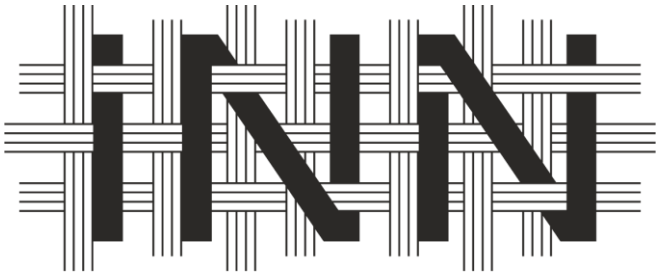

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Women's Experience of the Postpartum Period in Norway

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Abstract

The postpartum period is a pivotal life change, affecting over 50k birthing women in Norway each year. The need to understand how women experience and view this period of life stems from the fact that it is a neglected aspect of maternity care. It is the part of maternity care women are least satisfied with, which is true for both international as well as national evidence. In addition to this, the covid-19 pandemic has negatively impacted mother's mental health in Norway and show similar trends in international findings.

The aim of the study was to investigate how women experience the postpartum period and the postpartum health services. Furthermore, the study looked at how women experienced the health services received at the postpartum ward, the public health clinic, and how women viewed the 6-week postpartum visit. The study utilized a qualitative approach, with a phenomenological design. The study investigated mothers own lived experiences of the postpartum period using semi structured interviews. Fourteen participants aged 23-39 were recruited either through public health clinics using a gatekeeper in Inland County, or via social media. The interviews were analysed using thematic analysis, using the software program OpenCode 4.03.

Two themes emerged from the analysis, namely positive and negative experiences during the postpartum period. Negative experiences regarded the health professionals at the postpartum ward as too busy, and there was a lack of continuity in the care they received. Several women struggled to successfully initiate breastfeeding and felt the information, help and guidance as lacking. Women also noted several shortcomings in the public health services, resulting in the use of costly private services. Furthermore, covid-19 had impacts on women's access to social events, which also led to feelings of isolation. In contrast, some women experienced social restrictions as a positive, where less social contact contributed to a quiet and calm postpartum period. Other positive experiences included good quality of health services at the hospital, positive experiences of the municipal public health clinics and that the partner was essential to a sense of security.

These findings show clear areas for improvement in the postpartum health services, both at the postpartum ward, at the public health clinics and the 6-week postpartum follow-up. Women felt a lack of continuity in care, the health professionals at the hospital were too busy, women struggled to initiate successful breastfeeding and women were discontent with the 6-week postpartum follow-up. In addition to this, women experienced feelings of isolation and a loss of social arenas due to covid-19 restrictions.

Even though covid-19 was noted as a contributing factor, it can be argued that some of the experiences of health services indicate a general lack of good care. Further research is needed to uncover whether there is a systematic lack of good care, or if the negative experiences from this study are due to covid-19 and restrictions that followed. The study additionally implicates that policymakers should concentrate their efforts on fulfilling the criteria of the AAAQ-framework, as the findings show that women utilized privately funded health services. In this way postpartum health services can be seen to contribute to widening the social inequalities in health in Norway.

Chapter 1 - Introduction

Background

The postpartum period is a pivotal life change, affecting over 50k birthing women in Norway each year (Statistisk sentralbyrå, 2020). It is a time to explore a new family member, a time for large physical changes, adaptation to breastfeeding and motherhood as a whole. In essence, it is a new world to explore and adapt to for the new or growing family. While many transition through this time uneventfully, several women experiencesd this period of life as strenuous (Finlayson, Crossland, Bonet, & Downe, 2020).

The need to further understand how women experience and view this period of time stems from the fact that this is the part of maternity care women are least satisfied, regardless of whether one looks at international or national evidence (Alderdice et al., 2020; Holmboe & Sjetne, 2018). In addition to this, it is broadly recognized in the research literature that women's health care needs during the postpartum period are devoted significantly less attention than other parts of maternity care (Cheng, Fowles, & Walker, 2006; Finlayson et al., 2020; Tully, Stuebe, & Verbiest, 2017).

Ensuring that this period enhances positive experiences, this can empower women in the role as a mother and strengthen her emotionally during her transition into motherhood (Slomian, Honvo, Emonts, Reginster, & Bruyère, 2019). Inversely, negative experiences during this period of life may increase the risk of negative health outcomes for the mother, such as postpartum depression (Shorey et al., 2018), and with possible long-term effects on the mother, infant and the family (Slomian et al., 2019). If stressors of the postpartum period are left unmitigated, evidence suggests higher rates of anxiety and decreased self-care, which

in turn are associated with increased risk of physical and mental illness (Fahey & Shenassa, 2013). To ensure that every family receives the help and support they need, it is crucial that health care services delivered during the postpartum period are up to date and evidence based.

In addition to these issues, the Covid-19 pandemic has further limited women's access to both maternal and postpartum care services, and has had adverse effects on mother's mental health in Norway (Eberhard-Gran, Engelsen, Al-Zirqi, & Vangen, 2022) and show similar trends in other countries as well (Tomfohr-Madsen, Racine, Giesbrecht, Lebel, & Madigan, 2021). Exploration of women's experiences of the postpartum period and postpartum health care services during these two years of the covid-19 pandemic will therefore be important.

A matter of public health

Public health concerns its efforts how to promote health and prevent disease, by looking at the efforts of society (Jones & Douglas, 2012). Analysing the social determinants of health of a population and the threats it faces is the basis for public health (Jones & Douglas, 2012). These are non-medical factors that influence health, which can be classified as general socioeconomic, cultural and environmental conditions, living and working conditions, social and community networks, individual lifestyle factors and age, sex and constitutional factors (Dahlgren & Whitehead, 2021). Being aware of the social determinants of health can ensure that health services are not further contributing to social inequalities in health. Social inequalities in health are systematic differences in health that exists between different groups in society (Jones & Douglas, 2012). White paper 12 claims that good maternity services can contribute to reducing social inequalities in health (St.meld. nr. 12, 2008-2009), which further press the need to investigate how women view the postpartum period.

The Marmot Review

Interventions and efforts made during the first years of a child's life are seen as important to give every child the best start in life (Marmot et al., 2010). The 2010 Marmot review states that inequalities present during the early years of a child's life have lifelong impacts and is the period in which interventions are most effective to disrupt inequalities. In addition to this, the report has shown that early interventions are cost effective where financial investments are seen to deliver significant returns in profit. Furthermore, the key messages from the Marmot et al. (2010) report were:

> "Good quality early childhood education has enduring effects on health and other outcomes. These outcomes are particularly strong for those from disadvantaged backgrounds. A good quality workforce makes a difference to health outcomes but the childcare workforce remains low paid and low status. Pre and postnatal policy and services should be integrated (p. 102)."

The 2010 Marmot report underpins the importance of the postpartum period as a crucial period for both mother and infant, and in ensuring that the care mother and baby receive during this period are adequate, this will contribute to give every child the best start in life. Ten years after the initial Marmot review, a new report was produced. The Marmot (2020) report on updated evidence with the same analytical framework as the Marmot et al. (2010). The report showed the importance of social determinants of health acting through the life course.

The United Nations Sustainable Goals

The United Nations Sustainable Development Goals (UN SDGs) are a collection of 17 goals with 169 targets, that all UN Member States have agreed to work towards achieving by the year 2030 (World Health Organization, n.d.). These 17 goals are set to make a world free

from poverty, hunger and disease, and recognize that strategies for health and education go hand in hand with these. Health has a central place in the SDGs, where the third sustainable goal states to "Ensure healthy lives and promote well-being for all at all ages" (World Health Organization, n.d.).

Health promotion and preventing disease

According to the Norwegian directorate of health, politicians and health authorities are demanding attention towards health promotion rather than curative treatment (Helsedirektoratet, 2014). Both maternity and postpartum care are examples of health promotional work. Women and children make use of health care services without being ill, and children are followed up within an established program (Helsedirektoratet, 2014). This is a perfect example of health promotion and prevention – health care services implement measures/actions before illness or diagnosis is present (Jones & Douglas, 2012). The postpartum period poses an opportunity for maternal risk reduction and health promotion at a time when women are motivated and engaged with health care (Spelke & Werner, 2018). The postpartum period is a time when women are in frequent contact with the health care system – utilising health care services both for the new-born and themselves.

Both health promotion and health prevention are a way of working upstream – that is to say, tackling a problem before it occurs rather than treating the symptom – and can be associated with several positive factors (Jones & Douglas, 2012). Firstly, preventing ill health and promoting health will mean that less people will fall ill and need treatment. This is not only of benefit to the individual but can also have economic consequences.

Clarification of key terms and concepts

The period following birth has been subjected to different naming and definitions in the research literature. Beecher, Devane, White, Greene, and Dowling (2020) notes that the

concept of "women's experiences of their maternity care" is ambiguous and ill-defined. The reason why this occurs is namely due to the different definitions and focus of interest in the literature.

The World Health Organization (WHO) defines the postpartum period as the 6 weeks following birth (World Health Organization, 2010). Others identify it as the time it takes for the body to feel non-pregnant again (Kvam, 2020) or simply the fourth trimester (Berens, 2020). Due to this, the postpartum period is not a clear-cut medical definition, but a term that describes the period after giving birth, where the woman needs to adapt to a non-pregnant body again, with varying length and inclusion criteria.

Another term frequently used in the research literature is the postnatal period. The terms postpartum and postnatal period are often used interchangeably, but also separately (World Health Organization, 2010). The WHO has made a distinction between the two, where the postpartum period refers to issues pertaining the mother, whereas the postnatal period refers to those of the baby (World Health Organization, 2010). Due to these different definitions of the postpartum period, this study has applied the WHO definition and will utilize the term postpartum period and will refer to the 6 weeks following birth and issues pertaining the mother (World Health Organization, 2010).

The health care women receive during the postpartum period is also a part of the broader term maternity care. Maternity care involves the care the woman – and baby – receives from conception through birth and the postpartum period. This study will concentrate its efforts on health care the mother receives during the postpartum period and are referred to as postpartum care services throughout the thesis.

The Norwegian postpartum care service

Norwegian postpartum health care is funded through taxes, provided at hospitals and municipal public health clinics. Hospital care falls under specialist health care and is, if the

woman did not give birth at home, typically the first point of contact with the postpartum care services. On average the Norwegian woman spends 2-3 days at the postpartum ward at the hospital, or at patient hotels (Norwegian Institute of Public health, 2022). Health professionals involved at the hospital or patient hotel are midwives, public health nurses, nurses, and paediatricians. Policies and practices at hospitals may vary (Helsenorge, 2022). This includes visitors allowed, father allowed at the maternity and postnatal ward, as well as traditions for length of stay at the hospital (Helsenorge, 2022).

During the postpartum period, the woman is in frequent contact with primary health care. Primary health care involves health services outside institutions, and often emphasize health promoting and health preventing work, such as general practitioners, and nurse services outside a hospital setting (Braut, 2018). Norwegian primary health care is often used synonymous with municipal health care services and is in essence a collective term for all health services the municipality is responsible for operating (Braut, 2019). Postpartum women have consultations at the public health clinic with health professionals such as midwives, public health nurses and paediatricians. Working toward efficient and equitable primary health care is not just in the interest of the individual postpartum woman, but to the society in general.

Context of care in Norway

The Norwegian guidelines for postpartum care "*Retningslinje for barselomsorgen – nytt liv og trygg barseltid for familien* IS-2057» intend to ensure that postpartum care is evidence-based (Helsedirektoratet, 2014). The guidelines apply regardless of whether one is at home or in hospital during the first period after childbirth and must be adapted so that it is perceived as predictable and family friendly. These guidelines state that individual centred postpartum services must consider the needs of the family, the mother, and the infant. The guidelines are divided into three specific chapters that contain detailed recommendations that should be

provided to the baby, mother, and family. The chapter called a good start for the family aims to provide support to the parents, ensure secure attachment to the child and secure mastery in parenting.

To ensure that these goals are reached, the postpartum care services should include opportunities for skin to skin contact with the child for at least one hour after birth, support for breastfeeding, postpartum conversations with either a midwife or their general practitioner, home visit from a midwife 1-2 days after returning home for first-time mothers, and 3-4 days for mothers who have previously given birth (Helsedirektoratet, 2014). Further home visits are recommended if the mother has issues regarding breastfeeding, a complicated birth or other risk situations. In addition, the guidelines state that information about the postpartum period should be provided both written and oral, as well as individual conversations rather than group sessions (Helsedirektoratet, 2014). To prevent postpartum depression, the guidelines suggest intensive and flexible support, but state that screening for depression is not advised. A 6-week follow up of both mother and child at the public health clinic marks the end of the postpartum period and includes a physical check of baby and mother (Helsedirektoratet, 2014).

Research questions

With this in mind, the aim of the study was to explore how women in Norway experience the postpartum period and postpartum care services. The main research question was *"How do women in Norway experience the postpartum period and postpartum care services?".* Furthermore, three sub-questions were explored:

1. "*How do women experience postpartum care services in the hospital/patient hotel setting?"*

2. *"How do women experience home visits from the public health clinic, and the 6-week follow up?*
3. *How did women experience the postpartum period and postpartum care services during covid-19?*

Delimitations

The main focus of this study was to look at women's experiences of the postpartum period, and the postpartum care services. Nevertheless, the baby receives health care at the same time as the mother. How well the baby is taken care of by health services will inevitably affect how the mother views the postpartum period. The study does not specifically investigate how women view the care the baby receives, due to this study's interest in the woman. Nevertheless, participants were free to elaborate on topics they viewed as important, and topics concerning the baby could therefore surface. This study has therefore chosen to keep the women's experiences of the postpartum period and postpartum health services a centre of attention.

The partner's experience of the postpartum period is not investigated in this study. The partner's experiences are just as important, as the individual family member's experiences cannot be seen in a vacuum. Due to the scope of the project, only mother's views were included. Further research is needed to uncover the entire family's experience of the postpartum period.

Chapter 2 - Literature review

Health care services during the postpartum period

The postpartum period is the initial time following birth, and as stated earlier there are several definitions for this period. The World Health Organization (WHO) consider the 6 weeks following birth and issues pertaining the mother as the postpartum period (World Health Organization, 2010). By this definition of the postpartum period, postpartum care will involve both hospital and community care.

Throughout the world, health care provided during the postpartum period is wide-ranging, and each country has its own guidelines and practices (Haran, van Driel, Mitchell, & Brodribb, 2014). However varied these practices may be, the key aspects of postpartum care more often than not includes all or most of the following facets – midwife home visit, breastfeeding support, attention to the physical health of the mother, psychological well-being of parents, medical follow up of child and education regarding what the woman should expect after birth and regarding infant care (Haran et al., 2014). In addition to these aspects, contemporary postpartum care in most Western countries is characterized by a short length of stay at hospital (Aune, Voldhagen, Welve, & Dahlberg, 2021; Hildingsson & Thomas, 2007), a home visit (Cheng et al., 2006) and parental responsibility for care of infant (Hildingsson & Sandin-Bojö, 2011).

Women's experiences with postpartum care

A study conducted in Sweden states that there is a need for better follow-up of women's health needs, both psychologically and physically, during the postpartum period (Barimani & Vikström, 2018). Their proposal is to make structural and organizational changes in counties and regions. In this way one can secure better continuity and provide accessible, safe and equal maternity care across the country. A systematic review found that family centred care

appears to be an important component for parent's sense of security in postpartum care (Wiklund, Wiklund, Pettersson, & Boström, 2018). This involves factors such as continuity, participation, individual adaptation, consistent information, and preparation for parenting. In order to respond to the women's and family's needs in the postpartum period, one needs to understand the factors that contribute to a sense of security and those that do not.

A recent qualitative study in the UK revealed that postpartum care is the part of maternity care that women are least satisfied with (McLeish, Harvey, Redshaw, Henderson, et al., 2020). The study shows that women's satisfaction was affected by the extent to which their individual postpartum needs were met. In their conclusions, the key to supporting and caring for women is to have rapid and responsive assessments of each woman's individual need, and appropriate adjustment of care thereafter. McLeish, Harvey, Redshaw, and Alderdice (2020) states that together with clinical care, health professionals can play an important part in supporting women during the postpartum period. By also focusing on emotional support, this could be of importance to women during this initial time with the infant. Alongside these, Finlayson et al. (2020) note that postpartum care is an underserved aspect of maternity care in the UK. In their meta-synthesis of qualitative studies, they found that what matters to women in the postpartum period is achieving positive motherhood. When positive motherhood is achieved, it will also contribute to joy and self confidence in the new identity as a woman and mother.

A Canadian quantitative study uncovered several factors mothers report room for improvement (Ziabakhsh, Fernandez, Black, & Brito, 2018). This included concerns about going home, infant feeding, feelings of being overwhelmed, and not knowing how to settle their baby. Women also found the hospital environment less restful than desired. Quantitative studies in Finland note that knowledge about women's experiences with maternity care are limited, and that there are several aspects that needs addressing even though most women

seem satisfied with the care they receive (Kortet, Melender, Klemetti, Kääriäinen, & Kaakinen, 2020).

Norwegian women's experiences with postpartum care

The Norwegian Government has programs for surveying patient-reported outcomes, that hospitals are obliged by law to acquire. These surveys collect user experiences with the services as a means to achieve user involvement. The Knowledge Centre for the Health Services has therefore issued surveys concerning pregnancy, birth and postpartum care in 2011, 2016 and 2017 (Holmboe & Sjetne, 2018). These reports show that women in Norway are least satisfied with postpartum care, and this has been evident through all three reports (Holmboe & Sjetne, 2018).

The 2017 report has been seen to use an acceptable, valid and reliable tool called PreMaPEQ for collecting women's experiences of the whole course of maternity care in health systems that have features in common with the Norwegian health system (Sjetne, Iversen, & Kjøllesdal, 2015). The main data of the 2017 report comprise quantitative measures, but women were given the chance to give free text comments (Holmboe & Sjetne, 2018). In this report, about half of the women gave comments of varying depth. In addition, the report shows that women report overall less satisfaction with the postpartum ward compared to the maternity ward at the hospital. This applies for all 8 indicators in the report, which are 1. Care of partner at maternity ward, 2. Personnel at maternity ward, 3. Organization of maternity ward, 4. Information on child's health (postpartum ward), 5. Information women's health (postpartum ward), 6. Care of partner postpartum ward, 7. Personnel at postpartum ward, 8. Organization of postpartum ward. Results from such user experience-studies in Norway show that the trend of women being least satisfied with postpartum health services has been evident over time, and that little has changed regarding these experiences (Folkehelseinstituttet, 2018a).

A Norwegian study conducted in 2011 concluded that mothers are not satisfied with teaching of childcare during their stay at hospital, and mothers wish for more care during night than health professionals are willing to provide (Valbø, Iversen, & Kristoffersen, 2011). Other Norwegian studies have focused on the early postpartum period, and how women experience home visits from midwives. Aune et al. (2021) found that a home visit by a midwife from the postpartum ward could help parents opting for an early discharge. They found that this visit, in addition to the ordinary visits from the public health nurse at approx. 10 days after birth, were suitable for healthy mothers with healthy babies who decided to return home early.

Other studies show that women receiving an additional home visit by a midwife at 2-3 days after returning home reported higher scores on predictability and continuity in the midwifery care than a control group that did not receive such a visit (Aune, Dahlberg, & Haugan, 2017). These studies have looked at how an early postpartum visit by a midwife can contribute to women opting to leave the hospital sooner. A drawback to these studies is that they do not investigate how women view and experience the postpartum health services, and if this is an alternative women wish to opt for. In addition, this study has merely investigated women that have opted for an early return home themselves, and not women that do not have this choice. Taken together, the Norwegian user-experience reports and studies regarding the early postpartum period show that more research is needed regarding how women view the postpartum period and the care they receive. Thus, the aim of this study was to look at women's experiences of the postpartum period and postpartum health services in Norway.

Guidelines not met

Studies show that the recommendations of the initial part of the postpartum period in Norway are not met, and that there are regional differences in what care the family receives (Holmboe & Sjetne, 2018). The guidelines state a screening of postpartum depression is not advised, but

despite this recommendation, around 50% of Norwegian midwives and public health nurses use the Edinburgh Postnatal Depression Scale (EPDS) to assess mental health issues pertaining the pregnant and postpartum woman (Solstad Olavesen, Haug, Lindberg, & Wickberg, 2017). It is therefore evident that women receive different health care services depending on where they live and what standard the specific municipal public health centre exerts, and to what extent the public health nurse/midwife utilizes this tool

A Norwegian study found that the EPDS is effective in detecting women with depressive symptoms (Glavin, Smith, Sørum, & Ellefsen, 2010). Several international studies have shown similar results, where the EPDS show high sensitivity (Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Ove Samuelsen, 2001). It is therefore unclear why the Norwegian guidelines state that screening is not needed, whilst a large percentage of the Norwegian public health clinics utilize the EPDS.

Covid-19 and postpartum care

The World Health Organization (WHO) declared covid-19 a global pandemic on 11 March 2020. Since then, numerous restrictions and infectious disease control were set into action and had significant effect on the health services provided throughout the Norwegian health care services. A European online survey investigated women's perspectives of the care they received at the time of childbirth during the covid-19 pandemic (Lazzerini et al., 2022). According to this study, one in five women that gave birth between 1-15 March 2020 reported that they were not met with respect and dignity, and one in three reported that they did not receive help when asked for it. Over 3000 Norwegian women participated in the study, and the overarching themes raised by women were low staffing, lack of continuity and exclusion of partners. In addition to this, Eberhard-Gran et al. (2022) found that 1 in 3 women experienced depressive symptoms in the early postpartum period during covid-19 in Norway. Eberhard-Gran et al. (2022) note that this number is three times as high as it was ten years

ago. Mothers in the study were discontent with care provided at the postpartum ward, and the lack of attention and follow up of mother's mental health after returning home.

There has been an increase in early discharge from hospitals during the covid-19 pandemic in Norway (Jùlìusson, 2020), and an additional Norwegian study show that restrictions and infectious disease control might have had an adverse effect on the help primiparous women received regarding breastfeeding (Stette, Thorsteinsen, & Henriksen, 2021). The same study shows that women admitted to hospital for more than two days received more information and guidance, than those who were discharged early. A qualitative online survey was conducted in Norway and found that covid-19 had an impact on giving birth and becoming parents (Eri, Blix, Downe, Vedeler, & Nilsen, 2022). The Norwegian research findings coincide with international findings on how the covid-19 pandemic has affected the health services provided during the postpartum period (Tomfohr-Madsen et al., 2021). It will therefore be of interest to see if restrictions and infectious disease control are issues raised by women that gave birth during the pandemic.

Evaluative measures of postpartum care

Evaluations of postpartum care have traditionally been measured in so-called "hard outcomes" (Alderdice et al., 2020). Maternal morbidity and mortality, discharge from hospital and breastfeeding initiation are all examples of such measurements. These hard measures give an initial review on the state of art of postpartum care and are therefore important measures of the postpartum. Nevertheless, these measures focus on medical outcomes and do not factor in the patient's assessment of quality and will thereby not show a complete picture on how women view the postpartum period and the health services provided.

Maternal mortality and morbidity

Maternal mortality is used to monitor maternal health, the quality of reproductive health care

and the progress countries have made toward international development goals (Geller et al., 2018). Most high-income countries have low maternal death rates and these rates have decreased in the last 25 years. Low- and middle-income countries still bear 99% of the burden of maternal mortality (World Health Organization, 2015). Due to this, Sustainable Development Goal number 3, good health and well-being to all, for 2030 is to reduce the maternal mortality ratio. Mortality is therefore an important measure of global public health.

The maternal mortality ratio is considered one of the main indicators of a country's status on maternal health, but in western countries the burden of maternal mortality is only a small fraction of the burden of maternal morbidity (Firoz et al., 2013). High income countries have low maternal mortality, and due to its rarity, have a greater interest in maternal morbidity to monitor maternal health and quality of care (Geller et al., 2018). Although the definition of maternal morbidity is somewhat unclear, as Firoz et al. (2013) note "the literature and the experts had non-uniform criteria for the identification and classification of maternal morbidity, including its severity and time frame (p.794)."

Discharge from hospital

Discharge from hospital is another measurement of postpartum care. The average time spent at hospital in Norway after giving birth is 2-3 days (Norwegian Institute of Public health, 2022), and has reduced significantly in the last 30 years (Aune et al., 2021). The reduced time in hospitals is linked to the tendency to consider birth as a natural process but is also affected by changed priorities within the healthcare services (St.meld. nr. 12, 2008-2009).

Postpartum depression

Postpartum depression rates are as high as 17% of both healthy mothers (women without history of PPD) and women with history of depression before pregnancy (Shorey et al., 2018). PPD can have severe consequences, for the woman as well as her infant and extended family. PPD has been found to adversely affect the bond to the child, children of depressed mothers

are more likely to end up in the foster care system, and children of depressed mothers have higher rates of mood disorders (Ukatu, Clare, & Brulja, 2018). In addition to affecting the child, women with PPD have poorer health outcomes and lower quality of life than nondepressed women (Owora, Carabin, Reese, & Garwe, 2016). Despite these dire foresights of women with PPD, as many as 50% of all postpartum depression cases go undiagnosed (Beck & Gable, 2001). From a health promotional and disease prevention view, it will be of importance to uncover mothers struggling early in the postpartum period, as studies have shown that early diagnosis and uncovering postpartum depression (PPD) can be cost effective (Wilkinson, Anderson, & Wheeler, 2017).

Measures of satisfaction/dissatisfaction

The hard outcomes of postpartum care are critical health concerns that need addressing, but they fail to report the complete experience women encounter in the postpartum period. Other aspects are equally expressed as important to women, and research shows that parenting confidence, psychological well-being, appropriate adjustment to care, individualised care plan and rapid and responsive assessment of needs are keys in supporting women effectively at this transition in life (Malouf, Henderson, & Alderdice, 2019). Hard evaluative measures therefore fail to address what women value as important during the postpartum period.

Other studies have utilized quantitative measures to evaluate women's satisfaction with postpartum health services. When measuring satisfaction through quantitative inquiries, there are a number of methodological considerations (Hildingsson & Sandin-Bojö, 2011). Firstly, the timing of the investigation is important. Dichotomisation of variables is another concern when measuring satisfaction. Another issue regarding the measurement of satisfaction and quality of care is that women tend to prefer the care that is familiar. As Hildingsson and Sandin-Bojö (2011) explains, women feel "*What is, is best* (p.738)*"* despite clear areas for improvement.

The 6-week postpartum visit

The 6-week postpartum visit is included in maternal health services in most western countries (Cheng et al., 2006). The content and implementation of this follow up is wide-ranging and practices vary both within countries and between countries (Haran et al., 2014). The Norwegian guidelines state that every woman should receive a 6-week follow-up (Helsedirektoratet, 2014). Women schedule this appointment themselves, either with a midwife, their general practitioner or at the public health clinic in their municipality. This includes a physical check if needed, and a time to raise issues regarding mental health. In addition, the appointment provides opportunities for adequate contraception counselling and initiation, breastfeeding support, vaginal examinations, screening for mood disorders such as postpartum depression and anxiety or other issues raised by women (Haran et al., 2014). This is a valuable opportunity for women to raise concerns, to seek help and advice. It will therefore be of importance that this follow-up is adequate to women's needs. Nevertheless, studies show that many do not attend a postpartum visit despite the belief in importance of such a visit (Henderson et al., 2016). In addition, research has shown that the 6-week visits are poorly attended, and do not sufficiently address issues that concern women (Tully et al., 2017). Socially and economically vulnerable women are amongst those with the highest non-attendance and show that postpartum care is not equitable (Henderson et al., 2016).

Women that do not schedule such a visit inevitably miss a valuable opportunity to raise concerns that have arisen during the postpartum period. Moreover, issues left unattended may aggravate the matter even further. Making sure that the 6-week visit is attended and of good quality will therefore be of importance, both in relation to a health promotion aspect, but also in a health prevention view.

Tully et al. (2017) states that "the intense focus on women's health prenatally is unbalanced by infrequent and late postpartum care" (p. 38). During pregnancy, Norwegian

women have nine appointments with the maternity services, and additional appointments are scheduled if the woman is overdue (Helsenorge, 2018). In contrast, the woman has three appointments during the postpartum period. Two home visits, one by a midwife and one by a public health nurse, and a 6-week follow up (Helsedirektoratet, 2014). It is understandable that some women feel left alone in the postpartum, when they have had close follow up during pregnancy. Mehta and Srinivas (2021) note that this is a unique positioning for health professionals who provide postpartum care services, as it leaves them with opportunities to deal with issues raised by women in the postpartum period, with potential for lasting positive effects.

Chapter 3 – Methodology

Research approach and design

To investigate how women experience the postpartum period and postpartum health services, the study utilized a qualitative approach. A qualitative approach is a method of collecting knowledge, where the researcher is interested in the participants meanings and experiences of an event, and how these can be interpreted and understood by others (Bryman, 2016). This study was carried out with a phenomenological design, where the aim was to investigate women's own lived experiences with the postpartum period and postpartum health services. A phenomenological design concerns how a phenomenon is experienced, and concentrates its efforts on the kind of experiences that are pure, basic and raw in the sense that they have yet to be subjected to processes of analysis and theorizing (Denscombe & Denscombe, 2017). The task of phenomenological studies is then to present these lived experiences and the subjective reality of the subjects within the study. In this way the researcher can provide an authentic description of the phenomenon of interest. The phenomenological design will therefore involve an in-depth investigation of the postpartum period and postpartum health services and gathering of new information on the topic of interest.

Philosophical stance

Epistemology is the study of human knowledge (Bryman, 2016). The epistemological root of this study lies within a constructionist paradigm. Social constructivism states that scientific knowledge is seen to be influenced by social factors and are in constant revision (Bryman, 2016). In this school of theory, the researcher understands that he/she is actively conversing to create knowledge together with the participant. Information created through such a process is therefore socially constructed. By working in a social constructivist stance, the researcher is

aware of his/her contribution in creating knowledge and can therefore be reflexive in his/her position. Reflexivity is important in all qualitative research, where the values, beliefs and lived experiences of both the researcher and participant can have an impact on multiple stages during the scientific process.

Selection and recruitment

Selection

Participants eligible to partake in the study were Norwegian-speaking women who gave birth between March 2020 and January 2021, aged over 18 and had completed the 6- week postpartum period and gave birth in Inland County. The aim of the study was to gather 8-15 participants, in the end, 14 were recruited to participate. Data saturation is often used in qualitative research to justify the sample size and is often defined as the point where no new information is gathered, and where no new codes and themes emerge from the data (Braun & Clarke, 2019). The exact number of participants required to meet saturation are a question up for debate and determining sample size in advance is often difficult and not feasible. Despite this, Braun and Clarke (2019) note that there is often a practical reason for determining sample size in advance. They also suggest that the researcher provide a roughly anticipated lower and/or upper sample size. A master thesis has a smaller time frame than a large-scale project, and pragmatic considerations regarding sample size therefore had to be made.

These three forms of recruitment are called purposive sampling. This implies that the probability for participation is not known and are used to ensure that the participants recruited are purposive for the research question (Bryman, 2016).

Recruitment

Recruitment was carried out via local public health clinics in Ringsaker municipality using a gatekeeper. A gatekeeper is an essential mediator for accessing participants and may represent

a group of individuals who is invaluable for gaining access primarily due to their connections with a research population (Bryman, 2016). In this study, the gatekeepers were health professionals at four municipal public health clinics in Ringsaker - Brumunndal helsestasjon, Moelv Helsestasjon, Nes helsestasjon and Brøttum helsestasjon. The public health clinics are a part of the municipal health service that provides health-promoting and preventative health services to all pregnant women, children and young people and their families (Ringsaker Kommune, 2020). Women recruited from these public health clinics gave birth at different hospitals, according to what hospital they lived closest to. The hospitals that were relevant to this study were Elverum, Lillehammer and Gjøvik hospital. These hospitals are of varying size, which may have contributed to different perspectives involving experiences with postpartum care. As Norway has shown to produce regional differences concerning postpartum care, women from this municipality provided participation from hospitals and public health clinics that might yield different responses, and therefore secure diversity.

Recruitment was administered through an invitation via the four public health clinics mentioned above. The invitation stated the aim of the study and contact information of the researcher was provided. The invitation can be viewed in *Appendix A*. The personnel at the public health clinics were asked to provide these to mothers visiting the clinic, as well as leaving the invitations in the waiting rooms.

A further strategy for recruitment was through social media. Three Instagram accounts were contacted, and subsequently asked to post information about the project, with attached contact information to the researcher. In this way the different social media accounts acted as gatekeepers as well. The Instagram accounts that were contacted were barselopproret, tryggerestart and kvinnehelse_fysio. Information posted on Instagram can be viewed in *Appendix B.* In addition, an invitation to participate was posted on Facebook, which can be viewed in *Appendix C*.

Additionally, the snowball technique was utilized, where currently enrolled research participants were asked to recruit further participants (Bryman, 2016). Mothers were therefore asked if they knew anyone eligible to participate in the study, who were then contacted by the researcher. Table 1 shows an overview of the research participant's characteristics.

Table 1.
*Research participant characteristics (*N=*14)*

Age range	23-39 years
Primiparous	7
Multiparous	7
Vaginal birth	13
Caesarean section	1
Hospital birth	13
Home birth	1
Gave birth in Inland County	12
Gave birth elsewhere in Norway	2
Range length of stay	1-7 days

Note. Numerical values are reported as number of cases, if not otherwise stated.

Methods of data collection

Semi-structured interviews

To gain insights into the experiences of the postpartum period and postpartum health services the study used semi-structured interviews. Individual interviews were favoured as the purpose was to explore human experiences and as the situation of sharing information depended on the participants feeling of security (Bryman, 2016). An interview guide was created to gain an overview of the different phases of the interview. Open ended questions were favoured as they encourage for detailed responses to the specific themes that would be touched up on during the interview. These themes were divided into five categories: 1.

Demography, 2. Giving birth, 3. Stay at postpartum ward/ patient hotel, 4. Health services in the municipality and 5. covid-19.

The interview was structured around three phases. The first phase involved "warm-up questions". The participants were asked about demographic questions and eased into the theme by asking them shortly about their birth. The next phase of the interview was the reflective questions, which was the core of the interview session. Questions such as "*How did you experience the time spent at the maternity ward?*" were asked, and open-ended questions were favoured. The last phase was to round off the interview. Participants were given the chance to elaborate on other things important to them in the postpartum period not covered by the interview-guide and were given information on how the material was going to be handled. The interviews were conducted in Norwegian, and the complete interview guide can be viewed in *Appendix D.* The first few interviews were used to salient issues that were emerging and the interview guide was adjusted accordingly during the process of data collection.

The interviews took place digitally via Zoom, where the average time for an interview was 45 minutes. Video call interviews were utilized due to covid-19 restrictions. Due to these restrictions, video call interviews were viewed as more flexible than face-to-face interviews and could easily accommodate for last minute changes. Furthermore, video call interviews tend to generate participants that would otherwise not have participated (Bryman, 2016).

Data management

The interviews were recorded using the "nettskjema" Dictaphone App with a mobile phone as recording device. Interviewing though zoom was based on a HINN/Feide account, and not a personal account. The Dictaphone App forwarded the audio files to the "nettskjema". For security reasons, it was not possible to play back the recordings directly from the phone. The recording was encrypted on the phone and sent in securely. If there was no network when recording, the recording was temporarily encrypted on the phone and sent when the network

became available (Wifi or 4G / 5G). The recording was not downloaded to any device, and only listened to thorough "nettskjema". The Dictaphone App had a limit of 45 min per recording. When the interviews lasted longer than this, the recording needed to be encrypted before a new recording was started.

The aim of the study was to gain insight into women's experiences of the postpartum period and postpartum care services, it was therefore likely that women raised health issues either concerning themselves or the baby. Hence, the project was registered in Tjenester for Sensitive Data (TSD). Research projects registered in TSD connected the "nettskjema" Dictaphone App, and the recordings were uploaded directly to the project's secure storage in TSD. In practice, this means that the Dictaphone recording was activated for secure storage in TSD.

Analysis of data material

The recordings were transcribed and anonymised. The participant was given a pseudonym when data material was transcribed, and transcriptions were done verbatim. Directly identifiable variables such as age, hospital and education were rewritten as categories, to ensure that these were not identifiable in the transcription. Transcriptions were stored on a HINN office 360-onedrive account. The transcribed material was analysed using thematic analysis, more specifically Braun and Clarkes method of thematic analysis (Braun & Clarke, 2006, 2013). Their method involves a six-stage process that has gained popularity due to its theoretical and methodological transparency.

The first step involved familiarising oneself with the material (Braun & Clarke, 2006). The data were transcribed and read to be confident with its content. Step number two involved generating initial codes. This form of coding involved systematically coding the information into codes and collating data relevant to each code (Braun & Clarke, 2013). When the initial coding process was completed, step three included collating the initial codes into themes and

gathering all the relevant data to each theme (Braun & Clarke, 2006). Step four involved revising the initial themes, checking if the extracted codes fitted into the generated themes. The fifth step was to name the generated themes. Under this step there was an ongoing analysis to refine the specifics of each theme, and clear names were then allocated to the themes. The sixth and final stage of Clarke and Braun's method to thematic analysis, involved writing the report on findings (Braun & Clarke, 2006). Appropriate extracts were selected, the discussion of the analysis was made, which were related back to the research question and literature review. See table 2 for an overview of categories and themes that emerged during analysis.

Table 2. Overview of themes and categories

Theme	**Categories**
Negative experiences during the postpartum period	Lack of continuity in care Health professionals at the hospital too busy Breastfeeding initiation unsuccessful Dissatisfaction of 6-week follow up Unaffordability of services Feelings of isolation Loss of social arenas and contact
Positive experiences during the postpartum period	Health services at hospital of good quality Positive experiences of the municipal public health clinics Partner essential to a sense of security Positive impacts of covid-19

The analysis was carried out using the program OpenCode 4.03, which is a tool for coding qualitative data generated from text information (Umeå University, n.d.). The program allows for a systematic analysis of the transcribed interviews, where the researcher assigns

codes to segments of the text, and then synthesise these into categories and themes.

Inter-rater reliability in qualitative research is important, as researchers may ascribe different meaning and values to themes and codes within the data material (Bryman, 2016). The transcriptions, codes and creation of themes were therefore reviewed by the supervisor of the thesis.

Trustworthiness in research

Qualitative studies differ from quantitative sciences as they do not use concepts such as reliability, validity and generalizability. In order to ensure trustworthiness in the qualitative design of this study, notions of credibility, dependability and transferability were utilized (Graneheim & Lundman, 2004). Trustworthiness refers to the study's rigour, and are used to describe the study's quality (Connelly, 2016).

Credibility, dependability, and transferability

Credibility in qualitative research refers to how well the study's research analysis and process was at investigating the topic of interest (Graneheim & Lundman, 2004), here women's experience of the postpartum period and the postpartum care services. This study chose participants from a variety of hospitals, which shed light on the experience from different angles. Credibility also involves selecting the most appropriate meaning units, too small and large units will both distort the credibility of the study. In addition, this study ensured credibility by having the academic supervisor review the transcribing, coding, and choosing themes.

Dependability refers to the consistency over time in data collection (Graneheim & Lundman, 2004). It is both important that all participants are asked the same questions, but at the same time data collection is an evolving process which can subsequently lead to different follow-up questions in interviews. One way of ensuring that the content was consistent over

time was to allow for the academic supervisor to read transcripts.

Transferability of research relates the studies applicability to other contexts, meaning other situations, similar populations and phenomena (Connelly, 2016). A rich and vigorous description of the data collection and process the analysis has been presented in the thesis and will enhance the transferability of the project in other similar contexts. However, this decision has to be reached by readers if they see the study context similar and if the findings resonate to these contexts.

Role of researcher

The researcher has an important role in qualitative research, as he or she can influence both data and findings throughout the research process. It is therefore important that the researcher is reflexive of his or her position. Reflexivity in research involves questioning one's own procedures, analysis and conclusions (Malterud, 2013).

I will as a mother have my own views on the postpartum period, which were important factors to take into consideration when data were collected, evaluated, and analysed. Being too close to the topic of interest can hinder reflexivity, and this is important to be aware of. It is feasible that the participants were more trusting of a person with the same experiences as themselves. In this regard, I acted as an insider to the topic. The position of the insider has been viewed as privileged, in that the researcher gains trust and openness easier (Bryman, 2016). However, when the researcher and participant share the same understanding of a topic, it is likely that these themes remain uncommented or not sufficiently commented. It was therefore important to be reflexive of this during interviews and to ask paraphrasing statements such as "is it true that when you say X, you mean Y". Furthermore, as a former health worker - working as an assistant in a nursing home, I could relate to health professionals providing health services during the postpartum period. Time constraints,

resources available and hierarchical structures within the health sector are forces I know from experience affect the services health professionals can provide.

Ethical considerations

Informed consent

Informed consent was secured through an informed consent form that the interviewee was forwarded through email. The participants read the informed consent prior to the interview, and then answered the email by stating “I consent to participating in a digital interview”. The informed consent form is included in Norwegian and can be viewed in *Appendix E.*

Anonymity and privacy

Anonymity and privacy of participants are aspects to be respected. Participants signed an informed consent form as stated above. In this way participants understood what they submitted their information to, and the privacy of the participant was taken into consideration. Anonymity was ensured by using pseudonyms during the transcription process. In addition to this, the raw data (recordings) were stored in TSD, which was a secure place where only the student researcher had access. Transcripts were stored on a HINN office 360-onedrive account. Recordings and transcriptions are to be deleted as soon as the thesis has been submitted and marked.

Institutional clearances

The project was registered to NSD, Reference number 494783. Registry to NSD ensured that data protection requirements were met, and can be viewed in *appendix F*.

Theoretical framework

This study utilizes the AAAQ (*Availability, Accessibility, Acceptability and Quality*) framework to assess health services provided to women during the postpartum period. The AAAQ framework has its roots in human rights research (Hunt & Mesquita, 2006; Yamin, 2008) but has increasingly been used in other research settings as well. The framework has demonstrated to be useful at monitoring health care in general and has been viewed as particularly beneficial in monitoring maternal and child health services (Hunt & Bueno De Mesquita, 2007). Dagrou and Chimhutu (2022) used it to assess access to medicines, whereas Chimhutu (2011) used the framework to assess the maternal health services in Tanzania and others have used it to frame the right to health care services for women in Saudi Arabia (Walker, 2014). This study will therefore use the framework to assess the health services provided to women in the postpartum period. This framework involves four criteria to evaluate health services as shown in figure 1.

This framework is a valuable analytical tool that will deepen the understanding of economic, social, and cultural rights (Hunt & Mesquita, 2006; Yamin, 2008) in regard to postpartum health services. In addition to this, the framework will be useful in looking at the postpartum period and the services provided, as it stipulates that health services, goods and facilities shall be available, accessible, acceptable and of good quality (Hunt & Mesquita, 2006).

The first *A* of the framework concerns the *availability* of services, facilities and goods. This means that an adequate number of goods, services and facilities are necessary to provide health care, as well as sufficient number of qualified personnel to staff the services. In relation to the postpartum period, this regards the number of public health clinics available, and that there are qualified staff available. It also involves hospitals and patient hotels available, and

the staffing at these facilities.

Figure 1. **The AAAQ-framework**

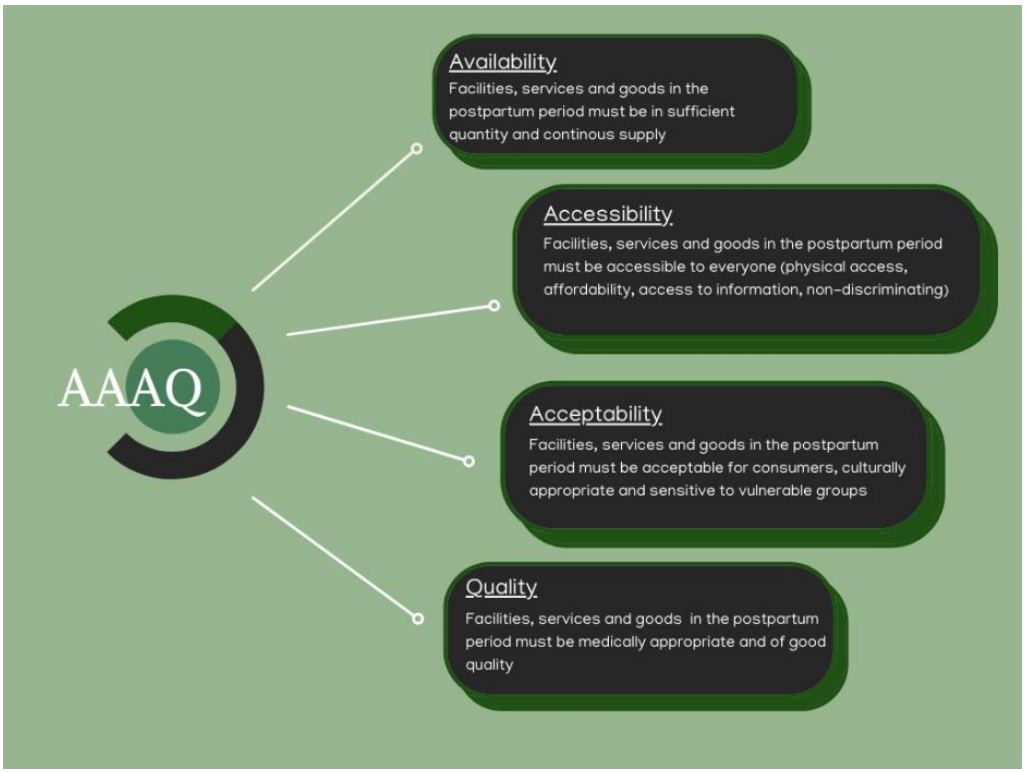

Figure 1. The four criteria adapted from the AAAQ framework to evaluate postpartum health services: availability, accessibility, acceptability and quality (Source: own adaptation).

The second *A* states that health services need to be *accessible*, both in relation to economical and physical aspects. To be accessible, health services provided during the postpartum period need to be affordable and in a geographical proximity to all women in order to be viewed as fulfilled. This is especially important in relation to community-based care such as the public health clinics. Access to information also falls under this criterion. Women should have access to appropriate information regarding health services provided, it needs to be in a language the women understand as well as taking women's health literacy into account. The last aspect that needs to be fulfilled in order to make health services accessible is that they need to be non-discriminating.

Acceptability is the third *A*, and states that health services must be culturally and

socially appropriate, and sensitive to vulnerable groups. Culture can have a strong influence on how health related issues are treated, it is therefore of importance that services provided during the postpartum period take into consideration the women's cultural background.

The last facet of the framework is the *Q* - and concerns the *quality* of health services. Health services provided need to be medically appropriate and of good quality. In the context of the postpartum period, this means that health professionals have the appropriate skills, education and training to deal with women in the postpartum period, both in regard to mental as well as physical issues.

Limitations

The research questions did not take into consideration the views of the father/birthing partner. Furthermore, the health care services considered in this study were only those that the mother received. How well the infant was perceived taken care of by health professionals might have an impact on how the mother experienced the postpartum period.

Due to covid 19, the thesis might not be representative of a full functioning health care system in Norway. Nevertheless, this study shows what women experience during a time of crisis and how the health services have handled this.

This study required the participants to contact the researcher if they wished to participate. The study might have exclusively recruited women that had negative experiences during the postpartum period, and therefore were particularly willing to participate and share their views. The biased effects of this were attempted counteracted by using several recruitment strategies.

Even though earlier research has shown differences in satisfaction between large and small hospitals in Norway (Holmboe & Sjetne, 2018), this is not covered within this master thesis. It is still noteworthy that participants gave birth at hospitals of varying size, which may have impacted their experiences of the postpartum period.

Chapter 4 – Negative Experiences during the postpartum period

The following chapter will present the results and describe themes and categories that were created as shown in table 2. For many women, the postpartum period brought along difficult times and strenuous experiences. This chapter will therefore present the negative experience mothers had with health services and on how covid-19 impacted on their social life during the postpartum period.

Lack of continuity of care

Lack of continuity of care were pointed out by both primiparous and multiparous women as an area for improvement. This regarded both the help they received at the hospital as well as guidance and help received in the municipal public health clinics. Meeting different health professionals every time they received help or guidance were viewed as both stressful and confusing. Upon answering if she had any guidance on breastfeeding, Cecilie said she felt a lack of continuity in the guidance she received at the postpartum ward.

> *"Yes, but there were always new people coming by. And they said" no, you need to do this, you need to do it like so". So, it didn't feel like there was any continuity, always a way to do it differently."*

Marita agrees on this and elaborates on how it felt that there was always a different health professional coming into her room.

> *"It was a lot of different people to relate to. It was not the same person throughout a day. It was a different person for every single visit. There were no familiar people to relate to, a lot of*

different people in and out. And since I didn't have any familiar people with me, I had no sense of security. That was the hardest part really."

Dealing with different health professionals made mothers less secure, and according to another informant, Sarah, this also made women feel confused and somewhat stressed.

"There were different people every time who said different things, that gave different tips, and showed different positions. There was no system in it. So, I got more stressed and confused really."

Here the mothers are potentially indicating that there could be a lack of coordinated and common practice among health professionals at the postpartum ward. This lack of a coordinated system led to mothers' feelings of insecure, confusion among others.

Health professionals at the hospital too busy

Women perceived the health professionals at the postpartum ward as busy. For some this prevented women to seek and ask for help, as they did not want to disturb the health professionals unnecessarily. Multiparous mother Kristina said that this also contributed to her going home sooner this time around.

"If you needed anything we were supposed to pull the string, and there are some of us that are not very good at asking for help, if you need food and things like that. You wait until someone comes by, doesn't want to disturb anyone, you know they have enough to do anyways. And in a way, you were more enclosed in the room. I wanted to go home as soon as possible this time around. I wanted to get into the normal everyday life. I was there one night this time, last time I was there for two."

Often, when the health professionals at the postpartum ward were busy, women felt forgotten and left alone. Helene said that she had to go to the toilet in a lot of pain, because the health professionals forgot to bring her the medication she asked for.

"Because if something were to happen, it would take time. So that was not good to hear. And then I had to go to the bathroom by myself, and I had asked for painkillers so that it would be easier to go to the toilet. But they forgot about me. And I had to go to the bathroom by myself in excruciating pain, and in addition you are a bit shaky, whilst the baby was in the room alone because I couldn't take him with me. That was not a good experience, just hours after giving birth."

Other women felt that because it was so busy at the postpartum ward, health professionals only did routine checks and were perceived as too busy to sit down to have a talk with the women. Helene continued her story by saying that they only did what was strictly necessary before leaving the room.

"There were not a lot of people in my room without me calling for help. They only came by to bring me food. Some were very quick, and only did what they had to before leaving the room. Other times, no one came when I called for help, so I had to call multiple times before someone eventually came to help me."

Marita explained that because the health professionals seemed busy and only did the routine checks, she felt a lack of compassion.

"They did what was strictly necessary in relation to food, equipment, and things like that. But to ask how things were going, to show any kind of compassion, I didn't feel like there was any of that. It gave the impression that they were too busy."

Women also noted that health professionals at the public health clinics were perceived as busy and only concerned with routine questions and check-ups. Tonje said that she did not feel seen and therefore did not express difficult emotions that she had experienced during the postpartum period.

"No, I didn't tell anyone. I felt that the person responsible for my follow-ups at the public health clinic, I didn't like her very much. I felt that she was only there to do her job. She did

weight and measurements, and then she was like "is there anything else?". I didn't feel cared for if you understand. If you don't have time to listen, I don't think you have the time to understand. And then I didn't see the point in talking about something she doesn't feel is her job."

Breastfeeding initiation unsuccessful

Several primiparous women struggled with breastfeeding initiation and felt that there was a lack of knowledge amongst the health professionals to appropriately guide the women. This was evident for health professionals at the postpartum ward as well as health professionals at the public health clinics. Sarah said she did not feel the health professionals at the hospital had the knowledge or system needed to help her initiate successful breastfeeding.

"I did expect some sort of system regarding something as fundamental as breastfeeding. More knowledge and such, more direct guidance in relation to it. So, I was a little surprised about that, that it didn't seem like the people working there had that under control."

Fiona felt that she didn't receive the help she needed regarding breastfeeding and felt that the health professionals at the hospital did not take her problems seriously.

"We had some difficulties regarding breastfeeding. Because the baby didn't want to or wasn't interested. There was a lot of hassles regarding this. I felt poorly looked after regarding this. There were different instructions from everyone that came in [to help]. I felt that they gave up. […] I didn't feel they took me seriously when it came to breastfeeding. […] When I called for help regarding breastfeeding I was met with an attitude of "what do you want me to do about it". I felt that there was a lot of people that didn't take us seriously." […] I thought that perhaps they would take better care of me, and that they wanted me to succeed with breastfeeding. I did at least think it was going to be different than it was."

Marita added to this and said that she felt the health professionals at the public health clinic didn't have the appropriate knowledge to help her initiate breastfeeding. The inability to breastfeed then made her feel like a failure.

> *"I felt very much like a failure during the first part* [of the postpartum period]*, because I didn't succeed at anything. We were trying our best, tried googling the webpage "ammehjelpen". […] I remember that it was stressful, getting into the car, driving there, and then she was supposed to help me breastfeeding whilst sitting on an uncomfortable chair, but we got no further. I missed having a home visit. […] I did have a conversation with the midwife where she asked some questions, but the baby pooped, and I was very stressed. I don't remember anything from that conversation, it gave me nothing. And then the appointment with the public health nurse, weighing and measuring. That is important, but I felt that we got not further with breastfeeding. I felt that the guidance was lacking. […] after three weeks I couldn't do it anymore, so I went on to pump 100% and bottle feed. So, I pumped a little over 6 months. […] And regarding that* [pumping] *the public health clinic didn't have any competence at all. So, I googled a lot, and found out everything on my own. That was ok to a certain degree. But things would have been easier if I had gotten a little more guidance."*

Dissatisfaction of the 6-week follow-up

The 6-week follow-up appointment were scheduled with several different health professionals. Some women had this either at their general practitioner, at a gynaecologist or with a midwife. Other women did not schedule such a follow-up, where several multiparous mothers made a conscious choice not to schedule such a follow-up. As Monica explains, her previous experience with this follow-up made her not schedule such a visit during her latest postpartum period. This was due to the visit being uninformative, and that she felt the visit was pointless.

"No, I didn't have that. And the reason for that is that I got zero from the last one, so I didn't schedule one. […] I remember thinking after the visit «why were we here just now". […] It was uninformative. So, I chose not to have one, this time around."

Other women explained what was done during the 6-week postpartum, but that it was not very useful.

"It was fine, but not very useful if I can put it like that. It was Ok, but I didn't feel like I needed it."

Sarah agreed that the 6-week postpartum visit felt pointless and felt that there was too much focus on the use of contraception at a time where this was not one of her concerns.

"The 6-week postpartum visit seemed a little, I felt that it was pointless. Firstly because of the focus, there was a lot of attention paid to contraception use. Grown adults, I was 36 at that point in time, and I thought, well I understand that it is in the guidelines, but I do understand how that works. […] It felt more like something I had to do, and it didn't help me a lot. It was so early on, everything was a chaos, I didn't know what I needed help with and not. My body still felt broken, and I didn't know what was normal or not at that time. So, the visit was a bit too early, and the focus was a bit off."

Unaffordability of services

Several women reported the need to privately source health services, which they had to pay for themselves. Marita explained that she used private health services during her postpartum period, both a gynaecologist and a physiotherapist. She argued that this makes the health services provided in the postpartum period inequitable, as health services only will be available to those who can afford it.

"I have been using private services a lot. […] But I think if I have another [baby], *I will have to use private services to get some guidance on breastfeeding as well. And that is a shame,*

because then good care will only be available for those that can pay for it, whilst some get nothing."

Helene explained that her partner was initially allowed to stay at the hospital over night, but he would be charged for it. Due to their financial situation, they were not able to afford this, and he therefore didn't have the opportunity to stay at the hospital.

"If he were to stay, he would have to pay almost 400kr per night. And that was a bit much. So, we didn't have the opportunity to do that."

Johanne stated that she had her 6-week postpartum visit at her general practitioner, which she was expected to pay for herself. She explained that this was something she though should be free of charge.

"At the general practitioner it was very short. And you need to pay for that yourself. It was ok, but I think that should be free of charge."

Veronica expressed that her new-born had a medical condition that made it difficult to latch successfully to the breast. She explained that this was a procedure that they were reluctant to do via the public health services, and if she were to go through with it privately, she would be expected to pay over 40 000kr.

"I had to prepare myself to do it privately most likely, and that is 40 000kr straight out. […] Purely because the [public] *hospital does not know enough about it."*

Feelings of isolation

Covid-19 was a contributor to many restrictions and infectious disease control and affected the amount of people mothers were allowed to meet. Additionally, strict restrictions in visitors were introduced and these made mothers receive very few visitors. For many mothers this contributed to feelings of loneliness and isolation during the postpartum period. Although

visitor restrictions could be understood as measures to reduce infections in health facilities, it negatively impacted on mothers of the new-born. Kristina explained that because she felt alone, she wanted to go home rather than staying at the hospital.

> *"I sat alone 20hours of the day. There were many long hours, so I wanted to go home as soon as possible. Because of that it was easier to be home. That feeling of loneliness is not good. I was like, what should I do. You are bored and have a computer, and then you either watch the computer or the baby. They do sleep a lot in the beginning, so then you become quite alone. Which contributed to me wanting to go home."*

For multiparous women it was a sore feeling that siblings did not get the chance to visit the new-born at the hospital. This further aggravated the feeling of being alone at the postpartum ward and added to the urgency of needing to leave the hospital as soon as possible. As Veronica explains:

> *"I knew that there were two others waiting back home* [the siblings], *so we wanted to go home as soon as possible. […] A little sore that the siblings weren't allowed at the hospital. […] it is perhaps even tougher for us with other children because you want to go home as quick as possible. You know there are people at home waiting for you, and then they don't get the joy of coming* [to visit]. *They took it hard that they weren't allowed. We didn't get to take the baby out of the postpartum ward, so we didn't get to meet the siblings outside the postpartum ward even though we asked. No, we couldn't do that because our baby was a new-born and vulnerable, so we couldn't. And that is, well, a bit strange from my point of view. It is perhaps the one place where you value having other people around you and being seen of other people."*

In addition to this, after returning home from the hospital, women stressed that they felt alone and that even though they wished to see other people, restrictions inhibited this. Johanne explained:

"You are naturally isolated during the postpartum period, but there is something about not having any opportunities and you cannot do anything, even though you want to and have the energy for it. There are no activities, you are all alone. Having to wait to have visits from friends, waiting to have visitors from the extended family. Yes, I thought it was lonely."

Loss of social arenas and contact

In addition to loneliness during the postpartum period, several women noted that covid-19 had restricted their opportunities for social interactions. Restrictions and infectious disease control inhibited the opportunities for meeting other people because activities normally present during the postpartum period were either cancelled or limited. Ida explains that her postpartum period was less joyful, and that she felt that she lost the community feeling normally available during the postpartum period. She elaborated on this several times during the interview and stressed that she would have liked to be more social, and that it had an impact on how well she handled difficult situations during the postpartum period.

"Even though I am here with my partner, it does become a totally different postpartum period in the beginning because you are all alone. I think it became less joyful and not so enjoyable. It was a much tougher experience. Even though there are good moments as well, I missed the community that follows. There are still friends that has not met the child because of it, and that is a bit sad to not share something that is inherently nice. […] It would have been nice to be more social. To meet others in the same situations and with children the same age. But there was none of that. I definitely missed having an arena to meet others, I missed that. […] I didn't expect to be so much at home, it affected us in a way that we had very little input to handle what was demanding, because we were so much at home, always on our own. A lack of that community surrounding us. I did expect it to be more of that. I think it has affected how hard it has been, and my well-being in the postpartum period."

Tonje recounts that she did not have access to activities due to covid-19, and the activities that were accessible were limited due to new restrictions at the time. In addition to this she would have liked to be more social and met mothers that were in the same situation as her.

> *"There were no maternity groups, or anything. So, for the most part it has just been me and my partner. That you couldn't, that you haven't met other mothers. You cannot exchange experiences and emotions. We did start a few swimming lessons, but new restrictions cancelled that. It was only a couple of times. […] I can imagine that it would have been better to meet others in my situation, maybe it would have helped my mental health and in the everyday life. When my partner started work, I was alone a lot of the time."*

Chapter 5 – Positive experiences during the postpartum period

This chapter presents the positive experiences women had during their postpartum period, including their experiences of health services and the impacts covid-19 have had on their postpartum period.

Health services at the hospital of good quality

Several women reported that the initial time at delivery ward gave room to rewind and relax after giving birth. As Ida remarked:

> *"The delivery ward was not busy, we got 7-8 hours together there. The partner did not have to leave at once, as so many others have had to where they have just seen the baby and then are asked to leave. I am glad we got to rewind a little before he had to leave. […] There were no one in que to get in [to the delivery ward] so we were lucky to get that time together."*

Sarah made the same remark:

> "*I gave birth on Monday evening and got some quiet hours at the delivery ward when the baby had been born. There was no rush to get us out of the room. I got time to have a shower and eat. We got time to pick ourselves up again, so that was nice."*

Moving from the delivery room to the postpartum ward, several multiparous women stated that meeting a familiar person at the postpartum ward was a positive experience. This was a health professional they had encountered during a previous pregnancy and birth and noted that this gave a sense of security. Ida continues her story by telling about the health professionals at the postpartum ward:

"I think they were very nice for the most part. And it was the same person that I had met before. It felt very safe. She even remembered me, she remembered that I had worked so hard with breastfeeding. I had contact with her after I went home as well."

Camilla described the health professionals at the hospital as accommodating and helpful. Moreover, it was important for women that they got help when they asked and needed it.

"I think they are very nice, accommodating and helpful. And felt, as I have said earlier, that they came at once when I asked, and that they had time to talk to me. Very positive, I think they are very good [at their job]*."*

First-time mother Tonje explained her positive experiences with the health professionals at the hospital even further. She emphasized that health professionals were very helpful, and she valued that they were good at conveying information about the new-born.

"In a way available for all kinds of questions about care and love. […] they were good at keeping us up-to date all the time. They were good at telling us to rest, that it was important to rest after giving birth. […] It was very nice, got a lot of guidance on breastfeeding, they had breastfeeding counsellors or what they are called, it is a person who gives advice on breastfeeding, she was very nice to deal with. There were new people every day, but all in all everyone was nice and very helpful. If there were things you wondered about, you could just pull calling button string and then they were there at once. Got answers to everything we wondered about. All the doctors were amazing. Examined our baby from head to toe, I don't know what they didn't examine. I felt that we were really taken care of. Especially my son. I can sum up that feeling in one word, and that is simply security."

Positive experiences with the municipal public health clinics

For those women that had a home visit by either a midwife, public health nurse or both, it was noted as a positive experience to have someone come into their home and familiar settings. It was viewed as a nice experience. Both in terms of geographical proximity and that it was less

stressful than traveling to the public health clinic themselves. Upon asking how Johanne (28) experienced the home visits, she said that it was nice that they came to her home.

> *"It was nice, or it was practical that she came home [to us] so we didn't have to go there."*

Cecilie elaborated on her experience, by adding that she enjoyed her home visit and liked that it was the midwife she had follow-ups with during her pregnancy.

> *"I thought that it was lovely that they came here, that I didn't have to make a scene about travelling anywhere. That it was nice, it seemed she had all the time in the world. She was open to answering anything. We had a good tone and connection throughout the whole follow-up, so it was very nice that she was the one that came* [to visit]. *Someone I knew. So, it was very positive that they had follow-ups in that manner."*

Partner essential to a sense of security

All fourteen women interviewed noted that a key to feeling a sense of security was having the partner or a familiar person present at the hospital, both during birth, at the postpartum ward and the initial time after coming home. Giving birth is a lifechanging event and Sarah reported that it was important that the partner was present during birth to experience the child coming into the world.

> *"It is alfa and omega, to have the partner around, if you ask me. In relation to it being a very special experience to give birth, and you are not, how should I put it, it is a moment you want to share with you partner, and it is a big moment. And to be alone, I can picture how that is like, because it is a moment you will never get back. It is a special experience, and you want to share it. I am very glad we got that together, and the time after, because it is something about the time after the baby has arrived, to get that peaceful time together with the baby."*

Kristina, a multiparous woman, agreed and further explained that it is important to have someone you trust with you during birth, as well as it is important for the partner to experience the birth of their baby.

> *"If there is one person you need the first time, it is a person you know very well. There is no other time in life where you are as vulnerable as in that situation. I have noticed a great difference in how it is to have someone you feel secure around and someone you are not secure around. It is of great importance, I think about those poor people that didn't have anyone with them, that didn't make it there in time. […] That is something that I would grant every partner, it is the only thing they get to experience from the pregnancy feeling. And everything with the birth, to see that the baby is actually here. I would grant that experience to every partner."*

Sarah says it was nice to have the partner there to share parental duties and to start the initial time after birth together as a family.

> *"It was a little, again, very happy to have my partner there. That we were two to share and experience everything, to watch the baby and taking shifts to sleep, and a tiny defenceless creature, how to handle the baby, how to sleep with the baby. Very new and scary really. Having my partner there – I know people who didn't – made it better for all of us. That we got to start together as a family."*

Furthermore, the partner was seen as valuable support for women to stay at hospital to receive the help and guidance needed. Primiparous mother Cecilie added that including being an emotional support, the partner was a key to staying in hospital long enough to get started with breastfeeding.

> "*I have spoken to several others that were like "he got to be there two hours after and then he had to leave again", I think as this is my first baby, I would have felt very lost if I were to be there all alone. Trying to understand instructions, keep up and remembering. One thing is that*

you must put the baby down to have a shower, and then you know dad is there so it will be just fine. So, it was nice to not have to feel so alone. Because I was there for three days, I do not think I would have stayed as long if I were alone. I felt the need to start breastfeeding and to understand the child. I would not have stayed there as long if he hadn't been allowed to stay."

Women also stated that it gave them a sense of security to have the partner present at the postpartum ward. Veronica added to this by pressing that the partner was her voice during the stay.

"For me it is very safe because he became my voice. I do not want to be a bother, I do not want to nag, I understand that it is busy and all of that. That has an affect when I am in pain and do not want to bother anyone. Then it is a sense of security to have him with me, he knows me very well. I am not going to speak up for myself, but then he will do that."

Helene agrees that her partner was vital for her sense of security and to speak her cause, and that she would not have been able to communicate her issues on her own.

"For a sense of security. I know very well, that had there been something, or if something had aggravated the situation, I would not have been capable to bring that up myself. I am very good at hiding it if someone tries to talk about it. So, then it will not have surfaced. If I do not feel seen or heard, I shut down."

Primiparous mother Anna explained that the partner's attendance is something women nowadays expect in a birthing and postpartum situation, and that the partners involvement in this situation would have made all the difference in her circumstance.

"Nowadays it is expected to bring the partner, and in the past, it wasn't like that, and they managed fine, but today you have expectations to have someone with you and support you, so you get a little shock [if you don't]. *[…] for me it would have made a great difference to have my partner with me at the postpartum ward. To have had help with the care of the baby and not have felt so alone in the hormone rush you get right after birth."*

Positive impacts of covid-19

Even though covid-19 was a worldwide pandemic with severe implications for restrictions and infectious disease control, several mothers explained that these said factors had a positive impact on their experience of the postpartum period. As multiparous mother Monica explained, the visitor restrictions made the initial time at the hospital both quieter and more peaceful.

> "*It gave a different kind of peace because there were not many visitors from the family, and you had to just wait. So, it gave a more peaceful stay as well if I compare it with the other. […] You get to rewind and relax in a different way, not so much back and forth*."

For others, the pandemic did not affect them to a point where they paid much attention to it. As Camilla said, the time at the hospital was quiet and she got to relax and sleep.

> *"I didn't think about corona, I was very lucky, it was quiet. […] And I thought it was lovely to be left alone in peace. To be there for two days, and this time I had a baby that was very calm and slept a lot, there were no issues with breastfeeding, and I felt safe."*

Chapter 6 – Discussion

This chapter will discuss the results from chapter 4 and 5 using the AAAQ-framework. The AAAQ-framework is a tool to assess goods, facilities and services provided during the postpartum period using the following criteria: availability, accessibility, acceptability and quality (Hunt & Mesquita, 2006; Yamin, 2008). By using the four criteria of the AAAQ-framework, this will demonstrate reasons why women have negative experiences with the services provided during the postpartum period, and what women assert as important to their experience. The discussion will additionally examine the positive experiences women have during the postpartum period. The discussion of these experiences is also shown to be in context of covid-19, making this study relevant and novel.

Availability

The first *A* of the AAAQ-framework states that services, goods, and facilities in the postpartum period must be *available* to women. Women in this study argued that the health professionals at the postpartum ward were busy and not available to women when needed. Corroborating earlier quantitative research, women demonstrate that the health professionals were not available for the services they should provide at the postpartum ward (Lazzerini et al., 2022). Women perceived the health professionals as concerned with routine checks, such as weight and measuring the new-born. As Lazzerini et al. (2022) found, this led to women asking for less help than optimal and gave a feeling that the staff were too busy to talk with the mothers. Potential issues pertaining the mother are therefore left unmitigated. Furthermore, in the context of covid-19 this builds on recent research which shows that during this period, women were discharged earlier than usual (Jùlìusson, 2020).

Women that had positive experiences of the postpartum period noted that available delivery wards and having available health professionals were viewed as essential to a sense

of calm and security. Ensuring that women do not feel rushed can contribute to ease their way into motherhood. From a health promotional and disease prevention view, the mother's physical and mental health will be of interest in order to promote good health and prevent disease and illness. It is shown that early detection of both physical issues as well as mental problems such as postpartum depression, will be cost effective to society (Wilkinson et al., 2017). Low staffing at hospitals is thereby creating a potential issue regarding early detection in order to timely prevent disease and promote health in the long run.

Moreover, this study showed that some women did not have a home visit by either a midwife or a public health nurse. Some women were given the opportunity to have this visit at the public health clinic, whilst others had a telephone call with their midwife. Services previously available to women were therefore limited, as compared to before the covid-19 pandemic (Eri et al., 2022). The unavailability of these home visits affected women's susceptibility to guidance and information. Women were expected to go to the public health clinic but noted this as stressful. Equally, women who did not have a home visit or a telephone call stated that they missed having such a visit in their familiar settings.

Social arenas normally available during the postpartum period were either closed, scaled down or restricted during covid-19, where the lack of these activities was viewed negatively by the majority if the informants. During the postpartum period, women need to meet others in similar circumstances to share experiences, and this is especially important for primiparous women. Some of the activities that creates social arenas for women are visits at the public health clinic where women meet other mothers in groups sessions and in the waiting rooms. Additionally, swimming lessons are normally offered to families and their new-borns in groups, but this was also hindered by covid-19. Lacking these social spaces and arenas was noted by women as something that made the postpartum period much harder and less joyful. Finlayson et al. (2020) assert that achieving positive motherhood is of importance

to women. Losing the social arenas that is available during the postpartum period can therefore hinder women in achieving positive motherhood, as they lose social spaces, arenas and functions that ease the hardship during the postpartum period.

Wiklund et al. (2018) found that continuity in giving care and guidance, and in the professionals giving this care and guidance as a critical factor that led to parent's sense of security in the postpartum period. Several women in this study declared a lack of continuity. Women expressed that there were numerous health professionals during their stay at the postpartum ward, and sometimes these professionals were giving conflicting messages. This did not only lead to confusion and insecurity but also to a lack of continuity in care and guidance. Sense of security is important during the postpartum period, and ignoring it negatively affects the wellbeing of both the mother and infant (Wiklund et al., 2018).

Furthermore, women noted that meeting a health professional they had encountered at a previous consultation, were a positive experience. This was true both at the postpartum ward and regarding the home visits from a midwife. These experiences therefore show the importance of continuity in care, where both the negative and positive experiences point to the same conclusion, that continuity of care is a valued aspect to mothers during the postpartum period.

Women in this study noted that having the partner with them at the postpartum ward were essential to their sense of security. Women noted that the partner was a valuable resource both emotionally, but also regarding practical issues as shared parental duties. In this way women felt they could stay in hospital as long as they needed to receive the help they needed from health professionals, whilst also having the partner there to help care for the baby. If the partner is excluded, resources traditionally available to mothers are cut short and can worsen the women's sense of security.

Accessibility

The second *A* of the framework, *accessibility*, regards both physical access, affordability, access to information as well as services, goods and facilities need to be non-discriminating. As noted, some women were asked to travel to the public health clinics instead of having a home visit. Women therefor had limited physical access to the services normally provided during the postpartum period. Leaving the house with a new-born were experienced as stressful, and the quality of guidance and follow-up at the public health clinic was affected because of it. Similarly, women that had a home visit noted this as a positive experience, both in terms of geographical proximity and that it was less demanding of the mothers in the early days after returning home. Furthermore, health professionals at these home visits came across as not in a hurry and had time to answer any questions the women might have. At full capacity of the health services, home visit serves as a health promotional aspect as women are calmer and in their familiar settings, where women can utilize the valuable resources of health professionals better.

Affordability was revealed to be of importance for women, as some had to seek out privately funded health services. As women in the study exclaimed and earlier research shows, there are social inequalities in health (Marmot et al., 2010). This implies that women with lower socioeconomic status fair worse, due to fewer resources to seek out help from private clinics that provide other, faster, and sometimes better services. If women are expected to pay for health services they need, this will inevitably aggravate social inequalities in health. Working towards an equitable health care system will ensure that every child get the best start in life (Marmot et al., 2010). Wilkinson and Pickett (2011) argue that greater equality makes stronger societies, and that an unequal society is affecting everyone within them. Even though most postpartum services are funded through taxes, this study show that some women seek help through privately sourced health services because they do not view

the services they receive through the public services as accessible and covering their needs.

Affordability can also play a role in women's sense of security. If the partner is excluded from the postpartum ward at night due to not being financially able to pay for the stay, women are left without the support from the partner. As shown in the findings, women viewed the partner essential for a sense of security. Leaving women without their support in the partner due to financial reasons can therefore act as a hinder to achieve a sense of security. This also means that those with better socioeconomic status and can afford it, may have better experiences during the postpartum period as opposed to those from a low socioeconomic status. This is telling especially for Norway, a country known for promoting egalitarian social policies (Dahl, Bergsli, & van der Wel, 2014). These findings, however, also seem to indicate the recent debates that the inequality gap in Norway is widening (Mackenbach, 2019; Mackenbach et al., 2008).

Access to information need to be fulfilled in order for postpartum health services to be viewed as accessible. As Stette et al. (2021) found, covid-19 had an adverse effect on primiparous women's initiation of breastfeeding in Norway. Women in this study further exhibits evidence of primiparous women struggling to initiate breastfeeding during covid-19. Women expressed that they did not feel they had the appropriate information, and found the information given by health professionals both at the postpartum ward and the public health clinics as lacking and confusing. The inability to initiate successful breastfeeding were both affected due to the lack of information and guidance at the postpartum ward, as well as health professionals being unavailable at the hospital. While women in this study attributed the lack of information and access to health professionals largely due to covid-19, it can be argued that some of the experiences of health services indicate a general lack of good care. The results show that information women were receiving was conflicting at times, and that there seem to be a lack of standardised way to impart knowledge to mothers. All these reports seem to

indicate that attention must be paid to these aspects of care, and that this goes beyond covid-19.

If one looks at the reports from women who received good access to information, this was noted as a positive experience. Women valued receiving information about the new-born, and that health professionals were available for help and guidance. It is evident that access to information is indeed important to women, and that this facet of care should be paid more importance and attention.

Acceptability

Acceptability presses that postpartum health services need to be acceptable for consumers, culturally appropriate and sensitive to vulnerable groups. As research has shown, health professionals can play an important part in supporting women during the postpartum period (Alderdice et al., 2020). Women in this study demonstrated that health professionals were too busy to ask how women felt, which led women to perceive the health professionals as compassionless. By also focusing on emotional health, this could further support women during the postpartum period (McLeish, Harvey, Redshaw, Henderson, et al., 2020). This is in line with mothers who had positive experiences in this study. These women noted that they received help and guidance when asked for, and felt that health professionals had the time to talk to them without emitting the sense of being in a hurry.

In line with other Norwegian studies (Eberhard-Gran et al., 2022), mothers in this study were discontent with the lack of attention and follow up of their mental health. In this way, women did not view the health services as acceptable to their needs, as health professionals were not perceived to respond to their individual postpartum issues.

In addition to this, women who have given birth are arguably in a vulnerable position. Giving birth is a strenuous physical situation, regardless of the mode of birth, where the body needs time to heal and recover. In addition, women are required to take care of an undeniably

vulnerable new-born. If women are left feeling like a burden, forgotten, and not receiving help when needing it, the postpartum health services cannot be viewed as acceptable to vulnerable groups. Similarly, if women view the attention and follow up of mental health as lacking, this is not fulfilling the AAAQ-framework's attention to vulnerable groups. As Marmot et al. (2010) argues, interventions during these early years are seen to be effective for disrupting inequalities, and especially strong for children of disadvantaged backgrounds. As women with depression seem to have an effect children in various ways (Ukatu et al., 2018), it is not acceptable to leave these women to fend for themselves.

As a consequence of covid-19 restrictions, women noted feelings of isolation. Leaving women alone in different settings had multiple implications on the help and guidance they received from the postpartum health services. Women stated that they felt isolated at the hospitals, where visitors such as partners and siblings were restricted. This led to an urgency of discharging from the hospital. Even though studies have shown favourable results regarding early discharge (Aune et al., 2021), these have been instances where women have received an early postpartum visit by a midwife. As women in this study noted, several did not receive such a visit due to covid-19 restrictions. Early discharge from hospital can therefore not be advised, as there is no evidence-based research on how early discharge affects women without such an early visit from a midwife.

Even though some women felt isolated and lonely due to covid-19 restrictions, others noted that restrained social contact made the initial time after birth peaceful and quiet. Mothers had time to rewind and gave an opportunity to tune in their focus towards the new-born. These women noted that there was no rush to go anywhere, as guidelines told them to keep a minimum of social contact. This study indicates that women with issues not addressed during the postpartum period felt isolated, whereas women who had an uneventful postpartum period regarding physical and mental issues did not seem to feel social restrictions as

inhibiting. What caused some women to feel isolated and lonely, whilst others noted this as relaxing, needs further exploration, as the methodology of this study does not allow to make concluding marks in this regard.

Quality of services and facilities

The last facet of the AAAQ model concerns the *quality* of services, goods, and facilities. This implies that postpartum health services need to be medically appropriate and of good quality. One reason women in this study had negative experiences during her postpartum period, was the lack of guidance and support concerning breastfeeding initiation. This coincide with other studies, where Stette et al. (2021) indicated that women during the pandemic had less than optimal help and guidance regarding breastfeeding, which led to more new-borns being formula fed, and fewer women who breastfed fulltime. The lack of appropriate guidance and quality of breastfeeding guidance were considered an area for improvement in this study.

Tully et al. (2017) showed that the 6-week postpartum visit is poorly attended and does not sufficiently address issues women view as important. As this study further explored, women felt that the 6-week postpartum visit was uninformative and at times even pointless. Several multiparous women noted that they did not schedule such a visit, due to such earlier experiences. As women also noted, the visit included untimely conversations about contraceptive use, and failed at addressing issues women deemed important. If such a visit, either at the general practitioner, at the midwife or the gynaecologist, seem pointless, it is evident that these services does not cover the needs of women in the postpartum period. Further research is needed to explore the role this visit has for postpartum women in Norway, to create a follow-up of women's health that is of good quality and cover issues pertained by mothers.

Chapter 7 – Conclusion

The main objective of this study was to explore how women experience the postpartum period and the postpartum health services. Women's experiences of the postpartum period did not fulfil the criteria of the AAAQ-framework. These findings show clear areas for improvement in the postpartum health services, both at the postpartum ward, at the public health clinics and the 6-week postpartum follow-up. Women felt a lack of continuity in care, the health professionals at the hospital were too busy, women struggled to initiate successful breastfeeding and women were discontent with the 6-week postpartum follow-up. In addition to this, women experienced feelings of isolation and a loss of social arenas due to covid-19 restrictions, as well as seeking out costly private health services.

The findings shed light on how women have experienced the health services provided during the postpartum period, throughout the course of a global pandemic. Even though covid-19 was noted as a contributing influence, it can be argued that some of the experiences of health services indicate a general lack of good care. Further research is needed to uncover whether there is a systematic lack of good care, or if the negative experiences from this study are due to covid-19 and restrictions that followed. The study additionally implicates that policymakers should concentrate their efforts on fulfilling the criteria of the AAAQ-framework, as the findings show that women utilized privately funded health services. In this way postpartum health services can be seen to contribute to widening the social inequalities in health in Norway.

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Appendices

Appendix A

Har du født barn under koronapandemien?

Delta i et anonymt intervju!

Vi ønsker å høre hvordan **du opplevde barseltiden** og **møtet med helsevesenet**.

Intervjuet vil være **digitalt, anonymt**, og kan gjennomføres når det måtte passe for deg!

Kontakt masterstudent Alida Sødal på instagram **@sodalida**
eller epost **alida_sodal@hotmail.com**

Eller si ifra til din helsesykepleier og hun tar kontakt for deg!

STUDIET ER EN DEL AV EN MASTERGRADOPPGAVE VED HØGSKOLEN I INNLANDET
Prosjektet er registrert hos Norsk senter for forskningsdata (NSD).

Appendix B


Bor du i
Innlandet og har
født barn under
koranapandemien?
Delta i et
intevju!
LES MER

Vi ønsker å høre hvordan **du** opplevde **barselperioden!**

Gjennom å delta i et intervju kan du bidra til å forbedre barselomsorgen i Norge!

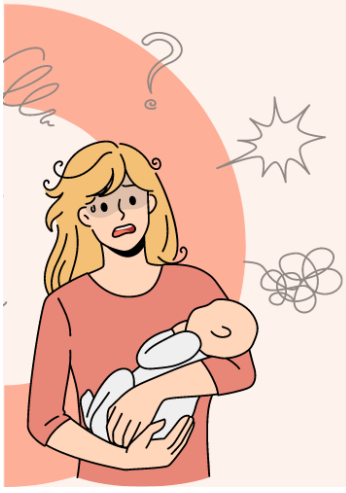
Studien ønsker å vite

hvordan kvinner

opplever møtet med

helsevesenet i tiden etter

fødsel.



Ta Kontakt

Om du ønsker å delta ta kontakt med **Alida Sødal** på Facebook, **@sodalida** på instagram, eller e-post **alida_sodal@hotmail.com**

Intervjuet vil være anonymt, og er en del av en masteroppgave ved Høyskolen i Innlandet.
Studiet er registrert hos
Norsk senter for forskningsdata (NSD).

Appendix C

Har du født barn under koronapandemien?

Delta i et anonymt intervju!

Jeg ønsker å høre hvordan **du opplevde barseltiden** og **møtet med helsevesenet**.

Intervjuet vil være **digitalt, anonymt**, og kan gjennomføres når det måtte passe for deg!

Kontakt masterstudent Alida Sødal her på facebook, instagram **@sodalida** eller epost **alida_sodal@hotmail.com**

STUDIET ER EN DEL AV EN MASTERGRADOPPGAVE VED HØGSKOLEN I INNLANDET
Prosjektet er registrert hos Norsk senter for forskningsdata (NSD).

Appendix D

Intervjuguide

1. **Demografi**
    - Hvor gammel er du?
    - Utdanning?
    - Hva jobber du med? student?
2. **Vil du fortelle litt om fødselen din?**
3. **Hvordan opplevde du tiden på barselavdelingen/barselhotell?**
    - Hvordan opplevde du møtet med personalet?
    - Hvordan var det å ta hånd om en ny baby?
    - Hvordan hadde du det på sykehuset etter fødselen?
    - Hvor lenge var du på sykehuset?
    - Hadde du noen forventninger til hvordan barseloppholdet på sykehuset skulle være – kan du fortelle noe om dette? Kjennskap til det fra før?
4. **Hvordan var det å komme hjem?**
5. **Hvordan opplevde du hjemmebesøkene av både jordmord og helsesykepleier?**
    - Fikk du hjemmebesøk av både jordmor og helsesykepleier?
6. **Vil du fortelle litt om oppfølgingen du fikk på helsestasjonen?**
    - Vil du fortelle litt om besøkene på helsestasjonen frem til 3mndkontrollen.
    - Kan du fortelle noe om 6ukerskontrollen for deg selv? Benyttet du deg av denne?

- Hadde du noen forventninger til barseltiden før du fødte? Kan du fortelle litt om disse?

7. **Hvordan opplevde du restriksjoner og regler i forbindelse med covid-19?**

   - Hadde du partner med deg?
   - Fikk du besøk etter fødsel?
   - Var det regler på barsel?
   - Mindre oppfølgninger? Video/ringe med jordmor?

8. **Oppsummert – hvordan vil du beskrive ditt møte med helsevesenet etter fødsel?**

9. **Før vi slutter av, er det noe du vil legge til?**

Appendix E

Vil du delta i forskningsprosjektet

Kvinners opplevelse av barselomsorgen i Norge

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å se nærmere på kvinners opplevelse av barselomsorgen i Norge. Her blir du gitt informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Formålet med prosjektet er å belyse ulike sider av barselomsorgen i Norge. Prosjektet er tilknyttet en mastergradsavhandling ved master i folkehelsevitenskap ved Høgskolen Innlandet.
Formålet med prosjektet er å belyse ulike sider ved barselomsorgen i Norge, og hvordan dette oppleves av kvinner. Her er man interessert i ulike problemstillinger som har dukket opp for kvinner.

Opplysningene som innhentes skal tas i bruk i en masteroppgave, og vil om mulig publiseres i et vitenskapelig tidsskrift.

Hvem er ansvarlig for forskningsprosjektet?
Høgskolen i innlandet er ansvarlig for prosjektet.

Hvorfor får du spørsmål om å delta?
Du er invitert til å delta i et intervju da du har født barn ved et norsk sykehus mellom tidsrommet mars 2020 – desember 2021, og er ferdig med barselstiden (seks uker etter fødsel). Studien er interessert i hvordan du har opplevd oppfølging av helsevesenet i tiden etter fødsel, både på barselavdeling og oppfølging ute i kommunen.

Hva innebærer det for deg å delta?
Dersom du velger å delta i prosjektet innebærer det at du deltar i et digitalt intervju, med en varighet på litt under 1 time. Intervjuet inneholder spørsmål om din opplevelse av barselomsorgen. Dette innebærer tid på barsel på sykehuset/barselhotell, oppfølging hos fastlege, helsestasjon, jordmor og opplevelsen din av 6-ukerskontrollen.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykket tilbake uten å oppgi noen grunn. Alle dine personopplysninger vil da bli slettet. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Intervjuet vil bli innspilt og lagret der kun masterstudent Alida Sødal og veileder Victor Chimhutu vil ha tilgang til informasjon du har oppgitt.
- Opptaket av deg vil bli slettet så fort det er skrevet ned og anonymisert.
- Deltakerne vil ikke kunne gjenkjennes i publikasjon.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Svarene fra oppgaven slettes når prosjektet er avsluttet.

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 NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- *Høgskolen i Innlandet* ved student Alida Falch Sødal, e-post alida_sodal@hotmail.com, eller veileder Victor Chimhutu e-post victor.chimhutu@inn.no
- Vårt personvernombud: Usman Asghar, e-post usman.asghar@inn.no telefon: +47 61 28 74 83

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.

Jeg har mottatt og forstått informasjon om prosjektet Kvinners opplevelse av barselomsorgen i Norge, og samtykker til å delta i et digitalt intervju.

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet i juli 2022.

Appendix F

Assessment

Reference number
494783

Project title
Women's experience of the postpartum period in Norway

Data controller (institution responsible for the project)
Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Project period
01.08.2021 - 01.07.2022

Notification Form

Date
17.03.2022

Type
Standard

Comment
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 in this project. 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.

TYPE OF DATA AND DURATION
The project will process general categories of personal data, special categories of personal data about health data until 01.07.2022.

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

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
We find that the information provided to data subjects about the processing of their personal will meet legal requirements for form and content, cf. art. 12.1 and art. 13.

So long as data subjects can be identified in the collected data they will have the following rights: access (art. 15), rectification (art. 16), erasure (art. 17), restriction of processing (art. 18) and data portability (art. 20).

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