policy and practice concept in the historical and contemporary context in Norway, drawing on the intersections and challenges that diversity imposes on its fundamental principles.

Through a historical analysis of universalism as a theoretical and practical construct tied to the evolution of the Norwegian welfare state, the article argues that universal welfare provisions are blanketed as they are designed based on normative needs. Bradshaw (2013) defines normative needs within social policy as those “which the expert or professional, administrator or social scientist defines as need in any given situation” (p. 2). In the case of universalism in Scandinavia, the welfare model was “built on the cultural construction of homogeneity” (Bendixen et al., 2017, p. 28). Consequently, in the historical context “the image of a homogenous population draws upon specific experiences… that left little room for acknowledging heterogenous categorizations” (Bendixen et al., 2017, p. 28). The issue is that needs of modern society are diverse, and immigration is one of the sources of such diversity, meaning that people will have different needs. However, the normative underpinnings of universalism in Norwegian welfare policy systematically silence difference, creating gaps through which some vulnerable people, such as immigrant women, fall. This poses a paradox for the principle of universalism as an egalitarian ideology and mechanism of distribution.

By focusing this discussion on an example of a Norwegian program that delivers maternal health services to migrant women, elaborated in the first article, this article argues for a nuanced definition of universalism, which is cognizant of different forms of diversity, and which addresses barriers to health equity. This enriches the discussions presented in the first article on universalism. The critical analysis contributes to enriching the discussion of universalism as an overarching theory in this dissertation, and also provides a context-specific analysis of Norwegian universalism and its approach to the changing needs of society, which is an important contribution to the explanatory framework.

Institutional Trust and Medicalization

As with other forms of universal provision, there is a uniformity in the maternal health care provisions in Norway, following the ideology of equal service provision. This uniformity of care results in less individual choice and decision making, making this normative model of care conformist. The Norwegian model of maternity care is an example of this conformity, which is linked to the idea of institutional trust (Rothstein & Stolle, 2008) and the universal welfare state.

Institutional trust is an important concept in the discussion of universalist normativity and conformity presented in Norwegian health policy. Institutional trust is "generalized trust that is embedded in the structure and characteristics of political institutions" (Rothstein & Stolle, 2008, p. 441). This concept has strong roots in the evolution of the Norwegian welfare state, as "generalized trust is built up by the citizens themselves through a culture that permeated the networks and organizations of civil society" (Rothstein & Stolle, 2008, p. 441). This confidence in the welfare system in Norway comes from the local development of social policies and of the eventual social democratic welfare state. Consequently, this translates into the general trust Norwegian society has in the health system as an institution of the state. This institutional trust, however, is not readily accepted by those who come to Norway from societies with stark institutional differences.

Medicalization in this study is a key concept in the discussion of the lived experiences of immigrant women with the Norwegian maternal health system and the means through which institutional trust is affected. It is defined as "the process by which former nonmedical problems become defined and treated as medical problems, usually as diseases or disorders" (Conrad, 2013, p. 196). Immigrant women may have different expectations and knowledge of maternity care from that offered in Norway, especially with regard to the medicalization of pregnancy and birth, which varies greatly in different countries.

The Norwegian maternity model is evidence based, and being a universal provision, it offers a standard of care to all women. However, the conformity imposed by the standardization of this universal model may lead to distrust of the maternity care services by some immigrant women, who want to exercise more individual choice in having a more or less medicalized maternity care experience. While some immigrant women may be able to circumvent or compensate for the care they would receive in Norway by using their social and economic resources to seek alternative care outside Norway, other immigrant women are not able to do so. Though some local actors in this universal health system, such as midwives and nurses, use their position as mediums between the state and their service users to gain the trust of immigrant women in the Norwegian maternal health system, this is only a discretionary response. The root of the issue – why there is distrust and how to gain the trust of those new to this universal system – remains unaddressed. This, as argued in the third article, is linked to the idea of institutional and social trust (Rothstein & Stolle, 2008) and the role played by social capital in serving or circumventing the universal provisions of the Norwegian welfare state.

Discrepancy in the medicalization of maternity care in the Norwegian model of care, as experienced by immigrant women, is thus an example of this institutional distrust, which is accentuated by the inflexible processes for individual choice and deviation from the standard of care within this system. Medicalization and institutional trust, as illustrated by the responses to the medicalization of birth and pregnancy as key concepts in the third article, therefore, offer a unique perspective of how universalism and its ethos of equality through generalized trust are being challenged by changing demographics. This links the discussion back to the lived effects of Norway's decentralized universal health policy in response to questions elicited by Bacchi's framework.

Street-Level Bureaucracy

The fourth component of the explanatory framework is the concept of street-level bureaucracy. This is applied in the fourth article to analyze the implications of Norway's universal health policy for practice by examining the practice of cross-cultural health care among primary health care providers working with immigrant women. Street-level bureaucracy is a concept coined by Lipsky (1980) referencing "public service workers who interact directly with citizens in the course of their jobs, and who have substantial discretion in the execution of their work" (p. 3). In this dissertation however, I mainly engage with Zacka's (2017) analytical application of the concept, which offers a contemporary and critical discussion on the work and function of street-level bureaucrats as agents of the state.

Although both of these authors write within the American context, the concept, and especially as deconstructed by Zacka (2017), is imperative to an explanation of the decentralized governance of the Norwegian health care system. This decentralized model of governance takes root in the history of social policy development and the evolution of the Norwegian welfare state, as outlined in the second chapter. This decentralized system is intended to give local governments some discretion in how they offer provisions to their populations. In Norway, which as noted by Vike (2018), is among "the most 'service intense' states in the Western world" (p. 246), the role of service providers is to link the state and the population, and as such, street-level bureaucrats have a significant part to play in how decentralization is enacted. Since ethno-cultural diversity is not outlined in health policy, as elaborated in the first two articles, it becomes an issue to be addressed locally by service providers, who encounter immigrant patients with different backgrounds and needs. Although street-level bureaucrats play an important role in the functioning of the Norwegian universal welfare system, the expectation that they should address cultural diversity in their practice without a central recognition of the issue becomes problematic. Zacka (2017) explains that "street-level bureaucrats retain a significant margin of discretion in performing their role. This discretion, moreover, is not merely technical, but also ranges over questions of value… the existence of such discretion makes it possible for street-level bureaucrats to inhabit their role in a variety of ways" (p. 66). In the absence of culturally congruent universal health policy, cross-cultural health care, or transcultural nursing as examined by Gustafson (2005), rests on the professional discretion and improvisation of the health care providers.

Street-level bureaucracy as a concept links the article back to universalism empirically. As an explanatory concept, it illustrates the implications of universalism's normative approach to maternal and child health care provision for practice and practitioners. Furthermore, it highlights the insufficient approach to addressing ethno-cultural diversity through local actors alone in a health care system that is universal.

In summary, this explanatory framework encapsulates the interrogation of universalism in this dissertation. Universalism as a theory and concept in Norwegian health policy is deconstructed in the first and second articles. Universalism as policy is analyzed using the concepts of proportionate universalism and institutional trust, while universalism as practice is illustrated through the experiences of immigrant women and of service users.

3.2 Critical Reflections

If I were to expand on this topic beyond this dissertation, there are two theoretical perspectives which I would explore in conjunction with universalism; they are feminism and critical whiteness theory. While these two concepts would fundamentally change the approach to studying the topic, they would offer novel discussions from two very important perspectives, which were not within the scope of this policy-oriented dissertation.

Although this study is gender specific in nature due to the type of service being provided, it bypasses a gendered analysis of women's experiences, because at its core, it is a policy analysis of universal health care provision. The analysis therefore focuses on the implications of ethno-cultural diversity for the women using maternal health services, those who provide these services, and the universal health system, rather than the experiences linked to being a woman or a women's service. Hence, the theories applied to identifying the issues presented across the data in this project are focused on culture and immigration as crosscutting elements to universalist policy. This is not to forgo the assumptions around the intersectionality of gender or being a woman in the contexts of immigration and health. In fact, the reason for focusing on maternal health care is directly linked to the limited research done in the field of immigrant women's health in comparison to other perspectives.

The second perspective relates to critical whiteness theory. As a theoretical dimension, this would interrogate the implicit race presumptions in Norwegian health policy and practice, which would be a pertinent intersectional layer to a gendered analysis on the implications of universalism for immigrant women. The initial choice was to study how immigrant women may be affected by a universal approach with the primary focus being on the "immigrant" status. A gendered analysis is a logical next step and a valuable research topic to pursue in this context. The policy focus of universalism revealed the normative nature, which effectively illustrated the racial component of its effects. Critical whiteness theory, which challenges normativity in relation to the social construction of race and ethnicity, is therefore another logical next step for further research.

3.3 Summary

This chapter presents the overarching theoretical framework that brings the different discussions contained in the articles of this dissertation together under one umbrella. A three-layer framework explains this process, wherein universalism constitutes the central theoretical framework for this dissertation. Bacchi's WPR framework is described as the middle or mediating layer and is used analytically to articulate some issues about universalism within the context of maternal health care provisions to immigrant women. The explanatory framework at the core of the overarching theoretical model serves to illustrate the content-specific discussions elicited through the analysis of the implications of Norway's universal health policy in the four articles, in responding to diversity, specifically in addressing immigrant women's maternal health needs. The four articles are, therefore, interconnected in investigating the implications of universalism- Table 2 presents these relationships, which are discussed in the sixth chapter. In summary, the theoretical engagements and thus the contributions of this dissertation are interdisciplinary, spanning sociology and public health.

Chapter 4: Methodology

4.1 Introduction

This chapter outlines the methodological framework and research process of this study as a whole. It covers the following in chronological order to offer in detail the processes of knowledge production incorporated in this study: methodological overview; description of the data and its processes; ethical considerations; methodological reflections with respect to researcher positionality; overall research quality and limitation; and finally, a chapter summary.

With the exception of the theoretical second article, the research articles included in this dissertation all have comprehensive methods sections. However, these four individual articles are presented as subsidiary research contributions to the overarching theme of this dissertation: *how universal is universal health care?* and to the central research question: *What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?* This chapter, therefore, serves to bring together these methodological discussions, to report the methodological nuances and unaddressed issues within the articles, and to present a comprehensive reflection on the underpinning knowledge production framework in this study as a whole.

4.2 Methodological Overview

The background and rationale for this PhD study is founded upon the fact that, despite the benefits of immigration for a host nation, it can also pose many new challenges for its health care and welfare systems. While social service provisions, including health care, can be efficient at targeting and treating the needs of the native population in a host country, they may not be prepared to address the specific needs of particular migrant populations (Munthe-Kaas et al., 2018). Immigrants, on the other hand, may face barriers to health care that can result in poorer health outcomes over time, known as the "healthy immigrant effect." Women are found to be more affected by this phenomenon (Ng & Newbold, 2011; Urquia et al., 2010), resulting in poorer and unequal health and birth outcomes in comparison to the non-immigrant population. In this project, I examine this issue within the context of Norwegian universal health care, using a qualitative approach.

4.2.1 Qualitative Research

According to Alvessnon and Skoldberg (2000):

> Traditionally research has been conceived as the creation of true, objective knowledge, following a scientific method. From what appears or is presented as data, facts, the unequivocal imprints of ‘reality’, it is possible to acquire a reasonably adequate basis for empirically grounded conclusions and as a next step, for generalizations and theory building. (2000, p. 1)

This positivist truth is far from the postmodern/poststructuralist purpose of this research project. Qualitative research focuses on the study of social life in terms of a process, acknowledging the multiple ways through which meaning can be discovered. The primary concern of this methodology is understanding the process of meaning making in terms of how people understand the world and interpret phenomena. As such, “qualitative research takes an interpretive, naturalistic approach to its subject matter” (Jones, 1995, p. 2) and thus requires descriptive detail of phenomena to “emphasize the importance of the contextual understanding of social behavior” (Bryman, 2016, p. 395). What distinguishes qualitative from quantitative methodology is its theory-laden process of exploring the “whys” and “hows” of phenomena and the production of rich, in-depth discussions.

This research project adopted a qualitative research approach to explore and examine the response of Norwegian health policy to migrant maternal health care, and the implications thereof. This approach enabled a deeper and richer understanding of the phenomena in question and the context within which they are embedded. The project included an examination of health and social policy, the experiences of immigrant women with the Norwegian maternal health system (NMHS), as well as those of primary maternal and child health care providers at community clinics. Data were collected in and around the regions of Oslo and Stavanger in Norway. Furthermore, the qualitative design allowed for a more open-ended research strategy, which was important in examining “social life in terms of a process” (Bryman, 2016, p. 395), contributing to the richness of the findings.

Qualitative methods are often criticized for lacking scientific rigor and for researcher embeddedness due to the absence of systematic procedures (Willis, 2014); qualitative research has been called “impressionistic and subjective” in comparison to quantitative research (Bryman, 2016). Common critiques relate to a potential lack of trustworthiness, validity, reliability, and credibility of research. Proponents of this method argue that the use of methodological rigor can address issues of trustworthiness and credibility (Guba & Lincoln, 1982). Transparency can be achieved though researcher reflexivity on the effects of their positionality across all stages of production, while the triangulation of data and representation of different perspectives can enhance the veracity of research (Noble & Smith, 2015). Another critique of this method is that of generalizability. The findings across this study are bound by location, time, and a sample size; therefore, the study is not constructed for the purpose of generalizing the representativeness of its cases to what is happening across the country. Instead, the objective is to achieve theoretical or analytic generalizations (Mitchell, 1983; Yin, 2009). I wish for this study's findings to serve as a working hypothesis, as coined by Cronbach (1975), for other researchers in the field in Norway or abroad when examining the social, migratory, and policy trajectories of health with regard to vulnerable populations.

4.2.2 Research Design

Research is seldom a linear process. This qualitative study was carried out at different time periods, and it therefore consists of multiple research strategies. It incorporates an article produced from my master's thesis as its starting point, as well as different research designs for answering the subsequent research questions in my PhD. The study design was adapted throughout the course of this project period due to reiterations of the research questions; challenges associated with field work; the organization and processing of data; and its dissemination as scientific articles, which in itself, required amendments because of both opportunistic responses to calls and the review processes.

The research strategies included in this dissertation consist of an instrumental case study (Stake, 1995) in the first article; content analysis of literature in the second article; and empirical analysis of interview data in the third and fourth articles. The combined use of qualitative research designs in this dissertation enables the development of different perspectives on the research question by engaging with different data sources. Together, these qualitative processes provide an intricate, multifaceted, and triangulated contribution to the investigation of the central research question from both bottom-up and top-bottom analytical viewpoints.

4.2.3 Case Study

I have used case study as a research design and not a method. The two are often used interchangeably when describing case studies; however, I make the distinction because I use the term "method" to describe how I collected data and "research design" to explain how I engaged with this empirical material. My choice of a case study for the first article, which is a product of my master's thesis, was motivated by circumstance. It allowed for me to overcome access barriers that I faced in recruiting interview participants, and to use multiple different sources of data in doing explorative research on migrant maternal health care policy in Norway. The greatest advantage of this research design lies in its capacity to accommodate multiple sources of data in order to construct a holistic understanding of complex phenomena (Baxter & Jack, 2008). According to Crowe et al. (2011, p. 1), "the case study approach is particularly useful to employ when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest, in its natural real-life context." Furthermore, it is an extensively used design in many disciplines, particularly in social science research.

The multifaceted quality of case studies in incorporating data, contributes to the depth and breadth of exploration, adding to the richness of interpretation. Multiple outlooks on the topic of inquiry add to the case study's rigor by way of triangulation. This is very important in enhancing the veracity of findings from qualitative case studies. Despite their advantages, however, qualitative case studies are criticized as a research method, with their limitations mostly intertwined with those of qualitative methods (Willis, 2014), as stated in section 4.2.1. Generalizations are, therefore, a critique of qualitative case studies, too. However, case researchers, including myself, argue that the purpose of this method of inquiry is not on generating findings that can be formally "generalized to a wider universe" (Bryman, 2016, p. 64). Each study is constructed within its own world view (Gordin, 2006) and thus can only offer practical, context-dependent knowledge in relation to that focus.

Flyvbjerg (2006) argues that particular knowledge can be far more valuable in understanding the world than general theoretical knowledge. His argument for this is that "predictive theories and universals cannot be found in the study of human affairs" (p. 224). Thus, the context-specific findings generated from case studies, although not universally generalizable, are of far greater value in offering in-depth understanding of a particular phenomenon than general knowledge. Flyvbjerg (2006) explains that generalizations as a source of scientific are overrated, whereas the " 'the force of example' is underestimated" (p. 226). One can therefore generalize based on a single case, by focusing on how well theory is constructed from the findings (Bryman, 2016).

4.2.4 Ontology and Epistemology

Cunliffe states, "our metatheoretical assumptions have very practical consequences for the way we do research in terms of our topic, focus of study, what we see as 'data', how we collect and analyze that data, how we theorize, and how we write up our research accounts" (2010, p. 5). Qualitative research methods are often associated with the constructivist ontological position on understanding the social world. Gergen explains that social constructivism emphasizes that “while the mind constructs reality in the relationship to the world, this mental process is significantly informed by influences from social relationships” (Gergen, 1999; as cited in Young et al., 2014, p. 907). This stance on social understanding further maintains that social phenomena are in a constant state of revision instead of a result of single interaction (Bryman 2016). This social constructivist study takes on an interpretivist epistemological approach, which is typical in this mode of understanding, to engage with theory in extrapolating the situated meanings of social life. Interpretivism, or interpretive understanding, is rooted in Max Weber’s theory of *Verstehen*. Weber did not see interpretations as an alternative way to explain behavior, but as a way to complement it (Silverman, 2017). Interpretivist thinking maintains that “…meanings are constructed by human beings in unique ways, depending on their context and personal frames of reference as they engage with the world they are interpreting” (Ajjawi and Higgs, 2007; as cited in Silverman, 2017, p. 147) The interplay of subject and its social environment is therefore essential in the construction of knowledge in this dissertation, which undertakes an exploration of service user and service provider experiences. Consequently, the methodological objective of this study is to interpret the relationship between multiple meanings and to use theory to extract and describe these complexities. In this approach to social research, “knowledge cannot be separated from the knower” (Steedman, 1991, p. 53). This is because “data and facts… are the constructions or the results of interpretation” (Alvessnon & Skoldberg, 2000, p. 1). Thus, the researcher’s attributes, both consciously and subconsciously, permeate the research activity and meaning making. I have actively tried to be aware of how I have influenced this study throughout the length of the project, and I have presented a reflexive discussion on this matter in section 4.5.

This project aims to contribute to the progression of the understanding of health and well-being from a social perspective by looking into the effects of policy in the provision of maternal health services to immigrant women in Norway. Health can be studied both objectively and subjectively. The medical trajectory on understanding health continues to be heavily influenced by the objectivist tradition. However, “people are reflexively embedded in their social world, influenced by and influencing discursive practices, interpretive procedures etc.” (Cunliffe, 2010, p. 8). Therefore, some qualitative aspects of health and well-being, like feelings and experiences, cannot be fully encompassed by this approach. A more subjective research positionality allows for the understanding of lived effects of health policy through the exploration of participants’ experiences. This research position can contribute to understanding health from a unique vantage point and also act in problematizing minority health in social policy. The methodological and theoretical constructions in this project maintain a social constructivist and interpretivist approach to understanding health. According to Merriam's (2009) categorization of research epistemologies, my study falls between the critical and postmodern/poststructuralist perspectives. My research design aims to bring together different views on the issue from various levels of analysis (policy, practitioner, patient) to uncover the implications of a decentralized approach to maternal health care.

4.2.5 Engagement with Theory

Accoding to Alvessnon and Skoldberg (2000), "how we interpret phenomena is always perspectival and that so called facts are always theory-laden" (p.4). I believe that pure induction or deduction are implausible in social research without the compromising of meaning; therefore, I did not limit my interpretations of data strictly to either tradition, and instead worked with what evolved through the analysis and rewriting processes through an abductive engagement with theory. Timmermans and Tavory (2012) explain:

> Abductive analysis emphasizes that rather than setting all preconceived theoretical ideas aside during the research project, researchers should enter the field with the deepest and broadest theoretical base possible and develop their theoretical repertoires throughout the research process. Theoretical relevancy is not limited to analogy but flourishes with theory-close and -far writings that inspire novel insights. (2012, p. 180).

Each article engaged with different sets of data in a unique way. Initially, the dissertation as a whole was informed by existing theoretical knowledge and ideas for engagement, with alternative perspectives to uncover different facets of the research question. However, the research process, data, and revisions of the analysis and articles by myself, my co-authors, and other academics, as well as submission processes to different journals, led to the emergence, reconceptualization, or refutation of some theoretical perspectives. For example, ideas about Norwegian welfare policy, universalism, and some of its limitations as a policy principle, evolved into a discussion of theories like proportionate universalism, social capital, institutional trust, and street-level bureaucracy. These concepts consequently formed some of the key directions for analysis and reconceptualization of facts from data, as explained in the third chapter.

Timmermans and Tavory (2012) argue that "theory construction is thus an ongoing pragmatic process of 'puzzling out' and problem solving that draws on existing ways of understanding what the phenomenon 'is a case of'" (p. 167). The revision processes and discussions that took place around the analysis of the data in the articles and their synthesis as an overarching whole in this dissertation were, therefore, fundamental in the abductive explanatory model of the work. Through this abductive engagement with theory, the contributions of this thesis, which are discussed in the sixth chapter, extend beyond the facts in contributing to policy, practice, and social science. This interpretive recontextualization of fact with theory is a feature of abduction, which distinguishes it from induction and abduction or "the two other, shallower models of explanation" as argued by Alvessnon and Skoldberg (2000, p. 5).

4.3 Data

This part of the chapter presents an overview of the data and the processes involved in its collection and processing.

4.3.1 Fieldwork, Access, and Sampling

Data were collected at three notably different stages for this project. The preliminary investigation into the topic of migrant maternal health policy in Norway, as mentioned earlier, began as part of my master's thesis in 2017. This segment of the project incorporated discussions with policy makers and health care providers in Stavanger, as well as observations of pre- and post-natal workshops for immigrant women at a public health clinic. Initial contacts were made during an internship at the town hall, and from there onwards through referrals.

The second stage of data collection commenced during my PhD, when I revisited some of my contacts in Stavanger in May 2019. Here, I was able to recruit some interview participants. At this stage, all my participants were primary maternal and child health care providers. During this phase, I conducted some observations of pre- and post-natal workshops held at one clinic in Stavanger, and secured opportunities for subsequent observations in the following fall.

The break between the second and third stages of my data collection was incurred by a three-month research stay at the University of California, Berkeley. During this period, I was attempting to remotely recruit participants by contacting clinic leaders in the Oslo and Stavanger regions, and was also asking those I had established rapport with to share my project information and invitation to participate sheets in English and Farsi with their patients and at the workshops they conducted for immigrant women. This continued to October 2019, by which time I had only secured contact with two clinics in Oslo County. I realized this strategy for the remote recruitment of immigrant service users would not be fruitful in the timeframe of my project. Therefore, between October and December 2019, I travelled to Oslo and later to Stavanger to explore my direct participant recruitment options. This proved successful after a lead led me to access public kindergartens as a site for recruitment of new immigrant moms. My ongoing remote recruitment strategy yielded one participant nearly a year later in March 2020. A reflexive discussion detailing researcher positionality in the access and recruitment process is presented in section 4.5.

At the end of fieldwork, more data had been collected than could be included in the scope of four articles constituting this doctoral dissertation. Data, therefore, had to be strategically selected to fit the scope of each article, and to be responsive to each article's research questions. Some of this unused data, for example, the observations conducted, were helpful in understanding the context of the interviews. The data not used in this dissertation is of great value and will be used in subsequent research articles. An overview of the data collected during this project is presented below, while the empirical articles provide more information on the data they engage with.

4.3.2 Overview of Data

Fieldwork was conducted in the two Norwegian counties of Rogaland and Oslo, which included the municipalities of: Stavanger, Oslo, and Bærum. Table 3 provides an overview of data sources from 2017 and from 2019 to 2020.

Table 3
Overview of Data and Sources

Type	**What/ who**	**Place & year**	**Anonymized details**
Observations	TEGRA workshops (pre-and post-natal workshops for immigrant women) 90-minute sessions	Stavanger 2017	3 pre-natal and 1 post-natal workshop
		Stavanger 2019	1 pre-natal and 1 post-natal workshop
		Bærum 2019	1 pre-natal workshop
	Open (public) kindergartens (each visit lasting 4 to 5 hours)	Stavanger 2019	2 days
		Oslo 2019	4 days
Interviews	Health personnel (30 minutes to 2.5 hours)	Stavanger 2019	6 interviews
		Oslo & Bærum 2019	2 individual and 2 dyadic interviews
	Kindergarten staff (30 minutes)	Oslo 2019	1 dyadic interview
	Immigrant women (30 minutes to 2 hours)	Stavanger 2019	5 interviews
		Oslo 2019	6 interviews
Demographic data	Retrieved from Statistics Norway - SSB	2017; 2019–2021	n/a
Auxiliary data	Unrecorded interviews and discussions; printouts and brochures provided by clinics about organization structure; programs; etc.	2017; 2019–2020	n/a
Policy documents and literature	Retrieved from various sources in both English and Norwegian	2017-2021	n/a

For more details about the interviews, refer to the following appendices:

- Overview of participants: Appendix 1
- Interview guides: Appendix 2
- Invitation to participate forms: Appendix 3
- Information and consent forms: Appendix 4
- NSD ethical assessment: Appendix 5

4.3.3 Data Collection and Processing

Given the scale of the project, the nature of data dissemination through the articles, and my engagement with different research designs, the data were not processed uniformly. Different methods of data processing were used for different sources and purposes. The first, third, and fourth articles entail methods sections explaining how their respective data were collected and processed, while the second article lacks this discussion due to its theoretical nature and the journal's layout requirement. This subsection summarizes these procedures, addresses the forgone methodological details in the articles, and discusses the data processing and analysis as a whole.

Interviews

Holstein and Gubrium (2016) explain, “meaning is not merely directly elicited by skillful questioning, nor is it simply transported through truthful replies; It is strategically assembled in the interview process” (p.69). Interviews were used for the third and fourth articles. This constitutes an important segment of the data. Contingent purposive sampling (Hood, 2007) was used in recruiting participants. The initial criteria for sampling were set forth by the research question but were reiterated throughout the data collection process due to the realities of the field, which are described in section 4.5; hence, the sampling criteria were adjusted to accommodate the convenience of the sample I was able to access. This meant that some initial criteria, such as the immigrant women’s period of residency in Norway by the time of their first pregnancy and birth, were compromised. This led to the collection of rich data and resulted in an important comparative aspect in the analysis of mothers’ experiences in relation to their different lengths of residency at the time of pregnancy and birth. The sampling criteria for service providers were not changed and were mainly determined by access.

I conducted all 22 interviews. The interviews were all audio recorded. I transcribed them verbatim in both Microsoft Word and NVivo12, and I translated those in Farsi and Kurdish during transcription. They were not double checked by another translator and, as such, a journal reviewer pointed to them as a source of translator bias. However, the critique on the validity of data translated by the researcher is not a significant limitation in this study. Instead, I found it to be an advantage as I translated the interviews while also analyzing their cultural implications. Temple and Young (2004) argue, “the researcher/translator role offers the researcher significant opportunities for close attention to cross cultural meanings and interpretations and potentially brings the researcher up close to the problems of meaning equivalence within the research process… and is in turn linked to how the validity of the work is itself constructed” (p.168). Critique of this role is bounded by the validity of how the entire research is constructed. This issue of validity, like others in qualitative research, can be addressed by transparency of the process and the reflexivity of my embeddedness in the study, which I address in section 4.5.

Two sets of interview guides were used, one for immigrant service users and the other for primary maternal health care providers. The questions in the interview guides had to be edited after the first couple of interviews. The order of the guiding questions, or rather themes, was edited. Some questions were deleted, and others were added. These changes were based on interviewee responses and the topics they addressed, such as their expectations of the NMHS and interactions with health care providers during birth, which I found to be of importance for my study. The interviews were semi-structured and open-ended, so the order of questions in the guide was not always followed; similarly, the questions were not always asked as they were written in the guide because often responses to those questions were addressed during an interviewee's reflections and responses. To have followed the guide meticulously in some situations would have been disruptive to the quality of the interviewee responses. Although this approach led to the collection of rich data addressing more topics than I had anticipated when writing the guides, it also posed obstacles during analysis. It was difficult to use the interview guide as a deductive tool in sorting through themes across the many transcripts. The transcripts had to be read many times to draw on common themes following Braun and Clarke's (2006) model for thematic analysis. The relevant coding process for the interview analyses is outlined in articles 3 and 4.

Observations

Detailed field notes were taken in a field diary during pre- and post-natal workshops. Observations of the kindergartens were written at the end of the day. All field notes were transferred to Microsoft Word files and saved on my computer; paper documents were discarded. While field notes from the pre- and post-natal workshops I attended in 2017 form the empirical foundation of the first article, subsequent observation notes were used as referential material during the analysis of the interviews for better understanding and description of the context, or for clarifying points of discussion. The field diary is also where I recorded the following: a summary of my field days' events and interactions; notes from conversations I had before and after interviews with my participants, which I thought would help me clarify context when analyzing the transcripts; plans for consecutive field days; to-do lists in connection to data collection; names of places; and any other points I thought were important in keeping me organized and on track while in the field and afterwards during analysis.

Policy Documents and Literature

Although all of the articles and this dissertation are theory-laden, the second article is structured as a theoretical discussion based on a review of literature on universalism. The research method for this article can be identified as qualitative content analysis. Drisko and Maschi (2015) explain, "the focus of discourse analysis and of conversation analysis is on the elements and forms of speech, in contrast to the focus on meaning in content analysis" (p.82). In this article, content analysis offered a descriptive focus on literature on universalism, provided the basis for a theoretical discussion of the concept, and led to suggestions for its rearticulation. The same method was used to analyze policy documents on Norway's health system and strategies for addressing inequality in health that were incorporated into the first article.

Other Data

Demographic data on the migrant population in Norway were retrieved deductively from Statistics Norway to develop the background of this study. They were also used to narrow down the list of clinics I contacted in Oslo County. Because I wanted to interview practitioners who had frequent interactions with immigrant women, I only contacted clinics in regions where immigrants comprised more than 25% of the total population.

4.3.4 Data Analysis and Philosophical Reflections

The data were subject to different analytical methods throughout the articles. The theoretical and conceptual chapter in this dissertation (chapter 3) explains how these analyses are brought together at a higher level (in chapter 6) using an overarching analytical and theoretical framework.

Isaac Reed (2011) distills interpretation and social knowledge construction into epistemic modes, based on how fact and theory are combined. Where interpretations point to evidence, he defines the interpretivist epistemic mode, in which a variety of theories are used to provide a deeper understanding of what is going on in a specific context. From an encapsulating perspective, the objectives of knowledge production and the strategies I have adopted in breaking down a general social question into a set of practical research areas resonate with Isaac Reed's (2011) landscape analogy of the interpretivist epistemic mode. Here, the overarching aim of exploring the equity and equality debate within universalism in Norway is the confines of what he calls the landscape, and the four articles present constructions of the different segments of this landscape. Each article tackles different aspects of my data using different theories and presenting different layers and levels of interpretation of the overarching research question, giving the landscape, in theory, a dynamic and colorful presentation of interpretations of the social facts. Furthermore, the structure of my article-based dissertation requires that these various interpretations from combinations of theory and fact are brought back together under one umbrella responsible to the facts and the objective of the study as a whole, as is presented in the discussions chapter.

In the first article, the problem of migrant maternal health in Norway is formulated and analyzed. The data were used in an instrumental case study. This investigation served to analyze underlying mechanisms and effects of the shortcomings of Norwegian health policy in addressing immigrant women's health needs. This was facilitated by applying Bacchi's (2009) WPR framework for policy analysis, which emphasizes the socio-historical and political factors underlying problematizations in policy, and presents recommendations for change. The second article dissected the theory of universalism as a concept from different perspectives of time and space. The tolerance of Norway's universal welfare state of inequality in its pursuit of equity is debated in a theoretical discussion, where new possibilities for universal provision are negotiated. Finally, the third and fourth articles of this study deal directly with data, redirecting the trajectory of analysis to a bottom-up perspective, rather than the system-oriented perspective highlighted in the first two articles. Both articles draw on theory to further deepen the analysis of the facts beyond the transcripts. Following Reed's (2011) landscape analogy, each article's unique contributions to the research project in synergy offer a painted landscape, or multifaceted understanding, of the historically specific overarching research question.

4.4 Ethical Considerations

Because this project was carried out within two different time frames, i.e., a master's thesis and a doctoral thesis, the ethical requirements for the project are worth clarifying beyond that of explaining a research board ethical assessment process. The first article included in this dissertation is a product of research conducted during my master's research (Mehrara, 2017), as stated earlier. This project did not require ethical approval from the Norwegian Centre for Research Data (NSD) because, as a policy analysis without direct participant involvement, it did not meet the requirements for applying to the ethics council. Nevertheless, ethical considerations were applied in carrying out this project because even though there was no direct participant involvement, there was human involvement at the different stages of this project. This included, but was not limited to, obtaining informed consent from those I observed and spoke to; respecting the privacy of my informants; and anonymizing any features that would identify my informants or those whom I observed. This points to the normative and arbitrary nature of the research council's ethics requirements in defining when and for what purpose a formal application for the undertaking of scientific research is required.

The Norwegian Centre for Research Data (NSD) offered an assessment based on the guidelines of EU's General Data Protection Regulation (GDPR) for the processing of personal data to be included in the PhD project in 2019. The project received a confirmation for its compliance with these regulation with reference number Medlemskjema 234675- this is attached in Appendix 5. This was obtained early in the project because the motive to conduct interviews with health personnel and immigrant women was clear. A revised application had to be resubmitted to the board during the process of data collection, when the simultaneous collection of health data occurred in the open-ended narratives of women participants about their birth stories. This application was approved, and data collection resumed. Prior to each interview, the participants signed a written consent form after the purpose of the project, processing and storage of data, confidentiality, and their rights as volunteers had been explained to them both verbally and in writing. A signed copy of the written consent form was requested from the participants who were interviewed over the phone or via Skype; this was sent by email before the scheduled interview. All identifying details of the participants were anonymized, and pseudonyms were used before any transcripts were shared with co-authors for additional analysis or advice. An ethics section is included in the three empirical articles, 1, 3, and 4.

4.5 Methodological Reflections

Cunliffe argues, “People are reflexively embedded in their social world, influenced by and influencing discursive practices, interpretive procedures etc.” (Cunliffe, 2010, p. 8). The challenges I encountered before and during fieldwork were not without effect on the reiteration of this project’s defining features and research questions, and their outcomes were tied to my positionality. In this section of the chapter, I reflect on how my positionality as a researcher shaped this study.

Central to the idea of reflexivity, academic work is political and cannot be separated from the self or from the environment of the self and the researched (Farahani, 2010). The motivation to study maternal health care and immigrant women in Norway is tied firstly to my personal history of being an immigrant woman, secondly to my academic background in both the health and social sciences, and finally to my subjective curiosity about Norwegian maternal health care. Therefore, there are many ways in which I associate myself with the group I have chosen to study, and to an extent, I feel responsible as an academic for bringing to light some issues around migrant maternal health care.

There are also many factors that differentiate me from, or place me on the “outside” of, this group. Firstly and most importantly, there is the unavoidable fact that I have never been pregnant, a mother, a nurse, or a midwife; consequently, I am not able to identify with the experiences of my target groups. Secondly, there are some factors that may contribute to my familiarity or place me as an insider, but that also set me apart. Explicit features, such as my gender, age, race (outwardly appearance), and implicit features, such as my assumed religion and personal history, cannot be overlooked in others' perceptions of me, or in my negotiations of positionality. Finally, my portrayed and assumed social and cultural capital set me apart and contributed to the power dynamics of my interactions. Included here are my educational attainment as a PhD student; my in-depth knowledge of the Norwegian health system; my transnational background and familiarity with different countries and various cultures; my fluency in multiple languages; and my presentation and speech. Nevertheless, my positionality in the study cannot be simplified to a mere dichotomy of insider or outsider because the majority of the time I felt like an "in-between-er." I present my reflexive methodological discussions through the challenges I faced during my fieldwork and how they affected my data. The two main challenges can be narrowed down to access and language, which affected my ability to access the field and recruit research participants. These highlight the most significant reflexive points in my methodology.

4.5.1 Accessing Clinics and Recruiting Practitioners

The location for my master's research was linked to my place of study in Stavanger. My choice of Stavanger and the Oslo area as locations for my doctoral project was both logistic and strategic. Logistically, I wanted to assess the maternal health service available to immigrant women in municipalities with a high population of immigrants; strategically, I included Stavanger because of my familiarity and networks, and Oslo for its diversity.

Initially I used my networks to gain access to the maternal health clinic in Stavanger. The trust I had developed during my previous research with the practitioners in Stavanger was a great advantage that allowed me to kickstart my research. Furthermore, I had also established myself as a researcher who was not there to police them or criticize them, as I had already shown through my master's research. I was there to study the Norwegian maternal health care provided for migrant women. There was little misunderstanding about my intentions, and the staff felt comfortable talking to me. The concept of trust, therefore, is embedded in the concept of power because the development of trust came while establishing my position as a researcher.

Being invited into the clinic setting and having the endorsement of those who knew me, I was able to recruit health practitioners. This occurred during lunch breaks, where I gathered informally in the makeshift lunchroom to eat and socialize with those who worked at the clinic. Here, I engaged in informal conversations with those sitting around me about who I was and why I was there, eventually asking them if they would like to participate in my study. This informal situation helped me in connecting with and recruiting participants that I would have otherwise had difficulty reaching.

I did not have this leverage in the Oslo region. The only contact I had near Oslo was with a nurse I had met a year earlier at a national migrant health conference. I had to revive this contact, first by email and then by phone. The reason our connection had sparked at the national conference amid the crowd was partly by coincidence and partly due to our shared knowledge of a local health initiative in Stavanger, TEGRA. After several months, we finally scheduled a meeting, to which she also brought one of her colleagues. This was valuable in the sense that she had believed in my work and intention enough to engage one of her colleagues working on the program to meet me. Despite my attempts to use the same strategy I had used in Stavanger to recruit other practitioners by spending time at the clinic, I was not successful. Perhaps this was because of the short time I spent at the clinic and the number of people I could therefore connect with. Other reasons for not being able to recruit more participants could have been due to my positionality as a researcher with whom a challenging conversation was assumed to be had, or it could have been due to language and the fact that if they were interested in talking with me, they had to do so in English as my knowledge of Norwegian was insufficient to hold an interview without compromising much of what was being said.

I located six other clinics in migrant-dense districts in the Oslo region, and I contacted each one by phone and email; however, I was only able to secure a meeting with one clinic after going back and forth about my intentions as a researcher. Contact with the other five clinics was not successful despite my following up with them several times. Their leaders said that they were not interested or were too busy to have a researcher visit them. I think my researcher position created some hostility in that I "cold called" these clinics and asked to interview them about their experiences with immigrant women. In retrospect, perhaps contacting the general information line of the clinic or their leaders was not the best strategy. Another reason I was denied a chance to visit the clinics could have been linked to my positionality as a foreign researcher in Norway, and the fact that I communicated in English. Not communicating in Norwegian to predominantly Norwegian practitioners in Norway certainly had an impact in my study, especially in terms of recruitment. This fact could have invoked feelings of mistrust or discomfort towards talking to me, and thus placed me on the "outside."

In summary, there are some characteristics that stand out when wanting to interview working professionals about their jobs. These include the need to be accommodating and compromising as a researcher, and the need to work to gain their time and trust. I cannot discount the leverage the mobilization of my capital in terms of networks gave me in gaining initial access to these institutions and for having the foundations to build on trust. Furthermore, the scope of data I was able to access or the sorts of information they gave me was influenced by my immigrant background. There was sometimes a great deal of explaining about rudimentary topics, such as what free health care in Norway is, and how it works. Data were constricted by language, which I noticed often made my participants uncomfortable when they tried explaining concepts in English. Finally, I do not believe that my gender, race, and younger age had as profound an impact on this segment of the study as it did in recruiting immigrant women and interviewing them about a very intimate topic. This is presented below.

4.5.2 Recruiting Immigrant Women

Conti and O'Neil say, "Studying those in positions of power invokes similar types of methodological problems as studying those excluded from power networks: problems of access, problems of authority in the interview setting, problems related to language, style and cultural capital" (Conti & O'Neil, 2007, p. 68). Recruiting immigrant women was the most challenging part of my study. Aside from the two participants whom I recruited through personal contacts in Stavanger, the others had to be sought through different methods; these are described in this section.

My contacts at the clinics in Stavanger and Bærum (in the Oslo region) agreed to help me recruit immigrant service users by sharing information and invitation flyers with their patients and at maternity workshops. However, this strategy only yielded one contact after nearly a year, whom I interviewed over Skype due to the Covid-19 pandemic. This approach failed because it required the women to contact me, and almost none did. This was, without a doubt, an issue of trust due to the lack of physical and personal interaction. I found it easier and quicker to make an impression on someone in person as compared to on a sheet of paper. My positionality as a young woman with the appearance of someone with an immigrant background in Norway was an advantage in recruiting immigrant women and interviewing them about an intimate topic like pregnancy and birth. Moreover, my approach to in-person and on-site recruitment was likely also persuasive, and the places where it took place were convenient as will be detailed in the following paragraphs. I was eventually able to recruit eleven immigrant women for the study. They had diverse ethnic and cultural backgrounds, reasons for immigration to Norway, lengths of residence in Norway, education levels, language proficiency levels in Norwegian and English, and regions of residence (Oslo or Stavanger).

TEGRA Workshops

Unlike the service providers, who were accessible through designated physical addresses, emails, and phone numbers, requiring only a negotiation for their time, the immigrant service users had to be sought in other ways. They were recruited either through referrals from the service providers or were approached in a setting where they gathered for a common reason, specifically, TEGRA or maternal health workshops for immigrant women. Although making announcements about my project did not result in any participants, taking part in these workshops and their group activities helped me connect with the mothers at an informal level. This gave me the opportunity to chat to the participating women about informal topics, and to tell them about myself and why I was there without a baby, before asking them if they would be interested in participating in the study at a time that best suited them. I recruited two participants in this way.

Public Kindergartens

Public kindergartens (*åpen barnehage*) in Stavanger and Oslo were where I recruited most of the other immigrant women. These kindergartens were a lead from one of the service providers who had tried to help me recruit mothers in the Oslo region without success. Open kindergartens in Norway are free state-funded kindergartens, where parents and their babies (often between 6 and 24 months old) can go to play and socialize from morning to mid-afternoon, three to four days a week. These kindergartens operate on a walk-in basis for anyone with a child. Many of the parents and children at the kindergartens I went to were new immigrants. This could have been partially due to the location of the kindergartens I chose to visit (being in more immigrant-dense neighborhoods), but was most likely due to the probability that the children of new immigrants did not yet have a spot at a regular kindergarten; the parents could not pay the tuition fees of a regular kindergarten due to their precarious employment situations as new immigrants. Another reason could be that, not having work to return to, immigrant mothers had more time to take their children to open kindergartens compared to Norwegians or more settled immigrants. For these reasons, open kindergartens were the perfect place for me to find study participants.

Considering these are public places, I had almost no trouble getting in. The only notable obstacle I had was explaining why I was going in without a child. This required me to explain the purpose of my research orally and also in writing. At one kindergarten, I had to speak to a manager over the phone and declare orally and by email that I was not there to report on the kindergarten before I was granted entry. I had to leverage my position as a professional researcher with dependable institutional contacts and research permissions that they could trust, while appearing non-threatening to their institution in order to gain trust and access. Once in the kindergarten, finding mothers who were willing to speak to me was not difficult. Access and recruitment also rely on how much the intended participants value the research or see it as important. I spent full days at the kindergartens, during which time I participated in activities, played with the children, spoke to the parents, and helped the staff. Some days were more successful than others in conducting interviews. During the first few days, I was endorsed by the kindergarten supervisors and staff, who themselves took me to mothers they knew and thought of as good participants for my study, even briefing the mothers about what they knew about me and my study. Some of the staff printed my interview invitation forms, which I had given to them as part of the certifying documents allowing me entry, and taped them onto lunch tables and walls. Other days, I approached mothers who looked foreign, which failed on two occasions because the women turned out to be first- or second-generation Norwegians.

Establishing trust with the mothers while they were minding their babies was a stressful and demanding task, but the environment we were in helped tremendously. Power differences were significantly diffused because the kindergarten was a relaxed and safe place. While sitting on the floor surrounded by toys and babies, I engaged in conversation with parents about mundane topics like the weather and public transport before gradually moving on to inviting them to participate in my study, all the while playing with their children. The informal chatter also enabled me to select my participants. The environment of the interviews at the kindergartens was also very relaxed and allowed mothers to play with their babies or take pauses from the interview to tend to them. I believe that my gender and age facilitated the ease we created around and during the interview. This was a time-intensive and tiring process, which only allowed me to carry out one interview in the span of two to three hours.

Yarning and Empathetic Distance

The process of reflexivity has introduced me to the concept of yarning. I refer and reflect on this concept intentionally at the end of this subsection, as I view it as a more encompassing reflexive analysis of the whole recruitment experience. Yarning by definition is a form of conversation that comes from Aboriginal and Torres Strait Islander culture (Brown & Lambert, 2012). It is a process of sharing stories and experiences in a comfortable and relaxed environment and "is a powerful way of building understanding between people from different cultures, generations or life experiences" (Brown & Lambert, 2012, p. 269). However, yarning is more than an informal conversation; it is "both a process and an exchange; it encompasses elements of respect, protocol and engagement in individuals' relationships with each other" (Fredericks et al., 2011, p. 7). This concept has been adopted as a methodology in the social sciences, particularly when doing research on indigenous populations, but also in other fields.

The process is useful in developing mutual trust between people who do not know each other, or who are from different backgrounds, because “yarning time may provide welcome relief and a more informal exchange of ideas in an intensely structured program seeking to address a particularly challenging problem” (Brown & Lambert, 2012, p. 269).

My approach to recruiting research participants, specifically immigrant women, resembles this process. We got to know each other in an informal and relaxed environment, and slowly, through the process of what I can relate to yarning, we started to speak about an intimate and sensitive topic. One limitation or rather different facet of this approach was difficulty in maintaining empathetic distance in some interviews that got very intimate. As the interviewer, I faced the dilemma of what I should do. Should I maintain professional distance, sympathize, and acknowledge their narrative, or to empathize and express that I felt the impact of the experience too? There are no clear instructions on this, but because we had already established an intimacy in our dialogue together, sometimes I could not hold back the empathy I felt.

4.5.3 Participant Pool

Looking back on my research holistically, my positionality affected my participant and data pool. My ability to carry out the interviews only in English, Farsi, or Kurdish excluded several interested participants who did not speak these languages; it also influenced the scope and quality of data collected from non-native speakers of these languages. In the case of service providers, it deterred some who did not feel comfortable taking part in an interview in English. In the case of immigrant women, where it had the biggest impact, the language requirement for participation limited recruitment to immigrants with a higher degree of socio-cultural capital, i.e., those who had university degrees and proficiency in English. The number of languages I was able to carry out interviews in by myself also presented great advantages for this study. I was able to interview immigrant women and service providers from nine different countries in three languages. My immigrant background further benefited me in accessing immigrant women due to a shared sense of familiarity. Similarly, I leveraged my transnational knowledge to connect with women from different countries, leading to a lot of my participants saying “you know” or giving shared cultural references. I often understood these references, but when I did not, I asked the women to elaborate. Consequently, I was very much embedded in the interview process and the data collected for this study, both from the immigrant women and the service providers. The effect of researcher embeddedness is a feature of qualitative interviews that needs to be acknowledged because the “resulting narratives are interactional accomplishments, not communicatively neutral artifacts” (Holstein & Gubrium, 2016, p. 68), no matter how hard the interviewer tries to distance themselves. As the “interviewee experiences are shaped by the dynamics of the interview process" (Silverman, 2017, p. 156), this embeddedness enabled the collection of very rich data, especially from the immigrant women about their pregnancy and birth experiences.

4.6 Research Quality and Limitations

The methodological reflections of this research project have been discussed throughout this chapter. These include limitations associated with qualitative inquiry and the case study design; those linked to field work and sampling; and the impact of time, language, and access on the participant pool. Acknowledging that I did my best with the time and resources I had in this project, there are some things that I would have done differently if my research plan had been different. Primarily, I would have spent more time in the field and would have involved translators. This way, I could have included the narratives of practitioners who did not feel comfortable speaking English, as well as a more socially diverse group of immigrant women. This may have offered more diversity and richness in the data. Nevertheless, their input would still not be generalizable to the experiences of any population of immigrant women. As such, though my participant pool and their experiences may not be representative of those who are most vulnerable and experience the most challenges with the Norwegian health system during pregnancy and birth, they offer rich and generalizable analytic insights on the implications of Norway's universal approach to maternal health care. Finally, although the completion of this doctoral project coincided with the Covid-19 pandemic, its influence on my fieldwork was minimal. It would have been interesting to include the experiences of practitioners and service users during the pandemic because it surely affected everyone differently; however, this would have to be investigated in another study.

4.7 Summary

This chapter provides a framing overview of the methodological perspectives and issues involved in the production of this dissertation. It provides both a recapitulation of what is described as methods in the four articles, and also discusses what has not been mentioned within their scope but was an essential part of their production process. The objective throughout the chapter has been to discuss details, while maintaining an encompassing perspective on the analytical, theoretical, and philosophical implications of these methods. This is significant in the positioning of the study, type of knowledge produced, and as an integral part of this, the positioning of myself as the researcher with influence in this study. Lastly, it presents reflections on ethical considerations, research quality, and study limitations.

Chapter 5: Summary of Articles

This chapter presents a summary of the four articles that constitute this dissertation. It highlights the research questions addressed in each article, their main findings, and the methodological and theoretical contributions. In doing so, this chapter provides the foundations for summative discussions, addressed in the following chapter, on the contribution of these individual articles to the overarching research question guiding this dissertation: *What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?*

5.1 Article 1

Mehrara, L., & Young, S. (2020). Health equity and universal provision in Norway: A case study. *Nordic Journal of Social Research, 11*(1), 39–65. https://doi.org/10.7577/njsr.2638

This article is a product of my master's thesis, which provides the background on which this doctoral project is built. It is an exploratory study that offers an interpretive understanding of migrant maternal health policy in Norway. Its contribution to this dissertation lies in its conceptualization of the issue of migrant maternal health in Norway's universalist health system, and in its provision of an overview of health policy operation in Norway. The aim of this research article was to explore the policy–practice nexus of health policy in Norway in relation to the provision and delivery of maternal health services to migrant women. The study combines qualitative methods of document analysis and observations in developing an instrumental case study that reports on a particular program, TEGRA, which provides maternal health services to migrant women. Data were collected through review and analysis of policy documentation, observation of this program, and discussions with people responsible for implementing health policy. Bacchi's (2009) WPR framework for policy analysis was utilized as an analytic process in investigating the data to explore the questions: *How does Norwegian health policy provide maternal health services to migrant women?* and *How have these policies enabled accessibility and acceptability of maternal health services to migrant women?*

The examination of maternal health services provided to immigrant women showed that national health policy did not identify this group as having differential needs or needing targeted services. However, given the decentralization of health governance, municipalities were given the discretion to distribute and thus target services to best meet the needs of their local populations. TEGRA, the program studied in this article, is an illustration of one municipality's initiative to address the maternal health needs of migrant women. Although this program is a demonstration of progress in terms of targeting of universal services, it has limitations in providing culturally responsive and appropriate health care, because it is underpinned by discourses around the problematization of migrant maternal health at the national policy level. Hence, despite its positive intentions, it does not tackle the issue of health inequity as an effect of cultural diversity, in Norway's universalist welfare system. The study concludes that "this approach to equity imposes a weakness on the principle of universalism and has the potential to further deepen inequality" (Mehrara & Young, 2020, p. 61). In suggesting proportionate universalism (Carey et al., 2015) as a policy strategy, the article raises the question of how much inequality a universalist system can tolerate in its pursuit of equity. This is addressed in the second article constituting this dissertation.

5.2 Article 2

Mehrara, L. (2020). Seeking the ideal of universalism within Norway's social reality. *Social Inclusion 8*(1), 133–144. http://dx.doi.org/10.17645/si.v8i1.2535

This article makes a theoretical contribution to this dissertation by examining the concept of universalism and its nuances. It undertakes and refines the question raised by the first article to analyze: *How much inequality in policy instruments can a universalist welfare state tolerate in its pursuit of equity?* The article investigates the concept of universalism as a theoretical and practical construct, as historically and currently applied in Norwegian health policy. It critically reflects on the paradox of equality and equity as a manifestation of universalism in the face of growing diversity within the contextual frame of migrant maternal health care in Norway. The theoretical discussion highlights the nuances and limitations of universal health policy as a policy aim and operational principle. It thereby challenges universalism's orthodox notions of idealism and equality in the face of diversity within the frame of health equity, which is itself a differential concept implying difference. The discussions continue to question the sustainability of universalism in addressing health equity, examining whether and how a gap between policy and practice is bridged. The article suggests that an equilibrium between equity and equality may be attained through collaboration at different levels by rearticulating the concept of universalism in accordance with the needs of contemporary society. Finally, the study offers a retheorization of universalism in Norwegian health policy in response to the challenge of growing cultural diversity. As such, the article forms the overarching theoretical foundation for this dissertation.

5.3 Article 3

Mehrara, L., Gjernes, T., Young, S. Immigrant women's experiences with maternal health care in Norway. Under Review at *International Journal of Qualitative Studies on Health and Well-being.*[6]

This article makes an empirical contribution to the dissertation. It presents an analysis of immigrant women's experiences with the Norwegian maternal health system (NMHS). This offers a bottom-up addition to the greater research question in this dissertation by exploring the lived effects of Norwegian universal health policy from the perspective of immigrant women from different backgrounds. The aim of this article was to explore how immigrant women experienced and navigated the NMHS during pregnancy and childbirth. Eleven semi-structured interviews with immigrant women in Norway from diverse countries and ethnic backgrounds formed the basis of this investigation. The results showed the different experiences of immigrant women with the NMHS. While some were satisfied with the scope of maternity health care, others found the NMHS to be under-medicalized and emphasized the lack of individual choice in treatment. How these women dealt with such discrepancies between their expectations and NMHS provisions was a result of their social and financial resources. While the majority of the women who experienced these discrepancies relied on their personal resources to circumvent this system, this was not an option for all. Explanations offered by Rothstein and Stolle (2008) of institutional trust and social capital are applied to analyze the normative characteristics of Norway's universal health policy. In this way, this study contributes to understanding the implications of cultural diversity for Norway's universal maternal health care policy through the lived experiences of immigrant women.

5.4 Article 4

Mehrara, L. More than health care: Midwives and public health nurses working with immigrant women in Norway. Under review at *Journal of Comparative Social Work.*

Contributing to another bottom-up analysis of the implications of universalism, this article investigates the effect of current policy in the practice and experiences of primary health

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[6] Mehrara, L., Olaug Gjernes, T. K., & Young, S. (2022). Immigrant women's experiences with Norwegian maternal health services: implications for policy and practice. *International Journal of Qualitative Studies on Health and Well-being*, *17*(1), 2066256. https://doi.org/10.1080/17482631.2022.2066256

care providers working with immigrant women and their children in a cross-cultural context. It too, therefore, adds to the overarching discussion of the effects of diversity on Norway's universal health policy, this time from the practitioners' perspectives, and thus the continued discussion of health equality and equity in the dissertation. The aim of this article was to explore the implications of cultural diversity for health care practice in a universal system. The analysis was based on data from nine semi-structured interviews with midwives and public health nurses at different community public health centers (*Helsestasjon*) across three Norwegian municipalities. The findings illustrate the practitioners' different approaches to meeting with culturally diverse patients, the challenges they face in their work, and how they overcome them.

The discussions address the practice of cross-cultural health care (Gustafson, 2005) in the absence of national guidelines or formal training using street-level bureaucracy (Zacka, 2017) as an analytical concept. This study highlights the imperative role of these local actors to mediate between the state and service users in meeting both the demands of the universal health care system, and also the diverse needs of their patients. This article contributes to the overarching debate around universalism in this dissertation through the analysis of service provider experiences with cross-cultural health care in Norway. Finally, it emphasizes the need and the importance of a nuanced rearticulation of universal health policy which is cognizant of diversity for equitable health care opportunity.

5.5 Overview of Articles

Table 4

Overview of Articles and Contributions

	Article 1	Article 2	Article 3	Article 4
Title	Health equity and universal provision in Norway: A case study	Seeking the ideal of universalism within Norway's social reality	Immigrant women's experiences with Norwegian maternal health services: Implications for policy and practice	More than health care: The implications of cultural diversity for health care practice in Norway
Co-author(s)	Susan Young	-	Trude Gjernes; Susan Young	-
Status	Published	Published	In review[7]	In review
Research Question(s)	How does Norwegian health policy provide maternal health services to migrant women? How have these policies enabled accessibility and acceptability of maternal health services to migrant women?	How much inequality in policy instruments can a universalist state tolerate in its pursuit of equity?	How do immigrant women from diverse countries and ethnic backgrounds in Norway experience and navigate the Norwegian maternal health service during pregnancy and childbirth?	What implications does cultural diversity have for health care practice in a universal system?
Theory *Refer to Figure 6*	WPR policy analysis framework; proportionate universalism	Universalism	Institutional trust and social capital; medicalization	Street-level bureaucracy; transcultural nursing theory
Methodology	Document analysis, observations	Literature/ theoretical investigation	Interviews	Interviews
Contribution	Problematizes the issue of migrant maternal health and provides an overview of the Norwegian health policy system. In discussing an approach to equity, it offers proportionate universalism as a consideration for policy. This raises the question addressed in the second article.	Deconstructs universalism and contributes to a critical discussion of universalism as a policy concept in Norwegian health policy, suggesting rearticulations to address the contemporary needs of society from an equality and equity perspective.	Offers knowledge on the implications of diversity on Norway's universal health system though lived experiences of immigrant service users. It highlights the importance of fostering institutional trust in a universal system.	Illustrates the different approaches of health care provides to meeting culturally diverse women. It examines the practice of cross-cultural health care in the absence of national guidelines, underscoring the limits of street-level bureaucracy in this universal system.

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[7] Published in 2022

Chapter 6: Discussion and Conclusion

This chapter summarizes the discussions in this dissertation, underscoring its theoretical and empirical contributions to social science, policy, and practice. It begins with a summary of what has been studied and how the central research question has been answered. This is followed by a discussion guided by the overarching theoretical framework on the main findings of this dissertation, its contributions, and its implications. The chapter ends with concluding remarks noting limitations and suggesting directions for further research.

6.1 Overview of Dissertation

This dissertation has been constructed around the following question: *What are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women?* The first two chapters framed the importance and purpose of this project from both contemporary and historical viewpoints. The undertaking of this question was divided across four empirical and theoretical articles. The fourth chapter reflected on the methodological processes involved, and the fifth chapter offered an overview of each article's contributions. Critical for this closing chapter is the third chapter, which presented an overarching theoretical framework under which the findings of the articles could be brought together as a coherent whole.

6.1.1 Contribution of Articles

Each research article unmasked a different facet of Norwegian health policy, maternal health care, and the implications of diversity for Norway's universal welfare system.

The central research question was approached via secondary research questions addressed in the articles. These were as follows:

Article 1

I. How does Norwegian health policy provide maternal health services to migrant women?

II. How have these policies enabled accessibility and acceptability of maternal health services to migrant women?

Article 2

III. How much inequality in policy instruments can a universalist state tolerate in its pursuit of equity?

Article 3

IV. How do immigrant women experience and navigate the Norwegian maternal health care system during pregnancy and birth?

Article 4

V. What are the implications of cultural diversity for health care practice in a universal system?

Through this analysis, the first article laid the foundations for this dissertation by problematizing Norway's universal health policy using Bacchi's (2009) methodological tool for analyzing policy. It examined the underlying discourses as well as the effects of the health care system and its response to immigrant maternal health using policy, literature, and ethnographic data. The second article presented an intricate theoretical assessment of universalism as a concept, contributing to more contemporary discourses on the paradox of equality and equity in universal social policy. Simultaneously, this analysis provided the theoretical backbone to the dissertation as a whole, strengthening the foundation upon which the rest of the study is debated. The third article analyzed the experiences of immigrant women with the Norwegian maternal health system during pregnancy and birth. It used the concepts of medicalization, and institutional trust and social capital (Rothstein & Stolle, 2008) to analyze immigrant women's encounters, navigation, and circumventions within this system. This illustrated the perceived limitations of this universal health service through an intercultural perspective emphasizing the consequences of its normativity. Finally, the fourth article examined the experiences of primary maternal health care providers working with culturally diverse immigrant women. Engaging with Zacka's (2017) concept of street-level bureaucracy in interpreting and illustrating the implications of cultural diversity for universal health policy for practitioners, this article highlighted the importance of local actors in the distribution or targeting of universal provisions, but also drew attention to the limitations of this practice. The four articles, therefore, construct an interwoven argument for the central research question on implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women.

The articles further contribute to an overarching theoretical framework, discussed in the third chapter, which enables an encompassing discussion on their combined contributions to the issue studied. The theoretical framework, which I have likened to the construction of a landscape of meaning following Isaac Reed's (2011) analogy, brings the four articles together within a three-layered analytical process. Universalism as the overarching theory, Carol

Bacchi's WPR model for policy analysis as the analytical framework (Bacchi, 2009, 2012), and the content theories of the explanatory framework signify the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women from policy, practice, and scholarly perspectives.

The emergence of this theoretical framework was tied with the findings of the articles and their contributions to universalism. This dissertation is a policy analysis subjecting Norwegian maternal health service policy and practice to enquiry using the WPR framework as an analytic tool. Universalism in this dissertation is engaged with as both a theory in policy and a concept for practice. It encapsulates a normative explanation of how policy works, and how it *should* work – which, as another role of theory, is a dimension to explanation in specifying what it leads to. Thus, if universalism is about ensuring access and equity, then the implementation theory should answer how that should be done. In the case of universalism, this means making sure all services are available to everyone.

The analytical framework (WPR) subjected the policy and its practices to in-depth critical enquiry, which found that there were gaps in the provision of care, in contrast to the intention. These were explored through two empirical articles on the experiences of service users and service providers within this system. The theories that then explain their findings (experiences of the mothers and the service providers) seek understandings of universalism that have been put forward by Rothstein and Stolle (2008) about social and institutional trust, which was enhanced or reduced on the basis of the mothers' expectations of the extent to which their treatments were medicalized. There was also evidence of social capital use and generation, which can contribute to a universalist positioning or oppose it. The findings from the service providers and TEGRA suggest street-level bureaucracy (Zacka, 2017) is used to adjust services to the needs of culturally diverse patients, and Rothstein and Stolle (2001) provide the theoretical base for this. Overall, there are questions as to how well universalist policies can accommodate these differences, which leads to the concept of proportionate universalism by Carey et al. (2015) as an avenue for rearticulating universalism as a policy and practice concept and enhancing the attainment of equity among a diverse population with different needs.

6.2 Implications for Policy and Practice

Implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women are varied. The analyses throughout the articles illustrate the policy response to diversity in health care provisions to immigrant women. The combined blanket approach to health care universalism and its decentralized governance make the targeting of health provisions, such as addressing diverse health needs of immigrant women, the responsibility of street-level bureaucrats like nurses and midwives. This approach implies that addressing cultural diversity in Norway's universal health system is dependent on the discretionary responses of local actors and organizations, and not of the national health policy. Although some adequate initiatives have been enabled by this model of health care governance in some Norwegian localities, this approach simultaneously imposes the risk of inequity, because such acute local responses are regionally limited, inhibiting equal access of immigrant women in other regions to the same initiatives they may also benefit from. Implications for migrant maternal health care are nation-wide and not a regional issue, requiring policy recognition and response. Hence the current decentralized approach to addressing the need of immigrant women is contradictory to the universal welfare ideology upon which this health system is founded. This paradox of equality and equity within Norway's universal policy was examined in the second article, where I suggested a modification of the system and the adoption of principles of proportionate universalism (Carey et al., 2015) to attain a more equitable universal health system.

For example, although TEGRA has been developed in response to a recognized need by the municipality when it comes to migrant maternal health care, it has practice limitations since it is developed within the current frame of maternal health care services that are nescient different forms of diversity. Limiting the response to challenges of diversity in health care to an issue of distribution at the local government level means that such issues do not become problematized or embedded in national health policy, as analyzed in the first article using Bacchi (2009). Subsequently, cultural diversity, as an example of a challenge brought forth by immigrant service users, is not presented systematically in training, or in practice guidelines, in this health system. This leads to systemic inequality, which goes against the ethos of universalism as a policy position.

Debesay et al. (2014) discuss the effects of diversity for nurses working in Norway, making important contributions to the understanding of their organizational culture and their roles as street-level bureaucrats. Their study examines how the organizational requirement of efficiency inhibits the cross-cultural work that nurses need to perform when working with immigrant service users. They argue that "local authorities and the management of human service organizations should therefore promote less standardization of tasks, instead fostering the quality of professionals' discretionary power by ensuring cultural competence and allowing more professional autonomy," and that this would be "an important step towards improving equal access to quality care or diverse patient populations” (Debesay et al., 2014, p. 80). This study’s findings support my findings about the need for cross-cultural health care and cultural competency in the Norwegian maternal health system, but it falls short in linking this analysis to policy and the inherent shortcomings of tasking street-level bureaucrats – even when given organizational support – with handling issues of cultural complexity in health care. This is an important factor of analysis in addressing diversity in health care, because “the structure of contemporary institutions is an important and overlooked factor that matters for the generation of generalized trust” in health care as an institution (Rothstein & Stolle, 2003, p. 207).

I therefore argue that another ramification of this decentralized approach to universalist health care governance is that the responsibility for “amending” the challenge of diversity is left to the discretion of the lowest members of the welfare hierarchy – the practitioners. As such, these street-level bureaucrats become critical players in sustaining the universal ideology of the system at the practice level. However, as agents of universalism, the weight of addressing cultural diversity in health care needs is imposed on them without giving them the proper tools and systemic knowledge to maintain a threshold of cross-cultural health care practice. Instead, addressing the forgone issue of cultural diversity in policy becomes dependent on variables such as practitioners’ personal discretion, tacit knowledge, and values of good practice as analyzed in the fourth article. This decentralized approach to addressing diversity, therefore, becomes the basis for the replication of ethnocentric ideals and normative health care needs. Local responses to challenges of diversity, linked to immigration, represent cultures of tolerance as an amendment strategy to retaining the equilibrium between equality and equity rather than policy reform and the questioning of these implicit underpinnings. Street-level bureaucracy should, therefore, not be the only solution for compromising the normativity of universal health policy in Norway in addressing cultural diversity in health care. While the actions of street-level bureaucrats are largely at “street-level,” they have a potential role to play in forming alliances with others in the larger systems as Vike (2018) maintains. In situations where “resources are chronically inadequate” (Hupe & Buffat, 2014, as cited in Vike, 2018, p. 247), the political leverage becomes much greater. This is an area for much more comparative research.

Different cultural models of health (Gjernes, 2004) illustrate the lived effect of this decentralized approach to addressing the maternal health needs of immigrant women. For example, the third article emphasizes the conceptualization of pregnancy and birth medicalization in the Norwegian maternal health system, which immigrant women from different cultural models of health, and thus different expectations of medicalization, found challenging in their encounters. Given the nature of universal health provision, it left little room for those women who were not satisfied to negotiate the care they received. Instead, it pushed them to either accept it or – for those with resources – to compensate or circumvent the Norwegian maternal health services. With no centrally endorsed program to address cultural diversity in health care, and thus no half-way meeting point, the consequences for those with different expectations of health care can be that they are pushed away or do not develop trust in the system, which may have accumulating implications for them and their families. However, if successful examples of cultural bridging and trust building, as carried out by some practitioners, were endorsed systemically, it could result in better integration of health care for immigrants, and could subsequently help immigrants to build their trust in the Norwegian health system as an institution (Rothstein & Stolle, 2008). This would reduce the probability of health stratification and inequity among those with immigrant backgrounds in Norway, especially for those without the financial and social resources to bypass its uniformity in service provision.

Rothstein and Stolle (2003, p. 195) argue that "the impartiality and fairness of political institutions that implement public policies are important dimensions of institutional trust and confidence that can be conceptually separated from conventional political trust." The conservation of universalism as an egalitarian welfare ideology evolved in Norway as a product of social trust and unity, and needs the trust of society in its provisions to remain the cornerstone of its political philosophy. With a changing demographic and increasing diversity, trust in its institutions cannot be assumed, because people from different countries have different experiences of political impartiality and trust in the government's institutions (Rothstein & Stolle, 2003). Therefore, this impartiality cannot be achieved from sameness in treatment based on the normative preconceptions of a homogenous population. Hence, going back to the discussion of universalism in the second article, a more nuanced rearticulation of Norwegian universalism in its health and welfare policies, whereby it becomes cognizant of cultural diversity, could be a realistic adjustment to this welfare ideology in practice and in light of the contemporary reality of Norway's population. This could, by extension, promote the willful integration of immigrants in Norway, which is a topic not studied in this dissertation but one worth examining.

So, what are the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women? In summary of this discussion, I argue that universalism, as currently applied in welfare policy and health distribution in Norway, is myopic in its definition of equal opportunity, as it is founded upon normative values which neither extend to nor encompass wider society – especially a diversifying and ethno-culturally diverse society. The utopic ethos of egalitarianism is uncovered in the analysis of how difference in societal needs, as contextualized within the frame of cultural diversity in this dissertation, imposes a paradox of equality versus equity in Norway's universal health system in the way it is addressed.

In light of the contributions of this dissertation to social policy, I further argue that the consequences of this decentralized approach to addressing cultural diversity in universal health policy in Norway juxtaposes the egalitarian ethos and ideologies embedded in universalism as a policy concept, which is to enable equal access from which equal outcomes are assumed. This is a paradox of universalism exemplified in this dissertation through the example of maternal health services for immigrant women in Norway. However, there are different types of diversity and difference within the populations and across the countries – particularly the Nordic countries – that adopt universalism as a welfare ideology. This raises questions about the sustainability of a monoculturally informed universalism and suggests the need its rearticulation.

6.3 Scholarly Contributions

This dissertation makes important scholarly contributions to social science from an interdisciplinary perspective on analyzing the Norwegian welfare system through its health policy and response to maternal health needs of immigrant women. The theories and findings of this dissertation contribute to multiple bodies of literature, including sociology of health and illness, sociology of migration, social policy, nursing, and political science.

This dissertation makes a qualitative contribution in examining the implications of Norway's health policy on maternal health care for immigrant women and primary health care providers. Subsequently, it addresses the dearth of research in addressing migrant maternal health policy in Norway from a qualitative and multidimensional perspective, offering important findings for policy and practice. This contributes to ongoing national and international discussions on migrant maternal health, health care systems facing cultural diversity, and welfare systems – particularly universalist – in addressing challenges associated with immigration and integration.

6.4 Limitations and Directions for Future Research

If I were to redo this study – or better, continue it – I would primarily adopt additional theoretical perspectives, which would enhance my analysis of this issue. These would be centered around feminism, critical theory, and whiteness, as individual and collective tangents of discussion on Norwegian health policy. On the one hand, I would apply critical theory and whiteness to analyze the ethnocentric underpinnings of Norwegian health policy and its implications for a changing demographic. This would add to the socio-political analysis of the welfare state, and the organization and practice of health care. On the other hand, feminism would be a fundamental theoretical approach in analyzing how women's needs are addressed in policy; the medical rhetoric in Norwegian maternal health care; and the interactions of health care providers and immigrant women.

Methodologically, including a more socially diverse immigrant participant pool, including women with fewer resources, could contribute to the analysis of the experiences of those most vulnerable in encountering the Norwegian maternal health system. Furthermore, expanding the locations of this study to more remote places in Norway that are not as migrant dense as the locations of this study could provide a contrast in the ways in which cultural diversity are being handled. Finally, I would suggest the expansion of this study internationally to compare how other Nordic countries with universal welfare systems are addressing challenges of diversity, and to analyze what could be learnt from them in terms of rearticulating universalist policy to better meet the needs and challenges of society today.

6.5 Conclusion

Health has been defined by the World Health Organization (1948) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." The argument this dissertation makes goes beyond the right to health as it uncovers how this right is perceived and experienced, specifically, by those who come from different countries and different health care systems. In doing so it also investigates the experiences of those providing health services informed by the Norwegian model of health care to those not familiar with it. This dissertation has critiqued the universality of universal health care, and by extension of universal health and welfare policy, in Norway for its normativity and indifference towards ethno-cultural diversity brought on by a growing immigrant population and a changing demographic. The discussions have highlighted the implications of this blanket approach for policy and practice, emphasizing cleavages in society driven by implicit system-imposed inequity in health care.

In conclusion, although this is a study on Norway, the demographic changes and challenges brought on by diversity are not unique to this context. This dissertation is an illustration of the essence of universalism as an ideal versus a reality. It offers important theoretical and practical contributions, which can be applied to studying and amending the effects of diversity in other welfare systems. It is at its core a policy analysis of the underpinnings of universalism and equality, focusing on a group of beneficiaries from this system, migrants, which have not previously been considered. Health care can be a gate to integration into society; hence, this is a critical area for development of policy as the world continues to globalize and as more people migrate across borders. A multicultural rhetoric in policy adaptation is key to creating better societies with less stratification.

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Appendices

Appendix 1: Overview of participants
Appendix 2: Interview guides with service users and service providers
Appendix 3: Invitation form
Appendix 4: Information and consent form
Appendix 5: NSD approval

Appendix 1: Overview of Participants

Location & date	**Group & pseudonym**	**Interview style & place**	**Country of background**	**Language of interview**	**Education/ profession**
Oslo Region					
	Service Providers				
Autumn 2019	Barbara	group; clinic	Norway	English	Health care
	Josephine		Norway		Health care
Autumn 2019	Barbara	individual; clinic	Norway	English	Health care
Autumn 2019	Ida	individual; clinic	Norway	English	Health care
Autumn 2019	Mona Micky	group; kindergarten	Norway	English	childcare officer kindergarten teacher
	Mothers				
Autumn 2019	Natasha	individual; kindergarten	Israel	English	Bachelor's degree
Autumn 2019	Merve	individual; kindergarten	Germany	English	Bachelor's degree
Autumn 2019	Samantha	individual; kindergarten	Serbia	English	Bachelor's degree
Autumn 2019	Cindy	individual; kindergarten	China	English	Bachelor's degree
Autumn 2019	Zara	individual; kindergarten	India	English	Bachelor's degree
Winter 2020	Patricia	individual; Skype video call	Indonesia	English	Master's degree

Location & date	**Group & pseudonym**	**Interview style & place**	**Country of background**	**Language of interview**	**Education/ profession**
Stavanger					
	Service Providers				
Spring 2019	Sandra	individual; clinic	Norway	English	Health care
Spring 2019	Sharon	individual; clinic	Norway	English	Health care
Spring 2019	Tamara	individual; clinic	Norway	English	Health care
Spring 2019	Linda	individual; coffee shop	Norway	English	Health care
Autumn 2019	Maryam	individual; clinic	Iran	Farsi	Health care
Autumn 2019	Sharon	group; clinic	Norway	English	Health care
	Joan		Denmark		Health care
	Mothers				
Autumn 2019	Amy	individual; at work	Thailand	English	Bachelor’s degree
Autumn 2019	Soha	individual; phone call	Egypt	English	Bachelor’s degree
Autumn 2019	Shania	individual; coffee shop	Canada	English	Bachelor’s degree
Autumn 2019	Parisa	individual; coffee shop	Iran	Kurdish	Master’s degree
Autumn 2019	Melika	individual; home	Iran	Farsi	Master’s degree

Appendix 2: Interview Guides

NSD Interview guide for service users

Biography

1) Nationality
2) How many years ago did you leave your home country?
3) How long have you lived in Norway?
4) What is/was your profession?
5) How would you rate your Norwegian?
6) Do you consider yourself an immigrant in Norway? How well integrated do you feel?
7) Tell me about your networks in Norway – social capital
8) How many children do you have?

Pregnancy in Norway

9) Tell me about your pregnancy (and birth) experience in Norway
10) How was your birth? Walk me through it if you feel comfortable
11) Did you feel like you were in control during birth?
12) How would you describe your experience with the health services available to you during your pregnancy compared to your expectations?

Maternal health care in Norway

13) What do you think of the quality, availability and accessibility of maternal health services during your pregnancy and after birth?
14) How helpful do you find consultations with your health service provider?
15) What are some challenges/difficulties you faced/face as a service user?

Reliance on Norwegian maternal health services

16) As time goes on from your consultation with your health service provider/visit to the clinic/ workshops, what sources information do you rely on?

Opinion on Participation and need for improvement

17) What is important for you as a service user? What does good quality of care mean and look for you?
18) Thinking back on your consultations/hospitalization, is there anything that you think could have been done better to enhance your experience? Help you prepare better? Felt more comfortable about the whole process/journey?
19) How do you think maternal health services in Norway can be improved to better address the needs of a more culturally/linguistically diverse women? (Speaking from your own experience)
20) Is there anything else about your pregnancy and birth experience in Norway that you wish to add to our discussion today?
21) Would you go to a program like TEGRA?

NSD Interview guide for service providers

Introductory questions

1) Male/female
2) Background/nationality
3) Profession
4) Years in practice
5) Experience from any previous profession (if applicable)

Describe your job and your workplace

6) What do you do in a typical day?
7) Who are the service users? Do you have direct interaction with them? How do you meet them?
8) What are the goals/demands of your job?
9) What are some guidelines you follow in service delivery?
10) What challenges do you face in your job?

Good practice

11) What is an ideal day/week at work for you? What would you describe as good practice in (your profession/ in maternal health care)?
12) What strategies do you use to plan your work? Service provision to different women?
13) Do you have personal/organizational models or guidelines for good practice?
14) Can you tell me what an ideal appointment with your migrant patient is like? What helps you achieve this? What gets in the way?

Cultural sensitivity

15) How do you work with patients from different cultures?
16) Have you seen the practice of service delivery change/evolve when it comes to providing care for women from different cultures?

Experience with migrant women

17) What are some of the challenges you have experienced in providing care for migrant women?
18) What do you see as the future of maternal health care for migrants in your practice? The organization? The municipality? The country
19) What do you think can help achieve this goal?

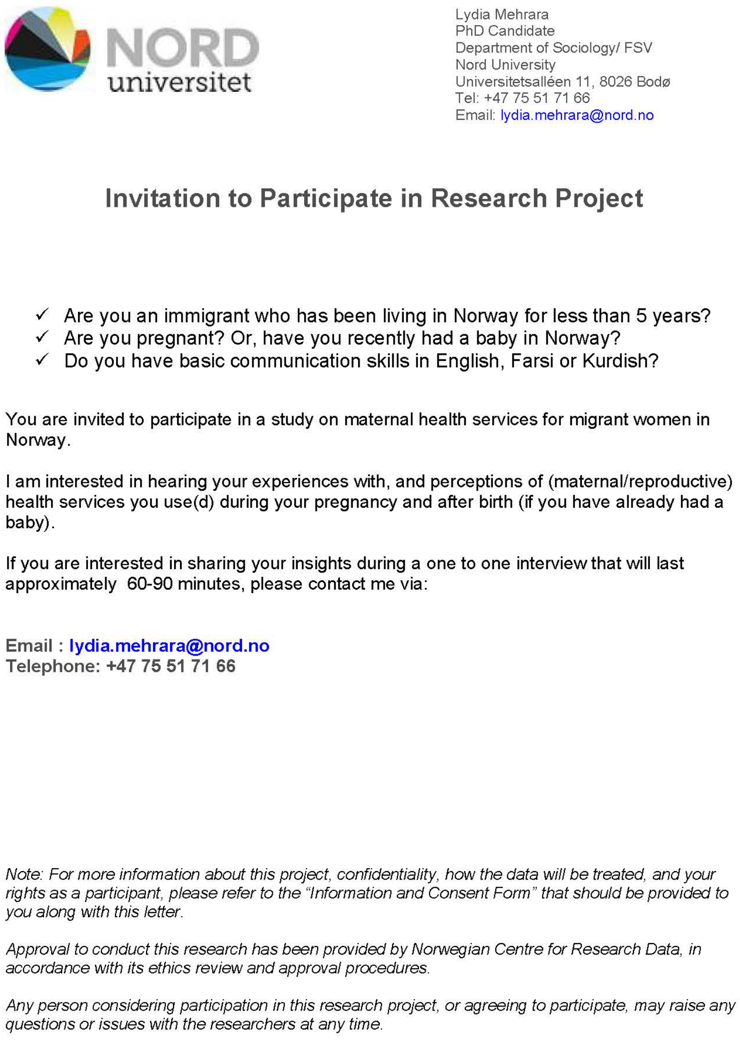
Opinions on participation in policy/practice change

20) Would you be open to/ or have you been open to recommendations from your service users in improving maternal health care delivery? If so, what is the process? What changes have come of it?

Do you have anything else to add in relation to our interview today?

Appendix 3: Invitation Form

Participant recruitment forms: service users



Lydia Mehrara
PhD Candidate
Department of Sociology/ FSV
Nord University
Universitetsalléen 11, 8026 Bodø
Tel: +47 75 51 71 66
Email: lydia.mehrara@nord.no

Invitation to Participate in Research Project

- ✓ Are you an immigrant who has been living in Norway for less than 5 years?
- ✓ Are you pregnant? Or, have you recently had a baby in Norway?
- ✓ Do you have basic communication skills in English, Farsi or Kurdish?

You are invited to participate in a study on maternal health services for migrant women in Norway.

I am interested in hearing your experiences with, and perceptions of (maternal/reproductive) health services you use(d) during your pregnancy and after birth (if you have already had a baby).

If you are interested in sharing your insights during a one to one interview that will last approximately 60-90 minutes, please contact me via:

Email : lydia.mehrara@nord.no
Telephone: +47 75 51 71 66

Note: For more information about this project, confidentiality, how the data will be treated, and your rights as a participant, please refer to the "Information and Consent Form" that should be provided to you along with this letter.

Approval to conduct this research has been provided by Norwegian Centre for Research Data, in accordance with its ethics review and approval procedures.

Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

Lydia Mehrara
PhD Candidate
Department of Sociology/ FSV
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Tel: +47 75 51 71 66
Email: lydia.mehrara@nord.no

دعوت برای شرکت در پروژه تحقیقاتی

- ✓ آیا شما مهاجری هستید که کمتر از ۵ سال در نروژ زندگی کرده‌اید؟
- ✓ آیا شما باردارید؟ یا به تازگی بچه ای در نروژ به دنیا آورده اید؟
- ✓ آیا شما به یکی از زبان های انگلیسی، فارسی یا کردی آشنایی دارید؟

شما برای شرکت دریک برنامه تحقیقاتی درباره خدمات سلامتی دوران بارداری برای زنان مهاجر در نروژ دعوت میشوید

من علاقمند به شنیدن تجربه یاتصورتان از خدمات بهداشتی دوران بارداری که شما در دوره حاملگی یا بعد از بدنیا آوردن فرزندتان دریافت کرده‌اید می باشم

اگر مایل به اشتراک گذاشتن تجربه تان با من در یک مصاحبه ی رو در رو و یکنفره که به مدت ۶۰ تا ۹۰ دقیقه طول می کشد می‌باشید با من از طریق زیر تماس بگیرید.

Email : lydia.mehrara@nord.no
Telephone: +47 75 51 71 66

Note: For more information about this project, confidentiality, how the data will be treated, and your rights as a participant, please refer to the "Information and Consent Form" that should be provided to you along with this letter.

Approval to conduct this research has been provided by Norwegian Centre for Research Data, in accordance with its ethics review and approval procedures.

Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

Appendix 4: Information and Consent Form

You are invited to participate in a research project on maternal health services for migrant women in Norway. This is a doctoral research project in Sociology at Nord University in Bodø, Norway.

Purpose of the study

The research aims to explore the availability and quality of maternal health services for migrant women in Norway by looking at the experiences of migrant women who have used or are using maternal health services in Norway, and also the experiences of the providers of such services to migrant women. In doing so, I will analyze whether and how participation of service users, and practitioners can help enhance the quality and the delivery of maternal health services to migrant women, and how this can inform policy change.

Request for participation

You are selected as a participant because you meet the criteria of respondents needed to realize the objective of this research project.

Your participation in this study will enrich understanding of the intersections of migration, maternal health, health policy and participation through a sociological perspective. Furthermore, the findings will contribute to a knowledge pool for practitioners, policy makers, and other researchers in this field.

What does participation in the project imply?

The research is qualitative, signifying that data will be collected through semi-structured Interviews guided by a few broad interview questions. Interviews will have a duration of approximately 90 minutes, during which narratives in relation to experiences of maternal health services will be sought. The interviews will be audio recorded.

What will happen to the information about you?

All personal data will be treated confidentially. The recordings will be transcribed, and the transcribed data will be stored in a personal computer and secured with a username and password that is only accessible by the researcher. Pseudonyms will be used in reporting; hence no direct personal data will be used that can reveal your identities. The indirect identifiable information will be published; hence you will be availed an opportunity to read through your own information and give approval before publication.

The project is scheduled for completion by December 2021, however the data collected will be stored for a maximum of 10 years after the project completion date by me for further research purposes after which it will be anonymized or deleted.

Who will have access to this data?
I as the researcher will be the primary processor of data. Additionally, parts of this data will be shared with my two supervisors (listed below) for advising and analysis purposes throughout the research process. Please note that one of my advisors (Susan Young) is based in Australia where data protection laws and definitions may vary from the European context.

What are your rights?
In signing this consent form, you provide me the legal basis to process your personal data. However, you as the participant have the right to request access to, deletion/correction/ limitation of your personal data at any time during the processing of data.

Furthermore, you have the right to send a complaint to the Data Protection Officer for the data controller or The Norwegian Data Protection Authority in the case you believe your rights are being violated.

Voluntary participation
It is voluntary to participate in the project, and you can at any time during the processing of data choose to withdraw your consent without stating any reason by contacting me or my supervisors. If you decide to withdraw your consent, all your personal data will be deleted.

If you would like to participate or if you have any questions concerning the project, please contact:

Researcher
Lydia Mehrara: lydia.mehrara@nord.no; +4775517166
Project supervisors
Trude Karin Olaug Gjernes: trude.k.gjernes@nord.no
Susan Young: susan.young@uwa.edu.au

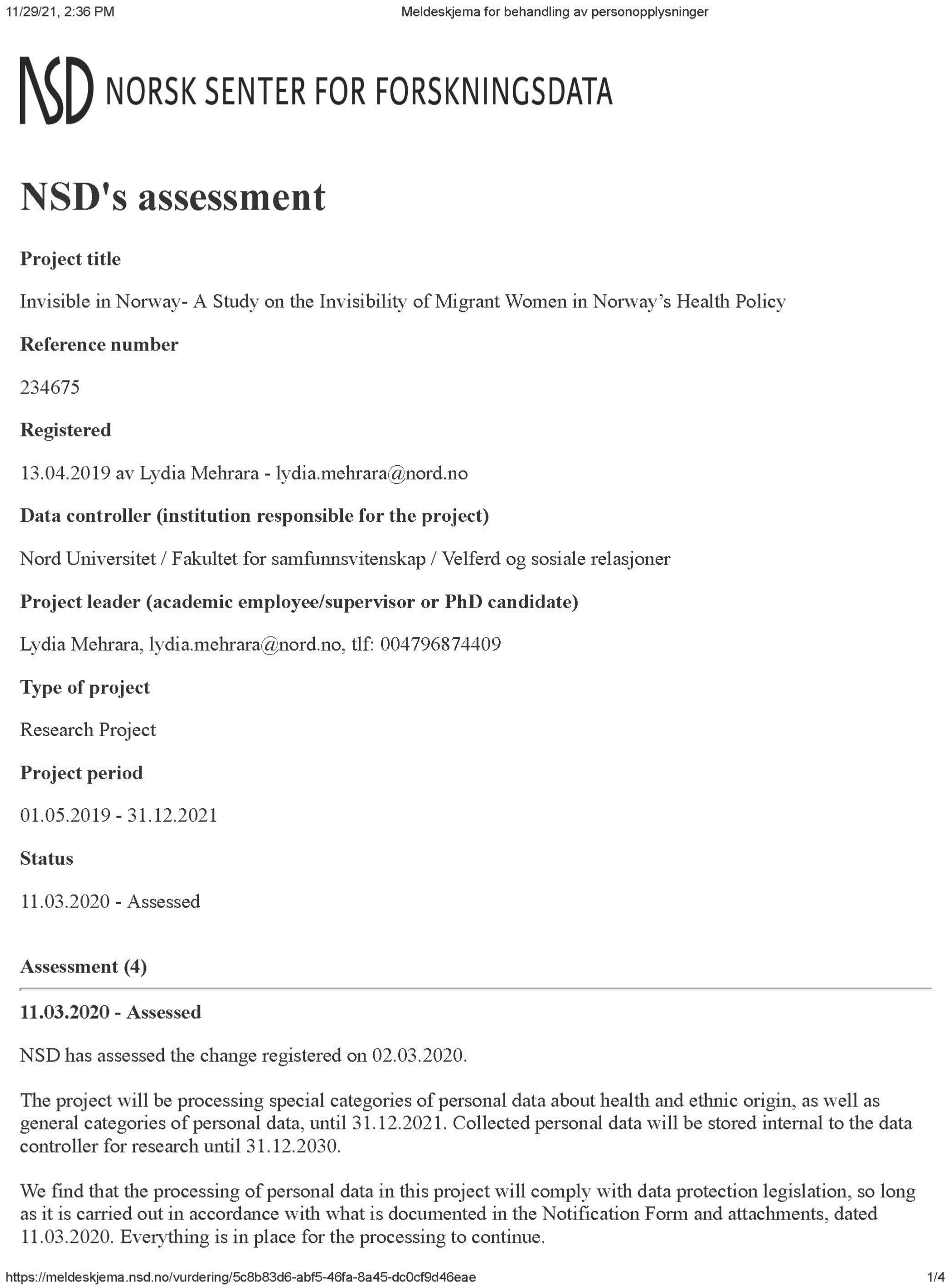
Data Protection Officer at Nord University:
Nord University: personvernombud@nord.no; +47 74 02 27 50

NSD, Norwegian Center for Research Data
This study has been notified to and approved by the Norwegian Data Protection Official for Research on 09/05/2019

Consent for participation in the study
I have received information about the project and am willing to participate

----
(Signed by participant- name and last name, date, location)

Appendix 5: NSD Ethics Assessment



NSD NORSK SENTER FOR FORSKNINGSDATA

NSD's assessment

Project title

Invisible in Norway- A Study on the Invisibility of Migrant Women in Norway’s Health Policy

Reference number

234675

Registered

13.04.2019 av Lydia Mehrara - lydia.mehrara@nord.no

Data controller (institution responsible for the project)

Nord Universitet / Fakultet for samfunnsvitenskap / Velferd og sosiale relasjoner

Project leader (academic employee/supervisor or PhD candidate)

Lydia Mehrara, lydia.mehrara@nord.no, tlf: 004796874409

Type of project

Research Project

Project period

01.05.2019 - 31.12.2021

Status

11.03.2020 - Assessed

Assessment (4)

11.03.2020 - Assessed

NSD has assessed the change registered on 02.03.2020.

The project will be processing special categories of personal data about health and ethnic origin, as well as general categories of personal data, until 31.12.2021. Collected personal data will be stored internal to the data controller for research until 31.12.2030.

We find that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 11.03.2020. Everything is in place for the processing to continue.

FOLLOW-UP OF THE PROJECT
NSD will follow-up the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Karin Lillevold
Data Protection Services for Research: +47 55 58 21 17 (press 1)

27.09.2019 - **Assessed**

NSD has assessed the change registered on 19.09.2019.

We find that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 27.09.2019. Everything is in place for the processing to continue.

FOLLOW-UP OF THE PROJECT
NSD will follow-up the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Karin Lillevold
Data Protection Services for Research: +47 55 58 21 17 (press 1)

20.05.2019 - **Assessed**

NSD has assessed the change registered on 20.05.2019.

We find that the processing of personal data in this project will comply with data protection legislation, so long as it is carried out in accordance with what is documented in the Notification Form and attachments, dated 20.05.2019, as well as in correspondence with NSD. Everything is in place for the processing to continue.

FOLLOW-UP OF THE PROJECT
NSD will follow-up the project at the planned end date in order to determine whether the processing of personal data has been concluded.

Good luck with the project!

Contact person at NSD: Karin Lillevold
Data Protection Services for Research: +47 55 58 21 17 (press 1)

08.05.2019 - **Assessed**

Our assessment is that the processing of personal data in this project will comply with data protection legislation, presupposing that it is carried out in accordance with the information given in the Notification Form and attachments dated 08.05.2019, as well as dialogue with NSD. Everything is in place for the processing to begin.

NOTIFY CHANGES
If you intend to make changes to the processing of personal data in this project it may be necessary to notify NSD. This is done by updating the Notification Form. On our website we explain which changes must be notified. Wait until you receive an answer from us before you carry out the changes.

TYPE OF DATA AND DURATION
The project will be processing special categories of personal data about ethnic origin, and general categories of personal data, until 31.12.2021. Collected personal data will be stored internal to the data controller for research until 31.12.2030.

LEGAL BASIS
The project will gain consent from data subjects to process their personal data. We find that consent will meet the necessary requirements under art. 4 (11) and 7, in that it will be a freely given, specific, informed and unambiguous statement or action, which will be documented and can be withdrawn.

The legal basis for processing special categories of personal data is therefore explicit consent given by the data subject, cf. the General Data Protection Regulation art. 6.1 a), cf. art. 9.2 a), cf. the Personal Data Act § 10, cf. § 9 (2).

PRINCIPLES RELATING TO PROCESSING PERSONAL DATA
NSD finds that the planned processing of personal data will be in accordance with the principles under the General Data Protection Regulation regarding:

- lawfulness, fairness and transparency (art. 5.1 a), in that data subjects will receive sufficient information about the processing and will give their consent
- purpose limitation (art. 5.1 b), in that personal data will be collected for specified, explicit and legitimate purposes, and will not be processed for new, incompatible purposes
- data minimisation (art. 5.1 c), in that only personal data which are adequate, relevant and necessary for the purpose of the project will be processed
- storage limitation (art. 5.1 e), in that personal data will not be stored for longer than is necessary to fulfil the project's purpose

THE RIGHTS OF DATA SUBJECTS
Data subjects will have the following rights in this project: transparency (art. 12), information (art. 13), access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18), notification (art. 19), data portability (art. 20). These rights apply so long as the data subject can be identified in the collected data.

NSD finds that the information that will be given to data subjects about the processing of their personal data will meet the legal requirements for form and content, cf. art. 12.1 and art. 13.

We remind you that if a data subject contacts you about their rights, the data controller has a duty to reply within a month.

FOLLOW YOUR INSTITUTION'S GUIDELINES
NSD presupposes that the project will meet the requirements of accuracy (art. 5.1 d), integrity and confidentiality (art. 5.1 f) and security (art. 32) when processing personal data.

University of Western Australia is a joint data controller. NSD presupposes that processing meets the requirements of joint data controllers under the General Data Protection Regulation art. 26.

NSD presupposes that processing meets the requirements for processing personal data outside the EU under the General Data Protection Regulation Chapter 5.

To ensure that these requirements are met you must follow your institution's internal guidelines and/or consult with your institution (i.e. the institution responsible for the project).

FOLLOW-UP OF THE PROJECT
NSD will follow up the progress of the project underway (every other year) and at the planned end date in order

to determine whether the processing of personal data has been concluded/is being carried out in accordance with what is documented.

Good luck with the project!

Contact person at NSD: Karin Lillevold
Data Protection Services for Research: +47 55 58 21 17 (press 1)

Part II : Scientific Articles

Article 1

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Health Equity and Universal Provision in Norway: A Case Study

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Abstract

This article reports on a qualitative study undertaken to explore the policy-practice nexus of health policy in Norway in relation to the provision and delivery of maternal health services to migrant women. The research used a case study approach focusing on a particular programme which provided maternal health services to migrant women and collected data through review and analysis of policy documentation, observation of this programme, and discussions with people responsible for implementing health policy. While Norway is well known for its universal policy principles, which in the main enable good access to services, the case study indicated that there are some limitations in policy and practice. We use the principle of proportionate universalism to comment on and make recommendations for policy makers and practitioners in this area, to better attend to the principle of equity in service access and usage. The article provides an overview of the Norwegian health policy systems, structures and provisions; describes the service provision from a specific programme providing maternal health services to migrant women in Stavanger, Norway; and concludes with some recommendations which emerge from the findings.

Keywords: Maternal Health, Migrant Women, Migrant Health,

Social Policy, Social Work, Norway, WPR Framework

Background and Introduction

This study reports on data from a study conducted in 2017 to explore the application of a universalist provision of maternal health services to migrant women. This is an important area of research because migration not only poses new challenges for the welfare state in its delivery of health services, it also has consequences for the health of the migrants.

Health policy in Norway derives from its social democratic principles with the assumption that equality of provision equals equality of access and thereby of outcomes. However, this thinking is problematic. Although Norway has not experienced the same magnitude of people movements as some of its neighbouring countries, non-western migration to Norway has increased (Tronstad, Nygaard, & Bask, 2018, p. 16). The consequent changes in diversity have meant institutions in Norway have had to consider how they will meet different cultural needs (Regjeringen, 2017; Tronstad et al., 2018).

To avoid misconceptions, in this article the term 'migrant' includes both documented and undocumented women as for certain maternal health provisions undocumented women may access some pregnancy-related services. Access to these services are designated as 'absolutely necessary' (Kvamme & Ytrehus, 2015, p. 3), and as such constitute emergency treatment rather than the types of services women may choose to or be recommended to access, such as the programme to be described later in this paper. However, it may well be that some of the attendees of the programme were undocumented.

A local municipality-based programme offering health services and resources to migrants was used as a case study to explore the application of health policy in the area of migrant maternal health. Observations of the programme were carried out over a period of four months in early 2017; discussions were held with policy makers, programme directors and managers and policy documentation were reviewed. The structure of investigation was guided by the two principal research questions, listed in the methods section, which concern Norwegian health policy's considerations and provisions of maternal health services for migrant women. The findings and discussions were set within the larger Norwegian health policy context applying a critical policy analysis framework (Bacchi, 2009) to both analyse the findings around the research questions, and articulate suggestions for future policy research and policy development. The study concluded that, despite the social democratic intent of ensuring equality through equal provision, the implementation of the policy faced a number of challenges which needed to be addressed to ensure equality of access. It raised the issue of the equity-equality nexus and prompted a question for policy: to what extent can equality tolerate diversity, or, to re-phrase it, what unequal measures are necessary to achieve equity and what does this mean for the social democratic ideal? Reflecting on these questions, this article presents the argument that a targeted or proportional universalism (Carey, Crammond, & De Leeuw, 2015) is necessary to address the different needs of diverse groups of people, such as migrant women, at the same time as affording them equal or universal access and benefit.

This article begins by providing context to the issue being studied by introducing the significance of migration to maternal health and goes on to describe the current migration circumstances in Norway and Norway's health policy. An account of the methodology used, and description of the case example in the findings section follows. The subsequent discussion examines the Norwegian policy position in maintaining its type of Welfare State in relation to health, by considering the experiences of a localised service for migrant women. The paper concludes with some reflections on targeted or proportionate universalism as an aspect of a social democratic system which could contribute to both local and national policy development.

Migration and Maternal Health

Maternal care and women's right to their reproductive health for legal migrants in most European countries has been found to present challenges for the countries' service delivery systems, and have implications for the health outcomes of migrant women. Research reports challenges for service delivery systems, health outcomes, help seeking and differential access patterns (Darj & Lindmark, 2002; Dejin-Karlsson & Östergren, 2004; Ny, 2007; Rechel et al., 2011). Migration further increases the vulnerability of pregnant women and their new-born children, with Reeske and Razum (2011, p. 139) maintaining that "health differentials during pregnancy, birth, the neonatal period and the first year of life are sensitive indicators of social inequalities".

Multiple studies illustrate the concerns. Utilization of prenatal and antenatal care by migrant women is less frequent in comparison to non-migrant women (Nørredam & Krasnik, 2011); they begin antenatal visits later in their pregnancy; and make fewer appointments (Reeske & Razum, 2011). Induced abortions among non-western migrants are greater than non-migrant women, which may indicate lack of knowledge of preventative measures in reproductive health (Nørredam & Krasnik, 2011). Other disparities exist in such unfavourable birth outcomes as: still births; low birth weights; preterm birth, congenital defects or malformations; and an increased risk of maternal and infant mortality (Reeske & Razum, 2011). There is a growing recognition among these studies and others that the cause of these disparities go beyond the legal and physical access to health services, and in fact suggest a problem of knowledge, accessibility, appropriateness, or quality for migrant women.

While studies have examined the health concerns and outcomes for migrant women, very little research appears to have explored how the more implicit and informal social determinants, such as ethnicity and culture linked to migrant women's health, contribute to positive or negative outcomes, or whether these have been addressed in health policy. This is particularly the case in Norway where there appear to be no studies conducted on the effects of health policy on migrant women's health.

International Immigration in the Norwegian Context

Up until the late 1970s migrants comprised a very small percentage of the Norwegian population. But Norway's immigrant intake has changed from the latter part of the Twentieth Century to accommodate refugee and asylum seeker arrivals as well as the more common migration for work and education purposes. Persons with immigrant backgrounds constituted 16.8% of Norway's total (5,258,317) population (SSB, 2017b) as of January 1st 2017, comprising 724, 987 immigrants and 158,764 Norwegian-born to immigrants: a total of 883,751. Approximately 50% of this population is aged between 20-40 years of age, and less than 9% over 60 years of age, making it younger than the average population (SSB, 2017c). A significant number of this young migrant population are women of average childbearing age (20-44 years old). The source countries of more than half a million immigrants in 2017 were from Asian, Latin American and African countries as well as other non-European countries (Tronstad et al., 2018, p. 16). The health systems in these areas differ markedly from that in Norway, along with very different cultural beliefs and behaviours in relation to maternal health.

Settlement patterns show Oslo, the capital, and its surrounding regions to have the highest concentration of migrants, with Rogaland county on Norway's south-west coast having the fourth highest in January 2017 (SSB, 2017c).

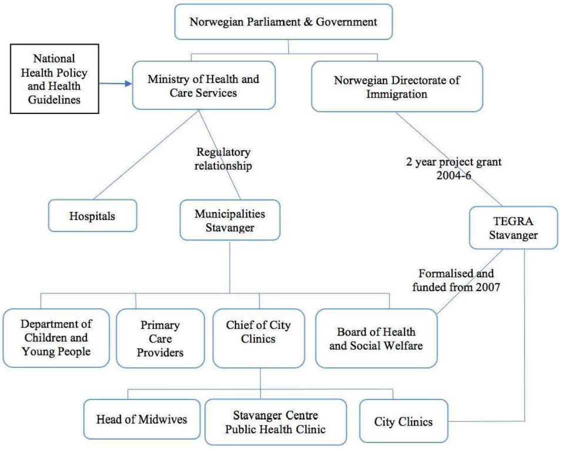
Stavanger, the location of this study, is one of the larger municipalities in Rogaland county. Moreover, Stavanger is known as the oil capital of Norway, and has “percentage-wise, the largest foreign population” in the country (Gjerstad, Johannessen, Nødland, Skeie, & Vedøy, 2016 p. 172). The migrant population is largely an even distribution between work migrants, their families, refugees and asylum seekers (Gjerstad et al., 2016). As of January 1st 2017, there were 19,791 women of immigrant and Norwegian-born to migrant background, who were of childbearing age (20-44 years of age) living in Rogaland county (SSB, 2017a). This represents more than half the entire (37,985) female migrant population in the region (SSB, 2017a). These features of the municipality made it a strategically advantageous location to carry out a policy analysis on migrant maternal health services.

Norwegian Health Policy System

The foundations of Norway’s social democratic welfare state rest on the principles of community, equality, mutual respect and trust (Esping-Andersen, 1996) using progressive taxation to reduce economic inequality and to finance generous public services (Pierson & Leimgruber, 2010). Its principle of universalism, offering all citizens equal access to services as a national priority (Kangas & Kvist, 2012; Ringard, Sagan, Saunes, & Lindahl, 2013), results in lower levels of inequality between the poor and the rich, and between men and women (Kangas & Kvist, 2012) than in other jurisdictions. Such measures and the commitment to “redistributive policies (both economic and social) and full-employment policies, such as the social democratic parties, are generally more successful in improving the health of populations” (Navarro & Shi, 2001 p. 181). Thus, Norway’s low levels of inequality, higher satisfaction with life, and the population’s overall high quality of health has been attributed to the country’s comprehensive and accessible health and welfare programs (Kangas & Kvist, 2012).

Norway operates a decentralised system for service provision as illustrated in Figure 1.

Figure 1 – TEGRA as a Health Service Provider



Adapted from Figure 2.1 in Ringard et al. (2013, p. 17)

An intricate set of relationships exists. Primary health care and hospital related services are separate from but responsible to the Ministry of Health, and do not indicate systematic collaborative relationships or partnerships. Furthermore, the decentralised system assumes that primary service provision operates most efficiently at the most local level possible and is therefore the responsibility of municipalities.

In Stavanger, maternal health services are offered by three main bodies: physicians including General Practitioners and Gynaecologists; primary care centres; and the Stavanger Universitetssjukehus hospital. The municipality of Stavanger has six public health clinics called the 'Helsestasjon' that offer free primary health services to families and children living across the city's seven boroughs. As indicated in Figure 1, potentially, unless there are specific initiatives, these services can and do operate independently from each other. All services are provided with no specific cultural or ethnic considerations, although the high level of migrants is acknowledged through the availability of interpreter services (Helsenorge, 2015).

A health programme called TEGRA, which stands for 'inTEGRAtion', is run by the Stavanger municipality. This program offers a range of maternal health workshops and other activities to migrant women and their families. This program was selected as the case study for this research. The detailed rationale for its selection as the site of study is presented in the subsequent Methods section, while a full description of TEGRA is provided in the Findings section.

Methods

Anecdotal narratives suggested that migrant women were not able to satisfactorily access some of the maternal health services which were part of Norway's universal health system. Therefore, this research used an exploratory process to examine the nexus between policy and practice in Norway in relation to the provision and delivery of maternal health services to migrant women. Having been conducted within a program setting certain time frames for the scope and design of the research, a case study approach was employed to provide as detailed an account as possible of one example of health provision to migrant mothers, in order to explore the application of Norwegian health policy. The research questions that enabled this exploration were:

How does Norwegian health policy provide maternal health services to migrant women?

How have these policies enabled accessibility and acceptability of maternal health services to migrant women?

Design

An instrumental case study approach (Stake 1995; as cited in Baxter & Jack, 2008, p. 549) was employed as the main focus was health policy and practice rather than the specific situation itself. As a research approach, instrumental case studies explore a complex phenomenon within its context, by way of gathering and interpreting data from various sources to answer "how" and "why" questions (Baxter & Jack, 2008, p. 545) allowing for the "multiple facets of the phenomenon to be revealed" (Baxter & Jack, 2008, p. 543). Thus, they provide for a more holistic understanding, and strengthen findings through data triangulation, enhancing their credibility and trustworthiness.

A case study design was selected for its ability to identify aspects of a phenomenon for further research as is fitting with an exploratory approach. While recognizing that findings could not be generalized, it was considered that examining a specific example of practice as illustration of policy could indicate areas worthy of further investigation. The programme TEGRA was selected for exploration as Stavanger is in a region with one of the largest migrant populations in the country and could be expected to provide useful information and indicate questions for future research. Further, TEGRA was selected as the site for the case study as compared to one of Stavanger's health clinics because of its extended services beyond pre- and post-natal group workshops and its customization for migrant women.

Data Sources and Collection

As the policy-practice nexus was the main focus for the study, policy documentation formed the main data source. These were supplemented by discussions with policy makers, programme managers and other health professionals in Stavanger. National and local policy documents provided information about the overall health policy principles and structures and the policy framework within which TEGRA and the municipality operated. Unstructured discussions were held with local policy makers and other health professionals, in which they were asked to describe how health policy was implemented and enacted in Stavanger. In keeping with an exploratory study, these descriptions filled in the detail of what is usually summarised in official documents and provided some history to health provisions and reasons for establishing TEGRA.

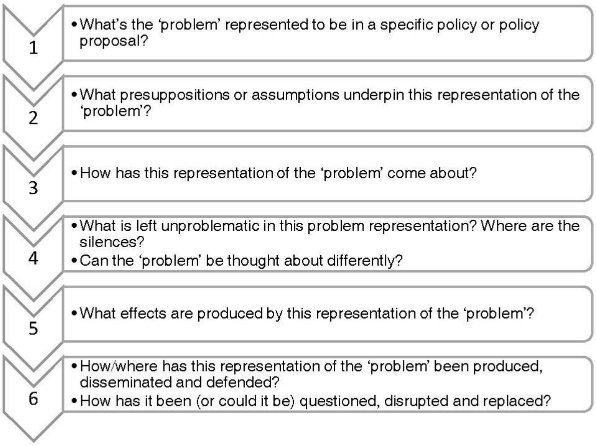
Observations of workshops and activities run by TEGRA provided ancillary data, which were considered in light of the policy documentation and comments from policy makers from the Board of Health and Social Welfare. The researcher attended four workshops and group activities at TEGRA during a four-month period with the permission of the health officials and TEGRA organisers. While not a participant, the researcher did interact with the programme leaders and participants who were informed about the study, and all of whom agreed to her presence. Notes were taken of the activities and information provided. No structured interviews or discussions were conducted with the workshop participants and organisers, and any conversations held were for the purposes of clarifying or confirming information. No participant or organiser was cited or quoted in this study. Another study may well wish to interview participants for their feedback on the appropriateness and effectiveness of the workshops and activities, and this would add to further knowledge.

Trustworthiness of the data was addressed through the multiple sources of data as well as through researcher and supervisor reflection. Being mindful that all researchers in qualitative research affect the research, the researcher's position as a female was noted as potentially influencing the research. These discussions explored the likely influences of her positionality on the findings which were scrutinised for any examples of such influence and revised accordingly.

Analysis

Bacchi's (2009) *What's the Problem Represented to Be?* (WPR) framework consisting of six critical questions, as presented below in Figure 2, was adopted as the analytical framework for the study and hence applied to all data: policy documents, discussions and observations. Founded on the four traditions of social constructionism, post-structuralism, feminism and governmentality, Bacchi's model aims to 'work backwards' and deconstruct any public policy to deduce implicit discourses underlining the construction and representation of 'problems'(Bacchi, 2012). The WPR was used both as an analytical tool, as well as a frame for how the analysis is presented and developed in the Discussion section. This approach to the presentation of discussions is critical, because the chronology imposed by the framework is an integral part of the process of the policy analysis in this report. Therefore, the aim in applying this analytical framework to the case study and other data was to critically review the connections between the policy and TEGRA's services, as an example of a programme for maternal migrant health.

Figure 2 – The six questions of Bacchi's (2009, p. 48) 'What's the problem represented to be?' (WPR) framework for policy discourse analysis



1
- What's the 'problem' represented to be in a specific policy or policy proposal?

2
- What presuppositions or assumptions underpin this representation of the 'problem'?

3
- How has this representation of the 'problem' come about?

4
- What is left unproblematic in this problem representation? Where are the silences?
- Can the 'problem' be thought about differently?

5
- What effects are produced by this representation of the 'problem'?

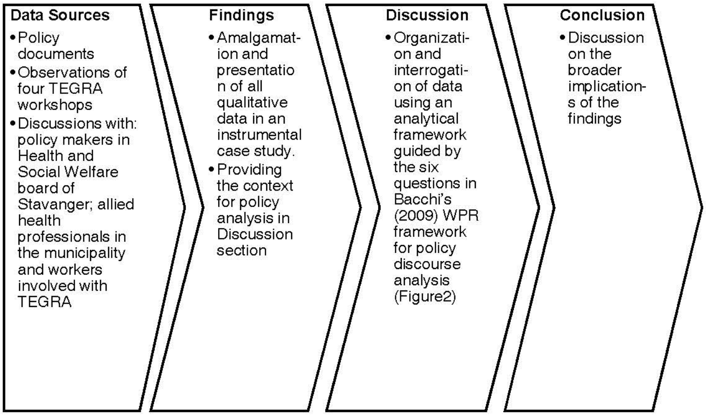
6
- How/where has this representation of the 'problem' been produced, disseminated and defended?
- How has it been (or could it be) questioned, disrupted and replaced?

Ethics

The Norwegian centre for research data (NSD) did not require ethics approval be sought for this project. Nevertheless, ethical practice applied in the informing of all contacts (advisors and health care personnel) about the purpose and significance of this study and in ensuring all data were treated with sensitivity and integrity, and importantly that all people associated with TEGRA were treated with respect and dignity.

A visual illustration of the research design is presented in Figure 3.

Figure 3 – Illustration of Research Design



Findings

TEGRA, a Case Example Addressing Migrant Maternal Health in Stavanger

This section offers a presentation of the case study, and in doing so the context for the analysis in the Discussion section. To begin, Figure 1 locates TEGRA as a municipally funded health programme in the Stavanger Kommune.

History of TEGRA

TEGRA's initial focus was to contribute to the national action plans against Female Genital Mutilation (FGM) in the early 2000s as part of the O.K. initiative (translated as Care and Knowledge against Female Circumcision) (Norwegian Ministries, 2008). Furthermore, in line with O.K's initiative, TEGRA aimed to increase the cultural competency of healthcare professionals and other service providers working with immigrant women and families, especially dealing with sensitive topics such as FGM. TEGRA's culturally diverse team highlighted the importance of multicultural understanding in effectively addressing sensitive health issues such as FGM prevention practice (Helsesøstre, 2007).

Commencing in December 2002 at the central health clinic in Stavanger (Stavanger Kommune, 2016a; Sykepleierforbund, 2014), TEGRA focuses on working with immigrant families, in particular with women and children to prevent their social isolation. The program operated mostly through volunteer work (Helsesøstre, 2007), until it was recognized by the UDI (The Norwegian Directorate of Immigration) in 2004 and received funding for two years. In 2007, after a year's pause (Helsesøstre, 2007), the project received formal recognition from the municipality and was integrated into the public health system (Sykepleierforbund, 2014).

TEGRA Today

In addition to working on the national action plans against FGM in Norway, TEGRA also organizes free childbirth preparation (Fødselsforberedende kurs) and postnatal (Barselgrupper) group workshops for immigrant families living in Stavanger. The workshops are held several times throughout the year, and families can request to have interpreters free of charge (Stavanger Kommune, 2016b). In 2016, there were 12 pre-natal groups, with a total of 172 pregnant women from 56 different nationalities; and 8 post-natal groups, with a total of 104 families from 46 different nationalities who participated.

TEGRA is one of few providers of maternal health services in Stavanger, however, it is the only provider that specialises in migrant women's health. Nevertheless, the intention of all maternal health service providers is to ensure that all mothers have equal access to maternal services, and information to obtain optimal pregnancy outcomes. The Norwegian Directorate for Health (n.d) strongly recommends that all municipal health centres offer prospective and new parents the opportunity to take part in group consultations. The purpose of a group-based initiative is to enable parents in the same situation to share their knowledge and experience about childcare and parenting with each other, and to also have the chance to meet and create a social network with other parents in their community. All the health clinics in Stavanger offer these post-natal group workshops.

Maternal Health Services and TEGRA

In addition to having a midwife and a GP, every pregnant woman is assigned a helsesøster (health nurse) or health visitor from their local public health clinic. After report of delivery, the woman's health visitor pays her a single home visit during which the mother is provided with information about the post-natal group courses (Barselgrupper) at her local health clinic. If she has a migrant background and is not fluent in Norwegian, the health visitor also provides her with information about TEGRA at the central city health clinic. Since these courses are voluntary, it is the mother's responsibility to make an appointment and register her interest for attending either one of the courses.

The post-natal group courses offered at the city's six clinics aim to enhance maternal and child health and have existed long before TEGRA was developed. However, their accessibility to migrant women who did not speak Norwegian has been limited, and hence migrant women's attendance at the courses has been very low. Women who wished to participate but did not speak Norwegian had the option of purchasing private courses in their language for a fee. This is not a feasible option for many, and as a consequence of accessibility, many migrant women have not been able to benefit from this service.

The Workshops

TEGRA's operations differ from and supplement the city-wide programs. They are targeted at migrant women, and provide information about the Norwegian health care systems as well as answer questions for people unfamiliar with these ways of working. Common questions concern the prominent role of midwives compared to gynaecologists, and different post-delivery practices, such as being discharged after three days and walking soon after birth; practices that differ from those in some other countries. Other information is intended to inculcate migrant women into the Norwegian system and approaches. These include discouraging women from opting for caesarean delivery and emphasizing the benefits of natural birth using scientific evidence. TEGRA staff have found that a significantly high number of migrant women prefer caesarean delivery based on their cultural norms and the stigma against natural birth in their home countries. Breastfeeding is another practice some migrant women reject, and the role of men in attending to infants is also a new concept to some. These differences are in part cultural and in part reflect western market and other influences in non-western countries, such as perceptions that formula milk is preferable to breast milk (Muula, 2007; Stevens, Patrick, & Pickler, 2009), and surgical procedures preferable to natural births. Such cultural norms which are passed down the generations are contrary to those of the health system in the host country and can create division and resentment if handled without sensitivity.

Cultural Sensitivity

TEGRA's organisers intend to be as culturally inclusive and responsive as possible. While genuinely attempting to provide useful information in engaging ways, presenters at the workshops would sometimes lapse into generalities. Some examples included characterising the help provided from TEGRA as akin to the 'watering wells' used in some countries for women to gather and exchange information and provide support, or disregarding specific cultural prohibitions, such as recommending the use of pork liver pâté ('leverpostei' in Norwegian) as infant food to an audience inclusive of Muslim women. Generalising can become stereotyping, not all migrant women have experience of 'watering wells', and additional options to pork liver pâté could be recommended to acknowledge cultural diets. Other potential but unintended cultural offences could occur such as illustrated by a demonstration of breastfeeding techniques via video and then repeated by a nurse using props being performed in front of male class attendants. At this workshop, it was evident that some men were uncomfortable as they frequently glanced away during this part of the course. Given the diverse range of nationalities and ethnicities of attendees, being able to provide culturally specific and appropriate information is a challenge requiring detailed knowledge and understanding.

Language

In addition to the range of cultural and religious backgrounds of attendees, language is another consideration, which is recognised through the free provision of interpreters on request. Observation of this in action found the courses to be facilitated by PowerPoint presentations, videos, handouts, and props with the presenters pausing regularly to allow for interpreters to translate the content and allow for questions to be asked and thoughts to be shared. Although all Stavanger health clinics offer post-natal workshops in Norwegian, Sykepleierforbund (2014) suggests that immigrant women have a much lower turn up rate to the city-wide program. Several factors such as language barriers and lack of knowledge have been suggested as contributing factors for the difference (Sykepleierforbund, 2014). It may be that the attendance is more regular and that more women are attracted to TEGRA than in the city-wide programme because of free access to interpreters. However, this has its limits. It would be impractical to have potentially up to 57 different interpreters in the classes, even should trained interpreters be available in Stavanger to cover all language groups. Furthermore, a common practice of employing male interpreters to work in the culturally sensitive areas of childbirth, breast feeding and other gynaecological matters for some groups could present barriers to participation.

Timing and Location

There are other limitations which face the TEGRA organisers including the timetabling of the courses and its location. Morning and afternoon classes on one day a week do not readily attract those workers on shift work, a common occupation condition for migrant workers making male partner attendance difficult. The central city location is convenient for public transport, but sometimes lengthy journeys, and having to travel with other children create unneeded barriers.

Accessibility and Availability

A major potential barrier is that of the lack of connection between the hospitals, clinics, health visitors and midwives. TEGRA is the only programme that covers all the topics associated with pre- and post-natal information over a period of time, which enables women to ask the questions as they emerge from their experiences or gestational changes. If they miss or do not attend the courses, they have to make special arrangements to call the clinics, ask their midwives or health visitor, or the hospitals after birth.

Figure 1 illustrates the lack of organisational affiliation between the state-run hospitals and the primary care centres in Norway. Subsequently, hospital-based midwives and other care providers are not associated with municipally run programs such as TEGRA. As a result, the quality of and sensitivity to culturally relevant care, and level of awareness is likely to vary across these institutions, because the care providers are trained according to different guidelines. Although examples cited above indicate that staff at TEGRA are not fully conversant with culturally appropriate protocols, it is possible that larger institutional organisations such as hospitals may be less so, despite the provision of interpreter services (Helsenorge, 2015). Accessibility to information about TEGRA suffers from a similar restriction. Women can find out about TEGRA if their practitioners (GPs or Midwives) inform them about it. Otherwise, information available on the municipality's website is restricted to a very short outline about the course and instructions on how to register, again only in Norwegian and English.

Norwegian Norms

Finally, the content presented in TEGRA has been selected and organized by Norwegian practitioners according to Norwegian notions of good practice. In other words, the program is founded upon a mono-cultural understanding of maternal health needs, which reflects Norwegian norms, mores and expectations. The focus is not on addressing any specific issues affecting migrant women or on making the Norwegian course content more culturally sensitive to the needs of women from diverse backgrounds.

Discussion

In this section, the six questions from Bacchi's (2009) "*What's the Problem Represented to be?"* (WPR) critical policy analysis framework (Figure 2) were used to tease out the policy implications of the TEGRA example of providing maternal health services to migrant women in Norway.

First Two Questions –the 'Problem' and its Presuppositions

One of the initial challenges to using this framework was presented by the first two questions: *What's the problem represented to be*? and *What are the underpinning assumptions*? In other applications of this framework, for example drug policy (Lancaster & Ritter, 2014), how drug use is constructed politically and through language, reveals much about ideology, partisanship, moral judgements, how the problem is conceptualised, is it a criminal justice or health matter and so on. In the case of the provision of health services in a universalist state such as Norway, the 'problem' is that this is not considered to be a problem. Here, everyone, with very few exceptions, has access to health services. The 'problem' becomes how the service provision itself is represented, or, how accessible are the services, and is that accessibility equal? On the surface, all women have equal access to services. But, as has been shown in the findings, the way services are provided mean that barriers exist in the form of cultural appropriateness, sensitivity and relevance.

The *What's the Problem Represented to be* framework is usually applied to policy texts and subject to critical analysis. Here health policy documents were used, supplemented by observations of the TEGRA programme and discussions with policy practitioners. Social activities such as described in the case study, are also considered to be text (Ricoeur, 1971) and so are also able to be included in Bacchi's framework. The observed and dialogic data were able to add a qualitative depth to the written policy documentation. While the 'problem' of access to the provision of maternal health services by migrant women is not represented as such in the policy documents, observational and discursive data indicate TEGRA's organisers considered it to be so, hence the development of the programme.

Third Question – a Historical Overview

Historically too, in reference to Bacchi's (2009) third question concerning the historical genesis of the issue (Figure 2), TEGRA's provision of its current services emerged from a national culturally specific policy to act against the practice of Female Genital Mutilation (FGM). Where FGM certainly was constructed nationally as a problem, even though, as Braun (2009) explores, as a problem it is variously represented, being able to access maternal health services was not. Hence the program was originally established and was funded to work with FGM. It was later that TEGRA organisers themselves constructed the 'problem' of migrant women's access to maternal health services as needing to be addressed in the absence of a suitable national framework at the time. It was not until 2007 that Norway released its policy on reducing social inequalities in health (Ministry of Health and Care Services, 2007), having accepted in 2003 that there was a need to do so (Strand, Brown, Torgersen, & Giaever, 2009). Largely defining social inequalities as related to economics, noting that Norway has a stratified society "where the most privileged people, in economic terms, have the best health" (Ministry of Health and Care Services, 2007 p. 5), the policy targets "income, childhood conditions, employment and working environment, health behaviour, health services and social inclusion" (Ministry of Health and Care Services, 2007 p. 6).

Norway's commitment to universalism is one in which "social equity is promoted through a distributive social security system" (Strand et al., 2009 p. 12). The general needs for the whole population are supplemented by strong social transfer programmes to ensure income inequality in particular does not lead to other inequalities. This is the cornerstone of the health strategy. While not rejecting the universalist principle, the Strategy acknowledges that some targeting is necessary, although not by using a means-testing approach which potentially "stigmatises" people (Ministry of Health and Care Services, 2007 p. 7). How otherwise to identify the most vulnerable groups for specific remedies is not stated, reiterating instead that still the most effective measures to overcome inequalities are through universal provisions. 'Immigrants' are among those groups identified as potentially vulnerable, showing higher levels of health concerns such as mental health issues, and specific diseases such as hepatitis, malaria and tuberculosis. Maternal health is also identified as potentially cause for concern, but that section concludes by stating “Further studies need to be undertaken to clarify socioeconomic factors and health among immigrants in Norway” (Ministry of Health and Care Services, 2007 p. 28). Although being an immigrant is identified in the Strategy as requiring attention, and so could be considered itself to be a health risk factor, it could be argued that relying on a universalist provision does not satisfactorily address the specific needs of immigrants, and more especially immigrant women and mothers.

While in this context the terms “equity” and “equality” are used interchangeably (Whitehead & Dahlgren, 2007 p. 4), it is questionable as to whether the Norwegian position on addressing inequalities fully reflects the Rawlsian (Rawls, 1972) concept of ‘fairness’ in its construction of equity. The Rawlsian principle of interdependence requires that resources and goods are distributed in such a way to ensure that the least advantaged members of society should be the greatest beneficiaries from public resources. Notwithstanding the commitment to attend to specific needs for specific groups, the overall principle that universal provision is the best solution to achieving social equity stands in this Strategy. Universal provision does not guarantee universal access, or that those services are relevant or culturally sensitive.

Fourth Question – the Limitations

The way by which these problems have been constructed, pointing to Bacchi’s (2009) fourth question (Figure 2), illustrates a central issue for a universalist welfare state. If social equity in health is defined using population wide measures founded (largely) on economic assessments, the strategy targets are likely to overlook specific groups in society such as migrants and migrant women who are not defined by their economic status in relation to health. By focusing on the more generally available health services through societally available institutions such as hospitals, GPs and clinics whose mandate is to ensure the services are available to all, there is no guarantee that these services ensure that all people access them. This is the gap that TEGRA sought to fill for migrant women in their need for specific maternal health services. Their additional goal was to encourage social inclusion, an aim that finds expression in the National Strategy in the form of an education-to-work design, believing that economic inequality results in poorer health, and dropping out of education is a precursor to lower income and/or unemployment. This design feature is not an aspect which would readily fit into any of the provisions from health services.

The AAAQ model from the UN Committee on Economics, Social and Cultural Rights (CESCR), (World Health Organization, 2007) is useful here to identify how well a policy may be assessed as meeting the four interrelated and partially overlapping elements of: Availability, Accessibility, Acceptability and Quality (AAAQ).

While the services to specifically address maternal and child health needs in the National Strategy (Ministry of Health and Care Services, 2007 p. 38) are available, they do not target the specific needs of migrant mothers for their own health care and knowledge. As mentioned above, GPs, hospitals and clinics all provide post-natal care for example and so are available, but their acceptance by non-Norwegian speaking migrant women as well as potentially their knowledge of these services may be questionable. This is not a comment on their quality, rather more one of whether or not these generalised services are those best suited to women who come from cultures which have different maternal health customs and expectations.

Fifth Question – the Effects

Following her Foucauldian trajectory, Bacchi's (2009) fifth question (Figure 2) enquires much more specifically into the discursive, subjectification and lived effects of the problematisations. The National Strategy (Ministry of Health and Care Services, 2007) is also applicable here, for although it allowed for some targeting to attend to potential inequalities, the discursive subject, in this case, is all women who need to access maternal health services, and that through provision of the universal services, all women may have their needs met. The effects on the subjects themselves is not necessarily one of blame or accusation for not accessing the provided services, but more of blindness to the particulars of their needs – a blindness TEGRA organisers recognised in their decision to target migrant women. Nevertheless, this provision is framed from a mono-cultural and 'white' oriented Norwegian perspective, with the potential consequence that women and their families, especially the men, withdraw from the workshops and presentations. Cultural awareness and responsiveness (Seeleman, Essink-Bot, Stronks, & Ingleby, 2015) is a necessary extension to the universal principles of service provision for specific groups. This is not only for the specific health outcomes for migrant mothers and their children, but more broadly as part of the larger integration initiative. Acknowledging the needs of these migrant women through policy and enhancing their relationship with a health system that is respectful of their cultures, their integration can be promoted in Norwegian society by way of increased trust and participation in the system. However, the opposite is highly likely as well, where their exclusion by disregarding their migrant milieus can lead to their isolation.

Bacchi's WPR framework primarily focuses on policy analysis and the representation of problems in policies. But she also reflects on the "effects of a given policy in terms of 'lived life'" where the primary focus is on "the effects of problem representations on the micro-level" (Cort, 2011 p. 29). Some of these effects can be inferred from the possible embarrassment of men to the breastfeeding information sessions, or the use of male interpreters for women's gynaecological health matters. Possibly some participants may be less inclined to attend future courses because of this, so affecting the acceptability of the provisions, but more importantly resulting in both lack of appropriate information about the Norwegian systems and services, as well as potentially missing out on necessary preventive services.

Sixth Question – Opportunities and Challenges

The final question in Bacchi's WPR framework (2009) (Figure 2), returns the gaze to the institutions and agencies which sustain the representation of the problem, and leads to the mobilisation of resources to effect change. As Goodwin (2011) articulates, this is the point at which there is the possibility of seeing the policy in a new light having uncovered "knowledge that is critically different from the existing system of meaning" (Goodwin, 2011 p. 174). Here targeted or proportionate universalism may be a policy direction of worth. Although noted as having acknowledged the necessity of some targeting, the National Strategy (Ministry of Health and Care Services, 2007), remains committed to the distributive mechanisms of the welfare state in achieving equity. This Strategy built on earlier policy directions, which relied heavily on the role played by municipalities through their health service provisions (Tallarek née Grimm, Helgesen, & Fosse, 2013). Such a decentralised approach must trust that the overall aim of national policies is both understood and supported at the local level. Oversight is maintained through non-intrusive or directive means, leaving the lesser-acknowledged policy needs either invisible (and so unaddressed) or dependent on local initiatives. TEGRA was one such initiative, but the extent to which similar initiatives and programmes that attend to maternal health provision for migrant women around the country is unknown, leading to asking a question about how equal health services are for a specific population.

Whitehead and Dahlgren (2007 p. 11), define Social Inequities in Health (SIH) as those "fair arrangements that allow equal geographic, economic and cultural access to available services for all in equal need of care". Such an articulation neither specifies the 'cultural' aspect, nor includes migration (Castañeda et al., 2015; Davies, Basten, & Frattini, 2006; International Organisation for Migration, 2017). Arguably, leaving decisions about these provisions to local municipalities could well lead to inequalities in provision and access, to say nothing of the more specific cultural needs. For all the challenges faced by TEGRA and the inadequacies of the programme in certain respects, the municipality of Stavanger has sought to meet its obligations, and more, in women's health. But it might be questioned as to whether leaving these crucial decisions to municipalities is enough to ensure that the principle of universalism is not undermined by the need for targeted services.

The concept of targeted or proportionate universalism may be usefully considered here. Carey and colleagues (2015), constructed a heuristic using subsidiarity principles from reviewing literature on universal and targeted policy frameworks to propose a mechanism for use by national governments to meet their policy objectives. An adaptation of the heuristic is reproduced in Table 1.

Table 1- Proportionate Universalism Heuristic

General universalism	Federal government responsibility: universal protections for all (e.g. sanitation)
Specific universalism	Federal government responsibility: universal protections for citizens (e.g. health care, education)
Positive selectivism	State government in partnership with other sectors (community and business): targeted policies and programmes based on differing levels of need
Particularism	Local government responsibility in partnership with other sectors (community and business) tailored services for different cultural, ethnic or otherwise differentiated groups

Adapted from Carey et al (2015 p. 5)

Operating from the imperative that decisions and actions are taken as close as possible to where they are to be implemented (the subsidiarity principle), different levels of government thereby have differing responsibilities. While Norway's arrangements of counties, municipalities and the national government differ from a Federal system, it could be said to have similar locational responsibilities. Hence, the national government sets policy including laws, such as the Health and Care Services and Public Health Act of 2011, specifying expectations and roles, for example intersectoral cooperation

(Ringard et al., 2013). Additionally, these laws allocate responsibilities, such as requiring municipalities to monitor health inequalities and ideally employ a local coordinator to advance such coordination (van der Wel, Dahl, & Bergsli, 2016). Thus, actions to address needs identified in the National Strategy of 2007 (Ministry of Health and Care Services, 2007) were codified in 2011 with directions to municipalities. Concern at national level continued with the release of a White Paper on Public Health in 2015 although as van der Wel (2016) and colleagues note details are lacking as to the specifics required to reduce inequalities.

Rogaland county could represent the Positive Selectivism governance arrangements through allocated roles from the Ministry of Health and Care Services. Dental care providers for instance are a responsibility of Counties rather than municipalities (Ringard et al., 2013). This represents an example of Positive Selectivism, as it is where community and business interests combine, although this remains unexamined in this study.

As the locus closest to the delivery of service, municipalities can enact particularist principles. The Stavanger municipality has a relationship through its clinic system, with TEGRA, having agreed to fund them in 2007. Although the municipality cannot take the credit for the work of TEGRA, especially the choices made as to how programmes should be implemented and offered to migrant women, it has a certain responsibility. This may be that TEGRA's work forms part of its reporting responsibilities in relation to intersectoral collaboration and other expectations.

Conclusion

The study reported here started because of observations in social work practice that some migrants from non-European countries had little knowledge of and hesitation in accessing maternal health services. A resultant exploratory research project then concerned how well the principles of universalism as a main policy orientation in all Norwegian service provision met the needs of mothers from very different health systems. A question about the policy-practice nexus was formulated to explore the intersections between what services were provided and how they were delivered. Given the then paucity of research in Norway about this issue, a decision was made to examine this nexus through an in-depth observation of a programme operating to provide maternal health services to migrant women in an area which had a large population of migrant women from predominantly non-European countries. Applying a policy analysis framework to this programme in its policy setting has enabled some insights into the tensions present between operating a universal system for people who are not native-born Norwegians. Universalism assumes all people are able to equally access the services provided. Within the universalist system, some targeting is implemented in the recognition that certain groups have additional and special needs. The examination of maternal health provision to migrant women has shown that this group was not necessarily an identified group for targeted services at a national level, and that municipalities were awarded the discretion to decide what services should be provided and how. The TEGRA example has shown that despite targeting at the local level, social equity cannot be guaranteed. Although TEGRA is an illustration of progress in addressing inequality in one municipality in Norway, the underpinnings and processes involved in the problem representation at policy level pose limitations to its effectiveness as there remain gaps in culturally responsive and appropriate services which lead to social inequity. The assumption that everyone has equal access under a universalist system, has inadvertently resulted in a degree of ambiguity in the ethos of equity and equality, leading to a questioning of equality within a universal system. In other words, how much inequality of provision in the interests of equity, can a universalist system tolerate? The answer to this question is for another research study, but this study has revealed that in this location and this reported programme, there are gaps in the theoretically equitable healthcare system, through which a fraction of the population, particularly people from migrant backgrounds could fall. Hence, this approach to equity imposes a weakness on the principle of universalism and has the potential to further deepen inequality.

Nonetheless, designed to fill an identified need at a local level, the experience of this programme has the potential to inform policy development and practice at a national level. Drawing on the principle of subsidiarity and the form of particularism as described by Carey et al (2015), amendments to the TEGRA programme in the form of greater cultural responsiveness and understanding could provide some guidance to similar locally based programmes elsewhere in Norway. Equally in the publishing of this analysis, it is likely that other programmes operating independently in other municipalities may have additional and different suggestions for culturally responsive strategies to contribute to a national health policy which seeks to preserve universalism at the same time as ensuring particular groups have their needs met.

To conclude, in addition to offering an essential contribution to understanding migrant maternal health policy in Norway, this exploratory study's greater purpose serves to trigger further discussion and research in this increasingly important arena in Norway where the migrant population in on the rise.

Acknowledgements

First and foremost, I thank my supervisor and mentor Dr. Susan Young for her guidance throughout the many stages involved in producing this work. I also extend my gratitude to all those who enabled this opportunity through their continued support. Furthermore, we both thank the reviewers and editors at the Nordic Journal of Social Research for their valuable feedback, and last but not least the Faculty of Social Sciences at the University of Stavanger for supporting this publication.

Funding

This article was made possible by funding from the University of Stavanger in Norway

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Article 2

COGITATIO

Social Inclusion (ISSN: 2183–2803)
2020, Volume 8, Issue 1, Pages 133–144
DOI: 10.17645/si.v8iX1.2535

Article

Seeking the Ideal of Universalism within Norway's Social Reality

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Submitted: 10 October 2019 | Accepted: 12 February 2020 | Published: 18 March 2020

Abstract

How much inequality in policy instruments can a universalist welfare state tolerate in its pursuit of equity? This article reviews the nuances of universalism as a concept through examination of its meaning and application in Norwegian health policy, with a contextual focus on migrant maternal health in Norway. The Nordic welfare model is generous and dedicated to achieving equality through the universal provision of social services; however, there are increasing gray areas that challenge the system, invoking the conundrum of equality versus equity. Universalism is a central principle in Norwegian health policy, however changes in the socio-political environment have meant the concept as originally conceived requires a more nuanced articulation. Population changes in particular, such as a growing and diverse migrant settlement, present challenges for how to achieve the equality desired by universalist measures, while maintaining the equity demanded by diversity. This article uses an example of a Norwegian program that delivers maternal health services to migrant women to question the concept of universalism as a theoretical and practical construct, as historically and currently applied in Norwegian health policy. This example illustrates how healthcare as an organization functions in the country, and the role of its key players in adapting policy instruments to meet the Norwegian welfare state's universal policy aims. The scholarly contribution of this article lies in promoting a critical reflection on the evolving definition of universalism, and in contributing to a discussion on the need to retheorize the concept in Norwegian health policy to attain equity.

Keywords
diversity; health policy; maternal health; migration; Norway; universalism

Issue
This article is part of the issue "'Universalism' or 'Universalisms' in Social Policies?" edited by Monica Budowski (University of Fribourg, Switzerland) and Daniel Künzler (University of Fribourg, Switzerland).

1. Introduction

The Nordic welfare model is most generous and dedicated to achieving equality through the universal provision of social services, however there are divergences between its ideals and their application. This view is shared by Anttonen and Sipilä (2012) in their review of the Nordic welfare model, which asserts:

> [The] model looks better on paper than in real life and it does not always perform according to its ideals. Many social programs are less universal than the ideology would suggest, and the policies that are strongly redistributive in intention often prove to be neutralized in the process of implementation. (Erikson, Hansen, Ringen, and Uusitalo, as cited in Anttonen & Sipilä, 2012, p. 28)

There are increasing gray areas in this welfare system that invoke the conundrum or paradox of equality versus equity, and the discrepancy between the ideal of universalism in policy versus its implementation in practice.

Universalism is a central principle in Norwegian health policy, however changes in Norway's socio-political environment, and the evolution of the welfare state since its inception, have meant that the concept as originally conceived requires a more nuanced articulation. The notion of universalism is faced with the challenge of diversity, particularly that of ethnocultural diversity brought on by a relatively new and growing segment of the Norwegian population, immigrants. Indicators of differing health outcomes among this group compared to the local population have led to discussions concerning issues of equity in a system founded upon a desire to attain equality. Responding to these challenges has not been easy or without consequence, thus leading to this article's primary analytical question: How much inequality in policy instruments can a universalist welfare state tolerate in its pursuit of equity?

This article examines the meaning and application of universalism in Norwegian health policy as both a theoretical and practical construct. It starts with a history of universalism and its adoption in Norway followed by an overview of Norwegian health policy in relation to immigrant women and their access to maternal health provisions. The argument presented here concerns the paradox of equality and equity as a manifestation of universalism in Norwegian policy. It therefore suggests a more nuanced approach to maternal immigrant health within Norwegian health policy. This task begins with a brief historical account of Norway's adoption of universalism. The next section offers a contemporary overview of Norwegian health policy and illustrates its enactment through the specific example of a local maternal health initiative for immigrant women, whilst addressing the definitions and relationships between the concepts of immigration, diversity, equality, equity and universalism. In light of this example, the following section theoretically explores the concept of universalism, distinguishing its nuances and shortcomings, as compared and linked to the policy and practice nexus of universalism in Norway. A discussion section merges the contextual analyses and the theoretical perspectives of the two preceding sections. In doing so, it reflects critically on the paradox of equality and equity brought forth as a challenge to universalism which Norwegian health policy needs to face in response to growing diversity in the population. This section presents an in-depth review of the divergences between the application of universalism as a concept in policy aims (theory), and in policy instruments (practice) in Norwegian health policy. Finally, the article concludes by examining possibilities of an articulated reiteration of universalism in Norwegian health policy as a resolution to the presented challenge.

1.1. A Historical Account of Universalism and the Development of the Welfare State

The welfare state as a national institution in many countries is relatively new, having emerged in the mid twentieth century in response to societal upheavals. In order to achieve its institutional welfare objectives, a series of social policies, some of which already existed in smaller scales, were gradually implemented by states and thus expanded to cover their entire populations. Norway's adoption of a welfare regime followed a general pattern in developed Western countries having instituted several social reforms during the previous century. The British welfare system, often considered to be the start of a recognized welfare state, emphasized the need for social protection against many of the social ills, and the provision of social insurance as protection built on previous systems, such as had already existed in such places as Germany and Norway. Such state-based protection systems were considered to be universal and their provisions were to apply to all of society irrespective of individual circumstances, because the improvement of society was the ultimate aim. Individual circumstances and meeting of particular needs could either be incorporated within the universal provisions or addressed separately as general eligibilities. While the Norwegian and British welfare systems differ, as will be described briefly below, universalism, as an ideology emergent from the idea of universally provided services, was a key factor in social provision, including health.

How and why Norway came to adopt universalism as a policy direction is open to different interpretations. For Kuhnle and Hort (2004), the many initiatives of social insurance in Nordic countries before and during the twentieth century paved the path for the adoption of universalism. They identify four central positions in support of universalism: community building, risk exposure, human dignity—i.e., the Universal Declaration of Human Rights in 1948—and economic and bureaucratic efficiency—i.e., eliminating means-testing (Kuhnle & Hort, 2004). For them, these offered the obvious foundations for institutionalizing the principle of universalism across the state. Kautto (2010) instead maintains, it was the particularities of the Scandinavian political, demographic, and cultural climates of the time that led to what has since been labelled the Social Democratic Welfare State system in Scandinavia. Given the largely homogenous populations of Nordic countries then, combined with a common history of social policy development increased the likelihood for the successful adoption of universal ideas. Universalism was justified in this welfare model because it supported national cohesion or unity and increased the functional capacity of citizens. It is beyond the scope of this article to trace these trajectories and conditions in depth, but universalism in Norway owes its particular regime to this history, which has shaped and affected public and social policy since. This article will explore the implications of this broad concept in Norway's welfare institution today.

2. Universal Public Health in Norway Today

Norway has one of the most comprehensive social policy models extending to health policy, with the universal application of provision assuming equal access and benefit. Decentralization is an operational mechanism to ensure efficient distribution, with the State maintaining a regulatory role and local governments being primary providers. Figure 1 illustrates this organization. Here maternal health services are highlighted as this will serve as an example for analyzing universalism as a policy aim (theory) and instrument (practice) in the subsequent section.

All non-hospital based primary healthcare are the responsibility of municipalities (Figure 1). This division of responsibility grants municipalities autonomy and thus a

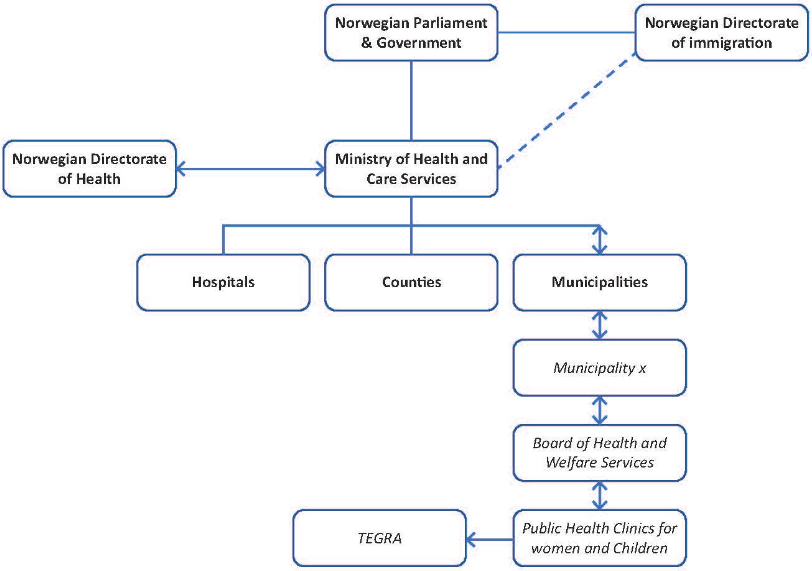

Figure 1. Organization of health services in Norway. Figure adapted from Ringard, Sagan, Saunes, and Lindahl (2013, p. 17, Figure 2.1).

degree of flexibility in tailoring service provision within the framework of national guidelines and standards to best meet the particular needs of their local populations. This governance system assumes that primary service provision operates most efficiently at the most local level possible.

Despite attempting maintenance of the welfare state's egalitarian and universalistic ideals through this healthcare distribution model, the responsibility of local municipalities to provide non-hospital based reproductive healthcare means that service provision may vary across the country. Various settlement patterns across the country further complicate the system, as do the challenges of growing ethnocultural diversity resulting from increased immigration in Norwegian society. To contextualize this issue, migrants made up less than two percent of Norway's total population in the 1970s (Vassenden, 2010). Whereas in 2019, persons with immigrant backgrounds, i.e., "persons born abroad with two foreign-born parents and four foreign born grandparents, in addition to persons born in Norway with two foreign-born parents and four foreign-born grandparents" (Statistics Norway [SSB], n.d.) henceforth referred to as migrants, comprise nearly eighteen percent of Norway's population (SSB, 2019). As migration is not explicitly recognized as a determinant of health in Norwegian health policy, where the focus mostly concerns access, there have been various responses to migrants' needs across Norway.

2.1. Migration, Diversity, and the Issue of Equity

Norway's relative ethnic homogeneity until recently has meant issues of cultural diversity being a necessary target for policy, such as in health, have not been prominent. As described earlier, the development of the Nordic welfare state and the adoption of universalism as a hallmark feature of this model were driven by a collective, post-War sense of unity and desire for equality, facilitated by the homogeneity of their populations. Though positive and progressive in intention, an unexamined ideology of universalism can exclude those who do not conform to the model's homogenic definitions. The dearth of research from a policy to practice perspective in Norway indicates that policy makers and implementors are not cognizant of how people from different sociocultural backgrounds experience universalism in its current blanketed approach. This topic will be elaborated through the example of maternal health services in the following subsections.

Keeping with the need for further research, there now exists an imperative to retheorize universalism and its coexisting nuances as currently applied in health policy to account for the emerging sociocultural diversity. Increasing indicators associated with the growing national migrant population that emphasize the challenges and shortcomings of health policy illustrate this need (Attanapola, 2013; Dahl, 2009; Munthe-Kaas, Bidonde, Nguyen, Flodgren, & Meneses, 2018). This is not only a Norwegian issue; multiple European studies highlight the differences in health outcomes, help seeking and differential access patterns of their migrant populations despite their right to health services (Darj & Lindmark, 2002; Dejin-Karlsson & Östergren, 2004; Ny, 2007; Rechel et al., 2011). Consequently, this presents the challenge of how to achieve the equality or sameness in opportunity desired by universalist ideals of Norwegian social policy whilst ensuring the equity or fairness demanded by Norway's diversity. These challenges are not limited to migrants, but also involve other underrepresented or unrepresented groups within Norwegian society. Immigrant women and the issue of maternal health services is one specific example referenced by this article. The following two subsections lay the contextual foreground for this debate in order to problematize and later address the multifold intricacies of the concepts of equity and equality.

2.2. Maternal Health Provisions for Immigrant Women

Despite the entitlement of all pregnant women to free maternity care regardless of their legal status (Helsenorge, 2019), the discrepancy between equality versus equity, resultant from a blanketed yet indeterminant approach to universalism, is evident in maternal health provision for immigrant women. Despite the universalist assumption of equal rights to health services enabling health equity, equal opportunity and health outcome is not warranted for all immigrant women. Differences in the utilization of prenatal and antenatal care by immigrant women in comparison to non-immigrant women, and a higher prevalence of complications and unfavorable birth outcomes among this group, indicate these disparities (Nørredam & Krasnik, 2011; Reeske & Razum, 2011). This demonstrates that there are issues of poor access, which must be considered from both institutional and individual perspectives. Institutional access barriers may be due to poor institutional knowledge and resources to address migrant women's health needs, dissemination of information in hard to reach immigrant communities, and perhaps even that of health center proximity. In combination with individual factors embodied by migrant women, such as cultural differences, language barriers, or education level, these can lead to different health seeking patterns, and subsequently to poorer health outcomes for both mothers and infants. Such circumstances are poorly addressed by universalist or state level policy and provisions. In keeping with the decentralized policy framework presented in Figure 1, action has been taken by some municipalities. One such health promotion program offered by a municipality is presented below to facilitate the discussion surrounding the analytical question of how much inequality in policy instruments or treatment can a universalist welfare state tolerate in its pursuit of equity. The information for this case which comes from a previous study by this author (Mehrara, 2017), is utilized like other investigative material in this theoretical article: to illustrate and analyze, but not to empiricize, the enactment of universalism in Norway.

2.3. Example of a Local Health Initiative for Immigrant Women

In the early 2000s, a group of primary maternal health service providers working in a Norwegian municipality with one of the highest concentrations of immigrants in the country designed a program named TEGRA (short for inTEGRAtion; see Stavanger Kommune, 2016). This development was in response to both the challenges they faced in working with migrant women, and the disparities of maternal and child health outcomes they saw in this group over time in comparison to the Norwegian population. After several years of voluntary operation, the project was incorporated formally at the municipal government level and has since received public funding.

TEGRA, which initially began to address the issue of female genital mutilation, has expanded its scope and aims to address broader topics of health promotion aimed at a more diverse group of immigrant women (Mehrara, 2017). TEGRA now offers free comprehensive and linguistically inclusive pre- and post-natal workshops, specifically designed for immigrant women. These workshops play an important role in promoting the integration of immigrant women into Norwegian society by developing their system knowledge, a type of knowledge required for them to understand and navigate the health and welfare system. Not only providing information around pregnancy, childbirth and motherhood in Norway, they support and empower immigrant women to gain an understanding of and access to the available resources. Furthermore, the workshops create a space for network building for these mothers. These actions accumulate and lead to better understanding, trust and use of not only the health system but other social services, and ultimately the integration and overall wellbeing of immigrant women. An additional program objective is to increase the cultural competency of healthcare professionals and other service providers working with immigrant women and their families through education, training and topic specific discussions both at the local and national levels (Helsesøstre, 2007).

This free local health initiative for immigrant women runs in parallel and in addition to the state-run health services in this municipality. The success of TEGRA both in overall qualitative measures of satisfaction from service users, and quantitative reports on the improvement of health and birth outcomes among the immigrant population, reaffirm its necessity. TEGRA's success has gained the praise of both local and national service providers. The municipality's formal recognition of TEGRA shows the incentive and need for such programs, where services are targeted toward specific population groups in Norwegian society who are otherwise overseen by standard distribution protocols. This demonstrates that a degree of selective universalism as described by Carey and Crammond (2017) and discussed further in section three, is well received and required. A similar program has recently been adopted by another Norwegian municipality, where it too has gained popularity. Together, these indicate that the decentralized health governance system allows for some local flexibility toward developing equitable approaches to healthcare.

The downside to this localized response is that due to differences in resources, demographics and responses between municipalities, this approach can inadvertently deepen inequality in the country and within the system. While women in certain municipalities can benefit from extended support programs, women in other Norwegian localities where such tailored programs do not exist, have the complex task of navigating the healthcare system as their own responsibility, which may impact their use and trust of the health system in the long run. This approach to maternal health provision within Norway's universal frame of health policy, leads into this article's critical discussion of whether this system's overarching ideology of fairness actually translates to equity in practice. Before taking this discussion further, it is important to clarify what is meant by equity and equality in the context of diversity and universalism.

2.4. Equity and Equality

Teasing out equity from equality is a complex task. Depending on context, the two are given various definitions. Within the context of this article, equality refers to a sameness in entitlement or right to a standard set of available health services, whereas equity in health is considered a critical aspect of accessibility, and it differs from equality in that it "concerns fairness" (Nørredam & Krasnik, 2011, p. 67). Furthermore, "equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (WHO, n.d.). Applying an equality focused policy to the distribution of health services, i.e., granting access to healthcare as a statutory right to all eligible residents in Norway, neither ensures equality in the ability of beneficiaries to access and use services, nor guarantees equality in outcome. An equality-oriented approach, though seemingly fair, overlooks that this equal right needs to be mobilized by its beneficiaries to become an opportunity through which they can benefit from healthcare services to their fullest potential, and to attain equal outcome. While equality implies a right, equity implies both equal opportunity and equal outcome; hence, a policy following an ideology that is meant to promote equality does not necessarily offer distributive justice or equity in practice. This system-oriented argument is not to insinuate that equality of opportunity and outcome in health are one-dimensional transactions independent of individual factors, or that all migrants have poor health outcomes. As already explained, access to health and consequently health-seeking behavior are multidimensional; therefore, equality of opportunity and outcome do not depend only on the health system, but also on the life course or previous experience of the migrants. This analysis, however, focuses on the role of healthcare as an institution in Norway, because though it may not be the only factor enabling equality of opportunity and outcome, its recognition and response to diversity makes it a significant contributor to broadscale change, and to achieving equity.

The assumption underlying the blanketed approach to universalism in Norway, or its equality focused social and health policy, implies that everyone's needs can be addressed by granting them the same right to healthcare and to a same set of general provisions. Entitlement to a right does not necessarily contribute to fairness because it does not take into consideration the subset of individual or institutional factors that may limit the mobilization of an opportunity. It is therefore important to consider the element of equity in health policy to recognize diverse needs. Though achieving absolute equity is a utopian idea, an equity-oriented policy, conscious of and proactive about the differences among people's needs can lay the foundations for more equitable healthcare system and more equal outcomes.

The recognition of differences is fundamental in order to mobilize a system that provides equal right to healthcare, to a system that offers distributive justice. Awareness of the individualistic needs existent in an ethnoculturally diverse population within the collectivist frame of Norwegian political ideology is essential for promoting equity. The case of TEGRA provides one example of how primary service providers recognized the need to address diversity within the universal approach of healthcare in Norway. Nevertheless, the relationship between equality or equity is more complex than a simple binary of a right and opportunity or outcome. Neither explore the intricacies of diversity within the scope of universalism, in this case, the diversity of immigrant women's maternal health needs in Norway's universal health system. Moreover, the issue goes beyond the scope of health equity, though it is the example through which the concept of universalism is analyzed in this work. The issue of blanketed universalism extends to a general question of inclusion and integration of immigrants in Norwegian social policy. To claim universal equality whilst not recognizing ethnocultural diversity, or how people from different backgrounds experience universalism, reinstates a monocultural view of privilege which may contradict the Norwegian ethos of social democracy, and also contribute to segregation within the population.

This of course is one lens through which the fairness of this universal health system can be analyzed. Another important perspective that the enactment of healthcare in practice should be critiqued from is through questioning whether its current approach to health equity can be problematic. More specifically, can this degree of governmental decentralization, and the autonomy of "street-level bureaucrats," itself be viewed as problematic?

TEGRA is an initiative developed in response to a demand, wherein an effort has been made to recognize the diverse maternal health needs of immigrant women. Absence of this program or similar ones, incorporated or accommodated at the central level of health policy in Norway, leaves the responsibility of targeting services and ensuring universalism in practice to primary service providers, such as midwives and health nurses. These actors can be referred to as "street-level bureaucrats," a concept coined by Lipsky (1980), which refers to those actors who use their discretion in amending policy practice: "Street-level bureaucrats in the Nordic states are supposed to implement universalist policies and statutory services within the context of local, democratic institutions" (Vike, 2018, p. 250). In the case of maternal health services for immigrant women in Norway, street-level bureaucrats play a key role in addressing policy shortcomings, by devising grass-root initiatives that tailor general policy recommendations to address the more specific needs of service users. The autonomy of street-level bureaucrats in their role as the 'nuts and bolts' of the policy practice nexus in Norwegian health policy has been fundamental to the continuous expansion and adaptation of social policy to meet the diverse needs of the population. However, this raises a question of whether this is an appropriate and sustainable way to address the challenges of diversity facing Norway's universal social policy.

This approach to universalism certainly has some benefits for health equity, such as providers being able to address the specific needs of service users, however it is simultaneously problematic. Designating street-level bureaucrats to bridge the gaps between the ideal of universalism in policy, to its enactment through practice in their social realities, does not eliminate gaps in central policy and its theoretical underpinnings. Rather, it provides a 'band-aid' solution, where the consequences of this imbalance are most visible, i.e., in municipalities with a high concentration of immigrants. With respect to maternal health initiatives such as TEGRA, the needs of immigrant women in more remote parts of the country without such initiatives are not as explicitly attended to, consequently imposing the service users with a larger burden of personal responsibility to navigate the healthcare system and beyond. Meanwhile, its availability in other regions privileges those immigrants within a specific geographic proximity. This links the argument back to the issue of equality and equity discussed earlier and calls for an examination of the meaning and application of universalism as a concept in Norwegian health policy. The following section dissects universalism as a concept, in order to provide the theoretical framing for the discussion to follow of whether there is a discrepancy between the ideal of universalism and its application in Norway's social reality in section four.

3. Contemporary Deconstruction of Universalism in Norway

Thus far, the article has focused on the inception of universalism and its application in Norwegian health policy. Some issues were raised with respect to the concept's meaning and relation to diversity, equality and equity, using an example of a local health initiative to both problematize and illustrate the different facets of the argument. This section expands its focus to deconstructing the meaning of universalism as a concept and retheorizing its application in Norwegian health policy. In doing so, it offers a critical review of the contemporary implications of universalism in order to position the analysis of universalism in Norway.

To start, universalism can be comprehended as both a simple or a complex concept; where its meaning has evolved from its traditional sense as a redistribution mechanism, to its meaning being context, time, location and discipline bound. When the concept of universalism was coined, its vague definition allowed for interpretation and thus for different stakeholders to appropriate it to suit their purposes at different times (Anttonen, Haikio, & Kolbeinn, 2012). Through the evolution of its application and more scholarly interest in its variance, the concept has been given multiple meanings: "Rather than referring to some single abstract principle, universalism can be seen as a multidimensional concept that refers to a set of principles" (Stefánsson, 2012, p. 42). Below, views of the concept are represented from three different perspectives, beginning with a theoretical overview, going onto an operational presentation, and finally a comparative analysis of universalism as a distribution mechanism.

3.1. Theoretical Overview

Universalism as a theoretical concept is contested. Anttonen et al. (2012, p. 37), explain universalism as a theoretical dichotomy in which, 'universal' refers to a mechanism of redistribution and the type of welfare state, whereas 'universalism' refers to a "particular kind of social ideology." They exemplify this referring to its adoption in the British welfare model as the nature of benefits, and in the Nordic model as a spirit and ideology. Stefánsson (2012) argues instead that from a theoretical perspective, universalism refers to person-state relationships and social inclusion, whereas in a procedural sense it describes a distributive process(es). A simple reiteration of these views can instead maintain that universalism can be used to define policy aims or instruments, one outlook emphasizing a theoretical ideology and the latter practicality or processes of distribution. This distinction is exemplified in Table 1.

Table 1. Universalism as policy aim compared to universalism as policy instrument.

Theoretical dichotomy	Universalism of policy aims	Universalism of policy instruments
Central dogma	Universalism as a social ideology	Universalism as an operational principle
Focus	Person-state relationship and social inclusion (Stefánsson, 2012)	Mechanism of distribution (Stefánsson, 2012)
Effect	Consequentialist (Anttonen et al., 2012)	Procedural (Anttonen et al., 2012)
Example	Nordic universalism	British universalism

Universalism, a complex theory, cannot only be described as a mutually exclusive dichotomy, as presented in Table 1. For the universalism of policy instruments to come about, some underlying universalist ideology is prerequisite; likewise, for the translation of universal policy aims, policy instruments require awareness of and operation within a universalist frame. One might argue, rather, that the theory of universalism exists on a continuum. Though universalism forms the underpinning ideology of welfare policy in Norway, Norwegian universalism cannot be distilled to emphasize only an ideology, or the universalism of policy aims and of social inclusion. Universalism in Norway is also an applied policy approach or instrument for the redistribution of social and welfare services across the country. In a comparative example, the UK policy framework predominately presents universalism as a redistribution mechanism (Anttonen et al., 2012). Though a degree of universal ideology exists, the focus in the UK is on the application of universalism as an operational principle for some services such as primary education and healthcare, as opposed to a political ideology encompassing all public services as in Norway.

This variation in characterization also continues in the application of universalism, where varieties of universalism coexist both at an institutional level and at the practice level, and where "each dimension of universalism is a matter of degree not a dichotomy" (Anttonen et al., 2012, p. 189). Scholarship thus emphasizes that the universality of programs lies on a spectrum of universalism in both its theoretical ideology and its practical application. The following subsection therefore examines different types of universalism on this continuum.

3.2. Operational Presentation

To begin, Carey and Crammond (2017) provide an operational definition of universalism by dividing the concept into two broad institutional approaches based on how a government defines service provision, i.e., general or specific universalism. They describe 'general universalism' as a type of universalism where "flat-rate benefits are applied to all, irrespective of citizenship, class, means or need" (Carey & Crammond, 2017, p. 304); whereas 'specific universalism' "supports free, universal availability of public services…to all on the basis of citizenship (though it does not necessarily guarantee universal access)," and "goes beyond flat-rate benefits in an attempt to redress existing inequalities" (Carey & Crammond, 2017, p. 305). This is presented in Table 2.

The concept of selectivism can be applied within the framework of specific universalism, where the definition and scope of social benefits still tend toward broad definition based on a general concept of common good. Selectivism differs from residualism, whereby benefits are not only targeted to the poor, and is concerned with targeting services to population subgroups based on their needs. Some scholars argue that like residualism, selectivism does not fit within the framework of universalism because it is not all inclusive and thus discriminatory (Anttonen & Sipilä, 2012). However, Carey and

Table 2. Operational overview of universalism as institutional approaches. Adapted from Carey and Crammond (2017).

Institutional approaches	General universalism	Specific universalism
Rationale	Protection of the population through flat-rate benefits for everyone	Universal social benefits to promote social rights and social equality
Examples	Infectious disease control and sanitation	Public health insurance; public schools
Eligibility	Impartial distribution to the entire population	Based on citizenship
Limitations	Can only be applied in certain contexts where the need triumphs above social, political and economic barriers.	Though there is more targeting, this type of universalism still too general as it overlooks sociocultural diversity and does not therefore guarantee equal benefit within society because it impartially favors predominant social norms.

Crammond (2017, p. 304) argue for selectivism within the frame of universalism, explaining that "while universalism is regarded as a precondition of equality, it does little to promote redistribution and ignores existing inequalities." Thus, a degree of targeting or tailoring of services is required within a proportionate application of universalism to achieve health equity (Carey & Crammond, 2017; Carey, Crammond, & de Leeuw, 2015).

Selectivism is further subdivided into two categories, positive and negative (Carey et al., 2015; see Figure 2). Within a universal system, positive selectivism addresses the specific needs of particular groups through a decentralized model of welfare governance, where without any means-testing schemes, "state funded agencies embedded in communities are sensitive to, and can cater for, difference and diversity" (Carey & Crammond, 2017, p. 305). Examples include programs, such as that of TEGRA illustrated in section two, that offer additional support within a public system to specific groups based on their needs. Negative selectivism however, "targets the provision of services and assistance on the basis of individual means (i.e., using means-testing) within a universal framework" (Carey & Crammond, 2017, p. 305). This type of targeted universalism is often argued to be stigmatizing because it is susceptible to defining disadvantage on the basis of means testing. Finally, there exists the notion of particularism, which is at the opposite end of general universalism on the impartiality scale, as it profoundly emphasizes recognition of all types of diversity in society and consumer choice in tailoring government services. In other words, particularism is a very individualized system and the antithesis of universalism's collectivist underpinnings, with a high degree of targeting at the cost of a high degree of impartiality or eligibility criteria. Figure 2 below represents these different distribution methods relative to their degree of impartiality and targeting.

The breakdown of universalism as theoretical and operational constructs, or as policy aims and policy instruments, sets the analytic framework for investigating universalism in Norwegian health policy. Bringing together this conceptual framework with the example of TEGRA in section two, the types of universalisms at play in Norwegian health policy can be extrapolated by analyzing the nuances surrounding this issue's policy and practice nexus.

4. Discussion

This article has examined the policy and practice of universalism in Norway, posing the question: How much inequality in policy instruments can a universalist welfare state tolerate in its pursuit of equity? This section synthesizes the various discussions on the topic thus far and reflects on both the adoption and application of universalism in Norway, offers suggestions for retheorization of the concept, and makes recommendations for policy and further research.

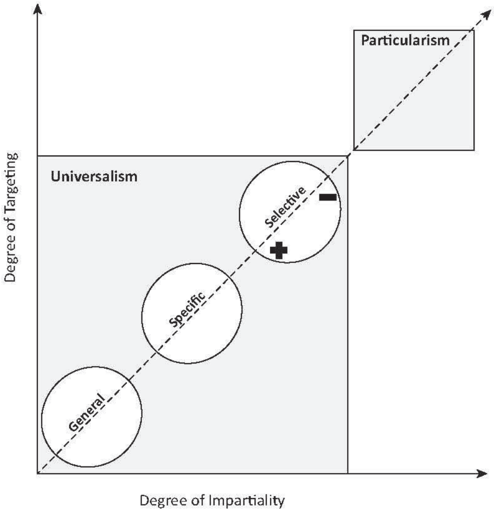

Figure 2. Universal benefit distribution based on degrees of impartiality and targeting. Adapted from Carey and Crammond (2017).

4.1. Reflections on Norwegian Universalism

Norway's approach to social policy aims strongly resonates with a generic notion of universalism, particularly, that of specific universalism, where the only eligibility criterion is legal residency status (Table 2). This simplistic and all-encompassing definition traces back to the principle's historical foundations. Meanwhile, in the implementation of its policy instruments, i.e., governance of distribution, and particularly healthcare, Norway's decentralized approach allows for a great degree of malleability. This enables different localities in the country to adopt various methods of redistribution and service provision within the frame of the central general government guidelines. Targeted programs that operate in addition and or in parallel to standard services for at risk or minority populations, who due to various factors may otherwise be impeded from benefiting from these services, are included here.

There are of course benefits to geographic localized targeting, the major one being cost savings, i.e., not spending on programs that are not uniformly needed across the country. The second benefit of this approach is the autonomy and the flexibility it gives municipalities and street-level bureaucrats to design and offer relevant programs within the scope of national requirements, as programs can be continuously launched and altered to meet local demands. This ties in with another benefit of small-scale local projects, their ability to circumvent bureaucratic hurdles.

Nevertheless, there are less favorable aspects to this approach. To begin, though needs may vary within a diverse population, the fact that many social and health needs are universal cannot be discredited; therefore, it is flawed to assume that a health disparity linked to ethnocultural diversity is only specific to a single municipality. It may be that some social challenges or needs are more visible or frequent in some parts of Norway due to demographic variables such as its immigrant population, average age, unemployment status, and more; yet they cannot suppose the regional specificity of these problems. Secondly, local programs may be cost effective in the short run; however, such needs often persist and grow in a population, and thus in the long run, and in lieu of systematic programs collectively targeting the common needs of a particular populations, the burden will fall on individual service providers and service users, resulting in the consumption of more time and resources. Likewise, in the absence of a standardized audited protocol, the effectiveness of the latter scenario may vary extensively from one provider to another. Hence, not only can this be financially costly to the system, it can also challenge the service providers and affect the quality of care they provide.

The selectivist approach to universalism, adopted to address the gaps inherent to this policy aim in the enactment of policy instruments, brings about yet another set of challenges. The case of TEGRA presents a 'positive selectivist' approach to targeting of services to immigrant women, wherein "positive selectivism aims to provide additional services and resources for certain groups on the basis of needs (e.g., without means testing)" by being more sensitive to difference and catering to diversity (Carey & Crammond, 2017, p. 305). Although at first glance, this seems like an equitable approach to distribution, even within this framework, the needs of beneficiaries are potentially defined homogenously through the lens of those in power, the mostly ethnically Norwegian primary care providers. Programs developed based on what the service providers assume a specific group of the recipients' needs to be can unconsciously counter their positive intentions of addressing different needs of the population (Carey & Crammond, 2017). This argument also questions the degree of choice that can be tolerated in a universal welfare system, and hence distilled into the paradigm of new public management; nevertheless, this article's scope is limited to merely signaling these possibilities.

4.2. Recommendations for Policy and Research

In asking whether the systematic targeting of services should be incorporated at the national level within the frame of universal social policies, it is argued that local initiatives targeting universal benefits through positive selectivist measures, should be audited by the municipality. If they are running as a formal function locally, they should then be audited by national authorities such as the Directorate of Health, and they should meet certain standards to ensure service users' satisfaction, or contribute to statistical improvements of dependent variables, such as better maternal and birth outcomes. Furthermore, there should be more dialogue between service providers and policy makers as to why these programs are beneficial, and whether and how they could be incorporated nationally to benefit more people. TEGRA's example shows that such programs respond to a common need or demand in addition to health promotion and preventive care, and that participation in such programs can improve the cultural health capital of immigrant women. Shim (2010, p. 1) defines cultural health capital as "the repertoire of cultural skills, verbal and non-verbal competencies, attitudes and behaviors and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal healthcare relationships." Participation in such programs expands benefits beyond a specific service by giving service users the knowledge, tools, and skills to navigate the system, and to mobilize and optimize the healthcare opportunities to which they are entitled. The question remains of why the systematic targeting of services, especially in cases where they have been tried and tested, is not incorporated nationally.

To summarize this conceptual review of universalism, the principle of universalism is loosely defined in Norwegian health policy, and in its current form, it cannot deliver to its ideals in practice. The principle, as it stands today, is a vague amalgamation of its nuances as a theoretical ideal from the time of its inception in the Norwegian welfare state, and of its locally defined and applied definitions as a principle for practice: "The conceptual history of universalism would appear to be closely linked with the making of social policy" (Anttonen & Sipilä, 2012, p. 37). While providing the foundations for constructing a welfare system with social democratic ideals and reflecting a collective interest in a common good, there are now greater expectations from the modern welfare state, and the needs it must cater to are wider in scope and variety than at its inception. Socio-political changes, population growth, aging population and more ethnocultural diversification impose new challenges on the universal policies of the welfare state, specifically on what those policies ought to imply beyond their theoretical shell of policy aims, and in practice as well.

In Norway, the burden of bridging the gap between the ideal of universalism in policy, versus its enactment at the service delivery level, is currently left to public service agents. However, without the formal recognition of these shortcomings at the national level, the paradox of the equality demanded by universalism and the equity demanded by diversity also remains.

Through providing 'equal' treatment or access to different groups, the thought in many universalistic welfare states, such as Norway, at least from a historical standpoint that remains deeply embedded in policy today, is that equality will result. However, "welfare scholars argue that many states which have been described as 'universal,' exclude certain groups by virtue of viewing populations as homogenous" (Carey & Crammond, 2017, p. 304). This indicates a problem with the sameness in treatment, as in the model of specific universalism adopted in Norwegian health policy, as assuming an impartial solution to provision can be insensitive to some people's needs and ability to access services, especially those whose needs fall outside the margins of the dominant society and culture. As stated earlier, though the core principle of universalism is considered prerequisite to achieving equality, in its application, when differences among individuals and their needs are overlooked, it consequently results in countering its objectives of equal distribution or opportunity (Carey & Crammond, 2017). To therefore ensure equality, differences must be considered and, with that, "to be sensitive to differences in need, Dworkin's theory of equality argued that individuals must be treated differently" (Carey & Crammond, 2017, p. 304). In the case of migrant maternal healthcare in Norway, notions of universalism in the distribution of maternal healthcare may obscure social diversity, because notions of good practice and understandings of diverse needs may vary across and within different localities.

Nevertheless, targeting services and redefining universalism with a felt-tipped pen in order to make it truly 'universal,' both in theory and practice, leads to the important question, posed by Carey and Crammond (2017, p. 304) of "how much diversity should policies and programs seek to encompass." More specifically, this leads to the central analytical question of this article: How much inequality in policy instruments can a universalist welfare state tolerate in the pursuit of equity?

Perhaps the answer to these questions lies beyond universalism, or perhaps it requires a more nuanced articulation of universalism. The reconsideration of social policy, including health policy in Norway does not require a total redefinition, rather it requires a rethinking and clarification of the conceptualization of universalism and its implications. Most certainly, "universalism is not a panacea" (Anttonen et al., 2012, p. 187) and there will always be shortcomings. But fine-tuning the theory, and its consequences in practice, can reduce some of the discrepancy the concept carries between equality and equity in Norwegian social policy. Despite some gray areas, Norwegian health policy remains one of the most comprehensive and successful health systems in the world. However, to uphold this status, it requires a more systematic and pragmatic approach to dealing with change, especially concerning its increasingly diverse ethnocultural population. The emphasis in Norwegian health policy should therefore go beyond the eligibility issues, i.e., specific universalism (Table 2), to how to be more inclusive and efficient in addressing the different needs of the population it covers, i.e., through positive selectivism. There needs to be recognition at the national level that, "citizenship is an equal status for all citizens but affects them differently" (Stefánsson, 2012, p. 62), which is true of universalism as well in that not everyone experiences it the same way. This primarily requires the problematization of this issue and its shortcomings in policy. Secondly, the engagement of service users from the population's minority groups and their collaboration with service providers and policy makers can enhance the understanding and accommodation of their particular needs.

The key for answering the article's analytical question is not in the invention of a barometer to measure the capacity of universalist policy aims in tolerating inequality of treatments through universal policy instruments in the pursuit of equity, but in exploring whether there is at all a capacity within this social policy framework to dissect the nuances of universalism as a concept in theory and in practice. This is undoubtedly a mammoth task, but through the theoretical analysis of health policy in Norway, and the concept of universalism, this article means to initiate this process and spark further discussion and research.

5. Conclusion

This article reflected on the concept of universalism in social policy, to challenge its orthodox notions of idealism and equality with the questions of change and diversity, within the frame of health equity in Norway. Labeling

Norway's health system as universalist, prompted a dissection of the concept as adopted and applied through an example of its enactment to explore the implications of universalism in this system, and whether and how a gap between policy and practice is bridged.

Despite the analyses and recommendations presented in this article, the overarching issue of whether universalism is a sustainable approach to health equity remains. The balance of equality and equity is sensitive within universalism, where too much emphasis on equality can overlook intricate effects of equity, and likewise, too much focus on equity may overthrow the notion of equality altogether. Absolute equity is a utopian ideal, and Norway's universal welfare system will unavoidably result in some degree of inequity within the population, as universalism as a theory or policy aim is inherently limited by its collectivist nature. Notwithstanding this barrier, a balance between equity and equality could be achieved in Norway's health policy through the collaboration of service users, service providers and policymakers in reevaluating policy measures and devising a more nuanced application of universalism in accordance to the diversifying needs of contemporary Norwegian society.

Acknowledgments

First and foremost, I thank all the reviewers and editors involved in the revisions of this work for *Social Inclusion* for their valuable feedback. Furthermore, I extend my gratitude to my doctoral supervisors, Professor Trude Karine Olaug Gjernes at Nord University and Dr. Susan Young at the University of Western Australia for their continued guidance and assistance. Finally, I thank Dr. Jessica Allen Hanssen at Nord University for her input and proofreading of this article.

Conflict of Interests

The author declares no conflict of interests.

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About the Author

Lydia Mehrara is a PhD Candidate in Sociology at Nord University, Bodø, Norway. Her doctoral project examines the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women across the country. It applies a sociological perspective to the equity and equality debate within the context of universalism by focusing on maternal health services for immigrant women as a representation of this dynamic, from both the macro (system) and micro (individual) dimensions.

Article 3[8]

Immigrant Women's Experiences with Norwegian Maternal Health Services: implications for policy and practice

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[8] Mehrara, L., Olaug Gjernes, T. K., & Young, S. (2022). Immigrant women's experiences with Norwegian maternal health services: implications for policy and practice. *International Journal of Qualitative Studies on Health and Well-being*, *17*(1), 2066256. https://doi.org/10.1080/17482631.2022.2066256

Abstract

Purpose: Navigating a health system which differs considerably from one's own can be a difficult and challenging process. Navigating this in seeking maternal health care can be additionally daunting. This article explores how immigrant women from diverse countries and ethnic backgrounds in Norway experienced and navigated the Norwegian maternal health service during pregnancy and childbirth.

Method: Eleven semi-structured interviews informed this analysis.

Findings: Principles of universalism underpinning all social and health policy in Norway expect equality of service provision and access. Necessarily, these principles result in less individual choice and decision making. The women in this study found these contrary to what they were used to but responded differently, with some experiencing the health provision as liberating while others distrusted that they were receiving the best care. A focus of concern was the expectation of more medicalized services. While some of these women used their own resources to circumvent the Norwegian health provisions, the implications for the health system extend beyond these women's experiences.

Conclusions: The analysis suggests a need to encourage those whose expectations of care differ to build trust in institutions providing care. This article contributes to knowledge on the implications of diversity on Norway's universal health system.

Keywords

childbirth; immigrant women; maternal health; medicalization; Norway; pregnancy; universalism

Introduction

This article explores the experiences of several immigrant women from diverse cultural backgrounds with the Norwegian maternity health care model during their pregnancies and births. When mothers encounter a new maternity care system that is culturally and organizationally different from what they are used to, it may affect their interaction with the health professionals and result in undesirable experiences (Ladha, Zubairi, Hunter, Audcent, & Johnstone, 2018, p. 66). Studies from Sweden and Finland, which have health care systems similar to Norway, indicate that immigrant women are more vulnerable to the risk of adverse pregnancy outcomes and poorer experiences with the maternity care services because of cultural sensitivity or communication issues compared to native-born women (Degni, Suominen, El Ansari, Vehviläinen-Julkunen, & Essen, 2014; Råssjö, Byrskog, Samir, & Klingberg-Allvin, 2013).

Over the past decade, research focus on the health integration of immigrants in Norway has increased (Næss, 2019), exploring the differential health outcomes and health care utilization patterns of immigrants. Most of the available research on migrant health in Norway focuses on problems of immigrants' access to and their utilization of the health care system in general (Mbanya, Terragni, Gele, Diaz, & Kumar, 2019; Næss, 2019). Research addressing the niche of migrant maternal health has mainly concluded that cultural diversity poses a challenge for the current Norwegian maternity care model (Lyberg, Viken, Haruna, & Severinsson, 2012). Other Norwegian studies on migrant maternal health address topics such as: nutrition (Garnweidner, Sverre Pettersen, & Mosdøl, 2013); domestic violence (Garnweidner-Holme, Lukasse, Solheim, &

Henriksen, 2017); post-natal feeding practices (Wandel et al., 2016); risk of stillbirth (Vik et al. (2019); and migrant women's experiences and perceptions of services (Egge, Kvellestad, & Galvin, 2018; Glavin & Sæteren, 2016; Herrero-Arias, Ortiz-Barreda, & Carrasco-Portiño, 2020; Viken, Lyberg, & Severinsson, 2015). This study adds to the body of research by exploring how immigrant women experience and navigate the Norwegian Maternal Health Service (hereafter: NMHS) during pregnancy and childbirth.

The maternity health system in Norway

Norway's social policy is founded on principles of universalism which require that everyone in society has equal entitlement to receive social goods, such as health and education. One of the definitions of universalism identifies the absence of means testing or differentiating between rights and needs (Rothstein, 1998). According to this definition, services therefore are available to all, but they are available in a standardized and uniform way, 'embracing the entire citizenry… without the application of economic needs-testing' (Rothstein, 1998, p. 20). The standardized nature of universal welfare provisions may seem rigid because they can be less adaptable to individual desires and demands in comparison to more privatized systems (Rothstein, 1998). More interested in the links between government and its citizens through universal policy, Rothstein further makes the links between institutional trust and the generation of social capital (Rothstein & Stolle, 2003), and the role played by 'street-level bureaucrats' as both impartial and conduits of social trust (Rothstein & Stolle, 2001) through what he terms 'ethical universalism' as a mechanism for a fairer and more just society (Uslaner & Rothstein, 2016).

The general structure and scope of maternal health services and delivery is universal across Norway, meaning that all pregnant women regardless of legal residency status are entitled to equal maternal health services. The NMHS in this study refers to the health services provided to a woman during pregnancy and childbirth by a doctor, midwife, and/or nurse at a community health center (*Helsestasjon* in Norwegian) or hospital. Maternal health care in Norway is offered at two organizational and professional levels; 'specialized doctors at hospitals and general practitioners in municipalities perform maternity care services in cooperation with midwives on both care levels' (Gamst, 2012, p. 3). Although historically, general practitioners (GPs) were primary maternal health care providers, reforms beginning in the 1970s gradually shifted this responsibility to midwives to improve birth outcomes, and 'from 1995 municipalities were bound by law to offer midwifery services' (Gamst, 2012, p. 4).

Midwives in Norway are specialized nurses (Lukasse, Lilleengen, Fylkesnes, & Henriksen, 2017). Today, maternal health services are mainly delivered by midwives at community health centers. A combination of antenatal consultations with a midwife and a GP is recommended in national clinical guidelines (Synne Holan, Mariann Mathiesen, & Kirsten Petersen, 2005); however, women can choose who they want as their maternal health care provider. Midwives at the community health center carry out most antenatal check-ups except ultrasounds, which are done at a hospital (Lukasse et al., 2017). Pregnant women are either referred to their community health center by their primary care physician or they contact the centers directly to register themselves and make an appointment with a midwife. If the pregnancy is normal, the women continue to see their midwives. If the pregnancy is high risk, or if complications occur, the woman is referred to a gynecologist or other relevant specialists for additional surveillance. Most births take place in hospitals in Norway with very few home births (Lukasse et al., 2017) and midwives at obstetric hospital wards have a prominent role in births, unless the pregnancies and subsequent births are deemed high risk. Women can give birth in the hospital with or without non-medical pain relief options, water births, and hotel stays after birth if the birth is not high risk. In the case that there is risk, pregnant women are taken to medically equipped obstetric wards for assisted birth and caesareans. According to Dahlberg et al. (2016), the midwives have an important role in helping women towards a normal birth, promoting the women's own capacity to handle the birth, and to have a positive birth experience.

Methods

A qualitative study design was adopted to gain a detailed understanding of immigrant mothers' experiences and reflections. Following ethics approval from the Norwegian Social Science Data Services (NSD-234675), purposive sampling was used to recruit eleven immigrant women. The eventual sample comprised women from nine different ethnic and cultural backgrounds who had carried out their pregnancy and birth in Norway. The interviewees were recruited from public kindergartens and community health centers in two Norwegian municipalities with a high population of people with immigrant backgrounds.

Overview of participants

The eleven immigrant women who participated in this study were ethnically and culturally diverse, had different reasons for immigration to Norway, length of residence in Norway, education level, and language proficiency in Norwegian and English. All interviewees were university educated and communicative in English despite being from different countries. This sample is therefore not representative of the most vulnerable population of immigrant women in Norway.

Data collection

Once written and verbal consent to participate were obtained from the immigrant mothers, semi-structured interviews were conducted by the first author between October 2019 and March

2020, in person, by telephone, and online via Skype. The in-person interviews were conducted at the place of the interviewee's liking, which was mostly in public kindergartens with their attending children, in their homes, or in cafes. The interviews ranged from thirty minutes to two hours in length and were carried out in three languages - nine in English and two in the participants' own languages, Farsi and Kurdish, in which the first author is fully proficient. Biographic details were collected before the immigrant women were asked to recount their experiences of navigating and negotiating the NMHS during their pregnancies and births. Despite their diversity, there was a notable commonality in their experiences.

Data processing

The interviews were audio-recorded and transcribed verbatim by the first author. To protect the participants' confidentiality, all were given pseudonyms, and identifying details were anonymized after transcription. The data were analyzed using thematic analysis (Braun & Clarke, 2006). The transcribed interviews were read carefully several times, commented on, and inductively coded. Pertinent themes were reviewed and conceptualized against literature with the second and third authors in the process of writing this article.

Data

Issues identified in these narratives related to the women's expectations of the services they should and did receive, comments on whether these expectations were met, and if not, why. The women reflected on the differences and similarities to their home countries and how they navigated this new system. Some did this successfully, other less so. Communication between the women and the health professionals was identified as very important. These reflections covered the antenatal care and monitoring provided during their pregnancies, and their experiences immediately preceding and during birth.

Findings

The community health centers were the first contact with the Norwegian health care system for many of the immigrant women interviewed, at which point most of them had little knowledge about the Norwegian health care and maternity care system. Furthermore, many of these women had not yet developed sufficient Norwegian language skills, were not in the workforce, and had not established a social network in Norway. All the mothers gave birth in hospital, with most giving birth within the first two years of their immigration to Norway. Their experiences on the navigation and negotiation of the NMHS are presented in this section under the headings of: approach to pregnancy; monitoring and follow-ups; approach to birth; and communication during labor.

Approach to pregnancy

Some women felt that the approach to pregnancy in Norway was empowering. Zara from India was surprised that she was not asked to change her lifestyle during pregnancy. She was instead encouraged to continue with her regular work activities and to exercise, which enabled her to maintain her independence throughout her pregnancy. She would not have been able to enjoy the same freedom if she were pregnant in India because of different cultural expectations about how pregnant women within her social group should behave. She said:

> Yeah, it is totally different [here]. In India, I would say there is more pampering. Here, it's, 'do whatever you like and keep doing what you did'. I am like an independent woman and like this [Norwegian] system very much than that one [in India]. Because there they would say, 'oh, you're pregnant, do not do this or that,' haha. But here, if you like jogging, you can jog, you can play, you can swim, you're totally free… Here, you're free as a bird!

The Indian mother appreciated the freedom permitted in Norway, where a normal pregnancy is not considered as a particular risk to women or treated as a medical condition.

Another mother, Samantha from Serbia, also commented on the difference in birth perception in her home country compared to Norway. She was surprised by the different services available during the birth process, and noted the calmness of the birth environment, stating:

> Everything was good. The midwives … they told me I could relax, I could take a bath … in my country, when you go into labor, there is no eating until you give birth. But here, you get dinner... It was a very good experience.

The Indian and Serbian mothers both focused on some differences in the approach to birth from their home countries which they considered positive and liberating.

Monitoring and follow-ups

One aspect of the NMHS several interviewees found worrying and frustrating was the perceived lack of monitoring and follow-up during pregnancy. The relatively natural and hands-off approach to maternity care was criticized. These women did not all have complicated or high-risk pregnancies but felt that this approach made them anxious and insecure.

Patricia from Indonesia compared NMHS with the services provided in Indonesia, where ultrasounds, for example, are undertaken monthly for paying patients, whereas in Norway, typically one ultrasound is taken between weeks 17-19 (The Knowledge Centre for Health Services, 2008). She was comparing two very different systems, reflective of differing policy frameworks and representing different user characteristics in willingness and ability to pay for private services. Nevertheless, the difference made her nervous.

> You get curious. 'Is the baby okay? Is it no okay?', you know, just waiting for that first ultrasound [in Norway] seems like a very, very long time. You really want to know [how the pregnancy is going].

Cindy, a Chinese mother, had her first baby in her home country and her second in Norway. She explained her dissatisfaction with the monitoring and follow-ups by comparing the two broader welfare systems. She suggested that the Norwegian system of minimal antenatal scans may be explained by the welfare system:

> In Norway they think, it doesn't matter if you have a normal healthy baby or not, because post-birth support is available. Whereas in China, if something is wrong with the baby, the government doesn't have the benefit to support you.

In her opinion, Norway, as a wealthy country with generous universal welfare provisions, could support families and their children if they had special needs; therefore, she posited that the NMHS did not prioritize detecting risks as extensively or as early in pregnancy as in China, whose welfare system relies on the assumptions of collectivist and familial provisions.

Merve from Germany experienced multiple late-term miscarriages in Norway. She believed they could have been prevented if the NMHS and maternal health care providers had observed her more closely during pregnancy. Believing her two miscarriages were caused by infrequent antenatal check-ups and being told there was nothing more that could be done except, '*you have high blood pressure, there is nothing we can do for you. So, wait at home. We will look again*', she decided for her next pregnancy to have her baby in Germany, where she birthed a healthy child. She noted:

> The medical [advice] they gave here [Norway] was different. The medicine that I was given here, I showed to my gynecologist in Germany, and she said no pregnant woman can get this. We stopped this in Germany 30 years ago. So… I understand that in this way Norway is behind 30 years maybe...

This mother criticized the Norwegian approach to pregnancy as laidback, and she was dissatisfied with her experiences. She did not trust the NMHS and its care providers' competence in dealing with high-risk pregnancies. She found the uniform treatment and emphasis on the normality of pregnancy and birth as reasons to blame for her late-term miscarriages. Her distrust of the NMHS was justified when she moved back to Germany for closer antenatal monitoring during her third pregnancy and gave birth to a healthy baby.

Zara from India explained how she handled uncertainty during pregnancy. She consulted her sister-in-law, who is a doctor in India, and stated that '*she forced me and my husband to take a scan, like ultrasound, and confirm everything is okay, whether the baby has formed in a proper way*'. The Norwegian system only provides scans between the 17th and 19th weeks (The Knowledge Centre for Health Services, 2008), and she visited a private clinic in Norway and paid for the scan at 8 weeks. She continued:

> I had very heavy vomiting, so I consulted the doctor and asked for tablets, but here they said no tablets… so I got the medicine from my sister in-law in India to subside the vomiting. That was helpful.

This mother's experience illustrates her proactivity in bridging the gap between her expectations of maternal health care, which was not only shaped but continually influenced by medical practice and advice from her social network in her home country.

Approach to birth

Birth was described as a challenging event by all the mothers. The two main contributing issues were linked to the degree of medical intervention and communication with health care professionals. These are presented in order. Excerpts from the interviews illustrate how discrepancies between the women's ideal birth plans and the standard Norwegian birth approach were managed.

The degree of birth medicalization in the NMHS posed dilemmas for some mothers in their birth plans. Many of the participants came from cultures where they described birth by C-section as a more common elective option in private health care settings compared to Norway. Although some of the mothers expressed a desire for more medical intervention during their pregnancy and labor, some acknowledged a developing confidence in the Norwegian system. Consultations with midwives contributed to their acceptance about their body's capability in the birth process.

Melika from Iran illustrates this growing confidence. At first, she wanted a highly medicalized birth, stating it was important for her to be able to '*see monitors and wires*' to put her mind '*at ease*'. But she formed a trusting relationship with her midwife, who gained her confidence in the NMHS and encouraged her to consider a natural birth.

> I had researched caesarean birth, but I can say that it was my [Middle Eastern] midwife's reassurance about my ability to give birth naturally because I had wide hips etcetera, that convinced me to go through with it. So that's why I decided to forget about caesarean. Of course, this was against my mom's advice, because she believed that I was physically too weak to push a baby out - and she was right, I have never been

> athletic or strong - but because research has shown that natural birth is better for the baby and the mom, I decided to accept the risk and do it.

When her birth was delayed, she was told that baby's head had grown too big and that natural birth may be too difficult, but she insisted on going through with it, saying:

> I have prepared myself for natural birth and will only do an operation if I can't handle it. The hospital contacted me to ask what I wanted to do, and I explained that I wanted to go through with natural birth and only have a caesarean birth if there were complications.

Benyamini, Molcho, Dan, Gozlan, and Preis (2017), found that 'the feeling of fear could lead to an appreciation of birth medicalization'. Melika perceived pregnancy and birth as a risky period that needed constant monitoring. Consequently, she thought of technology as a safe and reassuring way of handling risk during childbirth, which would give her a sense of security. Her shift in mindset was facilitated by trust in her health care provider as well as her own research into the topic.

Another mother, Parisa from Iran, also faced conflicting expectations between having a heavily medicalized birth and encouragement to have a natural birth. She felt pressured by the standardized Norwegian approach to birth, and doubted her ability to give birth naturally, while the emphasis on a natural birth in this system made her doubt its competency in performing caesareans and managing complicated births. Her pregnancy experience caused alarm as there was the possibility of a breech birth, which at the end did not occur. This enabled her to regain some confidence in the NMHS, stating: '*they have experience with all sorts of complications during natural birth, and so they are confident that even if the baby is breech, they will do a better and* *safer job birthing the baby rather than doing a C-section. So, their confidence is quite high in this regard*'. Her perceptions of the NMHS were influenced by her friends' negative experiences with complicated births in Norway. Parisa would have liked the opportunity to choose her birth plan rather than be convinced to trust the natural birth process. There is evidently a tension between the two models.

> Unlike the medical model, the midwifery model [here, the more 'natural' model] consistently sees the needs of the mother and the fetus as being in harmony, the two as one "organic unit" and posits that both pregnancy and childbirth are "health and entirely normal condition[s]". (Simonds et al., as cited in Brubaker & Dillaway, 2009, p. 37)

This model of maternity care is 'woman centered and holistic' (Brubaker & Dillaway, 2009, p. 37), meaning that the midwives try not to intervene, and rather attempt to empower the mother to take control of the pregnancy. However, Parisa interpreted this model as more prone to risk, yet was convinced that because of the emphasis on this approach, care providers would be more skilled in managing complications than performing a more medical birth. Hence, she compromised her wish for a medicalized birth with more trust in the capability of professionals.

Communication during labor

Communication rather than language played an important role in shaping the women's experiences during labor and birth. Several of the mothers experienced poor communication from their health care providers.

Natasha from Israel had a difficult pregnancy and gave birth prematurely. When she went to the hospital, she was given medication to stop the labor; however, this was ineffective. She went into labor at 24 weeks, which is considered an extreme preterm birth that would require lifesaving support (Syltern, Markestad, Saugstad, & Støen, 2018). She stated that her care providers at the hospital were making plans about her baby's resuscitation before her birth without involving her in the process.

> I wanted to keep the baby inside. They [maternal health care providers] had something else in their mind… I didn't know they were preparing me to give birth for two days until I was transferred to give birth … I even let my husband leave the hospital not knowing I was going to be induced soon. He didn't know what was happening either, even though he is Norwegian.
>
> 'Where [are] you take[ing] me? Where is the doctor?' That's what I was saying to the nurses. 'Don't worry… you just need to relax' [the nurses said] ...They didn't tell me that I was going to give birth we didn't know what was happening… Oh, now I'm emotional … that was hard.

Implicit in this Israeli mother's description of the birth is the lack of meaningful communication. She felt that she was not informed about decisions that were made about her and that she was treated as a passive participant. What is experienced as inadequate communication here is possibly related to the perceived locus of expertise, which resides with the medical practitioners, not the mother, father, or other patients. This is a consequence of increased medicalization of the pregnancy and birth process. This experience contrasts with the perceived under-medicalization of the NMHS by the other interviewees.

Shania from Canada also experienced challenges with communication during labor. She was surprised that she would not have one constant midwife who would follow her throughout pregnancy and birth, as was common in her country. She said, '*it's a nice idea to think you have one person who follows you before the pregnancy, is there for your birth and follows you after*'.

She assumed that the communication between the woman giving birth and midwives would be better if they had already established a relation before the birth, as had Melika, and that the midwife at birth would be better acquainted with the patient. In Norway, several different midwives may be involved during a woman's pregnancy and birth. One of her aims for her labor was to manage without epidural pain relief. She found that because she had not asked for it at the beginning of her labor, it was not provided to her when she eventually asked for it. She reflects: '*I would advise any future women giving birth in Norway who are apprehensive, if they want an epidural, they better ask for it right away!*' She identified part of the issue as the poor interaction and communication between her and the changing midwives during her labor about the labor process.

Discussion

The women's narratives raise several issues. The expectations the women had of their interactions with the professionals and the provisions of the health services were largely influenced by their knowledge of the systems and practices in their home countries. The interviewees in this study came from different countries and had diverse cultural backgrounds. They brought with them knowledge and ideal expectations of the types of care they wanted to receive during maternity which were shaped by their backgrounds and sociocultural positions. All the women had little knowledge of the NMHS. They were also coming into a system shaped by the principles of universalism which differed considerably from the guiding principles for the provision of health care in their own countries. For some women, having additional resources such as material wealth as well as professional and family networks that could be marshalled made a difference to their experiences. These were used to either enhance or bypass the Norwegian provisions. Some of the women experienced significant tension related to their expectations of highly medically supported or directed pregnancies and births. While the medical profession is central to maternity care in Norway, it is also expected that birth should be as natural as possible. The idea of pregnancy and birth as carrying unacceptable risk without medical intervention was uppermost for some women who sought certainty and control. For some, this influenced the extent of their satisfaction with the Norwegian health system. Therefore, how these women experienced the Norwegian maternity care varied. While some were able to compensate for the discrepancies between what they perceived to be on offer of the NMHS and their expectations of maternity care, others had to adapt. The differences in the Norwegian approach to maternity care subsequently caused positive responses as well as anxiety, frustrations, and even changes in these women's perceptions of maternity care. These experiences are analyzed as consequences of medicalization, membership in and use of social networks, and their participation in decision making. These discussions are presented in order.

Experiences of under-medicalization

Peter Conrad (2013) defines medicalization as 'the process by which former nonmedical problems become defined and treated as medical problems, usually as diseases or disorders' (p.196). Many countries' maternity health care systems have become increasingly medicalized, affecting how pregnancy and birth are treated. Advances in biomedicine and technology changed pregnancy and childbirth significantly during the 20th century, creating a shift from the home to the hospital (Riessman, 1983), taking pregnancy and birth from a natural process to a medical event (Prosen & Krajnc, 2013). These advances allowed for closer surveillance and control of pregnancy and birth (Prosen & Krajnc, 2013), and significantly decreased mortality rates for mother and baby. The medicalization of maternity today entails antenatal screenings, the use of epidurals, birth by caesarean and the like. Consequently, pregnancy and birth have been reconceptualized as a result of increased medicalization from a ‘natural, normal, woman-centered event’ to ‘a dangerous time wherein a woman and her fetus are at risk and in need of constant medical monitoring and intervention’ (Parry, 2008, p. 785).

Brubaker and Dillaway (2009) state that the natural birth approach denies women choice and agency, ‘essentializes’ women’s childbirth experiences, and reflects class and race bias. Some argue that birth medicalization empowers women by giving them control over their maternity care (Prosen & Krajnc, 2013), ‘accompanied by an implicit promise that risks can be managed’ (Hall, Tomkinson, & Klein, 2012); whereas ‘second-wave feminists have viewed the medicalization of childbirth as medical authority’s usurpation of authority, choice, and control over women’s reproduction’ (Brubaker & Dillaway, 2009, p. 35). The participants of this study who criticized the under-medicalization of maternity care in Norway would have felt more empowered if they had the choice of having more medicalized care.

Additionally, the participants expected more frequent surveillance to control for and perhaps respond to possible abnormalities in the fetus early in the pregnancy, as the Chinese and the Indian mothers pointed out. Cindy compared the limited antenatal care in Norway to the rigorous one in China, emphasizing that detecting abnormalities during pregnancy was a priority in China because of the serious implications it would have for the family in the absence of state support. The German mother, who had experienced several miscarriages in Norway, was particularly dissatisfied with the quality of maternity care in Norway, and care she received in Germany reinforced her view that the NMHS was not only under-medicalized, but also outdated. The medicalization of maternity care is therefore a wider reflection of the state and its policies on family and health care. As such, the medicalization of pregnancy and birth varies across different maternity care models. For example, ‘whilst the UK and USA are highly medicalized, Scandinavian countries and the Netherlands are less so, and there, where birth is seen as a normal physiological process, rates of clinical interventions such as Caesarean sections are significantly lower' (Nettleton, 2013, p. 144). On the critique of birth medicalization, Stoll and Hall (2013) state, 'the medicalization of birth is a cultural expression of the core values of technocracy. In a technocratic society, a highly functional natural process, like birth, is viewed as dysfunctional and in need of technological intervention' (p. 1501), and in a 'risk society' (Beck, 1992) the services are organized to handle birth as a risk. Although most births are normal, 'they are treated like an illness, and mothers as patients' (Nettleton, 2013, p. 143). The context in which childbirth occurs may therefore influence the experience of the pregnancy and birth (Macpherson, Roqué-Sánchez, Legget Bn, Fuertes, & Segarra, 2016), and to what degree it is medicalized.

Social networks

The data show that the interviewees' social networks might have contributed to how they encountered the NMHS. They had friends who informed them about what to expect from the NMHS, which can be considered system knowledge, an important type of knowledge for navigating the health care system (Willis et al., 2016). Willis et al. (2016) define system knowledge as 'a form of knowledge applied to the navigation of the field of healthcare' (p. 210). System knowledge is necessary for 'effective decision-making as patients navigate their way through the healthcare system' (Willis et al., 2016, p. 204). This can either be acquired from experience or assumed from 'networks of privilege' (Willis et al., 2016, p. 202), like social networks, to gain an advantageous understanding of the system. The latter was the case for some of the women interviewed who relied on their social networks to inform their decisions about their pregnancy and birth experiences in Norway.

Another example of assumed system knowledge evident in the data was linked to a midwife who acted as a cultural bridge builder (Næss, 2019) in acquainting some mothers with the NMHS and helping them navigate and develop trust in it. This midwife was able to gain the trust of Melika, an Iranian woman who was doubtful that the under-medicalization of maternity care would meet her needs. But through the relationship, she was encouraged to believe that she was capable of giving birth naturally. This midwife was a network of privilege for Melika in gaining system knowledge about the NMHS. This midwife simultaneously acted as an agent of universalism who gained the confidence of a skeptical immigrant woman in the NMHS.

Other women had transnational ties that helped them compensate for the differences they encountered in the medicalization of antenatal care. This, we argue, is a form of translational system knowledge used for bridging perceived gaps in a new medical model. One of the interviewees, for example, had a sister-in-law who was a physician in India who told her to get an earlier ultrasound and sent her medications the interviewee could not obtain from her Norwegian physician.

System knowledge as a concept is important in the immigration setting because immigrants must transfer, adapt, and sometime relearn this knowledge when encountering a new health care system. Social and cultural capital, such as networks, education, and communication skills, are therefore important assets in the transitioning of system knowledge which can enable the navigation and even the negotiation of a new health care system. The central point is that the interviewees' social networks, their social capital, and experiences contributed to how they applied system knowledge to navigating and negotiating the NMHS; hence shaping how they experienced and interpreted it.

Participation in decision making

Research shows that the relationship between health care provider and patient plays an important part in generating satisfaction with childbirth (Benyamini et al., 2017; Clesse, Lighezzolo-Alnot, de Lavergne, Hamlin, & Scheffler, 2018; Hildingsson, Karlström, & Larsson, 2021), but for immigrant women, this relationship may be influenced and disturbed by several factors. Immigrant women's abilities and styles of communication vary because 'culture and ethnicity can influence significantly how people communicate their healthcare needs' (Shrestha-Ranjit, Payne, Koziol-McLain, Crezee, & Manias, 2020, p. 1698).

The Israeli mother who had a premature birth felt that she had no opportunity to participate actively in decisions around her labor, and she experienced the event as disempowering. What she experienced could be considered as a form of over-medicalization over which she had no control. She was not involved in what, for her, was a critical life event. Although the acuteness of her condition may have led the health care professionals to prioritize intervention over communication, she felt that her involvement in decisions made about her body and her infant was necessary.

Conclusion

A common experience for most interviewees in this study was their expectation of a more medicalized service than the NMHS offered. For some of the women, their desires for more medical intervention led them to partially deviate from the universally provided services, seeking services outside the NMHS through private health institutions in Norway or abroad, including from their home countries. The women who were able to seek services outside the NMHS were those with financial resources as well as connections and knowledge about alternative services. Similar to Benyamini et al. (2017), we found that women's attitudes towards medicalized birth varies, and that this is often related to their sociodemographic and sociocultural background. What differs is that women in this study requested and expected a more medicalized maternity care than was offered, while women in the study of Benyamini et al. (2017), who were also used to an advanced medical system, were more reluctant to accept medicalized birth.

The medicalization of childbirth and pregnancy, however, is one of degree. The Norwegian system has, as much of the western world, embraced a medical framework for the management of pregnancy and birth, albeit not to the degree some of the women desired. This is because a more natural approach to maternity care with fewer unnecessary medical interventions has been emphasized in Norway since the 1970s midwifery reforms, both for better birth outcomes and more positive birth experiences (Dahlberg et al., 2016; Gamst, 2012). The Norwegian maternity health care system is continuously changing with the development of medical knowledge and technology, as are the standards of practice in maternity care. The use of caesarean births and epidurals are steadily increasing in Norway (Dahlberg et al., 2016), and recently, politicians have implemented earlier ultrasounds screenings during pregnancy.

As pointed out by Rothstein (1998), a universal health care or service system limits individual choice and instead directs individuals into a standardized and conforming system. Such systems may be experienced as rigid and less adapted to individual demands, and difficult to adjust to, especially for those whose experiences lead them to believe this system exposes them to risk. But Rothstein's interpretations of universalism are also concerned with the generation of social trust and social capital to achieve more just and fair systems. Here, the women from diverse countries experienced a very different health system from that which they were used to and, being distrustful, they circumvented it using individual choice. Others, however, found it liberating, and in this way, their experiences generated social trust and their own social capital which can contribute to greater social cohesion (Fonseca, Lukosch, & Brazier, 2019). These women are not representative of all immigrant women seeking maternity services in Norway, but in order to achieve the type of social trust Rothstein conceptualizes for a just and fair system, a universalist system needs to find ways to overcome the kind of social distrust some of the women in this study display. While lesser educated women with fewer resources may not have the wealth of social networks available to these women, they will almost certainly have some apprehensions about different systems, especially if communication forms a barrier to expressing desires and needs. Greater medicalization of childbirth need not only apply to resource-rich women, but expectations of greater care through medical attention may still be present in many immigrant women. A universalist system which seeks to engender social trust must pay attention to difference rather than sameness and seek to overcome concerns through generating genuine trust in the systems.

Some of the interviewees were satisfied with the system and some changed how they perceived it. The Middle Eastern midwife could be interpreted as an agent for the universalism of the Norwegian welfare state by working as a street-level bureaucrat (Lipsky, 1980) to make the NMHS more accessible and acceptable to those who come from different countries. This act of cultural translation and gaining of support from non-Norwegians for the NMHS is important in sustaining the universalist welfare state.

Expectations and demands differ, and they differ with situations. They may be related to culture, social class, social networks, knowledge, and personal experiences. While these women do not represent any group, ethnicity, or culture other than their own, the Norwegian maternity care model differed from their expectations. Some had generally positive experiences, whilst for others, their experiences fell short of their expectations. The findings of this study contribute to understanding the implications of universal maternal health care through the perspective of immigrant service users. It underscores the issues of diversity and choice within a universal system, contributing to a larger ongoing discussion on universalism in the Nordic welfare system.

Acknowledgments

Thanks to all the women who participated in this study, and to the reviewers and editors involved in the production of this work.

Conflict of interest

The authors report there are no competing interests to declare.

Funding

This study received no funding.

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Article 4

More than Health Care: The implications of cultural diversity for health care practice in Norway

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Abstract

The Norwegian community health centres are one of the main providers of maternal and child health care services. They are often the primary as well as a regular point of contact for women during pregnancy and after childbirth. As such, they are a place where encounters between primary health care providers like public health nurses, midwives, and immigrant women are frequent.

Midwives and public health nurses play an important role as state employees in the distribution of universal health provisions at the local level. This is especially important in meeting the diverse needs of service users in a universal health care system. This study investigates the implications of cultural diversity for health care practice in a universal system. It employs a qualitative approach, using data from nine semi-structured interviews with midwives and public health nurses across three Norwegian municipalities. It analyses their experiences in working with immigrant women during pregnancy and after childbirth through thematic analysis. The findings illustrate the practitioners' different approaches to meeting with culturally diverse patients, the challenges they face in their work, and how they overcome them. The discussions address the practice of cross-cultural health care in the absence of national guidelines or formal training using street-level bureaucracy as an analytical concept. This article contributes to knowledge on the practice of cross-cultural health care at Norwegian community health centres in the absence of culturally cognizant health policy. On a broader scale, this study illustrates the implications of diversity for policy and practice in a universal welfare state.

Keywords

cross-cultural health care; cultural diversity; midwifery; nursing; street-level bureaucracy; universalism

Introduction

Norway has a universal health care system funded by progressive taxation. This health system is decentralised, with the central government maintaining a regulatory role in addition to managing the hospitals, while local governments are responsible for the implementation of national guidelines by the Directorate of Health and the distribution of primary care services (Norwegian Directorate of Health, 2017a, 2018). This enables local governments to deliver universal health provisions in ways that best meet their populations' needs (Gjerstad et al., 2016). This is tied to the long history of local autonomy and the decentralised state in Norway (Borge, 2010). Primary maternity and child health care in the municipalities is offered by both general practitioners as well as midwives and public health nurses at community health centres known as 'Helsestasjon' in Norwegian (Mehrara & Young, 2020). Midwives at these community health centres are generally responsible for antenatal checks and family planning services, while the public health nurses are responsible for monitoring the development of children from birth to five years of age (Norwegian Directorate of Health, 2020).

Diversity as a whole poses a challenge for universalism (Anttonen et al., 2012; Mehrara & Young, 2020). Diversity requires inequal treatment for equality of opportunity and thus of outcome because 'to treat people equally is not always to treat them the same'(Zacka, 2017, p. 52). While teasing out the health equity debate is not the objective of this study, this article focuses on the effect of cultural diversity on the Norwegian maternal health system (hereafter: NMHS).

In recent decades, Norway has experienced an influx of immigrants, resulting in a more ethnically and culturally diverse population. People with immigrant backgrounds make up over 18% of Norway's population (SSB, 2021). This population is scattered across the country, though the majority are concentrated in and around Norway's larger cities. For primary health care providers in these municipalities, this has meant more frequent encounters with immigrant service users who have diverse cultural backgrounds, and consequently health needs, practices, and health care expectations.

The effect of immigration on the declining health of immigrants over time is presented across many studies as associated with barriers such as limited knowledge, language, costs, location, or cultural differences (Ng & Newbold, 2011; Nørredam & Krasnik, 2011; Norsk Sykepleierforbund, 2014). Immigrants are a diverse and heterogeneous population. Some are better equipped to manage life in a new country than others. Nonetheless, immigrant women constitute a vulnerable group. Multiple studies show that immigrant women have poorer birth and other reproductive health outcomes compared to non-immigrant women (Mehrara & Young, 2020; Reeske & Razum, 2011; Urquia et al., 2010; Vik et al., 2019). However, the analysis of these effects from a sociocultural perspective remains limited, especially with regards to the role of maternal health care providers who work with immigrant women in Norway. This perspective is important because it can offer insight into the barriers that health care providers face, and about how policy should systemically address these.

While Norwegian health policy recognises socioeconomic barriers to accessing health care, and offers the right to translators (Norwegian Directorate of Health, 2015), it overlooks cultural diversity as a determinant of health (Mehrara, 2020; Mehrara & Young, 2020). This may leave primary health care providers to handle challenges linked to cultural differences. Midwives and public health nurses, therefore, as mediums between the state and the service users, may become tasked with the responsibility of targeting standardised health provisions to their immigrant patients in order to enhance their health outcomes. The study investigates the cross-cultural meeting between practitioners and their immigrant patients, asking what the implications of cultural diversity for health care practice are in a universal system.

Community Health Centres (Helsestasjon)

The community health centres, known as *Helsestasjon* in Norwegian, are one of the main providers of primary maternal and child health care services in Norway. As part of the universal health care system, they are free of charge and located across towns and cities, making them an available and accessible health organisation. The clinics also operate on a walk-in basis and usually have open premises for those who need a private place to feed or change their babies while they are outside.

Midwives and public health nurses make up the majority of the task force at these clinics, along with some doctors and physiotherapists. Midwives are responsible for antenatal and post-natal health care services to women, and public health nurses carry out health checks on children from birth until they start school (Norwegian Directorate of Health, 2020). The structure and scope of health care for regular appointments is informed by the national health guidelines (Nasjonal faglig retningslinje) for pregnancy care (Svangerskapsomsorgen) and childcare (Helsestasjons- og skolehelsetjenesten) as outlined by the Norwegian Directorate of Health (2017b, 2018).

Accordingly, midwives conduct nine antenatal consultations. After birth, the midwife and a nurse from the health clinic do a home visit to check on the mother and the baby. From this stage, the midwife offers post-natal checks and family planning consultations, while the public health nurse takes over the primary care responsibility for the baby's development. From birth up to the age of five, children get 14 health check appointments with their nurse, who will sometimes be accompanied by a doctor or a physiotherapist, to assess their physical and psychosocial development and well-being as per national guidelines (Norwegian Directorate of Health, 2020).

These community health centres provide maternal and some child health services in parallel with care by family doctors (GPs) at the community level, however the structure and scope of health care is different. The care offered at the health clinic is meant to be more holistic, meaning that during these appointments, which are typically longer than a doctor's appointment, care is generally less acutely medical and covers other aspects and determinants of health related to the woman or the child (Helsenorge, 2021; Norwegian Directorate of Health, 2020). This structure differentiates the scope and quality of health care provided at these clinics, but also demands practitioners to be able and open to addressing topics outside but related to their speciality in health care.

Cross-Cultural Health Care

Culture is important in health care. It can have great implications for individuals' health and their perceptions of treatment (Petiprin, 2020). Immigrants coming from different countries and cultural backgrounds bring with them experiences and knowledge from various health care settings which differ from the Norwegian health care system. In this study, this is defined as cultural models of health. When immigrants meet a new health care system or model, they may find that it differs from their expectations. This meeting between different health care models is contextualised as meetings between different 'cultural models' of health (D'Andrade, 1995) in this study. Cultural models are more or less clearly formulated or explicit knowledge about the world that is common to members of a community, group, or culture, and that has a decisive influence on how members understand and act in the world (Måseide, 1986). They have a crucial impact on how people prioritise, what they consider as acceptable behaviour, and what is regarded as relevant knowledge. Cultural models are therefore essential for how people reason and act in relation to matters of health (Gjernes, 2004).

Culture has a significant impact in health care provision to culturally diverse service users. Cultural sensitivity and awareness are important aspects in providing cross-cultural health care to patients from different cultural background. If practitioners fail to recognise the cultural needs of their patients, 'the patients will be less inclined to continue care, or may be forced to seek care elsewhere' (Ng & Newbold, 2011, p. 563). Thus, cross-cultural health care can enhance the health outcomes and the experience of immigrant service users. However, this can be challenging for practitioners who may have ambivalent responses to cultural diversity (Gustafson, 2005). A prerequisite for this is cultural competence, which within the context of nursing, Gustafson (2005) defines as 'a quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of individuals and families from diverse backgrounds' (p.2).

Without a health care framework that is culturally cognizant, practicing cross-cultural care can become a laissez-faire practice. Midwives and public health nurses, as primary health care providers, are a medium between the state and service users. Their role as the most local agents of the state makes them street-level bureaucrats, whose job requires them to deliver standardised universal health care services to culturally diverse immigrant women. The conceptualisation of street-level bureaucracy by Zacka (2017) theorises this type of laissez-faire practice of cross-cultural health care.

In the absence of formal cross-cultural health care training or practice guidelines, the professional autonomy and discretion of these practitioners enables them to bridge ambiguous universal health policy goals where cultural diversity is left unaddressed. According to (Zacka, 2017), 'street-level bureaucrats retain a significant margin of discretion in performing their role. This discretion, moreover, is not merely technical, but also ranges over questions of value… the existence of such discretion makes it possible for street-level bureaucrats to inhabit their role in a variety of ways' (p. 66). How they practice discretion in meeting *the needs of culturally diverse patients* is therefore reliant on their tacit knowledge, their normative judgement, and consequently their moral disposition. 'Moral dispositions shape how bureaucrats perceive and frame the cases they encounter and what considerations they are inclined to prioritize when responding to them' (Zacka, 2017, p. 66). This article draws on the concepts of street-level bureaucracy and cultural health models in analysing the discretionary practice of cross-cultural health care and addressing the challenges of cultural diversity in a universal health care system.

Methods

Data for this study was gathered through a series of interviews with primary maternal and child health care professionals in three Norwegian municipalities with a high immigrant population. Once the study was approved by the Norwegian Social Science Data Services (anonymised), neighbourhoods in these municipalities were strategically selected as sites for this study based on their high percentage of immigrant residents. Community health centres in these regions were contacted by calling and emailing their clinic chiefs. Once approval from the clinic chiefs was obtained, participants were recruited both by snowball sampling and by purposive sampling at clinic lunchrooms or workshops.

Nine semi-structured interviews, of which seven were individual and two were in pairs, were conducted between May and December 2019. The nine participants included four practicing midwives and four practicing public health nurses, as well as a retired midwife. All the participants were female, reflecting the dominance of women in this sector. The participants had experience caring for women during their pregnancies, after birth, and their children from birth to five years of age. Eight of the participants were Scandinavian and one was a naturalised Norwegian.

Prior to each interview, the participants signed a written consent form after the purpose of the project, processing of data, confidentiality, and their rights as volunteers was explained to them both verbally and in writing. The interviews lasted between one and two hours. The purpose of the interviews was to gain a better understanding of the experiences primary maternal and child health care providers had working with immigrant women. The interviews began with open-ended questions about their professional background and what their work involved. Then they were asked semi-structured questions about their experiences working with immigrants, the challenges they faced, and how they worked around them. This allowed them to reflect on their experiences and to provide examples. Interviews were audio-recorded and later transcribed verbatim by the researcher. The transcripts were analysed on NVivo 12 software, following Braun and Clarke's (2006) model for thematic analysis. After familiarisation with the data, initial codes were recognised. These were then organised under themes and subthemes, which were later refined. The themes were reviewed against literature in the field, and a theoretical framework for the discussions of the findings was conceptualised. During the process, three themes were identified as significant in the experiences of the interviewees' on working with immigrant women. These themes were: importance of culture in health care, challenges of working with culturally diverse patients, and addressing challenges of cultural diversity.

Findings

At the time of the data collection, seven of the interviewees had between twenty and fifty years of professional health care experience, and the other two had between seven and eleven years of experience. As such, this was an experienced group of participants, most of whom had witnessed the changes in maternal and child health care as well as the increase in the immigrant population in Norway throughout their profession. There were no significant differences between the experiences of public health nurses and midwives in working with culturally diverse patients. The experiences of midwives and public health nurses in working with immigrant women differed in how they conceptualised or approached their health care encounter with culturally diverse patients, but shared similarities in the types of challenges they faced in working with this group. This section categorises these experiences, starting with how culture was perceived in health care interaction, challenges they faced in working with immigrant women, and how those challenges were addressed both at individual and institutional levels.

Importance of culture in health care

All practitioners were aware of the challenges of cultural diversity in their practice. However, the importance of culture in health care emerged on a spectrum of importance in the health care providers' practice experience with immigrant women. Some prioritised its effects in health care provision, while others did not view culture or its implications as a primary concern in their health care practice.

The practitioners who highlighted the integral importance of culture described it as key to enhancing the quality of care and improving the health outcomes of their immigrant patients, saying that acknowledging culture encouraged cooperation, dialogue, and trust development. Linda, a midwife, explained that:

> Communication is so very important because when a person feels understood, they relax. This is very important in developing a connection with a pregnant woman in a strange

> country [Norway] where she is worried about many things, has no network, no family or anything around her.

Josephine, a midwife, and Barbara, a nurse, together emphasised that recognising, demonstrating interest, and discussing the cultural background of their immigrant patients in their meetings was important. Barbara explained:

> It's very important to show interest in different cultural practices … once you ask them, you really feel that the meeting becomes more of a dialogue, and they develop more trust in me. This is very important for our practice.

Communication and cooperation are important in the type of holistic and long-term care they provide at these health clinics, and therefore, enabling the patients to become more active participants can have positive implications for their own and their children's well-being. Josephine claimed that 'I do not always do that [ask her clients about culture]'. She explained that doing so, or becoming culturally sensitive, is: 'a matter of time, and also consciousness. So, I have become more conscious and have started to be more like that [ask her patients about culture]'. Josephine points out the processual aspect of such work, especially when it is left to the professional discretion of the practitioners to incorporate culture in their meetings with immigrant patients.

Working with different cultures also raised the issue of cultural health models. Joan and Sharron, a midwife and a nurse in another dyadic interview, described that immigrant women often had questions that were different from those of Norwegian patients:

> Joan: 'We see that their questions are very often related to their culture. It's not the same questions as Norwegian groups'
>
> Sharon: 'No, it's very different. In Norway they [Norwegians] have different knowledge… they are at a different level in a way! Because there are basic things that we assume everybody knows, but they don't know if they are not from Norway. Like cod liver oil [for vitamin D], for example. Everybody knows that in Norway, but it's not common for people from other countries'
>
> Joan: 'And many think it's extremely cold here during winter, so they overdress their baby, or they just stay inside'.

Although some forms of knowledge may be assumed for the local population, they are not for immigrants. Identifying these in a culturally aware process of consultation can contribute to the better health outcomes of mothers and babies. Continuing on the topic of culture and health models, Sharron said:

> I know that it's very easy for us [practitioners] to think that 'oh, we have the knowledge. What we are doing is the right way to do it'. But I have to step beside myself and watch myself and think about the many ways there are to do things. Our way [Norwegian] is not the only right way. So, I try to ask my immigrant patients, 'how is it in your culture?'

Here, she additionally points out the discursive implications of cross-cultural practice by becoming more aware of alternative discourses on health care outside the dominant western or Norwegian ones.

Finally, those who found culture and its impact important when working with immigrant women explained that discussing culture enabled them to develop a better understanding of their patients' backgrounds and needs. This allowed for identifying cultural norms and practices adopted by their patients and finding ways to recommend alternative practices when they found certain practices to be harmful. This acquired cultural knowledge, however generalised, could also be useful while working with other patients and in helping colleagues who experienced challenges in working with immigrant patients. For example, through experience of working with immigrants, advising against the use of baby walkers and the use of certain foods like honey, or talking about alternatives to violence in disciplining children were common topics practitioners addressed when working with immigrants. They had learned through experience that these were common practices in many countries, but that they could be harmful to babies based on their professional training. In other cases, their acquired knowledge about different cultures resulted in promoting more understanding and tolerance of certain practices that would normatively be judged as harmful by the Norwegian-trained nurses and midwives. Linda, a midwife with a lot of international midwifery experience, recalled a story illustrating this:

> A colleague of mine that was working in the labour ward, called me one day, absolutely desperate, saying 'I've experienced the most awful thing today! They gave the new-born baby butter! That's bad for the liver! Babies aren't to have butter!' I said, 'Relax! All Pakistani babies get butter because they believe that gets that stinky stool out! All of

> Pakistan survived'. Okay, it's not the healthiest of things, but this is a cultural aspect that they had no idea about. The whole labour ward got to know it's to be expected.

Linda helped her colleagues become aware of a common cultural practice which was not ordinary in the Norwegian care model, but that it was to be tolerated due to its harmlessness, and by doing so shared her knowledge in helping her colleagues become culturally aware.

For others, culture was secondary to the common health needs. Ida, a nurse, thought that similarities in the needs of their patients were more important than the culture unless it concerned a harmful cultural practice like female genital mutilation. She explained that:

> At our clinic, there is no special focus on immigration because in the neighbourhood we service, there are other groups of women like the Norwegians who have low income, are not well educated, and they face similar problems. So, we try not to focus on immigration background, but on the similarity of needs and problems that we can address.

However, as the clinic leader, Ida later stated that she would like for the staff to become more culturally diverse because currently they were all Norwegian and working in a very immigrant-dense community. This shows that she was aware of the implications of health care provision to a culturally diverse population and thought that culturally diversifying the workforce would help address some challenges they encountered in working with immigrant women.

Another midwife, Maryam, supported the secondary nature of culture in her practice, stating:

> We're not there to police them for their cultural differences… because before I see culture, I see a human with certain needs. I think that needs are the same across all cultures... It doesn't matter where our patients come from. Our top priority is to make sure they all have a good pregnancy.

She prioritised the biological needs of the body in providing care, whereby the focus of their practice was on the common needs of the pregnant women, not their cultural backgrounds. Like Ida, Maryam had an attitude of awareness and tolerance towards different cultural practices, saying, 'so many cultures have so many different practices, but many of them are not harmful. So, I just listen patiently and won't intervene unless I see a risk'. When it came to trust building, Maryam argued that time and continuity of care were essential for developing a trusting relationship with the patient regardless of their cultural background. This differed from the first group of participants, who prioritised culture in the trust building process. Maryam said:

> One good thing about practicing midwifery at this clinic is that you continue to see these women until they give birth. I never rush into asking them sensitive questions… for instance, as per the national guidelines for our first meeting, we have to talk about violence, abuse, drinking, smoking, what family they grew up in, etcetera. But I never rush into these questions because I believe we need to establish trust first. They need to understand and believe that I am not asking these questions for my own curiosity.

Challenges of working with culturally diverse patients

The health care practitioners faced common challenges in working with immigrant patients. These were language and gaining their trust in the NMHS.

Despite immigrant women's entitlement to free interpreters in health appointments, language issues were not eliminated. Most of the participants noted challenges with interpreters regarding their professionalism, their suitability for the context, and their sensitivity to the appointments. Sandra, a midwife, recalled that once, the interpreter was a young girl with no experience about what they were going to talk about in the gynaecological appointment. Being in the examination room, she began to cry when she heard the woman being examined experience pain. Similarly, Tamara (also a midwife) explained that when the interpreters were contacted by phone to assist in an appointment, they sometimes caused disturbances: 'they are cooking sometimes, flushing the toilet, their children are screaming… we don't understand what they're saying… sometimes they translate a very long time, and maybe they're telling their own story or their own opinion'. There were other such examples about challenges with interpreters which often complicated the appointments instead of facilitating them. When interpreters were not used, practitioners felt that they had to spend more time to cover the same topics they would with patients fluent in Norwegian, linking the issue of language back to the need for longer appointments and time.

Another challenge some practitioners experienced in working with immigrant women was in gaining their trust in the NMHS. These practitioners felt that sometimes the responsibility of caring for immigrant patients extended beyond their appointments at the clinic. Josephine explained the consequences of immigrant women coming from different health care systems:

> It's a very different [health] system in Norway which they are not familiar with. They don't know where to go or what to do. It's very different from their home. Or they don't trust our competence [as midwives] or our methods at the clinic. They want to go to the hospital to get scans… So, that is a challenge, to convince them that they can trust us.

Developing trust was often described as a complicated and time-consuming process with immigrant women who were new to the NMHS. The health care providers felt that it was their responsibility to work on trust building to ensure these immigrant women and their children better health outcomes.

Addressing challenges of cultural diversity

Handling challenges in working with immigrant women from diverse cultural backgrounds were presented at two levels. One was at the individual level, where the practitioners personally dealt with the consequences of their immigrant patients requiring different or additional care. The other was at the clinic level, where such challenges were targeted collectively through grassroots initiatives developed by the practitioners.

Personal level

The need for extra time, by way of longer or additional appointments with immigrant women, was a common theme in the experiences of health care providers. Sandra, a midwife, explained that 'for a Norwegian woman, 30 minutes might be enough [for an appointment], but for a foreigner, we always need an hour each time… because we know they need so much more extra outside the pregnancy'. This can be due to several factors ranging from having interpreters for translation, to acquainting the woman with the Norwegian health and welfare system, to answering questions about differing health care and lifestyle practices. The care provided at the health centre is more than medical care, which is enabled by the structure of the meetings encouraging dialogue and knowledge building between the patient and practitioner. During these sessions, knowledge is shared, and when working with immigrant women, this may be help them understand the system.

Sometimes this extra time spent with immigrant patients left the clinic boundaries because the practitioners felt a sense of responsibility for those who had no one else to go to for information or help regarding the NMHS or general life in Norway. This altruism can be classified as empathetic work that goes beyond the job description. For example, Sandra explained:

> The women might be concerned about something totally different than their pregnancy. I really don't want to be their advocate ... because that's not what I'm educated in, but I sometimes see that it's important that someone helps them because they don't have the knowledge… they don't know where to go... and they're not treated fairly, so they don't get their rights.

Similarly, Maryam explained that when working with immigrant women, she felt responsible for helping them with issues outside of her role as a midwife, stating:

> Someone needs to be there for them and guide them, you know? And it's not forever, they need guidance now… there are a lot of issues they face as new immigrants here. I try to encourage the women to find work, and enter the system, become self-sufficient. I know this because as an immigrant, I've lived through it.

Whilst Maryam did not prioritise culture in health care provision, she acknowledged the implications of being a foreigner in Norway and how that could affect these women's health and life. She extended her care beyond her duty because she felt that by guiding them through the Norwegian welfare system and way of life, she was helping them integrate into this new society better, and thus helping them attain better health and life outcomes in the long run. In other words, as a primary health care professional, Maryam did not limit her role to midwifery but also functioned as a cultural bridge builder for these immigrant women to help them fare better in Norway.

Clinic level

Another response to these challenges of working with immigrant women occurred at the clinic level. One clinic started a grassroots initiative offering pre- and post-natal workshops for immigrant women. TEGRA, the name of the program, which is short for integration, serves to collectively address the common needs of immigrant women in Norway (Mehrara & Young, 2020). Seeing the success of the TEGRA program, Barbara's clinic which is in another immigrant-dense community adopted it as an initiative as well. She described the program as efficient, time saving, and cheaper in the long run. Barbara said:

> We saw that immigrant women needed many extra consultations. They had the standard program, but they needed more, and we used a lot of time talking to them again and again. I also believe that my colleagues and I did things a little differently from one another, like some would say one thing, and I would maybe say another thing. So, we wanted to collect all this knowledge and experience in one place.

Barbara's clinic had allocated extra time in appointments with immigrant women by midwives and public health nurses. Barbara explained that this was targeted towards 'those immigrants who are new to the country, especially if it's their first child in Norway… so we have the option in our consultations and use it when there is need for it'. Hence, in both cases, despite the absence of national or clinical guidelines on cross-cultural health care practice, the practitioners at these clinics recognised the need for extra resources such as time in working with immigrant women through experience and addressed it. Maryam said that 'increased immigrant population goes hand in hand with experience in working with immigrants and recognising their diverse needs'. The practitioners' experiences were therefore fundamental not only for individual level initiatives but also clinic-level ones in addressing the challenges of culturally diverse patients. Consequently, they would be critical for change at the national level.

Discussions

The findings present the experiences of midwives and public health nurses working with immigrant women and is by extension a representation of the effects of cultural diversity on the NMHS. All practitioners acknowledged that cultural diversity posed some challenges for their health care practice. Some explained that addressing culture was as of primary importance, while others saw culture as secondary in their health care interactions with culturally diverse immigrant women. The conceptualisation of cultural importance was dependent on their subjective experiences and knowledge of working with immigrant women and how they prioritised delivering good health care. Furthermore, working with immigrant women posed similar challenges for midwives and nurses alike. They described the effects of these challenges as a compromise to the quality of care they were able to provide to immigrant women, and as time-consuming. Most of the practitioners felt a sense of responsibility extending beyond their profession for making sure that their immigrant patients who were new to Norway and to its health and welfare system got some support and direction from them. These findings lead to the discussion of ‘doing more than health care’ to address cultural diversity, and the implications professional discretion would have in compensating for the lack of systemic guidelines on cross-cultural care.

More than health care

The experiences of the participants reflected that they were doing more than health care. In the case of working with immigrant women, this implied that the midwives and public health nurses had to address particular challenges. Establishing trust with women coming from different countries and backgrounds was one of their priorities because it was fundamental to having a good health care experience and ensuring good health outcomes for the mother and her child. Næss (2019) supports that ‘a lack of trust has been identified as a prevalent barrier to immigrants and ethnic minorities’ health care utilization” (p. 297). Developing trust was often a time-consuming process because the women came from different cultural health models, whereby their expectations of maternity care in particular were different than what they were offered by midwives in Norway. While some of the participants emphasised the importance of discussing culture in order to establish trust, others argued that the continuity and structure of care at the health clinics were important for establishing trust with both immigrant and non-immigrant women, thus not distinguishing culture as a factor.

Culture, however, is an important aspect of health care with a culturally diverse population. Næss (2019), for instance, highlights cultural bridge builders’ importance in gaining Somali immigrants’ trust in the Norwegian health system. Other studies show that ‘culture and ethnicity can influence significantly how people communicate their health care needs’ (Shrestha-Ranjit et al., 2020, p. 1698), which is supported by Ladha et al. (2018), who discuss the impact of culture on health care interaction with immigrant service users. Ng and Newbold (2011) found that ‘often, differences in cultural expectations or knowledge of different cultural groups resulted in less than optimal consultations’ (p.566), one of the reasons being that immigrant women ‘may feel that they are not receiving appropriate care when their cultural needs are not being met’ (p. 566). This specifically links back to the concept of cultural health models and the innate knowledge and expectations of health care immigrants bring with them to Norway. Consequently, acknowledging and addressing cultural differences is fundamental in cross-cultural health care practice, which is key to addressing differences between cultural health models.

Culturally congruent care requires cultural awareness, sensitivity and competence (Bauce et al., 2018), which demands that health care practitioners have cultural knowledge (Gustafson, 2005). The challenge in Norway is that health policy and maternal health care guidelines are not systematically cognizant of the challenges of cultural diversity. Thus, the practice of cross-cultural health care has become a laissez-faire practice whereby the midwives and nurses decide at the individual level and based on their experience, knowledge, and goals how to best provide care for culturally diverse women. While this degree of local and professional autonomy in a universal health system is required to target services to individuals, it can pose challenges as exemplified in this article. I address this from two perspectives.

On the one hand, this approach risks the essentialisation or the overlooking of culture and its nuanced implications for health care provision and reception. Practitioners may adopt a culturally blind attitude in providing health care, as presented in this study, by focusing on the biological needs of the body, or by addressing culture with a lack of awareness and by generalisations. This risks the representation of tolerant behaviour towards different cultures in an ethnocentric or prejudiced manner. Gustafson (2005) argues that:

> In a white, female dominated profession, demonstrations of tolerance, sensitivity, understanding, and empathy can stand in for being fair and being fairly represented. Those of us in positions of power have the luxury of expressing tolerance and sensitivity for nondominant beliefs and practices. (p.12)

This may have the opposite effect on the health care utilization and outcome of immigrant women than health care professionals intend.

On the other hand, this approach may require that midwives and public health nurses working in community health centres do more than health care. While this may to some degree be expected given their roles as primary care providers at the health centre, most of the interviewees explained that working with immigrant women was often demanding and different from working with non-immigrants due to their distinct needs and circumstances. Doing more than health care was demonstrated by practitioners taking more time at the clinic and sometimes outside the clinic to help immigrant women with what would often be assumed knowledge for Norwegians about life in Norway, such as coping with the weather, the welfare, health care, and child protection systems. Other times, the practitioners found themselves in difficult ethical situations where they had become the contact person or a part of the immigrant women's support network in Norway as knowers and agents of its system. They did more than health care because they believed that they were helping these women, and that by doing so they were contributing to the long-term well-being and better integration of these women and their children in Norway. I elaborate the implications of this using the concept of street-level bureaucracy by Zacka (2017).

Street-Level Bureaucracy

As explained under cross-cultural health care, Zacka (2017) describes the nature of street-level bureaucrats' involvement in cases they work on as a product of their moral dispositions whilst inhabiting their role. He explains moral dispositions as 'more enduring professional identities… revolving around a more explicit understanding of one's role and responsibilities… a "role conception", which is largely situation-independent' (Zacka, 2017, p. 87). Zacka classifies moral dispositions into three models of role conception: indifference, caregiver, and enforcer. Furthermore, he explains that

> Moral dispositions and role conceptions do not determine a bureaucrat's behavior in any given case but correspond to a propensity to handle cases according to a particular mode of appraisal (e.g., an inclination toward responding as an indifferent, as an enforcer, or as a caregiver). (p. 79)

The concept of dispositions is instrumental in analysing the caregiving and indifference roles purported by the participants in working with immigrant patients.

'Street-level bureaucrats acquire, over time, a deep knowledge of how the bureaucratic process works… this informal know-how is one of the most precious resources that street-level bureaucrats can distribute to their clients' (Zacka, 2007, p. 76). Those who extended their professional discretion beyond that of their role description during appointments or of the clinic boundaries in caring for their immigrant patients can be classified as caregivers. These participants, like Sandra, felt responsible, as faces of an institution, for helping those who had no one else to turn to in informal matters. Embodying the caregiving disposition, to them, 'clients are no longer "cases" or "numbers", but individuals who are treated with the compassion and attention they deserve' (Zacka, 2007, p. 105). While they were aware of overstepping ethical boundaries in their professions, being a caregiver has broader consequences. For the individual practitioner, this moral disposition can lead to emotional burnout, which as Zacka (2007) argues, may be justified by believing that they, 'unlike their co-workers, are in the right' (p. 106). It can have wider consequences for the health care system because the approach of caregiving does not universalise well because 'caregivers simply do not have the resources necessary to offer the same level of dedication and service to everyone' (Zacka, 2007, p.106). This is also supported by findings from Debesay et al. (2014) on the emotional burnout of nurses working with immigrant patients in Norway.

Indifference is an opposing moral disposition to caregiving whereby care is given in a 'person - neutral' way (Zacka, 2007, p. 101). Practitioners like Ida can be said to have an indifferent approach to cultural diversity in health care. Although they acknowledged culture, their indifference towards its possible implication about how care is received in their practice makes them impartial towards cross-cultural encounters. The advantages of this moral disposition over caregiving is that it is time-saving and does not lead to burnout or overstretching of labour; however, this blindness to cultural diversity can be problematic in terms of reproducing ethnocentric norms. Furthermore, providing cross-cultural health care relies on the health care providers' opposition to indifference, because different treatment in a universal system is the only plausible way of attaining equity.

Street-level bureaucracy at the organisational level was presented in the form of grassroot initiatives in an effort to tackle challenges with cultural diversity more systematically. By synergising their knowledge and experience in addressing the needs of immigrant women at the clinic level, practitioners aimed to reach a normatively categorised vulnerable group of immigrant women. This approach, too, has the potential to replicate stereotypes about cultural practices as analysed by Mehrara (2020). Hence, despite its good intentions, like the individual practices of street-level bureaucracy, this approach is not void of consequences for cross-cultural health care provision. This institutional approach does however fill a void in policy guidelines about caring for immigrant women, and despite its shortcomings, it has been successful. In this light, this approach may on a national level lead to inequity from inequality of opportunity for immigrant women in municipalities that have adopted this approach and those that have not.

Conclusions

The decentralisation of the Norwegian health care system has been necessary for the functioning of the universal health system, as it gives local governments and actors discretion in delivering national health services. Although Zacka (2007) writes in an American context about institutions, the clause '…institutional principles will have to co-exist with a significant margin of frontline discretion' (p. 53) describes the functioning of the Norwegian welfare state as a decentralised institution accurately. In this way, local actors such as health care providers are faces of the institution and are responsible for addressing challenges that may arise in their work, such as those linked to increasing cultural diversity and the normativity of universal health provisions.

Whilst professional discretion and local autonomy are cornerstones in Norway's universal health care approach, working with culturally diverse patients poses certain challenges to the system. These challenges have not been addressed by Norwegian health policy and are dealt with at the local level by health care practitioners. The focus of this study was on the response and experiences of midwives and public health nurses in working with immigrant women at community health centres, asking what the implications of cultural diversity for health care practice are in a universal system. The findings presented that the response to working with culturally diverse patients and handling of its consequent challenges had not been uniform. The practice of cross-cultural care has been varied, implicit, and at the discretion of practitioners. Health care providers, as street-level bureaucrats, have had to improvise cross-cultural health care, relying on their experience, knowledge, professional discretion, and moral dispositions.

In summary, this study offers insight into the experiences of primary maternal and child health care providers working with immigrant women at community health centres and discusses the implications of cultural diversity on the health care system. The findings suggest that midwives and public health nurses act as mediators and translators of policy and their patients' diverse needs. Although this is critical for the functioning of the universal health care system, enabling blanketed provisions to be targeted, this approach cannot be a compensation for oversight of cultural diversity in health care policy. The current approach, as exemplified in this article, poses challenges both for the professionals and for the clinics. Cross-cultural health care is improvised locally based on local knowledge and experience, resulting in its practice to be varied within and across health centres. This raises the question of how suitable this response to diversity is in a universal system. To conclude, this article contributes to knowledge on the implications of diversity for Norway's universal health system by illustrating the practice of cross-cultural health care in the absence of culturally cognizant health policy or practice guidelines. This study underscores the significance of primary health care providers' experiences in policy change and the need for multicultural health policy.

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In Norway, with universalism remaining the core principle of its health policy, the challenges associated with growing ethnocultural diversity as a result of increasing immigration are demanding universal health care to be suitable for its population, and accessible beyond a statutory right.

This dissertation critically examines the intersection of immigration and Norway's universal welfare ideology within the context of immigrant maternal health. It questions how universal, universal health care is in the face of growing diversity by analyzing the implications of Norway's decentralized approach to addressing the maternal health needs of immigrant women. This is undertaken qualitatively across four research articles, which employ interviews, participant observations, and documents as sources of data to critically investigate Norway's universal health policy and its implications for practitioners and immigrant service users. These articles are synthesized as an intertwined whole in the six foundational chapters of the dissertation.

The findings of this dissertation identify universalism as an inherently normative policy position whereby diversity is marginalized. This trickles down to how immigrant women are recognized and met in this system at the practice level. The effects produced by this decentralized system on the service users is conforming, requiring them to accept a generalized provision, and needs to be addressed at its roots by questioning the underpinning assumptions of Norway's universal policy.

Consequently, this dissertation argues that universalism and its egalitarian ethos are utopic. It concludes by underscoring that the future of Norwegian universalism requires the adoption of a multicultural focus and the embeddedness of cultural diversity in its socio-political ideology of redistribution principles to address inequity in its diversifying society. This study offers important contributions to policy, practice, and theory in the intersecting fields of migration, public health, public policy, social work, and medical sociology.

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ISBN: 978-82-92958-55-1
Print: Trykkeriet, Nord University
www.nord.no