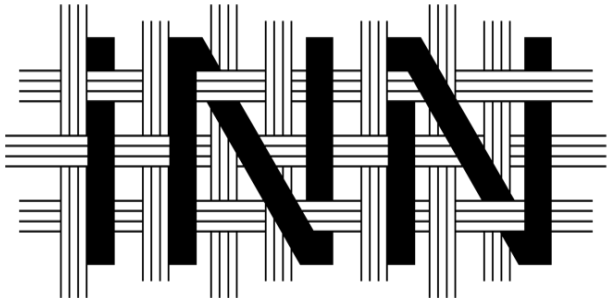

Høgskolen i Innlandet

INLAND NORWAY
UNIVERSITY OF APPLIED SCIENCES

1001 Days

A Qualitative study on how Midwives in Inland County view The Norwegian Maternal Service Provision and the ongoing Debate

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Master's degree in Public Health Science

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ii. Dedication and Acknowledgements

To Samuel

We are all ex-babies. We are all here because someone held us, and kept us alive. Everyone reading this, have once been curled up, kicking a uterus owner from the inside.

Ida Jackson

To my son, in so many ways you are my greatest contribution – this is for us, for the strength within, and for what I always tell you: be aware, you have a beautiful mind.

I would like to express my great appreciation to the midwives who have taken time out of their busy schedule to talk to me, and be part of this project. Your willingness, time, thoughts and engagement made this thesis possible, and I have thoroughly enjoyed being in "your world". In addition to making this project, your narratives have served as a strengthener to my interest and investment in this field.

I would like to thank my supervisor Victor Chimhutu, Professor Miranda Thurston and other employees at Inland Norway university of applied science, for all insights, feedback and support throughout this process. My journey on this master's program as a whole has been an educational and developing one, and I will forever be thankful for the opportunity, and the knowledgeable and dedicated people I have met during these years.

Finally, I would like to thank my forever loving and supportive partner Gina, my mother Tove who always inspired me to seek knowledge and my fellow students Ylva, Karen and Torunn for all support and encouragement during this project.

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vi. Abstract

Main aim: The purpose of this study was to look at how the midwives in Inland County view the Norwegian maternal service provision, women's need and the ongoing debate, mainly fronted by Barselopprøret and Bunadsgeriljaen and their followers.

Background: Each year approximately 60 000 children are born in Norway, a country who is known as one of the best countries in the world to give birth in. The last couple of years, a substantial amount of people has been protesting for change and improvement of the service provision, pointing out that the care's goal should not only be to have the mother and child survive, but also include a focus on mental health. Through these protests we have gotten the stories of hundreds of women's bad experiences with the Norwegian maternal service provision.

Methods: This study utilized a qualitative research approach, with a sample of eight midwives currently employed in health stations and hospitals in Inland County. Semi-structured interviews were used as method for data collection, and the transcribed interviews were analyzed using thematic analysis as described by Braun & Clarke.

Theory: To help explain the results and highlight different aspects of this study, the theoretical framework included Dahlgren & Whiteheads social health model and the AAAQ-framework.

Results: Three key themes emerged from the analysis of the data: Views and perceptions on the maternal service provision, Views confirming a need for debate and Views portraying a nuanced look at the debate. This study points to a consensus among the informants that the maternal service provision in Inland County is overall relatively solid, and that the criticism does not necessarily apply everywhere. However, the informants also agree that there are substantial differences depending on which health station and which hospital you visit, and that the care is often lacking compared to the Directorate of health's written standard. Further, the informants agree on the importance of adhering to the mental health perspective in the maternal service provision, and other points fronted by the critics, like too early discharge and an in general inadequate postpartum care. In spite of some thoughts on the need for a more nuanced debate as complex issues are involved, the criticism and debate surrounding the Norwegian maternal service provision is justified by this study's informants. Further research is needed to uncover more knowledge related to how different kinds of maternity care could influence the well-being of both women, babies and partners.

Keywords: midwives, maternal service provision, Barselopprøret, Bunadsgeriljaen, 1001 days

Formål: Formålet med denne studien var å se på hvordan jordmødre i Innlandet ser på den norske føde- og barselomsorgen, kvinners behov og den pågående debatten, hovedsakelig frontet av Barselopprøret og Bunadsgeriljaen og deres tilhengere.

Bakgrunn: Hvert år fødes ca. 60 000 barn i Norge, et land som er kjent som et av verdens beste land å føde i. De siste par årene har en betydelig mengde mennesker protestert for en endring og bedring av føde- og barselomsorgen, og påpekt at omsorgens mål ikke bare bør være å få mor og barn til å overleve, men også inkludere et fokus på psykisk helse. Gjennom disse protestene har vi fått hundrevis av kvinners historier om dårlige erfaringer med den norske føde- og barselomsorgen.

Metode: Denne studien benyttet en kvalitativ forskningstilnærming, med et utvalg på åtte jordmødre, ansatt ved ulike helsestasjoner og sykehus i Innlandet. Semistrukturerte intervjuer ble brukt som metode for datainnsamling, og de transkriberte intervjuene ble analysert ved hjelp av Tematisk analyse som beskrevet av Braun & Clarke.

Teori: Dahlgren & Whiteheads sosiale helsemodell og AAAQ-rammeverket ble benyttet til å forklare resultater og belyse ulike aspekter ved denne studien.

Resultat: Tre hovedtemaer fremkom i analysen av datamaterialet: Synspunkter og oppfatninger rundt føde- og barselomsorgen, Synspunkter som bekrefter et behov for debatt og Synspunkter som gir et nyansert blikk på debatten. Denne studien peker på en enighet blant informantene om at føde- og barselomsorgen i Innlandet er relativt solid, og at kritikken ikke nødevndigvis gjelder hele landet. Samtidig er informantene også enige om at det er store forskjeller på omsorgen avhengig av hvilken helsestasjon og hvilket sykehus man besøker, og videre at omsorgen ofte er mangelfull sammenlignet med Helsedirektoratets skriftlige standard. Videre er informantene enige i viktigheten av å ivareta psykisk helse-perspektivet i føde- og barselomsorgen, og andre punkter kritikerne trekker frem, som for tidlig hjemreise fra sykehuset etter fødsel, og en generelt mangelfull barselomsorg. Til tross for noen tanker om behovet for en mer nyansert debatt når komplekse problemstillinger er involvert, støttes kritikken og debatten rundt den norske føde- og barselomsorgen av denne studiens informanter. Videre forskning er nødvendig for å avdekke mer kunnskap knyttet til hvordan ulike former for føde- og barselsomsorg kan påvirke helsen til både kvinner, babyer og partnere.

Nøkkelord: jordmødre, fødselsomsorg, barselomsorg, Barselopprøret, Bunadsgeriljaen, 1001 dager

Chapter 1.0 - Introduction

1.1 Background

Approximately 130 million babies are born worldwide each year (Ritchie & Mathieu, 2023). Also yearly, 358 000 women and 3.6 million newborn babies die due to complications during pregnancy, birth and the postnatal period, and nearly 3 million babies are stillborn (Bar-Zeev et al., 2021). The mostly preventable or treatable complications often happen in low-resource settings, related to social determinants of health. These numbers represent a major global and public health challenge, making improving maternal health and contributing to the reduction of maternal mortality one of World Health Organization's (WHO) key priorities (WHO, 2019a).

In Norway approximately 60 000 children are born each year (Statistisk sentralbyrå [SSB], 2022). In comparison to the mentioned numbers worldwide, Norway is a well-developed country and the maternal mortality is considered to be very low, with an average of two deaths annually (Nyfløt et al., 2021). The number of stillbirths, or incidents where the baby dies within 28 days, is 175 a year (Folkehelseinstituttet, 2022). Despite these low figures, and the fact that Norway is considered to be one of the best countries in the world to give birth in, we currently see criticism towards the maternal service provision (Føleide, 2022). Under the names "Barselopprøret"[1] and "Bunadsgeriljaen"[2] thousands have given their voices to the protests, pointing out that the maternal care's goal should not only be to have the mother and child survive, but also include a focus on mental health (Barselopprøret, 2022).

[1] Can loosely be translated with "The maternity rebellion" and is an organization that works for the improvement of pregnancy-, birth- and maternity care, particularly through the spreading of knowledge, community building and attempts at political influence.

[2] Consists of the name for the Norwegian national costume and the word "guerilla", and is a movement fighting for adequate birth services throughout the country.

With slogans like “We survived – now what?”, “25 years of knowledge scrapped” and “Women’s health is public health” printed or painted on large posters several thousands have gathered to demonstrate (Føleide, 2022). Large groups are gathering, creating a debate with accusations that what is supposed to be care is an exercise in stress management (Vea, 2023).

1.2 The Norwegian maternal service provision

The Norwegian directorate of health have published different guidelines related to the maternal service provision. The purpose of these is to prevent unwanted variation, contribute to correct priorities and ensure good quality in a holistic patient centered process (Helsedirektoratet, n.y.). These guidelines emphasize that the premises for a safe experience are complex. The individual’s health, general well-being, finances, housing conditions, work, education and lifestyle affect the outcomes, and the challenge for the health care staff is to take into account the basic requirements of the individual family. This highlights how the maternal service provision is a service offer of a preventive character, where continuity is a prerequisite, and knowledge of the family makes it possible to arrange a predictable patient course (Helsedirektoratet, 2014).

1.3 Aim of the study and research questions

The aim of this study was to examine the debate related to the maternal service provision from midwives’ point of view, and Inland County was chosen as a geographical frame. The main research question utilized was: *How do midwives in Inland County view the criticism, and ongoing debate towards the Norwegian maternal service provision?*

In addition, two sub questions were used:

1. *How do midwives in Inland County view the Norwegian maternal service provision, and women’s needs related to maternal health?*

2. *To which degree do the maternal care implement a focus on mental health?*

1.4 Clarifications of key terms

This section will provide a clarification of key terms used in this thesis.

Maternal service provision: This study will concentrate its efforts on the health care women receive during pregnancy, birth and the postpartum period, and refer to this care as the maternal service provision throughout the thesis.

Postpartum: Postpartum refers to the six weeks following the birth.

Primiparous and multiparous: Primiparous describes a woman who has been pregnant and given birth once, and multiparous is a woman who has been through pregnancy and birth several times.

1001 days: 1001 days is the time space from conception until the child turns two years old. This time is known as a critical window of opportunity for the child, particular in the development of the brain (Department of health and social care UK, 2021).

Delivery rooms and maternity wards: Norway's public birth services are divided into three levels: Delivery rooms, Maternity wards and Women's clinics. Maternity wards and women's clinics have a varied offer, both for healthy women who expect a normal birth, and for the high-risk births who need a special follow-up. Delivery rooms are for healthy women with so called normal pregnancies and an expected normal birth[3] (Helsenorge, 2023).

[3] [3] The term "normal birth" is used when a birth is vaginal and follows the dilation stage, the expulsion stage and the placental stage, without medical intervention.

1.5 Delimitations

The main focus of this study was to look into how midwives in Inland County view the criticism of the maternal service provision. An understanding that the findings for this county does not necessary apply for other parts of the country is required, and further research is needed to uncover views and experiences in other counties.

1.6 Structure of the thesis

This thesis will present international and national literature on maternal health and maternal service provision, followed by a presentation of the AAAQ-framework, as this study's theoretical framework. Then, in chapter 3 the methodology and methods for this study's process is described, before the findings are presented in chapters 4 and 5. The discussion of the findings will be done separately in chapter 6, leading to limitations of the study with recommendations for further research, and remarks on the development of the study's research questions. Finally, chapter 7 gives the conclusion for this study, followed by references and relevant appendices.

Chapter 2.0 – Literature review

The purpose of this literature review is firstly to give global perspectives on maternal care, contextualized in public health, and secondly to focus on the Norwegian maternal service provision, and the ongoing criticism and debate mainly fronted by Barselopprøret and Bunadsgeriljaen, with research and facts supporting the criticism. Further, the chapter will include brief accounts of the development of the Norwegian welfare state and the "supply-

driven theory" New Public Management, before the final part of this chapter will present the AAAQ-framework, as a theoretical framework for this study.

At the start of this process, as well as during, searches were conducted in the databases Medline, SCOPUS, Web of science and JSTOR, as well as in the platforms PubMed and Idunn. The databases and platforms were accessed through HINN library search services (Oria). In addition to relevant research, this thesis includes several contributions gathered from so called "grey literature", to get a current and timely view of today's conditions.

2.1 Global perspectives on maternal care

As presented in the introduction, on a worldwide basis there is now an increased awareness of investing in maternal health (WHO, 2019a). The establishment of the United Nation's sustainability goals (SDGs), a collection of 17 goals with 159 targets formally adopted by all member states of United Nations in 2015, have made society's responsibility to strengthen the developmental conditions and welfare for all children more visible. The SDGs, otherwise known as the Global Goals, aims to end extreme poverty, reduce inequality and protect the planet by the year 2030, with an understanding that strategies for health needs to be holistic and evidence based (Morton et al., 2017). The third SDG is focused on ensuring healthy lives and promoting well-being for all at all ages, and includes goals of reducing global maternal mortality, ensuring universal access to sexual and reproductive health-care services, ending preventable deaths of newborns and children under 5 years of age, and reducing neonatal and premature mortality (UN Women, n.y.).

2.1.1 Maternal care as a matter of public health

The World Health Organization defines public health as all organized activities of society to promote, protect, improve and restore the health of individuals, specified groups, or the entire population (Bloland et al., 2012). A cornerstone in the public health work is the understanding that the social determinates of health, non-medical factors, influence health outcomes. Dahlgren & Whitehead's (1991) "Health Onion" show the different layers. At the heart of the structure is the individual with age, sex and inherited characteristics, surrounded by four layers of influences, from the individual's lifestyle, social and community networks, living and working conditions, access to health services and the general socioeconomic, cultural and environmental conditions. The model is built on the idea that all conditions exist in a mutual influence, and provides a holistic view of health (Dahlgren & Whitehead, 1991), with the understanding that these forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems health (WHO, 2019b). In other words, in all countries, at all levels of income, health and illness follow a social gradient; the lower the socioeconomic position, the worse the health (WHO, 2019b).

A British paper published in 2022 aimed to inform those involved in the care of pregnant women in the UK about the relationship between social determinants of health and the risk of maternal death. The paper emphasizes that despite the provision of free reproductive and maternity services, evidence suggest a strong relationship between social determinants and poor maternal outcomes, including an increased risk of maternal death (Jones et all., 2022). The reasons are complex of course, but the maternal outcomes are particularly poor for socially disadvantaged women, for example affected by physical or mental health problems, overweight or undernourishment, a low level of education, substance misuse or an unsporting or abusive partner (Jones et all., 2022). This highlights the need for a

nuanced and thorough care whenever a new child enters the world. One could also look at it from the opposite angle and point out, as stated by Norway's own White paper 12, a solid maternal service provision can contribute to reducing social inequalities in health (Meld. St. 12 (2008-2009)).

As mentioned, most maternal deaths are preventable with skilled health professionals working in a supportive environment (WHO, 2019a). Therefore, ending preventable maternal death is on the top of the global agenda. At the same time WHO stresses that simply surviving pregnancy and childbirth, should never be the marker of a successful maternal health care (WHO, 2022). Efforts should be expanded from only reducing maternal injury and disability, to also promote health and well-being. They recommend person-centered and respectful care, built on the principles of listening with empathy, building confidence, responding to the needs of women, babies and families, maintaining dignity, privacy and confidentiality, enabling informed choices and ensuring freedom from harm and mistreatment (WHO, 2022). WHO (2018) recommends that every stage of pregnancy, birth and maternity should be a positive experience, ensuring that women and their babies reach their full potential for health and well-being.

2.1.2 The Marmot review and the early years

The 2010 Marmot review stresses the importance of the early years, and how giving every child the best start in life is crucial to reducing health inequalities across the life course (Marmot et al., 2010). The report states that reducing health inequalities will require action on six policy objectives. In addition to healthy living standard, healthy places and communities, employment, empowerment and prevention, the report highlights the crucialness of giving every child the best start in life (Marmot et al., 2010). Not just related to health, but also development – cognitive, linguistic, social, emotional and behavioral skills. If we are to

reduce inequalities in health approaches must include improving services that break the link between deprivation and poor outcomes for children (Marmot et al., 2010). Further, what happens during these early years, starting in the womb to the age of five, has lifelong effects on many aspects of health and well-being, from heart disease and obesity, to educational achievement, economic status and mental health. Later interventions, although important, are less effective. Support to families need to start prenatally, as there are strong associations between the health of mothers and the health of babies (Marmot et al., 2010). Which means that early interventions before births is equally important as giving support during the first years of life. Positive attachment between a young child and their primary care-giver, has been consistently shown to be important for healthy early development, and contribute to the growth of a broad range of competencies, including self-esteem, self-efficacy and positive social skills (Marmot et al., 2010). As a contrast, isolation and depression are two important factors that impact negatively on maternal attachment capacity. There is strong evidence that early interventions through intensive home visiting programs during and after pregnancy can be effective in improving the health, well-being and self-sufficiency of parents and their children (Marmot et al., 2010). This highlights the need for a strong midwifery workforce which provides the infrastructure to support women and their partners during pregnancy, birth and early parenthood, for ensuring the right kind of support to those who need it. The report also highlights the possible savings effect of investing in prevention and promotion, rather than curative treatment (Marmot et al., 2010).

2.1.3 What women want campaign

In 2018 the White Ribbon Alliance conducted a survey called What Women Want campaign where 1.2 million women from 114 different countries participated. The women were asked open ended about reproductive and maternal health services, and answered that

the thing they most wanted was to be treated respectfully and with dignity. After this they went on to mention a need for clean water, sanitation, hygiene and adequate medicines and supplies (White Ribbon Alliance, 2018).

Norway was not included in the What women want campaign. However, a study done by Aune et al. (2015) in Norway aimed to gain an understanding of internal and environmental factors that are important for a normal birth, and a positive birth experience. The study found that a safe environment, close relationships and stability in everyday life are important factors (Aune et al., 2015). It seems reasonable to conclude that women all over the world have this in common, the basic need of feeling respected and treated with dignity, in a safe environment when in need of maternal care.

2.1.4 Health in the first 1001 days for mother and child

In close relations with the maternal health is the health of the newborn child. With reference to WHO's aim for a maternal care contributing to full potential for health and well-being (WHO, 2018), and the 2010 Marmot review stating that what happens during the early years, starting in the womb to the age of five, has lifelong effects, brain research tells us that the 1001 first days of an individual's existence is known as a critical window of opportunity for the child (Leach, 2018). During these first years, the brain develops faster than at any other time in life, and the foundations are laid for neural pathways and areas in the brain that influence learning, language development, emotional development and behavior. In other words, the first years of a child's life form the basis for, and shape, the child's mental and physical health and well-being for the rest of their life (Danielsdottir & Ingudotter, 2022, p. 6). "The first 1001 days are critical because they take a person from potential to actual" (Leach, 2018, p. 3).

The journey to becoming a mother constitutes a transitional process which starts during pregnancy and brings along changes, related to the social environment. As a part of the normal transition the prospective mother may also experience mild stress, such as insecurity about the pregnancy or her ability to become a mother. This mild stress may enhance her need to seek information, regardless of whether she is a primiparous or a multiparous. During the pregnancy it is important however, that the mother's support system and health care professionals manage to identify whether the stress becomes more severe or pervasive, and potentially escalates to distress (Jonsdottir et al., 2017).

Jonsdottir et al. (2017) did a study aiming to generate knowledge about the association between partner relationship and social support, and perinatal stress. The study found that women who were dissatisfied in their partner relationship were four times more likely to experience perinatal distress, and emphasizes that perinatal stress has adverse effect on both the prospective mother and the health of the fetus/infant (Jonsdottir et al., 2017). Further, Murray & Cooper (1997) point out that it is well known from research that children who experience depressive symptoms in their mother, may have a developmental delay.

Another potentially important relationship in this period might be the one between midwife and patient. Midwife-led continuity of care refers to a model where care is provided by the same midwife, or a small team of midwives, during pregnancy, birth and the postpartum (Sandall et al., 2016). Previous research suggests that women who received this kind of care during their pregnancy, birth and postpartum are less likely to experience intervention, and more likely to be satisfied with the care they receive, than women who received other models of care (Sandall et al., 2016).

2.2 Perspectives on the Norwegian maternal service provision

Pregnancy, birth and maternity are in Norway, as in most cultures around the world, viewed as a period of increased vulnerability for the mother and the child (Eberhard-Gran et al., 2003). Parallelly, as pointed on in the new Norsk Offentlig Utredning (NOU) on women's health and health from a gender perspective, presented in mars 2023, it is a fact that women's health in general is seen as something with low status, reflected in both less research and access to resources (NOU 2023:5). Regarding the maternal care, Rosenfield and Maine's (1985) study on maternal mortality is considered a classic work in showing how the mother's health has been considered to be less important than the child's health.

Parallelly, the changes in how maternal health is viewed over time are many (Eberhard-Gran et al., 2003). A hundred years ago most women gave birth at home, versus today, where most women give birth in hospitals. In the 1950s the hospital stay after giving birth would often be about 14 days long, and in addition, many women were provided help from the state in form of a "substitute housewife" when returning home from the hospital (Eberhard-Gran et al., 2003). In the 60s the hospital stay should not be less than eight days, and there were several rules for how the women and the child had to rest in order to grow strong. The woman had to rest in bed, and was only allowed to see the child every four hours when it was time to breastfeed. A reaction to these somewhat rigid routines came at the end of the 1970s, and a new practice were implemented where the mother and child got to be together in the same room around the clock (Eberhard-Gran et al., 2003).

The tendency now in the western world is that the length of the hospital stay after giving birth is gradually shortened. In the late 1990s, the length of the stay was 4-5 days after a normal birth. In recent years, the use of patient hotels as an alternative to staying in the hospital, has become more common (Eberhard-Gran et al., 2003). Eberhard-Gran et al. (2003) calls the development after the 1950s a gradual weakening, pointing out that the Norwegian

maternal service provision has become increasingly restricted, especially in the form of earlier discharge, without a properly functioning offer of home follow-up.

2.3 Criticism of the Norwegian maternal service provision

In May 2022, a historic demonstration on the need for change and improvement of the Norwegian maternal service provision was held outside the Parliament building in Oslo. At the forefront of the demonstration were the movements Barselopprøret and Bunadsgeriljaen, claiming that the Norwegian maternal service provision is characterized by low priority, large cutbacks and a general lack of resources (Barselopprøret, 2022).

Barselopprøret was started by Aida Leistad Thomassen and Cecilia Ingulstad in February 2021. The two women both gave birth in 2020, and found each other through the sharing of their bad experiences (Ingulstad, 2020; Thomassen, 2020). They decided that the anger and frustration they felt after their separate meetings with the service provision needed to lead to something, and started to collect stories from other women's experiences, both during and before the pandemic (Bjartnes, 2023).

Hundreds of women spoke up about their bad experiences. The stories can be read on Barselopprøret's website (Barselopprøret, n.y.), and are about not being allowed to enter the hospital in time, condescending and ridiculing statements from hospital staff, heavy-handed examinations without consent in the maternity ward, insufficient pain relief during a caesarean section, lack of breastfeeding guidance, in addition to an in general inadequate postpartum care and what the women feel are a too early discharge, either in the form of being asked to leave the hospital, or wanting to leave because of a lacking care (Barselopprøret, n.y.).

At the demonstration in May 2022 the leaders of Barselopprøret and Bunadsgeriljaen, together with Femihelse[4], submitted a list of seven demands to the Minister of Health, Ingvild Kjerkol. The demands are pointing to the need for a reorganization of the current maternal care in Norway, to a more holistic care model, where the women receive an appropriate and individually adapted follow-up (Føleide, 2022). Barselopprøret has been named the biggest mobilization in Norway for the right to safe pregnancy, birth and maternity since the 1970s (Bostadløkken, 2021).

2.3.1. Research and facts supporting the criticism

Norway and other western countries have over the last decade focused their maternal care on risk factors and mainly the survival of the mother and child (Aune et al., 2015). The hospitals are cutting costs and solving capacity problems with early discharging, and treating healthy maternity women on an outpatient basis. The plans of early discharge are accompanied by intended home-based services, which have been shown to work in other countries (Eberhard-Gran, 2018). Meanwhile a study done by Eberhard-Gran et al. (2022) found a significant dissatisfaction among mothers with the care in the maternity ward, and further related to an inadequate follow-up after returning home. Eberhard-Gran (2018) emphasizes that there is a need to gain more research-based knowledge on how home-based services could work in a Norwegian setting, before implementing these levels of early discharge.

Aas (2011) used her master thesis to look at whether the midwifery service could meet the political goals and ideals as fronted in White paper 12 on a coherent pregnancy, birth and maternity care (Meld. St. 12 (2008-2009)). The conclusion at the time showed that an unclear

[4] Femihelse is a Podcast on women's health, driven by Sigrun Stenseth and Helene Svabø.

division of responsibilities, plus lacking laws, financial resources and incentives made the maternal service provision difficult (Aas, 2011).

Also visible in the public debate and seemingly in support of the protesters is the national association for midwives, Den Norske Jordmorforening. The association is in general asking for more employees, preferably with a norm supported by earmarked funds (Dolonen, 2017), and more specifically related to the plans regarding a more home-based service. Jordmorforeningen estimate that on a national basis there is a shortage of between 600-700 midwives for the municipalities to have a proper home-based maternity care (Fladberg, 2018).

Regarding the hospitals, a study done by Johansen et al. (2017) concludes that all hospitals in Norway have written routines that are in accordance with national quality requirements. However, they emphasize, it is still unclear whether the routines are adhered to in practice (Johansen et al., 2017).

2.4 The Welfare state and demand on care

The Nordic welfare model was originally financed through a redistribution of tax incomes, and based on cooperation, support and correction from a thriving civil society (Heløe, 2003). Over the years, the changes in the society have become problematic for the welfare state (Heløe, 2003). Both reduction in the number of children per adults and medical technology's contribution to increasing life expectancy, has had the long-term effect of a new age-structure of the population, with the first indicator also leading to longer years of dependency at high ages. Another factor is women increasing their hours of paid work, and the need for an alternative solution for the care services they once provided, is needed (Folbre, 2004). The state and other public organizers gradually became dominant in terms of responsibility and financing of the welfare states services, and during the 1970s economists suggested a greater public restraint, also in welfare policy (Heløe, 2003).

Money related to the welfare state is complicated money (Isaksen, 2004). The use of money related to public welfare systems is based on moral considerations on how society's common fund should be managed, and the health care system is built on criteria that the government has adopted to regulate the relationship between supply and demand for public care. Assessments and allocations are again based on various formal and legal regulations, as well as contextualized judgement. Implicit in those assessments are different ideals and culturally based perceptions regarding care and the exercise of it (Isaksen, 2003). Overall, care is something that is hard to measure in supply and demand (Folbre, 2004).

2.4.1. New Public Management

The growing demand for modernization of the welfare services, became a driving force for creating change, and through a number of investigations and political guidance since the 1980s privatization, commercialization and a new management philosophy have become central goals. New Public Management (NPM) is a collective term for these changes, and to understand the changes in welfare services, the thinking linked to NPM is a useful framework (Dahle & Thorsen, 2004).

NPM is not a fixed philosophy, but rather a loose bundle of different elements built on two main pillars. One pilar is linked to a clear liberal market orientation, which is mainly justified by economic reasoning, and the second pillar is linked to management, with the notion that management principles from the private business world should be transferred to the public sector (Dahle & Thorsen, 2004).

Various elements of NPM have been implemented in Norway. Besides in the organization of the municipalities, examples are in the funding of higher education and the health care service, with the use of result-based financing to replace framework funding. Hospitals are now partially financed through a system called Diagnosis-related groups (DRG),

which gives a certain amount of money depending on the patient's diagnosis and treatment (Dahle & Thorsen, 2004). The demonstrations we see on the Norwegian maternal service provision are a reaction to some of these NPM-inspired changes.

2.5 Theoretical framework

To help explain the results of this study this thesis utilizes the AAAQ-framework. This part will give a short explanation of the theory, which then, in combination with Dahlgren & Whitehead's (1991) "Health Onion" as described in section 2.1.1 will be used as a theoretical framework in the Discussion chapter.

The AAAQ framework has its roots in human rights research and its purpose is to build consensus about the understanding of the content and interpretation of the international human rights standards and principles (Villumsen & Jensen, 2014; Yamin, 2009). The framework is used to identify potential barriers to accessing health care services (Unicef, 2019), and has proven to be particularly beneficial in monitoring maternal and child health services (Hunt & Bueno De Mesquita, 2007). The AAAQ-framework involves four criteria to evaluate health services (Unicef, 2019), see Figure 1.

Figure 1. The AAAQ-framework

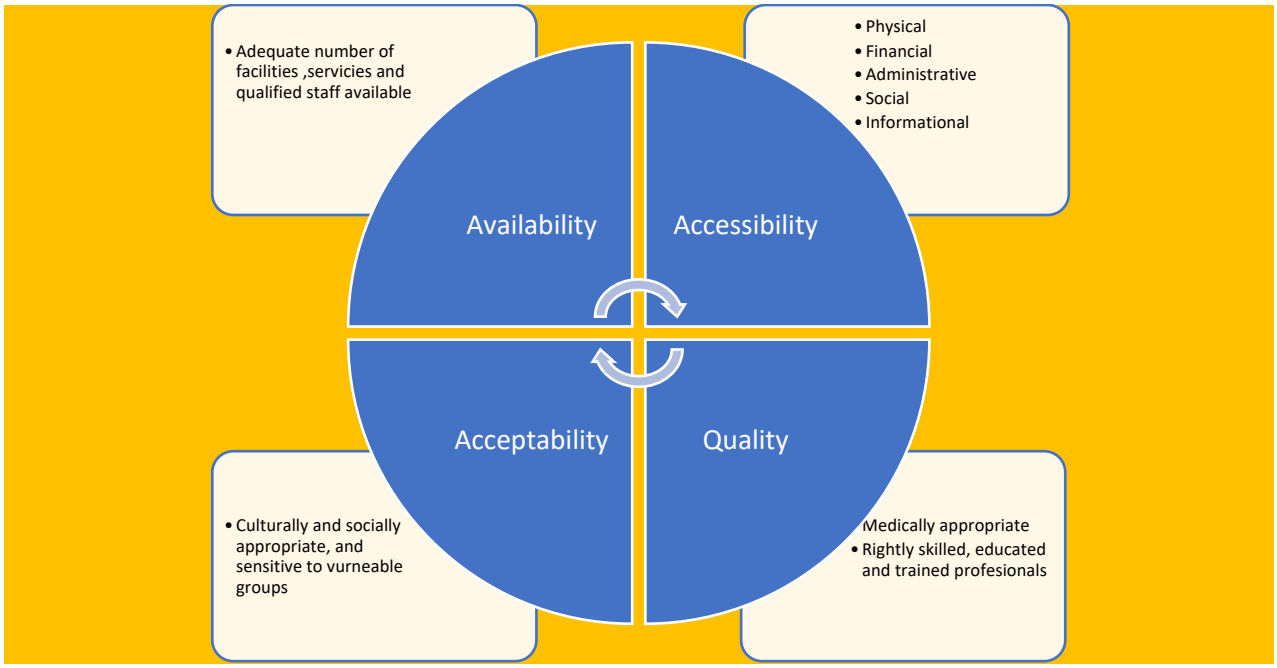

Figure 1. The four criteria adapted from the AAAQ-framework to discuss maternal service provision. Source: Adapted from *AAAQ and the right to water. Contextualizing indicators for Availability, accessibility, acceptability and quality*, p. 17, by M. Villumsen & M. H. Jensen, 2014.

The first A of the framework stands for availability and refers to the existence of the care services, and whether the services are sufficient in terms of quantity and type.

The second A stands for accessibility and includes different components, such as physical accessibility, financial accessibility, administrative accessibility, social accessibility and information accessibility.

The third A stands for acceptability and refers to whether the care services are designed to respect relevant ethical and professional standards, and further if the care takes into account cultural considerations.

The Q in the AAAQ-framework stands for quality and refers to whether the service providers possess the necessary skills and training, and further if there are adequate supplies that meet relevant standards, an appropriate environment, safe and sanitary facilities and a service provided at an acceptable standard of care in alignment with relevant guidelines (Unicef, 2019).

Chapter 3 - Methodology and methods

This chapter will first explain the research approach, and then the study design, with explanations of the epistemological paradigm social constructivism, and phenomenology. The chapter will then go on to explain the utilized data collection method interview, with sampling and recruitment, and how the data was stored and analyzed. Finally, the chapter will include some methodological reflections, including trustworthiness in research, role of researcher and ethical principles with institutional clearances.

3.1 Research approach

To look at midwives' view on the maternal care and the ongoing criticism this study utilized a qualitative research approach. Merriam & Tisdell (2016, s. 6) explain the qualitative research's quest by saying " […] how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences". Qualitative research prefers an inductive approach to the relationship between theory and research, and the approach overall views social reality as the constantly shifting creation of social actors (Merriam & Tisdell, 2016). This study aimed to capture interpretations, thoughts, meanings and experiences from midwives in Inland County.

3.2 Study design and philosophical stance

The design of this study was qualitative, with inspiration from phenomenology. According to Thoresen et al. (2020) phenomenology is a new way of doing philosophy, which both deals with, and springs from, the lived and concrete, rather than theoretical systems, dogma and predetermined truths. Phenomenology as a theoretical perspective has an important role in health research, specifically related to patients' awareness of various

diseases. On the basis that phenomenology is about the lived, a specific individual or a group's experience, it can also encompass research related to health care (Thoresen et al., 2020).

The phenomenological method implies an understanding that all human activity, including scientific work, has the lifeworld as its basis. Thus, there is no neutral zero point outside this lifeworld where the researcher can observe. Moreover, it is a fundamental prerequisite that the researcher and the participants share some basic conditions of life, such as time, space and physicality, as well as concrete reality (Thoresen et al., 2020). In other words, knowledge is created between researcher and participant (Kvale & Brinkmann, 2015). Further, Thoresen et al. (2020) point out the importance of linking phenomenological thinking directly to the planning and implementation of the interview method, as well as to the design of the interview guide, in order to contribute to a more comprehensive understanding of what a study inspired by phenomenology is. It all requires empathy and interest in the interviewee's perceptions, in this case the midwives: What is important and meaningful for this occupational group, related to the professional and practical perspectives of the care they provide?

The epistemological issue associated with social research is the question: What is – or should be – seen as acceptable knowledge in a discipline? This in turn leads us to the position of constructivism, which challenges the suggestion that categories such as organizations and cultures are external realities that social actors have no influence on (Clark et al., 2021). This study took the epistemological position of the social constructivist perspective, where the idea is that social phenomena and their meanings are continually being created by social actors. This included reflections on how knowledge is created, thus honoring the fact that all knowledge exists in a social setting, and relates to what you already know (Clark et al., 2021).

3.3 Data collection

3.3.1 Sampling

A sample in research is the researcher's way to the data, and the foundation for the findings (Malterud, 2011). Considering which occupational group follow the women in need of maternal care for the longest time space, midwives were chosen to be this research's focus. To understand the world from the midwife's point of view, required the beforementioned closeness between the researcher and the participants (Tjora, 2011). The utilized interview method allowed a deeper dive into each participant's thoughts and experiences (Bryman, 2015), and the process of the recruitment started with deciding some criteria. The informants had to be educated as midwives, which means a bachelor's degree in nursing, followed by minimum one year of professional practice as a nurse, and then a two-year specialization in prenatal care, birth care and women's health. The informants had to be currently or formerly employed in Inland County. Further, it was assumed that this background would mean the ability to speak Norwegian, and an age above 18 years old. In the interest of doing a purposive sample that could give relevant information for this study's research, it was in addition to the mentioned criteria preferable with different educational and work experience backgrounds.

As pointed on by Braun & Clark (2019) ideally saturation should be used to determine the sample size, with reference to the point where no new information is gathered. However, in qualitative research saturation is sometimes not a realistic goal as the practical aspect often has a role in the sampling (Braun & Clarke, 2019). Related to the framework of this study and the time available, 8 midwives were recruited to participate.

3.3.2 Recruitment

The participants were recruited through municipal public health clinics and hospitals in Inland County. The process started with emails sent to three different health stations, which resulted in one reply from a unit manager, responsible for one of the contacted health stations plus two others. The unit manager then functioned as a gatekeeper (Clark et al., 2021), who forwarded the request for participation in the study to her units' four midwives. Out of these, two agreed to participating. During the whole of the recruitment period, several emails were sent and calls were made, to eight different health stations, three hospitals and one delivery room. As mentioned, the practical aspect often has a role, and as anticipated midwives, and particularly the ones working in the hospitals, are a somewhat challenging occupational group to recruit. Several of the emails and calls went unanswered, and an extended process of trying to establish contact took place. In addition, invitations to participate in the study was posted in the social medias Facebook and Instagram (See appendices D and E). Further, when the first participants were recruited, the snowball method was utilized, which entailed that the enrolled participants were asked if they knew of anyone eligible to participate in the study (Clark et al., 2021). In summary, eight informants were recruited from three of Inland's health stations and two hospitals. See Table 1 for an overview of the informants' characteristics.

Table 1. *Research informants' characteristics (N = 8).*

Informant name	**Current employer**	**Work experience (years)**	**Institutional experience**	**Additional education**
Linda	Municipality 1	36	Municipality and hospital	Mental health, Management
Hanne	Municipality 1	13	Municipality, hospital and accompaniment services	Sexology
Gerd	Hospital X	45	Municipality and hospital	No

Ann	Municipality 2	36	Municipality and hospital	Mental health
Gabriella	Municipality 2	15	Municipality and hospital	Mental health
Tina	Municipality 3	23	Municipality and hospital	Acupuncture
Alice	Municipality 3 and hospital Y	7	Municipality and hospital	No
Lena	Hospital X	23	Hospital	Mental health, Acupuncture, Knowledge-based practice

Source: Fieldwork data 2023

3.3.3 Semi-structured interviews

The semi structured life world interview is defined by Kvale & Brinkmann (2015, p. 6) as "[…] an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena".

This method of data collection is an attempt to understand the world from the subject's point of view, and unfold the meaning of their experiences and their lived world (Kvale & Brinkmann, 2015). Interviewing, including research interviewing, is a method based on everyday conversation, involving a cultivation of conversational skills that most adult humans already possess. These well-known conditions, makes it important to see the difference between everyday life conversation and professional ones, and recognize that the cultivation of these skills can be challenging. Further, the professional conversation should include a different set of rules and techniques, with structure and purpose (Kvale & Brinkmann (2015).

The interview technique utilized in this study aimed to gather varied data related to the informants view of maternal health and the maternal service provision, with an informal setting that traditionally contributes to a closeness between the researcher and the research

(Tjora, 2011). The interviews were done one on one, face to face, in a place chosen by the informants. The meetings started with a recap of information regarding the study and the formalities related to their informed consent to participate, before continuing with an interview based on an interview guide (See appendix III). This means pre-written questions, with the possibility of follow up questions, to delve deeper into something the interviewee says. The interview guide started, as recommended by Merriam & Tisdell (2016) with factual, sociodemographic-type questions, and was structured around themes, categorized from this study's research questions.

In the interest of building rapport, the researcher used visual cues of friendliness, such as smiling and maintaining eye contact (Clark et al., 2015), knowing that the knowledge potentially produced in a study like this depends on the social relationship of interviewer and interviewee. This social connection depends on the interviewer's ability to create a stage where the interviewee feels comfortable to reflect and share (Kvale & Brinkmann, 2015).

3.4 Data management

The data was recorded using the Dictaphone app on a mobile phone. As security, a second recording was done with an iPad. The data was then stored using Nettskjema, and Educloud. Nettskjema is a digital tool for collecting data from questionnaires, interviews and images (University of Oslo, n.y.a), and Educloud is a platform for safe storage of research data (University of Oslo, n.y.b). The recordings were then transcribed verbatim and stored in a HINN office 360-onedrive account.

3.5 Data analysis

The transcriptions were analyzed using Thematic analysis, a method for identifying and reporting patterns within data (Braun & Clarke, 2006). Thematic analysis should be seen as a foundational method for qualitative analysis, and provides a phase-by-phase guide suitable for novice researchers. The method is called the first method a researcher should learn, as it provides core skills that will be useful for several other forms of qualitative analysis, and has an accessible and theoretically flexible approach, which can be applied across a range of theoretical and epistemological approaches. It is thus compatible with both essentialist and constructionist paradigms within psychology (Braun & Clarke, 2006), and in turn this study. Below follows an account of Braun and Clarke's reflexive approach to thematic analysis.

3.5.1 Thematic analysis's six-stage process

The six stages of Thematic analysis started out with getting familiar with the data (Braun & Clarke, 2006). In this first phase the focus were on trying to look at the data with fresh eyes by being aware one self's initial reaction to the interviews, and actively trying to unpick the assumptions the project was entered with. In other words, the process contained the question: Would the interpretation of these words be different, with no previous knowledge of this field? Transcribing the material verbatim had an important role in this, and the process started as soon as the first interview was done. To ensure anonymity the informants were given pseudonyms, and relevant characteristics such as current employer, experience and education were organized in a table. See Table 1.

Throughout the process, when possible, the transcription would start following each interview. In between, parts of the recordings were listened to, sometimes related to a specific need to revisit something that was said during the interview, sometimes just to become more

familiar with the data. The transcripts were read several times, actively searching for meanings and patterns in the data, plus ideas to explore further in coding. Braun & Clarke (2006) assert the importance of becoming familiar with the data before the coding process starts.

3.5.2 Establishing themes and sub-themes

In phase two the data was coded with NVIVO, a program used to organize data, and further to uncover insights and produce articulated and trustworthy findings (QSR International, 2023). The coding was done inductive, where the analysis is located within the data content, resulting in codes, themes and sub-themes coming from the data (Braun & Clarke, 2022). In inductive coding the researcher aims to produce codes that are free from any pre-conceived theory or conceptual framework, meaning that this study's data was "open-coded" in order to best represent the meaning as communicated by the informants (Braun & Clarke, 2013).

In phase three the codes were then combined into themes with relevant data to each theme, before potential sub-themes were written down. Phase four involved revising the initial themes, and checking if the extracted codes fit into the generates themes. The fifth phase was to give adequate names to the generated themes, and the sixth and final phase involved writing the report in findings (Braun & Clarke, 2006).

During each step of the analysis, and finally in the writing of the findings, a conscious thought to preserve the atmosphere in each interview was implemented. The analysis needed to sufficiently capture both discourses and emotions present in the data (Braun & Clarke, 2022). The entire data set was through the process systematically worked through, to achieve codes, themes and sub-themes that are consistent with the data.

According to Braun & Clarke (2006) a theme captures something important about the data. How "important" the theme is, is not necessarily dependent on quantifiable measures, but rather on whether it captures something important in relation to the study's aim. See table 2 for an overview of themes and sub-themes that emerged during analysis.

Table 2 – An overview of themes and sub-themes

Theme	Sub-themes
Views and perceptions on the maternal service provision	Information Person-centered care Someone to talk to/reassuring Regular follow up vs. something extra Blood pressure, urine test, baby's heartbeat, measure size of stomach, blood work General health/sickness Birth control, STD test, smear test cervix Preparation birth Breastfeeding Map network – who can you turn to? Screen for depression Screen for violence "Ti smarte tips" Prepare for birth Postpartum conversations Home visits 6 week follow up
Views confirming a need for debate	Better the maternal service provision Streamlining and profit-based care The partner needs to be present at birth The midwives on the postpartum ward are being replaced with nurses A narrowing maternal service provision Worry about the future maternal service provision Midwives are fleeing the hospitals The directorate of health's written standard is not followed Result-based financing and normal birth Mental health in pregnancy

	A passive government A government that won't listen to professionals The role of the media Arrogance in management Poor working conditions in hospitals Lack of staff Lack of competent staff Postpartum care neglected for years More complicated than low numbers on maternal mortality and stillbirths Spiral effect with unprocessed trauma Great variations around the country Midwives leaving the hospitals Midwives leaving the profession
Views portraying a nuanced look at the debate	The centralization of maternal service provision is necessary because of adequate staffing The criticism does not fit this county More complicated than the protesters say No great distances in Eastern Norway Transport births will never be completely eliminated A lot of emotion in such a debate, not necessarily objective inputs Aggressive tone in the debate - if you scream too loudly, you won't be heard Great variations around the country

3.6 Methodological reflections

3.6.1 Trustworthiness in research

Trustworthiness in research is about choosing some criteria to assess the quality of the research (Thoresen et al., 2020), a process which is crucial to the usefulness and the integrity of the study (Cope, 2014). In order to ensure trustworthiness for this study, notions of credibility, dependability and transferability were utilized, with the presumptions that a text

always involves multiple meanings and opens for some degree of interpretation (Graneheim & Lundman, 2004).

3.6.2 Credibility

Credibility of the study is about how believable the findings are. To ensure the credibility for this study's findings the research was carried out according to the principles of good practice, followed by a thorough examination of the data (Bryman, 2016). Further, reflective journaling was utilized to maintain a visible order throughout the planning, recruiting, interviewing and analyzing (Connelly, 2014). To maintain different perspectives, this study chose to contact both health stations and hospitals, located in both medium large and smaller cities. Lastly, a collaboration with an academic supervisor during the research process helped to increase the credibility of this study.

3.6.3 Dependability

Dependability is similar to reliability in quantitative research (Connelly, 2014), and refers to the stability of the data and the conditions of the study (Polit & Beck, 2014). Conditions may change over time, and the procedures for dependability include decisions about every aspect of the study (Connelly, 2014). The recruitment was done by email and/or telephone, with a determined content of information, followed by a question of participating in the study.

Every meeting started with information about the recording and the planned transcribing, and that a copy of the transcript, and later on the thesis, will be available for the informant, should she wish to receive it. An interview guide was utilized to ensure the participants were asked the same questions, followed by a verbatim transcribing to safeguard nothing would be lost between the conversation and the written data.

3.6.4 Transferability

Transferability is about the extent to which the findings are useful to persons in other settings. The data collection and results must be presented with a description of the context, location and people studied. In this thesis' case this will include an overview of the informant's characteristics (See Table 1) and relevant information included in the results chapters. In addition, transferability is about a need for transparency regarding the analysis part of the study, and the trustworthiness as a whole (Connelly, 2014).

In addition to the mentioned criteria Connelly (2014) emphasize that we also need to include considerations related to the ethical implications, for example a written consent from the informants to participate and safeguarding their anonymity.

3.7 Role of researcher and reflexivity

Every researcher needs a critical reflection regarding the position she is taking as a researcher (Merriam & Tisdell, 2016). Malterud (2011) points out that the question is not *if* the researcher affects the research process, but *how*. From the idea for a topic, via the research problem, the sampling and recruitment, the data, the analysis and the results, the professional interest, motives and experiences of the researcher will be influencing (Malterud, 2011). Being that I as a mother have been a patient and user of the maternal services this thesis is researching, thus both the topic and the results is something that I have an emotional investment in. Which also can be said to be the reason I chose this topic for my thesis, and to some degree made me capable of doing this study. This made it a point to actively keep one self in the background, but also not forget that I as a researcher is visible in the material (Malterud, 2011). Overall, it is necessary to keep in mind, that this study is not about my personal beliefs, nor about my experiences with the Norwegian maternal service provision.

3.8 Ethical principles

All researchers, and institutions where research is conducted, have a legal responsibility to ensure that all research take place in accordance to recognized ethics norms (Regjeringen, 2021). The ethical principles of no harm to participants, informed consent, whether there is an invasion of privacy and whether deception is involved, must be implied (Clark et al., 2021). Further, the topic of the research itself should preferably be something beneficial to society (Tjora, 2011), and when presenting the results, the anonymity of the participants must be ensured (Clark et al., 2021).

In accordance with guidelines the potential participants for this thesis received an information letter with consent form (See appendix II) via email. Included in the letter was a request to read the information in preparation for our meeting, and word that they at the meeting would be asked to sign the consent form, stating "I consent to participating in the interview".

The information letter also stated that they at any time during the process, could withdraw their consent, by sending an email and stating their withdrawal. Throughout the process, including in the transcriptions, the anonymity of the informants was guarded by using pseudonyms and removing personal details (Kvale & Brinkmann, 2006). As stated in the information letter, all recordings and transcriptions will be deleted when the thesis is graded.

3.9 Institutional clearances

Prior to the recruitment of participants this study was registered with Norsk Senter for Forskningsdata (NSD), to ensure that data protection requirements were met. The application was sent when the project description was accepted by Inland Norway university

of applied sciences, and the study was approved by NSD, reference number 482407 (See Appendix I) in January 2023.

Chapter 4.0 – The midwives' views and perceptions of the Norwegian maternal service provision

This and the following chapter will summarize the findings of this study. The analysis resulted in three key themes, with sub-themes, and the presentation of these is divided into two chapters. First, this chapter will provide a summary of the informant's experience, current employer and additional education.

With the emphasis that being a midwife working in the municipal health station is different day to day work from being a midwife working at the hospital, a presentation of the midwives' experience and current workplace across the sample is warranted. Of the eight informants six midwives are currently working in a municipal health station, two are working in a hospital and one is currently working both in a health station and in a hospital. Seven of the informants have during their careers gained experience both in the municipal health care service and in hospitals, and one midwife has spent her whole career in the same hospital. In addition, one midwife has experience from accompaniment service for birthing women living with distance to the hospital. The midwives' years of experience ranges from seven to 45 years, with seven out of the eight having more than ten years' experience. Four informants have an additional education in mental health, and five have additional education related to management, sexology, acupuncture and knowledge-based practice.

4.1 Midwives' views on their position as care workers

Four informants said they had always known that they wanted to be a midwife, mentioning that it was implied from a young age, either by themselves or people around them, that was where they were headed. Linda said: "My mother used to always say, when I was little, that you should be with children [...] Somehow it just felt very, very natural. I never thought that I could do anything else, than be a midwife."

In general, all informants talked fondly about their work, with a specific appreciation of having a varied work day with different tasks. Further, it was emphasized by the majority that being part of someone's birth is quite a special experience, and something they value. Both Linda and Ann expressed missing being part of this, from their time working in hospitals, with Ann pointing out: "I felt kind of high after every birth, you know. I always thought it was very, very cool to be the one to welcome the child, and be allowed to take part in that." Alice added: "If I ever stop thinking it's fun, or stop being utterly fascinated…or stop thinking it's the coolest thing on earth, then I should find something else to do." While Gerd, whose been working for many years in a hospital, summarized with a smile: "After all, we talk about our birth until we're six feet under!"

4.2 Women's needs in pregnancy, birth and maternity

When talking about their work and the women they meet, the informants expressed themselves with engagement and sometimes pure joy. They talked about how women's' needs in pregnancy, birth and maternity are multiple and sometimes complex, and Ann stated that the feeling of having meant something to someone is important. "People should walk out of the office feeling that they got something more than just me saying that their urine test and blood pressure were fine, that I have time to listen to them, that I care about how they feel."

Tina mentioned she has a mantra, a specific goal for her work, which is to guide the women through the journey of pregnancy and birth in the best way possible. Whereas Linda mentioned how when she experiences that solid contact, and a kind of alliance and an acquaintance, it is a truly good day at work:

> Right now, I have a SMS dialogue, with someone I did a home visit to yesterday, who was having problems breastfeeding. She's sort of started to crack that code, she and the baby. It's very rewarding, you know, when she tells me that: Yes, we made it, the kid has got it, I've got it. Yesterday she wanted to start with formula... So, I said give it one more day, we'll try together, right?

4.3 Satisfaction over being close to the patients

Another subject mentioned by all informants was the experience of getting close to the women, and the importance of taking the time to talk, and be an emotional support to them. Linda mentioned how she gets very close, and how the best part of her job is the "golden moment" when a deeper contact is being made. She explained how the women gets to choose if they want to do their checkups at their general practitioner or at a midwife, and emphasized that in addition to having the expert knowledge, midwives also have the time for a longer chat, with often up to an hour ear marked for each patient. Linda started out recognizing how the physical exams with urine tests and blood presser among other things are important, but that she firmly believes the most important part of her job is the pregnant woman's need for someone to talk to, about everything that is changing in her body, and everything that is going to change in her life. And, further what all these changes and the additional vulnerability does to her state of mind:

> The most important thing is that the girl, who is 23 years old, tells about when her mother died when she was twelve, and everything that happens when she becomes pregnant….the vulnerability becomes so clear. It comes out so violently when they become pregnant, the need to be allowed to talk about things.

Ann described how they at the first consultation have many points to go over, such as the mother's childhood, where and how she grew up, who she is close to, such as family and close friends:

> If the father is there, I ask him as well. What do you carry with you, from your own childhood, upbringing, in relation to becoming a parent? If there are things that have been difficult, then it is good for me to know, because then we can offer support, and perhaps prepare them in a different way during the pregnancy, to ensure that meeting the child will go well.

4.4 Assuring a sense of security

Hanne explained how you need to try to fill the information need of the pregnant woman, and adhere to her search for a sense of security in this new situation she is in. Then she talked about the changes, how she tries to prepare the woman, for everything a mother, particular a primiparous, has in store, with the body that changes, breastfeeding and the relationship between the mother and her partner. "Their relationship... which challenges the mother and her partner might experience, in relation to sexuality, closeness, intimacy…things like that."

Ann went on to explain that they are recommended by the health authorities to ask everyone if they have had any mental health challenges, and also to ask specifically about violence. Gerd, confirmed this, when talking about meeting the women for the first time:

> It's very exciting, every single time. I'm going to try to get to know her, and create a good relationship, so she will become confident in me, and confident in what we will go through together. And I will try to capture what expectations she has for her birth, and for what lies ahead. And I will also try to capture what experience she has in her life. Because we know that if you've had...yes, been exposed to sexual abuse, right, then it's more...tougher to go into labor, for example. Yes, there can be so much in life... So, if there is something that is important for birth, then it is important that I capture it. It creates a trust, in me, quite simply.

Ann summarized the first meeting and trying to get to know the woman for further follow up in one question: “Regular control program, or does she need a little extra?”

4.5 Different needs for the primiparous and the multiparous?

All of the informants described that there are differences related to what patients need. However, those differences are not necessarily linked to if they have been through pregnancy before or not. Gabriella described those primiparous who are well prepared and have read all about pregnancy and maternity. Tina described another type of primiparous: “Those who come a bit blue-eyed, naive, with an open mind, who think that this is probably going to go over well.” Both of these categories are over all satisfied with asking a few questions and go through the regular control program at each visit. This also, in general, goes for the women who has had a good experience giving birth the last time. However, for the

multiparous mothers a lot rides on how the last, or the previous experiences was, Gerd pointed out. “And then you have the first-time mothers who dread it from day 1,” Tina said. “But still, you have a different way of dreading it than those who have experienced it before.” Tina emphasized that there is definitive a general difference in meeting the primiparous and the more experienced ones, related to what you focus on during the meetings. However, as Ann pointed out, a general way to describe what the women need, regardless of previous experience or not, is a sense of security. It may differ what they need to achieve this, but the underlying need is always about feeling safe. The difference lies in how each individual, in each pregnancy, achieve this. Linda commented: “I consider that to be time well spent, that they are allowed to talk about what they want, and spend time on it, particularly during that period of pregnancy, I think that in the long run is money well spend!”

4.6 Person-centered care and Case load midwifery

The focus on the individual and their personal needs, with the phrase “person-centered care” was mentioned by several informants as something they strive to do, elaborated on by Alice: “A person-centered care, that is perhaps the most important thing. And the way you do it, with time as an important factor.” She went on to explain how, even though the system is not necessarily made for person-centered care, she tries to take her time with each patient and get them to open up about their needs. “But then they don’t always know themselves either. Sometimes it’s just that you have a concern that you can’t quite put into words, while other times they have very specific questions, right? Can I eat this? Or can I go to a concert, with a lot of noise?” Further, Alice pointed on the importance of seeing each patients’ individual challenges. “Pregnancy is not an illness. It's kind of a normal thing. But, also with that in mind, that there is nothing that you can get that sick from that quickly, like pregnancy. Some people get really sick from being pregnant, and they need to be seen.” Then Alice talked

about a patient of hers, a multiparous, pregnant with her third child, experiencing a severe birth anxiety, that she went some extra lengths to help. The patient had some help from a District psychiatric center, where she met a young, male, newly qualified psychiatrist with no experience of pregnancy, birth and maternity.

> So, then I offered her extra conversations, with focus on emotional support. I think she was with me almost every two weeks during her pregnancy. And I went to visit the hospital with her and partner, where we got a tour, and could look at all the equipment, we looked at everything...what is this for, what happens in here? During we talked about what she remembered from her previous birth. It was sort of like exposure therapy. In some cases, I go the extra mile.

Alice added: “To some degree I decide my own schedule; I can set up additional meetings if the individual needs it. In this municipality that is possible. I believe my colleagues do the same, to facilitate extra consultations for those who need it. However, it is very clear, that this is not the case in all municipalities.”

Alice also mentioned how she sometimes get to meet the patients again, in birth at the hospital, that she has gotten to know in her work at the health station:

> It's a stroke of luck when that happens, truly a heartfelt reunion where you see someone you know. I mean, my personal opinion is that it should always be that way. That you do sort of a Case load model, where the idea is that one small team of midwives follow each pregnant woman, through pregnancy, birth and maternity. So that you as a patient can get to know the people who’re there to assist you, also in birth

> and during the maternity. I think that would have been the absolute ideal. But the system is not like that, it is too expensive.

Alice summarized, by saying: “It is very good for the patient to have as few people as possible to deal with. I am thoroughly convinced of that fact.”

4.7 Views and perceptions of midwives on existing guidelines

The majority of the informants referred to the written guidelines provided by The Directorate of Health, saying that the care they provide at their place of work is somewhat deficient, compared to the guidelines. Gabriella specified that she thinks the care she and her colleagues provide during the patients’ pregnancies largely follows the guidelines, but that the care provided during the birth and the postpartum period is lacking: “Especially birth…you are supposed to be 1 on 1, and it is supposed to be a differentiated offer. When it comes to the time after birth, there are very few general guidelines on what to do.” She then modified her first statement, saying: “But it’s probably very different from place to place, I know that in the big cities pregnant women often wait a very long time before they get a midwife appointment.” Agreeing, Tina emphasized than none of the hospitals in Inland County follow the 1 on 1 standard, before she talked about how the standard has the phrase “proper health care” in it, and how that phrase requires a definition. “Proper health care should probably include that one could prevent depression, for example. That does not exist in the hospitals as of today.” Further, Tina highlighted that she thinks particularly the postpartum care has been neglected for years. “It’s been like, when you’re finished giving birth, you’re done with the hard parts... But if there’s one thing we see her at the health station, it is desperate mothers

who has become depressed because they did not receive sufficient help in the first days after the child's arrival."

Gabriella went on to explain how they often do not manage to do home visits within three days after birth, as recommended by the standard. This was supported by all the informants currently working at the municipal health service. Some spoke about only going on home visits to the primiparous, and not having the capacity to visit the multiparous, others talked about how they managed to prioritize doing home visits to everyone, but that they knew of municipals in Inland where no one gets a home visit. Ann talked about how the system forces the midwives to prioritize the pregnant women, and how the home visits then sometimes fall on the health nurses:

> And it is so important that it is the midwife who makes the first home visit. Because it is supposed to be an extension of the hospital stay. When we discharge quickly from the hospital, the midwife must come early for a home visit [...] so that the midwife can also take care of the mother's health, not only the child. How the mother feels after giving birth…. A lot of places, the care is lacking.

Linda explained: "We do not have the capacity to do home visits to all. We are not allowed to do that, because we do not have enough midwives for that. That is one thing that is lacking here, we should have a much higher vacancy rate, to reach the right amount of capacity."

Alice talked about framework versus the individual employee going above and beyond to deliver according to what they believe to be sufficient care:

> That's just because each individual has pushed themselves to the max, and that's what they've been doing for quite a few years. And then there is the question, how long will it take before that rubber band breaks? I am seriously concerned that we are facing such a situation, that we are really on the way to ruining the system...on a national basis, I mean, that we are about to sink that ship so thoroughly, that there is no way back.

4.8 Unmet needs

The majority of the informants admitted to believing that their patients might have unmet needs. Still, they emphasized that they felt lucky working in their county in particular, that the maternal service provision there is a solid one where the patients are *mostly* being met on their needs. Alice elaborated on this saying that she knows Inland is quite different than how it sometimes is in the big cities, where you might not see a midwife before you are way past the first half of your pregnancy, and where the responsibility is given to the individual with the recommendation to read a book or listen to a podcast on pregnancy. Tina talked about how the threshold for transferring the patients to other services is so high, that the health stations service should include more psychological help, in terms of giving the patients the “psychological tools” they need to come through the pregnancy and maternity in a good way.

Several of the informants emphasized how they believe the care during pregnancy is better than the service given during both the birth and the maternity. Linda talked about how the health authorities need to change the staffing at the hospitals:

> Especially regarding delivery rooms and maternity wards. Now nurses are taking over much of the maternity care in hospitals. I don't know if this applies to many hospitals,

> but at least here it's like that. Care that needs to be done by midwives! In a maternity ward, there must be adequate staffing, so that the midwives don't have to work around the clock, on Christmas Eve and the 17th of May[5]... When there is poor staffing in a maternity ward, it is simply misogynistic!

4.9 Mental health in pregnancy and maternity

All informants talked about a clearer focus on the mental health aspect of things, compared to how it was earlier in their careers. Tina mentioned how they now have several offers for their patients, that it is no longer purely a physical checkup, but a much more solid focus on preventing depression in pregnancy and postpartum depression. She described how they put in extra calls to the patients they know are struggling psychologically. As an example, she mentioned that they have recently introduced a depression survey, which also means more support calls to the women. She explained how these talks, in combination with the guideline on home visit, gives them a unique contact with the patients:

> They call, they text. They ask what is normal. So, the part of the job that you didn't have before, when you finished at birth, you have now taken back to the health stations, with much more breastfeeding guidance and not least in relation to these mothers who need support for ailments and challenges psychologically.

Tina summarized this by saying that she feels there has been a huge change in how they view the follow-up of a pregnant woman, just in the last few years, and further that she thinks that this leads to better care for a lot of the women.

[5] Norway's national day.

Mentioning the indicator that 1 out of 3 women are depressed, several of the informants expressed that that number seems somewhat high. Tina said: “1 out of 3 sounds like a lot. And I don't think I could have picked out that kind of amount from my patient list, you know?” But, she reasoned, it also depends how you define “depression”, and that a lot of women probably feel depressed without talking about it: “We know there are a lot of women who never tell anyone. Who believe that it should be like that. But who might realize it when they give birth to their second child. That this time around everything feels different. Then, maybe I was a little depressed the first time?”

The majority of the informants mentioned that they have included the program “Ti smarte tips” (“Ten smart tips”) developed by Stine Sofies Stiftelse[6]. It is part of a program developed in collaboration with parents, professionals and health personnel, which follows national guidelines for pregnancy, maternity and the health stations work. The program is free and available for all expectant and new parents, and aims to strengthen the parental role, provide support and give tools to deal with what is demanding, and thus prevent situations that are unsafe for the child (Stine Sofies Stiftelse, n.y.). The midwives called the program a helpful tool, that the patients respond well to. Alice emphasized that she uses a great deal of time with the patients and their partner trying to “form parenthood”, related to the first three tips, which are: talk about your childhood, talk about your expectations and speak up if you are not well. Regarding the time after the baby is born, the program urges the parents to think about who they can turn to when they need support, to pin out who are their network, and further to have an “Oh shit plan” (Stine Sofies Stiftelse, n.y.).

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6 Stine Sofies Stiftelse is a Norwegian non-profit organization that works for a childhood without violence and abuse (Stine Sofies stiftelse, n.y.).

Chapter 5.0 – The midwives' views and perceptions of the criticism and ongoing debate

This chapter will give an overview of the informant's thoughts and experiences related to the criticism and debate of the Norwegian maternal service provision. The majority of the informants were to a large part agreed with each other, when talking about the criticism and debate. To start with, all of the informants confirmed to having heard of the two organizations Barselopprøret and Bunadsgeriljaen, who are at the front of the criticism and leading the demonstrations. The majority talked about feeling a general support regarding the debate, and a perception of support amongst their colleagues as well. Linda said: "I think it's great that someone stands on the barricades. They stand on the barricades for women, and for women to get a better offer." Alice expressed: "It's a bit of a grassroots rebellion; lay people are also reacting to the conditions. And I think you should have that, they have very important voices."

5.1 Nuancing the criticism and debate

Further, the informants mentioning some nuances they felt were important and often left out of the debate, especially in relation to the criticism regarding the centralization of maternity wards and delivery rooms fronted by Bunadsgeriljaen. Gabriella specified how she in the beginning experienced that a lot of her colleagues were very positive to the message of Bunadsgeriljaen, but that after a while their message got a little too pointed: "I know that some people feel that Bunadsgeriljaen…that it sort of feels… It cannot be a goal in itself to preserve every maternity ward and every delivery room in every deserted place, you know."

Linda said:

I'm not so sure about the criticism regarding the birthing institutions. Because if I understand the message correctly, it's about all maternity institutions in the country being maintained. [...] You simply don't have enough people. Neither midwives, nor gynecologists, to look after all those maternity wards.

Tina stated:

It's two-sided. For me, I am very much in favor of there being maternity wards that are at a reasonable distance for the pregnant woman. Because it is clear that distance is a big concern for many. Not getting there in time, not getting satisfactory health care... But at the same time, I'm a bit ambivalent. Because I know what it means to stand alone as a midwife, and to feel that you don’t have qualified people beside you. When you work with only substitutes, also with substitute doctors, then that also doesn't feel particularly safe [...] And of course one understands, and certainly supports, Bunadsgeriljaen who wants to preserve these small maternity wards. You understand that, and you understand the local people who want it. But at the same time, I feel that if you don't have qualified people at work, it doesn't help to have an open maternity ward.

Gerd agreed with Linda and Tina, saying that she thinks the conditions related to staffing at the birthing institutions are more complicated, than how Bunadsgeriljaen is portraying things.

Alice said:

> When some people whine about it being too far of a drive between Hamar and Moelv[7], if that's where the new hospital will end up… But, I have never worked up north, and have no personal experience how it's like to travel for four hours with contractions, you know? Sure, Norway has a geography that makes it difficult in some parts of thew country. You simply do not have equal health care. And I don't really know how you could achieve that.

Regarding the criticism fronted by Barselopprøret Gerd said:

> I don't think the criticism is really fitting here. At this hospital, the ladies can stay for five days, if they want to. When I welcome them, I usually tell them that that's the heading for their stay here, yes, there is the birth, and then there is the postnatal period, and for them to get started with breastfeeding, and feel safe before you go home.

Alice agreed with Gerd, saying she thinks people in Inland County are privileged. Then she said: "You hear stories, typically from the largest maternity wards, where patients are being left to themselves, and don't get information about breastfeeding or..best case, you get a link, or something. And that's not what postpartum care should be. But I feel we are privileged here."

Emphasizing that she thinks the fight for a better maternal service provision is an important fight, Lena had some hesitation related to how the protesters do it: "I think they are

[7] The distance between Hamar and Moelv is about 18 miles.

a bit too aggressive," before summarizing: "I feel for Bunadsgeriljaen now. They're screaming their lungs of. But no one is listening."

5.2 Views on how the health authorities receive the criticism

The majority of the informants expressed thoughts that the authorities do not take the criticism seriously. Alice said: "I have to say that I think that the government we have now, I am very disappointed; there is no action, just words. And investigations and commissions, and just very bureaucratic." Tina said with a short laughter: "Only the wearer knows where the shoe pinches…I guess it's often like that when you're a little higher up the food chain," and then she went further to say:

> The Health Authorities look at numbers and statistics. How many children are injured, or die, or how many mothers get injured or dead… But for those of us who's working this stage, and see ladies who don't get help, ladies who don't get a midwife beside them during labor, when midwives have to run between patients, feeling that insecurity... Then it's about these human conditions, which you cannot measure in numbers.

Tina then went on to talk about her meetings with the women after they have given birth:

> I ask the women, what was the most traumatic thing you experienced? They answer: No one saw me. No one listened to what I was trying to say. No one saw how much pain I was in. Sure, they said everything was normal, but no one saw how scared I

> was… And being able to pass that on to the health authorities…we are not being heard.

Lena, who is working in hospital X said the same thing: “We are not being heard”, and Hanne said: “I can’t tell you much about what the authorities do, but I believe it’s all about the money. And that might also come at the expense of what would perhaps be the best for the patient.”

5.3 “We don´t even speak the same language”

Several of the informants singled out the closing of the ABC-Clinique[8] and the statements from certain health authorities in that context as something negative, and a sign that the authorities do not adhere to the guideline that says there is to be a differentiated offer for women giving birth. Alice said:

> It is very provocative, what has been said about ABC being a luxury offer for women with a high level of education[9]. Then you have misunderstood something very fundamental, you have simply misunderstood the concept, because it is about a holistic and person-centered care, and not about how high your education is, or what postcode your apartment is in!

Tina shared the same sentiments as Alice:

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[8] The ABC-Clinique was a midwife driven delivery room under Oslo University hospital, who after much protests closed down in mars 2023. ABC stands for “Alternative Birth Care”.

[9] During a meeting in August 2022, the director of Oslo University Hospital Bjørn Atle Bjørnbeth is said to have stated the following regarding the ABC-Clinique: *"Our task is not to create a maternity service for well-educated 32-year-old women from Ullevål Hageby"* (Berg, 2023).

> Even if the authorities stop by and have a look, they will never really understand how you feel as a midwife, on a shift where you are responsible for three births at the same time, and you know that if I make a mistake now, if I overlook something now, it could be fatal.

Alice added:

> There is a certain arrogance portrayed, which also contributes to people leaving the profession. The people who quit their jobs think that... well, if that's how you see it, then we disagree so much that we can't....we don't even speak the same language.

5.4 Demotivational conditions and concerns for the future

When speaking about whether or not the debate affects their job directly, the majority of the informants started out saying that it does not. Several mentioned that in Inland County the maternal service provision is mostly solid, and that they feel the criticism is mostly not relevant in their county. Still, several informants went on to reflections that made them conclude that parts of the criticism hit them in some ways. Tina talked about how the debate doesn't affect her personally, but that she can sense the insecurity it gives the women when they visit her office. Alice, who currently works both at a hospital and in a municipal health station, pointed out that of course the debate is a recurring theme when the colleagues meet. She went on to saying that she does not think the debate really affect her daily work, but that she herself sometimes feel a demotivation related to working at the hospital:

> You *know* it's going to be very busy. And you don't know what your shift will bring. How many people will come to work that day? How many substitutes are there? Who have their first shift. Which you have to take care of, to train, again and again and again, right? So, the motivation to work in the municipal health service is much greater. Because here I feel I have the framework to do the job I think I should do, and give the offer I think pregnant women deserve.

Gabriella said:

> I'm a bit worried about how things will turn out in the future. Because there is a huge shortage of midwives. And….many of the midwives who work now, they will soon be retired. So, I've sort of thought a lot about what maternal care will look like in a few years. And then I started to think about my own children, who might want to have their own children in the future. Who will help them then?

Alice specified: "So sometimes I'm happy that I'm done having children. If I had been 22 now, and heading into having a child for the first time, I would be terrified. Because you hear so much scaremongering, so many horror stories."

5.5 The best maternal care in the world?

Referencing the fact that our Minister of Health Ingvild Kjerkol several times have referred to the Norwegian maternal service provision as the best in the world, Gerd said: "I think that is true. If you look at the world, then we have nothing to complain about. I have to agree with her on that." Hanne problematized the same statements: "That might be the case, compared to many other countries. But at the same time, we need to pay attention to the

mental health of these women. That has to be taken care of. It kind of depends, on what kind of variables they're looking at, I guess."

Linda started her respond with giving the Minister right, by referring to the low infant mortality rate in Norway, and the solid follow-up the service provision gives pregnant women, and then said:

> But the resources at the hospital, I think that's where you have to do some changes. I don't know what it's like in other municipalities, and I can't speak for anyone but myself. But when you've worked in a hospital for 25 years, and know the pace there, and then you come here to the health station…. I mean, it's a very big culture shock [...] So I wonder about the distribution in our society, in relation to a hospital institution and a municipal institution.

Alice also started out referring to Norway's statistics, then added the following perspective:

> But whether we have the world's best care, I'm not sure. And if we have it, it is because of each individual worker. The Minister of Health cannot take any credit for that. It's those who go to work every single day, and despite the inadequate work conditions they have to do their job, somehow manage to do it anyway. Also, I know that colleagues at the hospital feel guilty all the time, that they didn't do enough. It wasn't quite as it should have been.

Alice went on to pointing out that it is always a question about money, asking in a rhetorical matter how many gynecological operations they have to do, in order to continue to do maternity care.

> With the system that's in place now, where you have that result-based financing, the hospital trust does not get one krone[10] on a normal birth. I have kind of envisioned it like a retro computer game, you know? You enter the hospital, and then the taxi meter starts running. How much money can we get out of this patient? And then…the less we do, the better for the patient. I mean, if you can go through a pregnancy without complications and have a normal birth, without any interventions, and you can breast feed, and do everything that comes naturally, then the hospital does not earn a single krone off of you. But the moment you walk through that door, and the game starts, and the taxi meter starts ticking…..you know, the jackpot for the hospital is if you have a complicated birth process and you end up with a grade 1 c-section[11], and an infection on top of that, you know. Then they get a lot of money in return. Whereas for a normal, uncomplicated birth, it's nothing. And that is really sick. Because what is best for the patient then, is not necessarily what is best for the hospital.

5.6 Midwives leaving the hospitals

Regarding the Minister of Health saying that we currently have what she calls a critical shortage of health staff, Tina said: "Yes, I think that is true. And it is going to become

[10] The Norwegian currency is Norwegian kroner (NOK).
[11] There are four kinds of caesareans, grade 3 and 4 are planned in advance, and grade 1 and 2 are acute, with grade 1 meaning an immediate threat to the life of woman/baby, and Grade 2 is urgent, without an immediate life threat.

worse than it is now. But you don't feel that they do much about it. There is more talking than action [...] And then there will be emergency solutions with substitutes."

When talking about Bjørn Atle Bjørnbeth's[12] comment that the midwife shortage in the hospitals is about midwives choosing to leave the big hospitals to work less hectic jobs in the municipalities, all the informants agreed to this, pointing out that that is true in a lot of cases. Linda, who is a few months away from her own retiring, said:

> And I understand that very well. Now, when my job is advertised, it's... well, everyone wants to come here. And….there are ultrasound midwives, who have received the world's finest education at St. Olav….now, they want a job here, meaning they want to get away from the hospitals. Hugely competent, brilliant midwives, who wants to leave the hospitals!

Ann said:

> Yes, and I understand that, with such poor staffing for many years. That you have to save and cut back on positions, and you're running to the point of exhaustion [...] And then you have to split yourself between many patients, right? A lot of people can't bear that. It feels unsafe [...] There can be incidents, where you will be held accountable. Here at the health station, it's not life and death, in the same way [...] I have worked as a union representative for many years, and have always found the fact that a maternity ward cannot be defined as an emergency department so terribly tragic…and staffed accordingly. You never know what will come in [...] Obviously, there are days that are calm, but you have to staff so that you can withstand everything.

[12] Bjørn Atle Bjørnbeth is the director of Oslo University Hospital.

Lena agreed, saying:

> There are many midwives around who no longer work as midwives, who have given up. I think they need to make the conditions much easier, in relation to increase your competence, and to increase your salary [...] It's a huge pressure, not just work pressure, but also the fact that you're the one who's responsible. You're there, carrying their life on your shoulders, and you're not even appreciated. It's very...yes, I think it's tragic, that we are...not heard.

5.7 Midwifery craft and skills take time to build

Alice talked about how she has several hospital colleagues who have given up, who have said that they don't want to work in conditions like that, and have gone elsewhere for jobs, for example to teach. Further she explained how there has been a generational change in the maternity ward where she works, and that she herself were lucky:

> I kind of got a few good years with the robust bauta ladies, who have been midwives for 40 years and have seen it all! Because there are a number of things in the field of midwifery that you just don't learn at school and cannot learn in theory, but that has to be experienced. I mean, what does it look like when a woman comes in with a placental abruption? You have to actually have seen it to know it.

Further, she added:

> I have experienced that some of these robust professionals say we do not want to participate in this anymore. This was primarily in connection with the summer closing of the maternity ward, and very, very much expertise just disappears out of the hospital. Because you can't bear to fight anymore. And it's really sad, because the result was that suddenly I was the most experienced midwife there. When I had been working for 2-3 years, you know, and then suddenly I was in charge of training the substitutes, and I was supposed to be the one they could lean on [...]. Those who have left their jobs have probably felt that the management fronts an attitude…that it doesn't matter to the hospital whether you stay or go, in a way. It's like, don't think you're indispensable, we can replace you. But that's not right at all, because those who have a lot of experience, they have a distinctive and very, very important knowledge, which takes about 20 years to build. You cannot put on fast forward, and be an equally competent midwife. It's not possible. It is a craft and an experiential skill that takes time to build.

5.8 A calmer heart

Poor working conditions at the hospitals for midwives were emphasized by several of the informants. Lena spoke about what it does to you, as an employee, as someone who has been working with women's health her whole career, to always have this uncertainty, related to how busy it will be, to if you will have the time to go to the toilet, and overall, the threat of being closed down:

> I have lived with that ever since I started my professional career [...] And they say that you have the possibility to influence. You answer a lot of surveys, and things like that. But nothing happens with that, there won't be...there's no point in answering, because

you´re not being heard anyway. That's my take on it. It leads to sort of an indifference. And it is very sad, for the provision, that it has to be like this.

Linda asked in an agitated voice:

You know what the midwives at the hospitals do? They clean the maternity wards, don't they, at 3 in the morning! There are two midwives on duty, and four patients giving birth. And then they have to clean floors! I think that's so upsetting. I don't understand why they don't put on their bunad[13] and go out into the streets and scream their lungs off. Here you have a shortage of midwives in Norway…then you damn well better take care of them!

Alice gave the same impression, adding:

It's absolutely ridiculous that we have to wash our delivery rooms ourselves, because the cleaning staff went home at five. It's a strange use of resources. And I understand that after 20 years you don't bother with it anymore. So yes, then you do early retirement, or find something else to do, which is more comfortable. And I have to say that for myself too, that working in the municipal health service gives a calmer heart, than working frantically in the hospital.

Chapter 6.0 – Discussion

[13] "Bunad" is the Norwegian word for the Norwegian national costume.

This chapter will discuss this study's findings, as portrayed in chapter 4 and 5, using Dahlgren & Whiteheads "Health Onion" model and the AAAQ-framework. In addition to the theory, literary in the field will also be used to help explain and contextualize results of the study.

6.1 Views and perceptions on the maternal service provision

Dahlgren & Whitehead's (1991) "Health Onion" viewing the different layers of non-medical factors, gives us a visual of the greater context every patient the midwives meet is a part of. When the midwives talk about the importance of having the time to talk to the patients, to create a trust and trying to fill the individual's need for information, with adhering to their sense of security, it involves an understanding that the women they meet are potentially very different individuals. Despite their common condition of pregnancy, which is what brought them to the maternal service provision, they potentially have very different needs on the road to achieving the same result. Based on Dahlgren & Whitehead's model the woman's age, inherited characteristics, lifestyle, networks, living and working conditions, access to other health service and general socioeconomic, cultural and environmental conditions, will be factors with influence on her health, and further how she is able to receive or implement the offer provided by the maternal service provision. In other words, the "Health Onion" is linked to a holistic view on health, and it emphasizes that all conditions exist in a mutual influence, including political and economic systems. The informants acknowledge this when they describe the health authorities and the hierarchy both them and their patients are a part of.

An interesting finding is when Linda and Alice both talk about the midwives in the hospitals having to wash the maternity wards themselves. One might argue that here the midwives are not only commenting the criticism, but also giving their own perceptions about the structure of the maternal service provision, and how there is a need for a restructuring.

When Lena talks about how it is no use to answer the surveys, because nothing happens and you are not being heard anyway, one might say she is commenting on how the health authorities structure the evaluation of how the service provision is built. Tina is more straight forward, saying that she does not think that the health authorities pay attention to what the midwives as professionals think about the structure of the maternal service provision. This structure, midwives having to clean floors now, and the time the midwives have available for each patient, is assumably a result of the midwives being asked to be more effective, changes derived from an NPM-inspired thinking. Further, one might speculate if the NPM-thinking and the DRG-system forces the midwives to priorities between patients, and help the ones who bring in more money (Dahle & Thorsen, 2004). With cutbacks on funds and less money from the government, and a streamlining where the public sector is encouraged to work more like the private sector, NPM-thinking has led to changes in the way health care is distributed (Schedler & Proeller, 2002).

6.1.1 A maternal service provision according to guidelines

White paper 12 includes the aim that women, during pregnancy and birth, and their families, should experience a coherent pregnancy, birth and maternity care as a joyful event (St.meld. nr. 12, 2008-2009). Delivered by the Directorate of Health the Norwegian guidelines for maternity care intend to ensure that the care given is sufficient. However, the word “should” is frequently included, both in the Directorate’s own description of the use of their guidelines, and also in the guidelines themselves (Helsedirektoratet, 2014). A separate website under the Directorate of Health explains their use of language, saying that their publications refer to certain laws, for example the patient and user rights act (Pasient- og brukerrettighetsloven, 2023), but emphasize that their advice and recommendations are not legally binding for the service providers. Further, when the Norwegian Directorate of Health

says "shall", it means that the recommendation/advice is based on law or regulations, or that it is so clearly scientifically based that it is rarely justifiable not to do as recommended. When it says "should" or "recommend", it is a strong recommendation/advice that will apply to the vast majority of people, and when it says "can" or "suggests" it is a weak recommendation/advice where different choices may be right for different patients (Helsedirektoratet, n.y.). In. other words, between the written words of the guidelines and the experience of the individual patient, there are several levels of judgement involved.

So, when the guidelines states that individual centered services must consider the needs of the family, the mother, and the infant (Helsedirektoratet, 2014), the use of the word “must” is clear, but to consider a need is arguably a process that can lead to different outcomes, related to who is doing the considering, and under what circumstances she is doing the considering.

Sometimes the levels of judgement can be said to lead to a positive outcome. Several of the informants mentions using the EPDS-scale to screen for depression. Despite that the guidelines states that a screening of postpartum depression is not advised, around 50% of Norwegian midwives and public health nurses use the EPDS to assess mental health issues pertaining the pregnant and postpartum woman (Olavesen et al., 2017). A Norwegian study done in 2010 (Glavin, Smith, Sørum, & Ellefsen, 2010), and several international studies (Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Ove Samuelsen, 2001), supports this, stating that the EPDS is effective in detecting patients with depressive symptoms.

However, the informants to a large degree confirm the criticism fronted by Barselopprøret, saying that the Norwegian maternal service provision is characterized by low priority, large cutbacks and a general lack of resources (Føleide, 2022). In other words, there is a consensus among the informants that the levels of judgement often lead to negative

outcomes, and that this process is characterized by New Public Management-inspired conditions.

6.1.2 Maternal service provision under New Public Management

A pilar in the debate seems to be whether the quality standards on paper (Helsedirektoratet, 2010, 2014) are followed in the actual exercise of care or not. When Alice talks about result-based financing, and her envision of the hospital as a retro computer game, where the question is how much money the hospital can get out of the patient, she is portraying a classic New Public Management way of thinking.

When Tina talks about how the health authorities look at numbers and statistics, and how many children and mothers who are injured or die, while the midwives "working the floor" see women not getting the help they need, and there is a lot of insecurity on both parts, she is acknowledging that the focus to some degree has shifted from care to money, numbers and results. She and several of the other informants portray a general resistance against the changes affecting the service provision, where New Public Management has led to a focus on saving money, with the result-based financing and emphasis on life efficiency.

The criticism towards the maternal service provision further point out there is lacking knowledge related to maternity care, shortage of staff and an unfortunate centralizing of delivery rooms and maternity wards (Føleide, 2022). The informants of this study partially confirm this, saying that Inland County is a county with a solid maternal service provision, but also that there is room for improvement.

6.2 Views confirming a need for debate

The informants mentioned several aspects that can be said to strengthen the idea that there is a need for a debate regarding the Norwegian maternal service provision. From

working conditions for midwives, to the midwives being replaced by nurses, to the Directorate of Health's written standard not being followed, to great variations around the country, the data in this study indicates there is a need for debate. Further, this study points to a consensus among the midwives of the importance of adhering to the mental health perspective in the maternal service provision. There are substantial differences depending on which health station and which hospital you visit. Further, both Linda and Ann mention that there needs to be a higher vacancy rate to reach the right amount of capacity. It is a paradox that there is talk of a midwife shortage, while many midwives are only offered part-time positions, despite them wanting to work full time (Barselopprøret, 2021).

6.3 Views portraying a nuanced look at the debate

The third and final theme of the analysis is based on the data where the informants explain a more critical look at the debate. In spite of the general consensus that the criticism is warranted, the informants presented some objections. Particularly the criticism towards the centralizing of the delivery rooms and maternity wards needs according to this study's informants to be more nuances, as complex issues surrounding ability to staff adequately are involved. Tina explained that the request for the feeling of safety connected to having a maternity ward or delivery room in an acceptable distance for pregnant women, is very understandable. However, having a maternity ward or delivery room without the right staff, is in itself much more unsafe than traveling a certain distance to get adequate help, and that this part of the debate must necessarily be about more than just geographical distance. Gerd pointed out that although understandable that it is dramatic or even traumatic for the individual, it is an unrealistic goal to completely eliminate transport births, because a birth in its natural form is something acute.

Further, several of the informants mentioned specifically that the criticism, or parts of it, does not fit in Inland County, but that they suspect, or even know, it might be different in other counties, as confirmed by Holmboe & Sjetne's (2018b) research saying that women on a national level are not satisfied with the care they received in the maternal service provision.

Several of the informants also felt that the language and the temperament of the debate sometimes leads to distance. Tina mentioned that the debate is filled with emotions, and might not always be objective, and Gabriella summarized by pointing out how the support for the protests had initially been strong, but lessened a little with time, as the message got a little too pointed.

6.4 The AAAQ-framework

The AAAQ-framework has proven to be beneficial in monitoring maternal and child health services (Hunt & Bueno De Mesquita, 2007), using four criteria to evaluate (UNICEF, 2019). This part of the Discussion chapter will look at the midwives' views and perceptions of the maternal service provision and the debate's main messages, through the lens of the AAAQ-framework's four criteria.

6.4.1 Availability

The first A of the AAAQ-framework stands for availability and is in the maternal service provision context linked to an adequate number of facilities, services and qualified staff available.

The midwives in this study argued the importance of having a service provision with an adequate offer to the patients' different needs, and over all the opportunity to invest the time needed. Further, they portrayed an understanding that for the patients it is important to have the care available at an acceptable distance from where they live. However, the

informants stress that whit today's problems related to staffing, there needs to be a balance between the amount of birthing institutions and the available staff at each institution. As stated by both our minister of health, Jordmordforeningen, and this study's informants, we currently have a lack of staff, both regarding midwives and regarding other occupational groups needed in delivery rooms and maternity wards. In other words, the informants of this study are clear on the need for an adequately qualified staff available for all patients.

Further, the findings of this study give empirical support to the Directorate of Health's statement on there being substantial differences related to which municipality you live in (Helsedirektoratet, 2014). The informants describe that women receive different health care services, depending on the standard of their specific municipal health clinic and/or hospital.

6.4.2 Accessibility

The second A of the AAAQ-framework stands for accessibility and is in this context linked to physical, financial, administrative, socially and informative accessibility to the services. The midwives in this study argued the importance of there being a sufficient dialogue between the midwife and the patient, and partner. Several informants explained how they as far as possible take the time to connect with the patients, to give them the information they need in an understandable form, and further to uncover specific needs they might have.

6.4.3 Acceptability

The third A of the AAAQ-framework stands for acceptability and is in the maternal service provision context linked to culturally and socially appropriate care, and a sensitivity to vulnerable groups. This sensitivity to vulnerable groups is of course closely linked to the beforementioned focus on an adequate communication between the midwife and the patient. As portrayed by this study's informants, different patients will have different needs, related to

religious, cultural and/or social aspects. Further, there is a consensus among the informants of the importance of a provision with a solid focus on mental health. This means person-centered care and a framework that allows the midwives to give the support they think necessary. The informants from the municipality health stations were focused on providing a mental health perspective on the significant events that pregnancy and childbirth is, with the ending being the transition to motherhood. They valued being able to get close to the women, following them through the pregnancy, and sometimes also be able to meet the same women after they had given birth. Linda talked in detail of how she helped a patient overcome her challenges with the concrete task of breastfeeding, and Gerd spoke about how every meeting is an opportunity to try to get to know the significant details of a woman's life, with thoughts on how she will go through the birthing experience. As mentioned in the literature review research suggests that women who received midwife-led continuity models of care are less likely to experience intervention, and more likely to be satisfied with their care, than women who received other models of care (Sandall et al., 2016). The informants of this study support this with their descriptions of what they believe is an adequate maternal service provision, a framework that allows them to get close to the patients over time, with engagement and the right competence.

6.4.4 Quality

The Q in the framework stands for Quality and is in this context linked to medically appropriate care and rightly skilled, educated and trained professionals, and further if there are adequate supplies that meet relevant standards, an appropriate environment, safe and sanitary facilities and a service provided in alignment with relevant guidelines. In this study's findings the aspect of having rightly skilled, educated and trained professionals is mentioned by several of the informants. They talk about the staffing at the hospitals being challenging, and

highly educated midwives leaving the hospitals to work in the municipalities. Further, across the data materiel there is throughout a focus on the need for a framework allowing a care that focuses on the patient's best, without being obstructed by a focus on what is most valuable for the municipality and/or hospital.

6.5 Limitations

The limitations of this study are linked to what is often seen as criticism of qualitative research. It is often suggested that the scope of findings in qualitative research is restricted, particularly with a small number of informants. This study is meant to be a closer look at how the midwives of Inland County view the maternal service provision and debate, and is not to be understood as representative of an entire occupational group (Bryman, 2015) as it is reasonable to assume that a sample either from Norway's largest cities, or from the parts of Norway where the distances between the birthing institutions are far greater, would serve other findings. It can be argued that this study should have been done in an area with other premises than Inland County. It can also be argued that Inland County is an interesting geographical frame as the county contains both medium sized cities and more deserted areas. It is an interesting fact that compared to the rest of the country's population growth, Inland County has a persistent birth deficit, being the only county in Norway with more deaths than births each year in the last decade (Innlandet fylkeskommune, 2019). The findings of this study should be read with a general understanding that the findings for Inland County does not necessary apply for other parts of the country in mind. Further, there should also be an understanding that the framework of a master thesis only allows for a certain amount of time use, and typically involves a novice researcher.

Another issue pertaining the informants in a qualitative study is that one might argue that the people choosing to take part in a study like this are a certain kind of people, maybe

driven by a particular need to express something. Further critically thinking leads us to the question: Would the people who said no to take part in the study, have given different answers?

Further, the interview method is a conversational form that is known for a power asymmetry between the researcher and the interviewee (Kvale & Brinkmann, 2015). While the midwives in this study have their professional knowledge and experience, the researcher typically have the scientific competence, and she is the one to initiate and define the interview situation, with topic, questions and lastly the termination of the interview (Kvale & Brinkmann, 2015).

Furthermore, qualitative research is in risk of being too subjective, where it can be argued that the qualitative findings relate too much on the researcher's views about what is significant and important (Bryman, 2015). These are important pitfalls to consider, through the study as a whole, and particularly during the analysis and the presentation of the results. As mentioned, the researcher is the primary instrument for the research, which in itself makes a critical reflection about the position you are taking necessary (Merriam & Tisdell, 2016). Overall, there is a need for transparency, related to how the study arrived at its conclusion (Bryman, 2015).

A final limitation worth considering is the translation of the data from Norwegian to English. When studies include translations there will always be a risk of something getting "lost in translation". All of the informants used "filler words" like "in a way", "so" and "like", plus a variation of typical Norwegian expressions that are somewhat hard to translate. To minimize the risk of altering, or missing the "true" meaning of the material, a constant back-and-forth reflection between the original dataset and the translations took place.

6.5.1 COVID-19's effect on the maternal service provision

Specifically for the findings of this study it can be argued that COVID-19 has had an impact on the maternal service provision the later years, both from a midwife perspective and from a patient perspective. After the pandemic a number of women have told harrowing stories about being pregnant, giving birth and becoming a new parent during a pandemic (Thomassen &Ingulstad, 2021). It can also be argued, with basis in the reports on user experience on a national level (Holmboe & Sjetne, 2018a), that the care in the maternal service provision has been problematic long before the pandemic was a facture. Either way, there is definitive room for more research on the topic.

Research shows that there is an explosion of hormonal and neurobiological changes in the brain in the period before and after birth (Duarte-Guterman et al., 2019). It seems reasonable to believe that such changes may lead to an increased need for emotional support. A study done in England showed that a public maternity care according to the woman's needs resulted in fewer incidences of depression after childbirth. The midwives attended less to the women with few problems, while those with a greater need received more care (MacArthur et al., 2002). Further, some studies have shown that the length of the hospital stay could affect the woman's mental well-being (Hickey et al., 1997, Dowswell et al., 1997). Therefore, remarks related to further research following this study agrees with the argumentation of Eberhard-Gran et al. (2003) that there is a need for more knowledge related to how different kinds of maternity care could influence the well-being of both women, babies and partners. In addition, with reference to this study's scope and geographical delimitation, further research is needed to uncover views and experiences of midwives in other counties.

6.5.2 Remarks on the development of this study's research questions.

Initially there were additional sub questions related to how different types of maternal care influence the well-being of women, child and partner, and what in the opinion of the midwife is adequate maternal care. During the process, including the analysis of the gathered empirical data, it was made clear that these questions were too comprehensive to be included in this study, and also incidentally partly something the informants, when asked in this matter, reported they did not know how to answer. Thus, the sub questions were reduced to two.

Chapter 7.0 – Conclusion

The purpose of this study was to look at how the midwives of Inland County view the Norwegian maternal service provision, women's needs and the ongoing criticism and debate. Three key themes emerged from the analysis of the data: Views and perceptions on the maternal service provision, Views confirming a need for debate and Views portraying a nuanced look at the debate. This study points to a consensus among the midwives that there are substantial differences depending on which health station and which hospital you visit, and that the care is often lacking compared to the Directorate of health's written standard. Further, the informant agrees on the importance of adhering to the mental health perspective in the maternal service provision, and other points fronted by the critics, like early discharge and an inadequate postpartum care.

A substantial finding of this study is that even though the informants view the maternal service provision in Inland County a solid one, they still describe it as lacking, specifically compared to the Directorate of health's written standard. This gives empirical

support to previously done studies showing that the recommendations are not met (Holmboe & Sjetne, 2018a, 2018b).

Thus, in spite of some thoughts on the need for a more nuanced debate as complex issues are involved, in particular the criticism towards the centralizing of the birth wards and units, and that the language used sometimes leads to distance, the criticism and debate surrounding the Norwegian maternal service provision are justified by this study's informants.

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Appendices

Appendix I

Approval from Norwegian Centre for Research Data

Vurdering av behandling av personopplysninger

Referansenummer
482407

Vurderingstype
Standard

Dato
03.01.2023

Prosjekttittel
1001 days – How midwives view the Norwegian service provision and the ongoing debate

Behandlingsansvarlig institusjon
Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Prosjektansvarlig
Victor Chimhutu

Student
Cilla Westbye Ackermann

Prosjektperiode
01.08.2022 - 01.08.2023

Kategorier personopplysninger

Alminnelige

Lovlig grunnlag

Samtykke (Personvernforordningen art. 6 nr. 1 bokstav a)

Behandlingen av personopplysningene er lovlig så fremt den gjennomføres som oppgitt i meldeskjemaet. Det lovlige grunnlaget gjelder til 01.08.2023.

Kommentar

ABOUT OUR ASSESSMENT Data Protection Services has an agreement with the institution where you are carrying out research or studying. As part of this agreement, we provide guidance so that the processing of personal data in your project is lawful and complies with data protection legislation.

We have now assessed the planned processing of personal data. Our assessment is that the processing is lawful, so long as it is carried out as described in the Notification Form with dialogue and attachments.

IMPORTANT INFORMATION You must store, send and secure the collected data in accordance with your institution's guidelines. This means that you must use online survey, cloud storage, and video conferencing providers (and the like) that your institution has an agreement with. We provide general advice on this, but it is your institution's own guidelines for information security that apply.

TYPE OF DATA AND DURATION The project will be processing general categories of personal data until the date documented in the Notification form.

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 general categories of personal data is therefore consent given by the data subject, cf. the General Data Protection Regulation art. 6.1 a).

PRINCIPLES RELATING TO PROCESSING PERSONAL DATA We find 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 As long as the data subjects can be identified in the data material, they will have the following rights: access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18), data portability (art. 20). We find 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 We presuppose 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. If you use a data processor (online survey tool, cloud storage or video interviewing platform) the processing must meet requirements under arts. 28 and 29. Use a data processor that your institution has an agreement with. 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).

NOTIFY CHANGES If you intend to make changes to the processing of personal data in this project it may be necessary to notify us. This is done by updating the Notification Form. On our website we explain which changes must be notified: https://www.nsd.no/en/data-protection-services/notification-form-for-personal-data/notify-changes-in-the-notification-form Wait until you receive an answer from us before you carry out the changes.

FOLLOW-UP OF THE PROJECT We will follow up the progress of 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!

Appendix II
Informed consent letter

Vil du delta i forskningsprosjektet

1001 dager – jordmødres syn på det norske servicetilbudet og den pågående debatten

Dette er en invitasjon til deg om å delta i et forskningsprosjekt hvor formålet er å se nærmere på jordmødres syn på det norske servicetilbudet og den pågående debatten. I dette skrivet gir vi deg informasjon om målene for prosjektet, og hva en eventuell deltakelse vil innebære for deg.

Formål

Prosjektet er tilknyttet en mastergradsavhandling ved master i folkehelsevitenskap ved Høgskolen i Innlandet. Formålet er en nyansert fremstilling av jordmødres syn på tilbud, behov og debatt. Alt av opplevelser/refleksjoner, og ulike standpunkt, er ønskelig.

Opplysningene som hentes inn vil brukes i en masteroppgave, samt potensielt publiseres i et tidsskrift og/eller sosiale medier.

Ansvarlig for forskningsprosjektet er Victor Chimhutu ved Høgskolen i Innlandet.

Hvorfor får du spørsmål om å delta?

For deltakelse i datainnsamling ønskes jordmødre, nåtidig eller tidligere ansatt i Innlandet, i ulike aldre, med ulik arbeidserfaring og bakgrunn.

Hva innebærer det for deg å delta:

Dersom du velger å delta i prosjektet, vil du bli kontaktet for tidspunkt for et digitalt intervju, med en varighet på ca. 1 time. Intervjuet inneholder spørsmål om din opplevelse av kvinners behov, dagens tilbud og den pågående debatten. Aktuelle stikkord kan være oppfølging av gravide, fødsel, opphold på sykehuset, barselomsorg, oppfølging hos fastlege/helsestasjon/jordmor, 6-ukerskontroll, Barselopprøret og Bunadsgeriljaen. Det vil bli gjort lydopptak og notater av intervjuet.

Det er frivillig å delta

Det er frivillig å delta i prosjektet, og til enhver tid mulig å trekke samtykket for deltakelse uten å måtte oppgi en spesifikk grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg, dersom du ikke ønsker å delta, eller senere velger å trekke deg.

Ditt personvern – oppbevaring og behandling av opplysninger

Vi vil bare bruke opplysningene om deg til formålene beskrevet i dette skrivet. Alle opplysninger vil bli behandlet konfidensielt, og i samsvar med personvernregelverket.

Intervjuet vil bli innspilt og lagret. På begynnelsen av intervjuet vil intervjuer lese opp en kode, som er knyttet til navnet ditt på et separat skriv adskilt fra øvrig data. Intervjuopptak, samt skriv med navn og kontaktdetaljer vil kun være tilgjengelig for student Cilla Westbye Ackermann og veileder Victor Chimhutu.

Svarene vil anonymiseres, og deltakere vil *ikke* kunne gjenkjennes i masteroppgaven/publikasjonen.

Hva skjer med personopplysningene dine når forskningsprosjektet avsluttes?

Prosjektet vil etter planen avsluttes når oppgaven blir godkjent, anslagsvis i november 2023. Ved avslutning av forskningsprosjektet vil alt datamateriale slettes, dette innebærer personopplysninger, samt opptak av intervju.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra *Høgskolen i innlandet* har Norsk senter for forskningsdata (NSD) vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Spørsmål til studien

Hvis du har spørsmål til studien, ta kontakt med:

Høgskolen i Innlandet ved veileder Victor Chimhutu, e-post: victor.chimhutu@inn.no

eller personvernombud Usman Asghar, på e-post: usman.asghar@inn.no eller på telefon:

+47 61 28 74 83

Student Cilla Westbye Ackermann kan kontaktes på e-post: cillawacker@yahoo.no

Hvis du har spørsmål knyttet til NSD sin vurdering av prosjektet, kan du ta kontakt med:

NSD – Norsk senter for forskningsdata AS på epost personverntjenester@nsd.no,

eller på telefon: 55 58 21 17

Med vennlig hilsen

Prosjektansvarlig *Student*

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet *«1001 dager – jordmødres syn på det norske servicetilbudet og den pågående debatten»*, og har fått anledning til å stille spørsmål.

Jeg samtykker til (kryss av):

- o å delta i intervju

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet i november 2023

_____

(Signert av prosjektdeltaker, dato)

Appendix III

Interview guide

INTERVJU GUIDE

INTRODUKSJON

***Spørsmål**: Kan du begynne med å fortelle meg din alder og din utdannelse?*

***Spørsmål**: Hvor lenge har du jobbet som jordmor, og i hvilke institusjoner?*

***Spørsmål**: Hvor lenge har du jobbet i denne institusjonen?*

***Spørsmål**: Kan du si litt om når og hvorfor du bestemte du deg for å bli jordmor?*

***Spørsmål**: Har du hatt andre jobber innen helsevesenet eller innen helse generelt?*

***Spørsmål**: Hva liker du aller best med jobben din?*

***Spørsmål**: Hva er en «god dag» på jobben for deg?*

TJENESTETILBUD OG KVINNERS BEHOV KNYTTET TIL FØDE- OG BARSELOMSORG

***Spørsmål**: Hvordan vil du forklare dine daglige oppgaver, til en person som ikke vet noe om jordmorarbeid?*

***Spørsmål**: Møter du de samme kvinnene flere ganger? I så fall, kan du forklare fremdriften fra det første møtet, og hvordan du går videre med møtene?*

***Spørsmål**: Hvordan opplever du møtet med kvinnene?*

***Spørsmål**: Har kvinnene ofte med seg partneren sin? Hvordan vil du beskrive det å møte dem?*

***Spørsmål**: Etter din mening, er det en forskjell på å møte førstegangsgravide og andre-, tredje-, fjerdegangs gravide?*

***Spørsmål**: Opplever du at det nå, eller tidvis i dine yrkesaktive år, skjer endringer i måten å organisere arbeidet på?*

***Spørsmål**: Hvordan vil du beskrive omsorgen du gir? Hvilke elementer vektlegges?*

***Spørsmål**: Hva er etter din mening den viktigste delen av omsorgen du gir?*

***Spørsmål**: Kan du si litt om hvordan du ser på pasientenes behov?*

***Spørsmål**: Varierer dette behovet fra pasient til pasient?*

***Spørsmål**: Tror du at pasientene, i spesifikke tilfeller eller mer generelt, har behov som ikke dekkes av omsorgen de får i møte med jordmortjenesten?*

KRITIKK OG DEBATT

***Spørsmål**: Kjenner du til organisasjonene Barselopprøret og Bunadsgeriljaen og hva de står for?*

***Spørsmål**: Hvordan opplever du at deres budskap mottas av jordmødre og andre ansatte innen servicetilbudet?*

***Spørsmål**: Hvordan opplever du at kritikken av servicetilbudet blir mottatt av helsemyndighetene?*

***Spørsmål**: Påvirker den pågående debatten deg, og/eller arbeidet ditt?*

***Spørsmål**: Helseminister Ingvild Kjerkol har flere ganger gått ut i media og beskrevet fødselsomsorgen og barselomsorgen vår som verdens beste. Hva tenker du om denne uttalelsen?*

***Spørsmål**: Samtidig sier Kjerkol at vi i dag har utfordringer på grunn av det hun betegner som «kritisk mangel på helsepersonell». Hva tenker du om denne uttalelsen?*

***Spørsmål**: Noe av det Bunadsgeriljaen er mest kritisk til, er den pågående sentraliseringen av fødetilbud. Kritikken deres er blant annet bygd på at de mener for lang kjørevei er forbundet med dødfødsel, spedbarnsdød første døgnet og uhelse for mor. Hva tenker du om disse påstandene?*

***Spørsmål**: Tidligere leder av Bunadsgeriljaen Anja Cecilie Solvik har uttalt at med dagens smale rammer, kuttes det på kurs, trening og ansatte. Hvordan opplever du denne påstanden?*

***Spørsmål**: Leder for OUS Bjørn Atle Bjørnbeth har sagt at jordmormangelen handler om at jordmødre velger å forlate de store sykehusene til fordel for mindre hektiske jobber i kommunene. Hva tenker du om denne påstanden?*

***Spørsmål**: Er det ditt inntrykk at utøvelsen av omsorgen i servicetilbudet til gravide, fødende og barselkvinner følger Helsedirektoratets nedskrevne standard?*

***Spørsmål**: Hvilke elementer bør en etter din mening tilstrekkelig omsorg for gravide, fødende og barselkvinner inneholde?*

***Spørsmål**: Hjerneforskere peker på at i løpet av de 1001 dagene fra barnets unnfangelse til det fyller 2 år er en kritisk fase for hjernens utvikling. Slik du opplever det, er 1001 dager-perspektivet en del av det norske servicetilbudet?*

***Spørsmål**: Vil du si at det er fokus på psykisk helse ved første møte med en ny pasient?*

***Spørsmål**: Hvis ja, følger dette fokuset på psykisk helse pasientene videre? På hvilken måte?*

AVSLUTNING

***Spørsmål**: Før vi avslutter, er det noe du syns burde vært med her, og gjerne vil legge til?*

Appendix IV

ER DU JORDMOR OG ANSATT I INNLANDET?

DA VIL JEG GJERNE HØRE FRA DEG

DELTA I ET
ANONYMT INTERVJU

ca. 60 min, når det passer deg!

JEG ØNSKER Å HØRE DINE TANKER
OM DAGENS TILBUD, KVINNERS BEHOV
OG DEN PÅGÅENDE DEBATTEN

Kontakt masterstudent
Cilla Westbye Ackermann på
cillawacker@yahoo.no

STUDIET ER EN DEL AV EN MASTEROPPGAVE VED HØGSKOLEN I INNLANDET
Prosjektet er godkjent av Norsk Senter for Forskningsdata (NSD)

Appendix V

ER DU JORDMOR OG ANSATT I INNLANDET?

DA VIL JEG GJERNE HØRE FRA DEG

DELTA I ET ANONYMT INTERVJU

ca. 60 min, når det passer deg!

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