Imperfections of a Perfect State

A social policy analysis of the provisions of maternal health services for migrant women in Norway
A case study on Stavanger

Lydia Mehrara

Erasmus Mundus Master's Programme in Social Work with Families and Children

Supervisor: Dr. Susan Young

University of Stavanger

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Abstract

Title: Imperfections of a Perfect State: A social policy analysis of the provisions of maternal health services for migrant women in Norway- A case study on Stavanger
Author: Lydia Mehrara
Supervisor: Dr. Susan Young
Key words: Maternal Health; Migrant Women; Social Policy; Social Work; Norway

Background: The increasing ethno-cultural diversity in European societies has posed new challenges for their health and welfare systems. As of January 2017, migrants constitute 16.8% of Norway's total population (SSB, 2017a). Studies show that despite the availability of maternal care and legal migrant women's right to access reproductive health services in most European countries, including Norway, migrant women have been found to exhibit different perinatal outcomes, and patterns of antenatal care utilization compared to non-migrant women (Dejin-Karlsson & Östergren, 2004; Rechel et al., 2011c).

Migrants are affected by an array of challenges that might act as barriers to attaining good health outcomes, even in an egalitarian society like Norway. Socio-economic inequalities are the most prominent issues discussed in policy for addressing barriers to access. Although they are important they tend to overshadow more nuanced factors such as linguistic and/ or ethno-cultural barriers for targeting inequalities. My literature search revealed that there is an inadequate body of research exploring the effects of more implicit and informal social determinants such as ethnicity and culture linked to migrant health. Although some studies acknowledged them as determining factors, none analyzed or evaluated how they have been addressed in policy. Therefore, it became the aim of this study to contribute to this knowledge gap by exploring:

1. How has health policy in Norway recognized and addressed barriers that affect migrant and refugee women's access to maternal health services?
2. How have these policies enabled accessibility and acceptability of maternal health services to migrant and refugee women?

Methods: I developed an instrumental case study using the provisions of maternal health care in Stavanger to illustrate Norwegian health policy. I analyzed the data using a policy analysis framework before subjecting them to further critique, using my conceptual framework containing four theories for understanding.
Results: There is a contradiction in the assumption that universal provision enables equal and effective access. Norway's universalistic approach to health policy has inadvertently resulted in a degree of ambiguity in the ethos of equity and equality, which has overlooked intricate determinants of health at the micro level of society. Consequently, this has led to the formation of loopholes in the theoretically equitable healthcare system, through which a fraction of population, particularly people from migrant and refugee backgrounds fall. Hence, this approach to equity imposes weakness to the principle of universalism and further deepens inequality.
Conclusions: It is time to challenge the underlying principles of health policy to elicit realization of inequality and induce action for promoting equity by addressing the needs of a diversifying society through multidisciplinary interventions and targeted approaches to universalism.

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This research marks not only the end of a rewarding endeavor, but the end of the most fun and fulfilling two years of my life in Europe. However, it too brings new beginnings. The knowledge I have gained, the experiences I have had and the many wonderful people I have met on this journey, have changed me for the better and opened a new world of possibilities to me.

I was able to defy boundaries and bring together what I am most passionate about in this dissertation, which I cannot imagine having been possible without the invaluable guidance of my supervisor Dr. Susan Young. Her expansive knowledge, dedicated supervision, practical advice, intriguing suggestions, and most importantly her encouragement and general enthusiasm made this research experience not only possible but considerably enjoyable.

I am also grateful to MFAMILY for this truly remarkable and life changing opportunity to pursue a study in the multidisciplinary field of social work at three European universities. Despite some ups and downs over the past two years, what I take away are the great friendships, and wonderful memories and the vast new knowledge.

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Dedication

I dedicate this work to my loving parents, Farkhondeh and Manouchehr.

Acronyms

SDH- Social Determinants of Health
UDI- The Norwegian Directorate of Immigration
UN- United Nations
WHO- World Health Organization
WPR- 'What's the Problem Represented to be' approach
RHA- Regional Health Authorities

Chapter 1
Introduction

In 2016, I met a young pregnant girl staying at a center for unaccompanied asylum seeking minors in Gothenburg. Alone, unsupported by family, unfamiliar with the Swedish systems of support, cultural expectations, knowing no Swedish, this young girl was facing a very unknown future, much less having no access to the sorts of familial or community supports she might have expected in her home country. Yes, she was now safe. But she was very vulnerable. I wondered what her child birth experiences would be, what her mothering experiences would entail, how she would manage her and her child's health needs in this new system. What would be the provisions which would make it easier for her?

This meeting prompted my research topic, which wanted to know how health policy in a Nordic country, and specifically Norway, attended to the needs of women such as this young girl.

Rationale for study

I am a migrant from an ethnic minority in a non-western country and my family emigrated to a western country with very different norms, cultural beliefs, and systems of support such as health services. While not an asylum seeker nor pregnant on arrival in a new country, I have both witnessed and personally experienced the challenges of migration and integrating into a new society.

My educational background includes both health and social work and the MFamily joint Masters offered me the opportunity to gain an in depth understanding of policy settings in Portugal, Sweden, and Norway, by spending a semester in each country. This social work education enabled me not only to seek what and where problems were in our societies, but also equipped me with spectacles through which I began reflecting on my own position and examining my values. The policy dimension of how health services can be provided to migrants and refugees in countries very different from their homelands, brings together for me an interest in health as a major contributor to wellbeing, and social work as a significant provider of supports to enhance wellbeing especially for families and children. My dissertation semester is being undertaken at Stavanger, so I chose to focus on health policy in Norway, with the expectation that findings may offer insights specifically into Norwegian policy but may also have considerations for other Nordic countries.

This chapter sets the scene for the study by providing an overview of the context of migration and maternal health in Europe in particular, and introduces the main themes that will be discussed throughout this dissertation. I will conclude by outlining the contents of the chapters in the study.

My research questions are:
3. How has health policy in Norway recognized and addressed barriers that affect migrant and refugee women's access to maternal health services?
4. How have these policies enabled accessibility and acceptability of maternal health services to migrant and refugee women?

I chose an instrumental case study (Stake, 1995) method using the provisions of maternal health care in Stavanger to illustrate Norwegian health policy. The application of a case study approach will be discussed in the methodology chapter as will its limitations. It is maintained, however, than an in-depth examination of provision through particular programs or activities may illuminate policy directions and applications as well as indicate where policy either fails or has significant limitations.

Aim

The aim of this study is to close a gap in literature and add to the policy debate by critically analyzing how Norway is providing maternal health services to migrant and refugee women through an instrumental case study of Stavanger.

Significance
Migration and Maternal Health

Migrants are becoming increasingly prevalent in European populations, bringing with them greater ranges of diverse experiences, values, norms and expectations. Many of the migrants have particular needs which present the host nations with new challenges in their health and welfare systems. The manner of countries' responses varies according to their own systems, but Nordic countries, with their social democratic systems, are expected to respond from the principles of equality and access. These principles are reflected in the UN position on human rights which, according to the United Nations High Commissioner for Human Rights on the right to health, maintain that:

"The right to health can be understood as the right to an effective and integrated health system encompassing health care and the underlying determinants of health, which is responsive to the nationals and local priorities, and accessible to all" (WHO, 2007)[1]

Maternal health is a particularly pressing issue for, according to World Bank Statistics (2015), maternal mortality rates are still unacceptably high, even in countries, such as Norway as a representative of one of the world's most developed countries, which has a low rate of 5 per 100,000 live births in comparison to 1,360 per 100,000 live births in Sierra Leone, one of the least developed countries.

Migration adds to the risk factors for mothers.

"Women migrants are among the most vulnerable to human rights abuse, both as migrants and as females", yet their experiences of migration are greatly unheard (UNFPA, 2007, p. 3). Pregnant women and their newborn children are among the most vulnerable groups of societies (Reeske & Razum, 2011), and migration further increases the vulnerability of this group. Reeske and Razum

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[1] World Health Organization, hereafter: WHO

(2011, p. 139) state that "health differentials during pregnancy, birth, the neonatal period and the first year of life are sensitive indicators of social inequalities".

Despite the availability of maternal care and women's right to their reproductive health for legal migrants in most European countries, migrant women have been found to exhibit different perinatal outcomes, and also follow different patterns in utilizing antenatal care than non-migrant women (Darj & Lindmark, 2002; Dejin-Karlsson & Östergren, 2004; Rechel et al., 2011b); therefore immigration has been found to pose an obstacle in seeking care (Ny, 2007).

Even though the maternal mortality rates in continental Europe are amongst the lowest in the world according to The World Bank (2015), there are other, comparatively more nuanced, indicators in maternal and child health outcomes that are sufficient to portray disparities and inequalities, between the maternal and child health of migrant and non-migrant populations in Europe. Some of these can include an increased prevalence of unfavorable birth outcomes (within the migrant population in Europe) such as: still births, low birth weights, preterm birth, congenital defects or malformations, and an increased risk of maternal and infant mortality (Reeske & Razum, 2011).

Multiple studies show disparities in utilization of prenatal and antenatal care by migrant women in comparison to non-migrant women (Hemingway et al. 1997; Choté et al. 2009; as cited inNørredam & Krasnik, 2011). Several studies show that migrant women begin antenatal visits later in their pregnancy and also make fewer appointments compared to non-migrant women (Rowe & Garcia, 2003; Petrou et al., 2001; David et al. 2016; as cited in Reeske & Razum, 2011). Furthermore, other studies show higher rates of induced abortions among non-western migrants, which can be an indicator of poor access or knowledge of preventative measures in relation to reproductive health (Rasch et al. 2008; as cited in Nørredam & Krasnik, 2011). These findings are indicative of gaps in health systems that fail to make services more accessible to migrant women. Forms of accessibility can range from physical accessibility, knowledge about health services, language barriers etc. It can also be indicative of the quality of services and their acceptability and appropriateness by migrant women.

Gap in Literature

My literature search on the topic of migrant health policy and migrant maternal health policy in Norway, did not reveal many results. In conducting broader searches on the topic of migrant maternal health I found numerous studies, which I refer to throughout this study, that: offered comparative statistics of birth outcomes between migrant and non-migrant women; there were several qualitative studies examining the experiences of women in utilizing maternal health services in several countries; the challenges health providers face in offering services to migrant women. Additionally, other studies I found in relation to migrant health were mostly focused on raising awareness about: social determinants that typically affect migrants' health in achieving optimal health; or recommendations on making services responsive to more plural populations etc.

Nonetheless, there were not many, and in the case of Norway, no studies that I found analyzing the underpinnings of health policy as a determining factor for migrant health, or analyses on the subsequent impact of how migrants are represented in policy.

The topic of this study is fundamental for filling in the knowledge gap that exist in this area, and for provoking a reevaluation of health policies targeting migrants to ensure equality across the whole population especially during a time that the migrant population in Norway is on the rise. Furthermore, this dissertation offers a representation of the multidisciplinary field of social work, and how their unique positioning in the field of social policy, is essential to developing effective and sustainable interventions that address issues of inequality. Finally, another important objective of this study is to offer the foundations for, and intrigue further research.

Dissertation Structure

This study is divided into seven chapters. The first chapter has presented an introductory outline of the study. The second chapter offers a literature and contextual review of Migrant and Health Policy in Norway, demonstrating the significance of this study and laying the foundations for further analysis in the following chapters. The third chapter includes a review of literature in relation to the context the study is being done, which consequently justifies the selection of the conceptual framework used to interpret and analyze the study findings. These concepts are the Availability, Accessibility, Acceptability and Quality (AAAQ) framework (WHO, 2007), the Social Determinants of Health (SDH) (Dahlgren & Whitehead, 1991; WHO, n.d.-b), Whiteness theory (Thompson, 2001; Young, 2004, 2008) and Targeted Universalism (Leubolt, Fischer, & Saha, 2014; Perry, 2011; Powell, 2008) all of which are explained and discussed in this chapter. Methodology including the choice of analytic framework for policy analysis are thoroughly explained in the fourth chapter. The fifth chapter presents the case study using a policy analysis framework known as 'What is the problem Represented to be?' (WPR) (Bacchi, 2009). Next, the discussions chapter analyses the implications of these outcomes by subjecting them to a critique using the conceptual theories. Finally, the seventh chapter, concluded the study by offering a summary of its findings, describing its significance and implications for future research, and ending with a series of recommendations for future research directions.

As indicated through the description above, the literature pertaining to: Migrant and Health Policy and in particular reference to Norway; the concepts of AAAQ framework which is a right based framework, SDH, Whiteness Theory, and Targeted Universalism; and the WPR Policy Analysis model is covered in detail in the relevant chapters. This presents an alternate approach to literature reviewing which is considered more appropriate to the form and structure of this dissertation.

Chapter 2
Migrant and Health Policy in Norway, A Literature and Contextual Review

Introduction

The context and accompanying literature in this chapter provide an illustration of health policy development, organization and governance in Norway in relation to its migration history, to later analyze what its impacts are on migrants, especially migrant maternal health care and access. This chapter is an argument demonstrating why this topic is of importance, and acts as a foundational point of reference in constructing the case study on migrant maternal health services in Stavanger, and throughout the analysis segments of this study.

The chapter begins with a summary on the development of the social democratic welfare state and its overarching values of equality; followed by a description of the government system which localizes fundamental decisions and programs; the welfare state's response to challenges imposed by the relatively new composition of its non-Norwegian populace; which leads to the final section offering a review of the Norway's migration history and the likely challenges the current distribution and composition of migrants can pose for the state.

Welfare State Norway

The aim of this section is to offer some background required for the better understanding of Norwegian health policy through its historical development.

The welfare state is a European creation, dating back to the last quarter of the 19th century (Castles, Leibfried, Lewis, Obinger, & Pierson, 2010). This period in history was associated with great political, economic and societal transformations including industrialization, rise of capitalism, urbanization and population growth (Castles et al., 2010). Welfare states developed in response to changing societal needs and which were exemplified by: these states assuming the traditional forms of societal solidarity from family, community and charity; post war expansion and long periods of peace and prosperity; expansion of civil rights and mass democracy; nation building; secularization; and an increase in social investment paradigms after years of laissez-faire liberalism (Castles et al., 2010).

Over time, the role of the state evolved from protecting the nation from war and maintaining order, to protecting society from ills resulting from societal changes through guaranteeing social and economic welfare from society to state. Bismarckian theories on insurance and social policy as a form of nation building in Germany during the 1880s, set the foundations and triggered the expansion of social protection policies such as social insurance, that over time came to incorporate pension plans, old-age protection, unemployment protection, industrial accident insurance and family allowances, across most post-industrial Western countries, including Norway, around the turn of the twentieth century (Kuhnle & Sander, 2010).

Although all the nations of Western Europe, North America and the Antipodes were affected by the same fundamental transformations, the timing of action and political responses to societal challenges were different (Castles et al., 2010). The expansion of welfare increased after World War II between 1947-1960s in response to the devastating social situation in many countries, a period known as the golden age of the welfare state (Castles et al., 2010). This period focused largely on the five main 'ills' of society following those societal conditions to ensure that people had access to supports that would enable them to participate in society. These included: want (poverty), health (disease), education (ignorance), housing (squalor), and employment (idleness) as described in the Beveridge Report (1942). While these were prominent in the UK, most European and some other western countries sought to ensure that citizens were free from these ills through the provision of social supports and services, although how they enacted these differed markedly.

The typology of the welfare states as we know them today are characterized by the generosity and extent of the social provisions and the enactment process of these programs (i.e. top down as in authoritarian societies of the time such as Germany, or bottom-up enactment by the people in democratic societies such as Norway (Castles et al., 2010). However, our understanding of the modern definition of welfare state is profoundly influenced by Esping Anderson's (1990) regime classifications. In his renowned publication, *The Three Worlds of Welfare Capitalism* he identified three types of welfare regimes with unique characteristics that classified post- industrial countries of Western Europe and North America (Cerami & Wagué, 2012). The Social Democratic (showing the greatest decommodifiaction and emphasis on citizenship rights); the Liberal welfare states, (most market dependent); and the Christian democratic welfare states (conservative) (Esping-Andersen, 1990). Norway along with the other Nordic countries, fall under his category of social democratic welfare states, with the most comprehensive public services and lowest levels of inequality (Esping-Andersen, 1990).

While Esping-Andersen has been widely criticized for his characterization of welfare regimes, nevertheless this typology is still in common usage (Emmenegger, Kvist, Marx, & Petersen, 2015). Norway is still considered to have what he termed a social democratic form of welfare estate which are founded on shared notions of community, equality, mutual respect and trust. Progressive taxation was employed to reduce economic inequality, and to finance generous public services (Pierson & Leimgruber, 2010). One of the striking features of the Norwegian and by extension the Nordic welfare state, with which Norway shares values, history and cultural values is universalism, where it is a national priority to offer all citizens equal access to services available (Kangas & Kvist, 2013). Nordic welfares states are known for their comprehensive universal public services, low levels of inequality between poor and the rich and between men and women (Kangas & Kvist, 2013).

Consequently, welfare states have become important determinants of health. How a society decides to distribute resources among citizens is important in determining health the overall wellbeing of the population. Therefore, the provision of health care differs among capitalist nations according to the type of welfare state regimes they have adapted. According to Navarro and Shi's (2001, p. 481) findings, "political traditions more committed to redistributive policies (both economic and social) and full-employment policies, such as the social democratic parties, were

generally more successful in improving the health of populations". Thus, Norway's low levels of inequality, higher satisfaction with life, and the population's overall high quality of health has been attributed to the country's comprehensive and accessible health and welfare programs (Kangas & Kvist, 2013).

Norway's social democratic state was founded upon the ethos of equality and is driven by the principle of universalism to ensures that everyone, including migrants and refugees, has equal access to basic needs (Ringard, Sagan, Saunes, & Lindahl, 2013). It accomplishes this by mobilizing provisions through its intricate organizational and governance system which divides responsibilities across different levels of administration and localizes fundamental decisions and programs. The following section therefore entails a comprehensive overview of the governance and organization of health policy in Norway to build the foundational context for this study's setting, act as a point of reference in the findings and discussions chapters.

Government in Norway

The country's welfare system is founded upon strong egalitarian values, whereby high taxation is used to fund generous public welfare services equally for the entire population. The distribution of tasks and responsibilities is divided across three levels of government: The central government; county authorities and municipalities. There are 19 county authorities and the 428 municipalities in Norway which make up a two-tiered local government system that holds administrative status and is supervised by the central government (Norwegian Ministry of Local Government and Modernisation, 2014). Moreover, the political system at the local level is a representative democracy, where members of both municipal and county councils are elected by citizens of their respective regions every fourth year (Borge, 2010).

Despite there being different political parties at local levels with varying views and agendas, the 'Norwegian Ministry of Local Government and Modernisation' (NMLGM) (2014, p. 8) states that "the national aim is to offer a high level of services with equal standards to citizens in all parts of the country" The generalist local authority system in Norway requires all county authorities and municipalities to take on the same responsibilities in the provision of public welfare services regardless of their size and (Norwegian Ministry of Local Government and Modernisation, 2014). The main representative of the central government (formally the king), in the counties are the County Governors who, act as a guardian of civic rights and are responsible for reviewing the legality of decisions made at municipality levels (Norwegian Ministry of Local Government and Modernisation, 2014). "The County Governor's office supervises and advises local activities- with due respect to the political judgment of the local government" (Norwegian Ministry of Local Government and Modernisation, 2014, p. 21).

Decentralization of the local public sector has a long history in Norway as Borge (2010) explains. The local governments developed a high degree of autonomy from the state with the establishment of local democracy and local self-rule in 1837 (Borge, 2010). During this period, economic differences developed between regions due to their different sizes, population and varying local tax rates. This triggered national response and the involvement of the central government in regulating and supervising the local government's finances and activities. In 1911 the Tax Act was introduced which established a maximum local income tax, and in 1936 the "tax equalization fund" was introduced in response to redistributive concerns, which set the foundations for today's grant

policies and redistributive schemes (Borge, 2010, p. 96). The income tax rate in Norway has been a flat rate of 28% since 1992 (Norwegian Ministry of Local Government and Modernisation, 2014, p. 24), which might seem low on the surface, but adds up to considerable sums with other forms of taxation. This tax is collected by municipalities and is distributed to the county and the state at rates of 2.65% and 13.75%, leaving 11.6% for the municipality (Norwegian Ministry of Local Government and Modernisation, 2014). Furthermore, "The municipalities also have a right to levy taxes on the population in order to finance their activities" (Ringard et al., 2013, p. 25).

Therefore, the main sources of revenue for the local governments come from local taxes, grants, charges and fees (Borge, 2010). Local taxes include: income (individuals), property (individuals and businesses), and wealth taxes (individuals), as well as natural resource taxes (power companies) account for the greatest share of municipal revenue (Norwegian Ministry of Local Government and Modernisation, 2014). However, the municipalities and counties vary greatly in size and population density, "ranging from 218 to approximately 600 000 inhabitants per municipality" (Ringard et al., 2013, p. 6). This results in varying levels of income from taxation and different levels of expenditure on public services across regions. Since the national aim is to offer all citizens in Norway a high level of public services with an equal standard, it is critical that there is some form of income redistribution between municipalities and county authorities to ensure that all regions have the financial means to provide sufficient services to their residents. This redistribution of tax revenue is achieved via the General Grant Scheme, which compensates for costs that would otherwise be endured by the local governments as a result of population density, and population characteristics (Norwegian Ministry of Local Government and Modernisation, 2014). In addition to this the state offers Rural Grants and Grants for Small municipalities with populations under 3200 to ensure that governments of small and peripheral communities can mean the national aim, and finally Urban Grants for the country's four largest municipalities: Oslo, Bergen, Trondheim, and Stavanger to compensate them for urban challenges (Norwegian Ministry of Local Government and Modernisation, 2014). Finally, the state also offers Discretionary Grants to local governments to compensate for unexpected expenses due to natural disasters (Norwegian Ministry of Local Government and Modernisation, 2014).

Figure 1- Composition of local government revenues in 2013
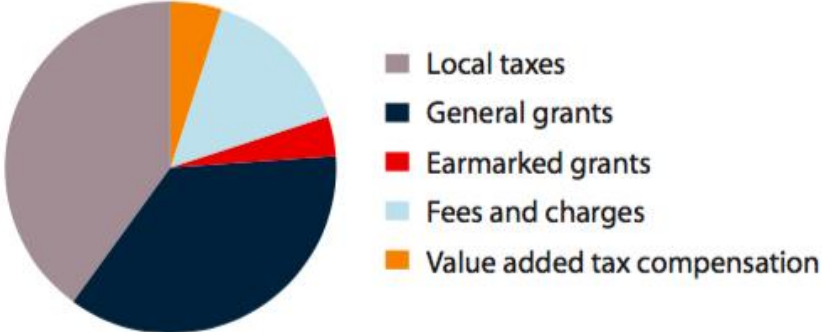
As cited in Norwegian Ministry of Local Government and Modernisation (2014, p. 23)

The local democracy and local accountability is still strong in Norway, as local governments are accountable and responsible for allocation of resources and redistribution of services (Figure1). Although municipal activities are overseen by the municipal council, they are also subject to state supervision (Norwegian Ministry of Local Government and Modernisation, 2014). There are consultations between the central government and The Norwegian Association of Local and Regional Authorities to discuss and review the distribution of revenues, financial situation of local governments and efficiency of measures (Norwegian Ministry of Local Government and Modernisation, 2014). The local governments have the autonomy to prioritize and devise their own service provision plans to fit their local needs, however the national government has overriding authority to make sure all local governments are respecting national policy guidelines and standards (Norwegian Ministry of Local Government and Modernisation, 2014). This is important, because it gives local governments the autonomy to devise social policy provisions in accordance to the needs of their population. Therefore, the Norwegian government can be summarized as having bottom-up development and top-down supervision.

Division of Responsibility

Multiple acts and legislations regulate and characterize the decentralized Norwegian health care system (Ringard et al., 2013). The following table provides a summary of the distribution of responsibilities at each level of government, as informed by Norwegian Ministry of Local Government and Modernisation (2014) and illustrates the different location of responsibility for health matters.

Municipalities	Counties	Central Government
Nurseries and Kindergartens	Upper secondary education	The National Insurance Scheme
Primary and lower secondary school education	County roads and public transport	Specialized Health services and hospitals
Primary Healthcare, outpatient care	Regional planning and business development	Universities and higher education
Social services	Culture (museums and libraries)	Resettlement of Refugees and Immigrants (refer to chapter two for more information) National road networks, railways, agriculture and environment issues
Care for elderly and disabled	Dental Care	Juridical system (police, courts, armed forces, foreign policy)
Local culture and business development		Specialized social services
Local planning, agriculture, environment, and roads		

Figure 2- Distribution of expenditure in municipalities

Legend:
- Care for the elderly and disabled
- Primary school
- Kindergarten
- Social services and child welfare
- Health care
- Water, sewage and waste
- Culture and church
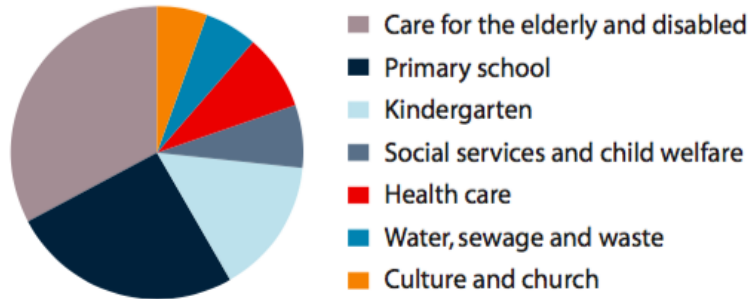
As cited in Norwegian Ministry of Local Government and Modernisation (2014, p. 22)

As evident from the table above, the local governments are the primary providers of public services, and municipalities, in reference to Figure 2, "play an important role in the allocation of resources and the provision of care" (Ringard et al., 2013, p. 25).

"The distribution of responsibility is based mainly on the degree of specialization of the services" (Gjerstad, 2016, p. 168). The specialized services are regulated and offered by the state, whereas primary health care which covers: "health promotion, preventive health measures, nursing services provided outside of hospitals and general practitioners (GP)", are the responsibility of municipalities (Gjerstad, 2016, p. 168).

Since 2002, the state (*central government)* has the overall managerial and financial responsibility for specialist care (Ringard et al., 2013). The state owns the four regional health authorities (RHAs) in Norway, and is therefore consequently the owner of the 27 health trusts and 21 hospital trusts in the country (Ringard et al., 2013). The RHAs include: Northern Norway RHA (Helse Nord), Central Norway RHA (Helse Midt Norge), Western Norway RHA (Helse Vest) and, the largest, South-Eastern Norway RHA (Helse Sør Øst)" (Ringard et al., 2013, p. 20). The municipality of Stavanger, is covered by 'Helse Vest' or Western Norway health authority which has one the largest hospitals in the country, the 'Stavanger Universitetssjukehus' (Stavanger University Hospital) (Helse Stavanger, 2016).

There is very little collaboration between the hospitals and primary care providers in the municipalities, unless an agreement for special initiatives exists, as they are essentially owned and regulated by different governing bodies.

"The Ministry of Health is in charge of regulation and supervision of the system" (Ringard et al., 2013, p. 15). Although many of the tasks and responsibilities are delegated to various government agencies, the Ministry of Health has the responsibility to supervise all activities to ensure that health and social services are delivered in accordance with national regulations (Ringard et al., 2013). The ministry is responsible for developing national health policy, allocation of funds within the health sector, preparing major reforms and proposals for legislation, and finally monitoring the implementation of national health policies through multiple subordinate agencies (Ringard et al., 2013).

Furthermore, in addition to overseeing and coordinating health care at local government levels, the

Ministry of Health, as the owner of the RHAs, and the subsequent owner of the hospital trusts, has a central role in the provision of specialist care. Moreover, as a supreme governmental body, "the ministry has administrative responsibility for a number of subordinate agencies" (Ringard et al., 2013, p. 20) as demonstrated in Figure 17 in Appendix 1 which includes the Norwegian Directorate of Health, The National Board of Health Supervision, National Institute of Public Health to state a few.

The Norwegian Directorate of Health is an executive agency, a regulatory authority and an implementing authority in areas of health policy, who functions under the Ministry of Health and Care Services (Helsedirektoratet, 2016). Its public mandate is to "improve the health of the citizens and the community as a whole through targeted activities across services, sectors and administrative levels" (Helsedirektoratet, 2016). The Health Directorate does so by issuing annual guidelines to municipalities entailing recommendations on issues of quality of care, priority setting and their responsibility in implementation (Ringard et al., 2013), to enhance the quality of health services, reduce inequality in health, and to promote enhancing the health of the whole population (Helsedirektoratet, 2016). As seen in Figure 3, there is no direct line of control from the national government authorities to the municipalities. Therefore, they enjoy a great degree of autonomy in tailoring health services to meet the needs of their communities, while staying in line with national guidelines and standards (Ministry of Health and Care Services, 2011a; Ringard et al., 2013).

Reporting

Lastly, all municipalities and counties are responsible for reporting their activities, public service provisions and finances on an electronic platform called KOSTRA on a yearly basis (Borge, 2010). Reports generated based on fixed indicators of the municipalities' priorities and needs system. The system is defined as a reliable tool for the proper evaluation of service efficiency and comparison between municipalities (Borge, 2010). Furthermore, KOSTRA aims to encourage and enable benchmarking between different municipalities (Borge, 2010).

Figure 3- Overview of the health system
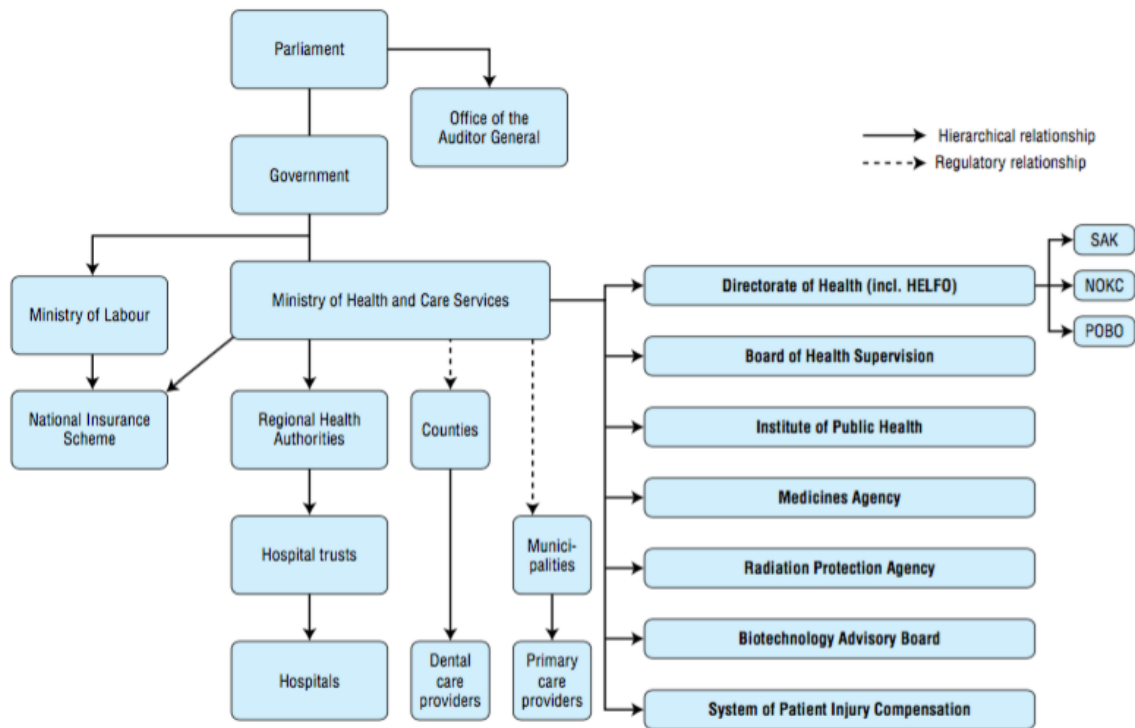
As cited in Ringard et al. (2013, p. 17)

Policy making in Norway

The parliament is the national decision making body whose activities are overseen by The Office of Auditor General (Ringard et al., 2013). The government, which is subordinate to parliament, is responsible for proposing bills addressing national priorities and financial plans. However there are mechanisms for influencing policy which can include those people most affected by any proposals (Ringard et al., 2013, p. 24). Ministries and other bodies may propose policy which may also include information sought from consultations with a wide spectrum of interested or affected people.

Maternal Health Service Provision in the Municipality of Stavanger

Helsestasjoner

Departing from an overview of the health care system, a closer look at the organization and governance of maternal health services is foundational for the purpose of this study, which analyzes health policy in relation to migrant women's access to maternal health services in an instrumental case study on Stavanger over the fifth and sixth chapters. The section begins with a summary of mechanisms for maternal health service provision, followed by a brief overview of public health governance and reporting structures in the municipality. The information represented

in this section is a combination of data I gathered from sources as cited, and my advisors as explained in the methodology chapter.

Maternal health services in Stavanger are offered by three main bodies, physicians including General Practitioners and Gynecologists (only in high risk or special cases), primary care centers, and the Stavanger Universitetssjukehus hospital. The Municipality of Stavanger has six public health clinics called the 'Helsestasjon' that offer free primary health services to families and children living across the city's seven boroughs (Figure 4).

The clinics play an important role in promoting health in local communities, by establishing contact between pregnant women and the health care services available to them. The primary staff include midwifes, a public health nurses, physicians and physiotherapist (Helsedirektoratet, 2014). They offer women routine check-ups during the course of their pregnancy, offer counselling services to parents entail practical and preparatory information about delivery and post-natal care, and finally they offer periodic health checks for young children which includes vaccinations consistent with national guidelines and the National Immunization Program from birth until the age of five (Helsedirektoratet, 2014). Furthermore, the clinics collaborate with the municipality family councillors, psychologists and other specialists if and when needed by the child or family(Helsedirektoratet, 2014).

Organization and Governance at Municipal Level

Each of the six 'helsestasjon' has a leader who holds regular weekly meetings with the clinic staff. The leaders of the city's six health clinics, along with the leader of all midwives in the municipality have meetings with the chief of city health clinics on a biweekly basis to discuss professional development goals, and evaluate services. The chief reports to the head of Children and Young People Department in Stavanger (Health Clinics, Child Welfare Institutions, School health services) who reports to the Director of Education, Health and Welfare Board in the municipality. This position is the highest authority figure in charge of Health at the municipal level and is in turn the municipality's representative in addressing health related issues in parliament.

Figure 4- Organization and reporting structure of public health clinics in the municipality

Director of Education, Health and Welfare Board in Stavanger Municiaplity	Head of Children and Young People Department in Stavanger (Health Clinics, Child Welfare Institutions, School health services)	Chief of City Health Clinics	Clinic Leaders	Stavanger Public Health Clinics (Helsestasjoner)
			Åse Tomine Berge	Hundvåg Health Clinic
			Mari S. Kolbenstvedt	Tasta Health Clinic
			Lise Gøransson	Sentrum Health Clinic
Per Haarr	Mona Kopperstad	Torunn Teigen	Berit Hamre	Madla Health Clinic
			Rita Kvalbein	Hillevåg Health Clinic
			Torill Strømsvåg	Hinna Health Clinic

Adapted from Original in Appendix 3

Figure 5- Organization and governance of health and social welfare in the municipality

City Manager — City Council — Municipal Executive Board:
- Department of Finance
- Department of Culture and Town Development
- Department of Communication
- Board of Education, Health and Welfare (Per Haarr) — Function: Early life, education, health and social services, public health and infection control
- Department of Personnel and Organization
- Department of Urban Development
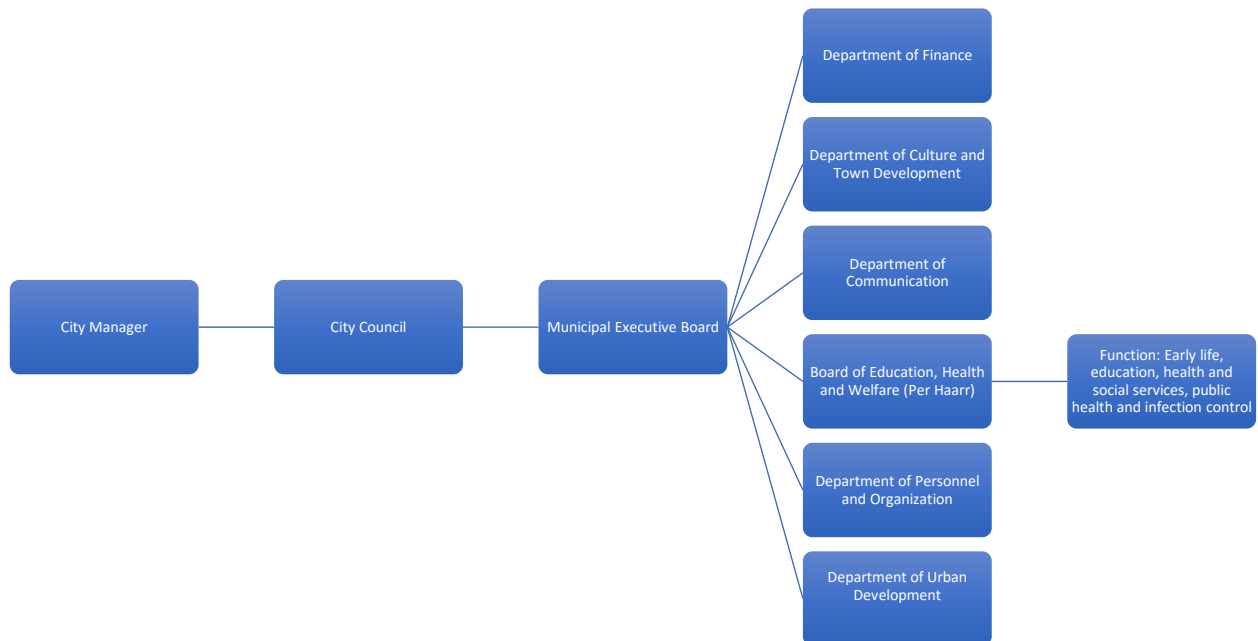
Adapted from Original in Appendix 5

Consequently, the Municipality of Stavanger is both funded to manage health provisions, along with others, but also has significant discretion as to what programmes should be performed and implemented and how (Figures 3 and 5).

Welfare state and Migration

To remain sustainable, welfare states have had to continuously evolve and adapt to the ever-shifting needs of society induced by processes of globalization, aging population, shifting gender dynamics, and migration.

Within a global framework, Norway's non-western migration history might not be as extensive as its neighboring countries, and some have explained this to be a result of the fact that the history of Norway as an independent state is rather a short one in comparison (Vassenden, 2010). Norway gained autonomy as an independent state in 1905 after four hundred years under Danish rule and nearly another century of dynastic union with Sweden (Vassenden, 2010).

Although there had been inter-Nordic migration during periods of Danish and Swedish rule, Norway was a rather ethnically homogenous society until the post-World War II immigration boom in Europe (Vassenden, 2010). In the 1970s immigrants constituted less than two percent of the Norwegian population (Blom, 1999, p. 617; as cited in Vassenden, 2010). However over the past few decades, Norway has transformed into a pluralistic society, with immigrants making up nearly 17% of the total population today, according to Statistics Norway- hereafter SSB (SSB, 2017a).

In response to the great changes it has incurred over the past few decades, the welfare state has had to adapt and reevaluate its social policy provision, to ensure equality in access and thus the retention of its egalitarian social democratic ethos.

Migrant Health Policy and Welfare States

Migrants face many obstacles in accessing and utilizing health care services everywhere (Chauvin et al. 2007; as cited inMessina, 2011, p. 37), and there is a growing recognition that these challenges go beyond legal restrictions and are indeed often times due to lack of information, cultural and lingual barriers (Mladovsky, 2011). "Ingleby et al. (2005) persuasively argued that different national ideologies concerning citizenship and diversity lead to different policy outcomes with regard to migrants' rights; moreover, the degree to which migrants are successfully incorporated plays an important role in health service delivery because good communication and mutual understanding are essential for effective care" (Messina, 2011, p. 49).

Many countries in Europe have responded to this problem by developing migrant health policies as a part of broader integration policies (Mladovsky, 2011), and despite a growing Europeanization of migrant policies, there are differences that persist between migrant groups (such as asylum seekers, undocumented migrants, and workers) within and across countries due to national differences in approaching to recognize the problem, accessibility, and quality of health services (Rosenow, 2009; as cited in Messina, 2011, p. 37).

Mladovsky (2011) explains that migrant health policies have four dimensions: i) population groups targeted i.e. migrants in general, or specific migrant groups such as asylum seekers, undocumented migrants, or a broader category such as ethnic minorities; ii) health issues addressed; iii) whether providers or patients are the focus of interventions; iv) and whether and how policies are being implemented. It is the subsequent consideration and undertaking of these dimensions that results in variations between governments' approaches to migrant health policy.

Furthermore, Sicakkan, 2008; as cited in Messina (2011, p. 38) supports the above hypothesis by claiming that, "differences in national policies on asylum, residency, citizenship and broader aspects of migrant incorporation contribute to much, if not most, of the variation evident in the ability of migrants to access health care across the EU".

Norway's Migration history

Ingleby (2011), offers a general overview of migration history in Europe to explain the nature of national policies in response to migrant health. He suggests that three distinct phases of migration over the past century may offer an explanation for the correlation between the increased interest on migrant health and migratory flows in Europe (Ingleby, 2011). The first phase followed the post war economic boom from 1950s to 1970s in Northwestern Europe in countries such as Sweden, Denmark, Germany, France and the United Kingdom (Ingleby, 2011). Soon after this, the World Health Regional Office for Europe (WHO EURO) held its first conference to discuss rising concerns about the health of migrant workers (Ingleby, 2011). This period was followed by a rise in immigration to southern European countries like Portugal, Spain, and Italy after subsequent economic expansion in these regions during the 1980s to 1990s (Ingleby, 2011). Last but not least, the third phase was characterized by a significant increase of migrant populations in Norway, Finland, Iceland, and Ireland at the turn of the twenty first century (Ingleby, 2011).

Moreover, he (Ingleby, 2011), suggests that the response to migrant health policies in European countries varies because they reflect interventions for their specific migrant needs. For example, he argues that countries such as those affected by the first phase of migratory flows in post war era are responding to the needs of aging migrants, whereas in countries such as Norway, where migration is a newer phenomenon, the focus is on the younger migrant population and their specific health issues such as sexual and reproductive wellbeing (Ingleby, 2011).

Migratory Flows

Despite Ingleby's (2011) claim, immigration to Norway has a longer and more complex history. Statistics Norway has its first "foreign-born persons" census dating back to 1865, when many the of 1.2% foreign-born population was from neighboring Sweden (SSB, 2017c). During the period of the first and second World Wars, the size of the migrant population fluctuated greatly in Norway do to mass emigration and immigration in Europe (SSB, 2017c). However, a steady rise of immigrants, most of whom were refugees, followed from Eastern Europe after the second World War (SSB, 2017c). This period was subsequently followed by labor immigrants mostly from Pakistan, Vietnam, Turkey, and Morocco in the 1960s until the scheme was halted in 1975 (SSB, 2017c). Consequently, this limited voluntary immigration to Norway (Figure 6), and resulted in a

surge of migrants seeking refuge in the country from Asia, Africa, South America and Eastern Europe (from countries like: Iraq, Somalia, and Afghanistan) around the turn of the twenty first century (SSB, 2017c) (Figure 7). However, after the 2004 EU expansion these patterns began to alter, and there was a surge of free moving migrants from European countries, particularly Poland and Lithuania, which continues to this day (SSB, 2017c) (Figure 7).

Figure 6- "Non-Nordic Immigrants by reason for migration"
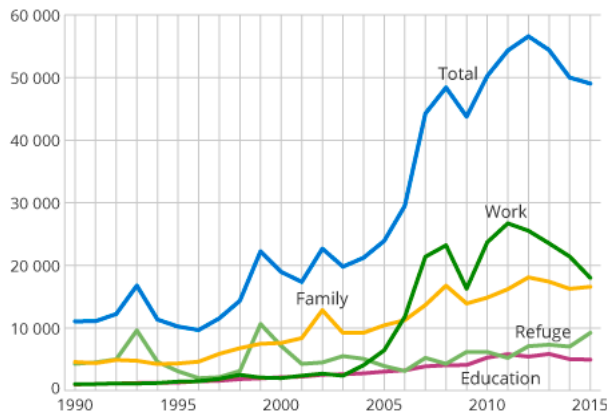
Figure 7- "Immigrants and Norwegian-born to immigrant parents, by country of origin"

As cited in SSB (2017c)
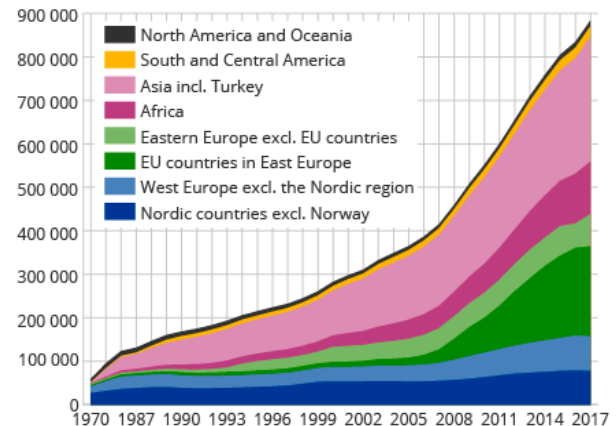
As cited in SSB (2017c)

Norway defines migrants as persons residing in Norway with an immigrant background, and those born in Norway to two immigrant parents (SSB, 2017a). At a combined population of 883,751 (724, 987 immigrants and 158,764 Norwegian-born to immigrants) as of 1 January 2017, migrants constitute 16.8% of Norway's total (5,258,317) population (SSB, 2017a)

Today, the migrant population includes persons with backgrounds from 221 different countries (SSB, 2017a), with the largest non-Nordic migrant groups being from Poland, Lithuania and Somalia. A significantly high fraction of migrants are immigrants who represent 13.8% of the total population in Norway (SSB, 2017a) as illustrated in Figure 8. Statistics show that, "the highest relative growth in 2016 was among immigrants from Syria" (SSB, 2017a), demonstrating the current 'refugee crisis' due to the civil unrest in the region.

Furthermore, the migrant population in Norway is younger than the average population, with approximately 50% of the population aged between 20-40 years of age, and less than 9% over 60 years of age (SSB, 2017c). Consequently, this poses particular challenges for the welfare state, one of these being the need to address the health needs of women of childbearing age, and their children, confirming Ingleby's (2011) postulation mentioned in the section before.

Figure 8- Migrant population by country of background as of 1 January 2017
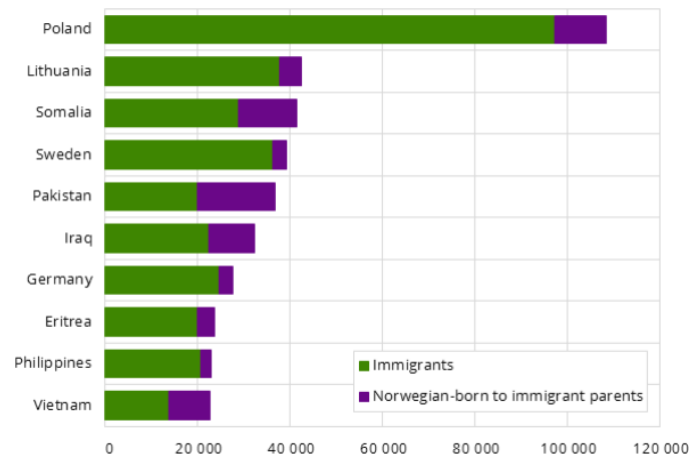
As cited in SSB (2017a)

Refugee Population

Since the objective of this study was to analyze what Norway's response to not only migration in general, but the increasing number of refugees resettling in the country has been within the context of maternal health, a closer look at the statistics concerning this group of migrants is fundamental for establishing the problem setting.

The latest available statistics show that as of 1 January 2016 a total of 199,400 refugees lived in Norway (SSB, 2016b). This corresponded to approximately 3.8% of the total population, and 29% of the immigrant population last year (SSB, 2016b). Furthermore, females, who are the focus group of this study, accounted for 91,644 of the total refugee population in Norway (SSB, 2016b).

According to Figure 9, the largest majority of refugees since 2000- 2016, seem to have predominantly migrated from a select group of countries. Although this is not an accurate presentation of figures that will be published later this year, a degree of proximity certainly can be assumed.

Figure 9- "Persons with refugee background" as of 1 January 2016

As cited in SSB (2016b)
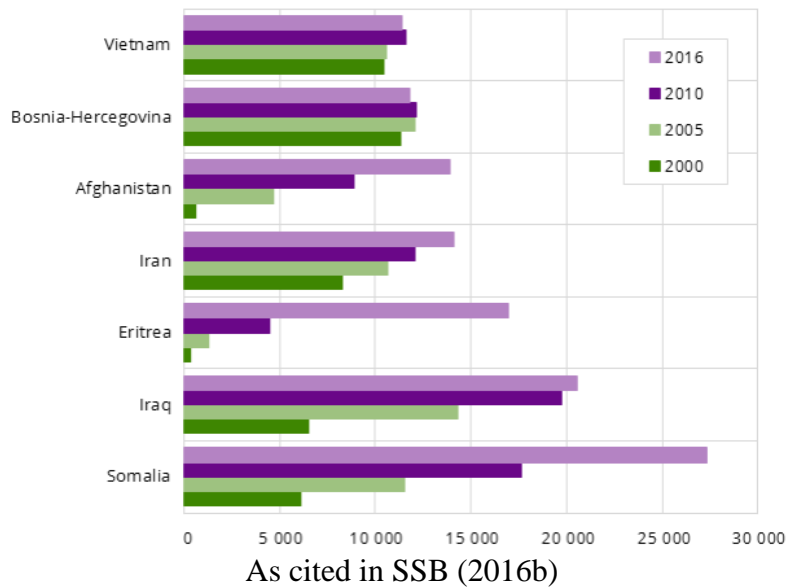
Distribution

Given the country's geographical location and vastness relative to its small population, population density varies greatly between regions (Norwegian Ministry of Local Government and Modernisation, 2014). This has naturally resulted in different patterns of migrant resettlement (SSB, 2017c). However, according to Figure 10, the highest concentration of migrants is found in Oslo, the capital, and its surrounding regions of: Østfold, Akershus, Buskerundand.

Figure 10- Concentration of migrant population by county 2007 and 2017

As cited in SSB (2017c)
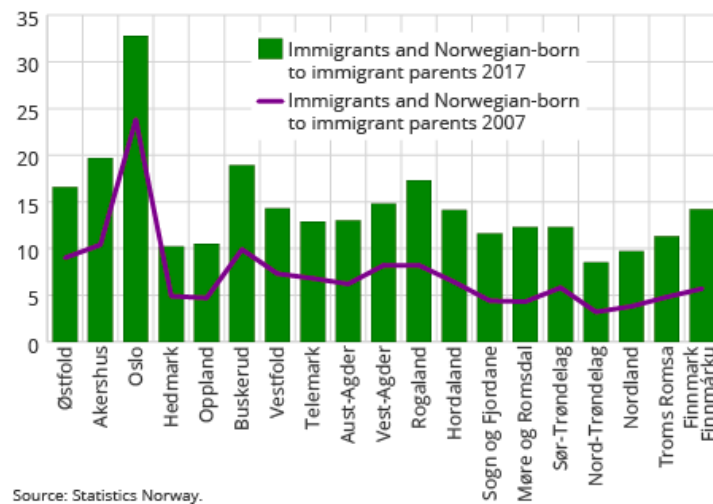
The region with the next highest concentration of migrants according to Figure 10 is Rogaland

county on the south-west coast of Norway. Stavanger, the location of this study, is one of the largest municipalities in this county. Stavanger is known as the oil capital of Norway, and has "percentage-wise, the largest foreign population" in the country (Gjerstad, 2016, p. 172). The migrant population is largely an even distribution between work migrants and their families, and refugees and asylum seekers (Gjerstad, 2016). These features of the municipality, made it a strategically advantageous location to carry out a policy analysis on migrant maternal health services.

Population of Migrant Women in Stavanger

Statistics on the exact facts and figures of I had wished to acquire to construct the background for my case study (i.e. population of refugee women, of childbearing age in Stavanger) were not available, despite contacting the statistics bureau for help as well (as described in the fourth chapter). Therefore, I gathered all relevant and available data that would allow for a proximate assumption of the setting i.e. size of the female migrant population in Stavanger.

According to Statistics Norway, the age of childbearing is described between 15-49 (SSB, 2016a). However, the mean age of mothers at first birth in 2016 was 29.0 years old, and according to Figure 11 there are a few births recorded before age 18 and after age 45. Therefore, the age variable I selected on the statistics website for determining the population of childbearing migrant women in Norway was 20-44. The results showed that as of 1 January 2017, there are 19,791women of immigrant and Norwegian-born to migrant background, who are of childbearing age living in Rogaland county. This represents more than half the entire (31,684) female migrant population in the region (see Appendix 2 distribution) (SSB, 2017b)

From these data, it can be presumed that there is a significantly large migrant and refugee population of women who are of childbearing age, living in the municipality is Stavanger, and who are likely to have to use maternal health services. The questions posed by this study are aimed at exploring what the realization of this population has been in both national and local health policy, and whether any initiatives have been developed to recognize the special needs of this largely vulnerable group, or help overcome the usual barriers they face in accessing and utilizing health services.

Figure 11- Live birth births, by age of mother -2016

Source: Statistics Norway
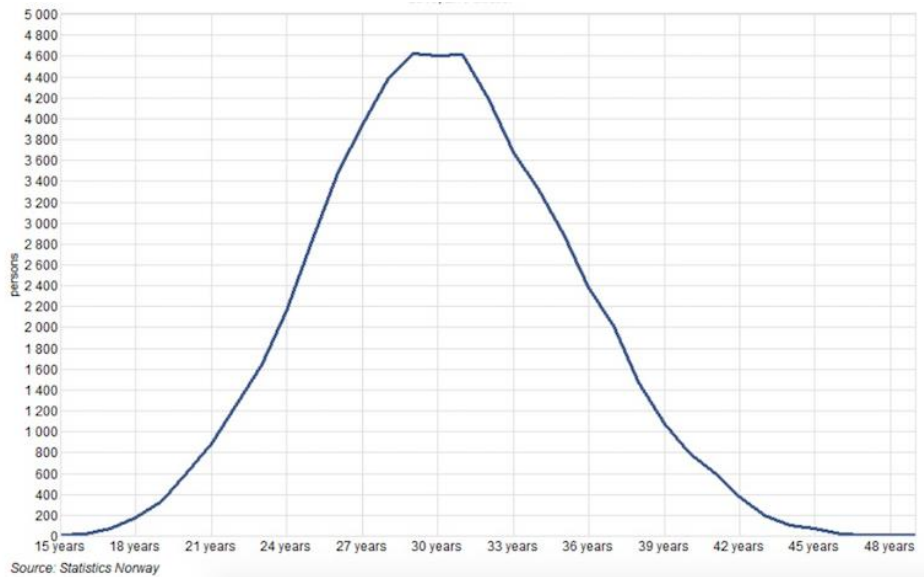
As cited in SSB (2016a)

Summary

Health and immigration services become intertwined when considering health provisions to new and impending mothers, as settlement services are a central government responsibility as are hospitals, with other primary health care being the responsibility of municipalities. This means that decision making authority as to who shall receive what type of service and how much can vary according to the locality and the type of immigrant. So, for example, undocumented mothers can only access basic emergency provisions while other documented migrants may access more specific and extensive services. However, this is also complicated by the fact that although Norway has a generous welfare system which also extends to health provision, it is only relatively recently that the population composition has meant service provision has had to be suitable for and accessible to people who are not ethnic Norwegians and come from many different cultural and linguistic groups. Having non-hospital based maternal health care provision as the responsibility of local municipalities means that service provision across the country can vary. The fifth chapter presents a case study of maternal health care in Stavanger in the Rogaland County.

Chapter 3
Conceptual Framework

Introduction

Theory is an integral component to qualitative research as it offers unique vantage points through which data can be interpreted. Over the course of reviewing literature, I realized the recurrent emergence of: rights-based theories and the social determinants of health (SDH), as two dominant concepts used in research on health policy, inequalities in health, and migrant health.

Therefore, the AAAQ rights based model, and migration as a social determinant of health were used as the central conceptual frameworks in this study to interpret and critique the overall findings that were informed by a policy analysis framework, explained in methods, throughout the discussions section. Furthermore, the two theories of: Whiteness Theory and Targeted Universalism were adopted as emerging subsidiary theories to migration as an SDH for additional criticism during the analysis process.

This chapter offers a brief review of literature pertaining to the definition and usage of the four conceptual frameworks employed in this study.

The Right to Health- AAAQ

The first conceptual framework that inspired this study is the Availability, Accessibility, Acceptability, and Quality (AAAQ) model from the UN committee on Economics, Social and Cultural Rights (CESCR) (WHO, 2007). This rights-based model was adopted as a "General Comment on the Right to Health in 2000" (p. 2) in compliance with Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which sets out "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Pace, 2011, p. 56; WHO, 2007).

The right to health extends beyond the physical and timely access to services, and is in fact impacted by underlying determinants of health. some of which include: "access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health" (WHO, 2007, p. 2). The AAAQ model operationalizes these determinants as fundamental in fulfilling the right to health within its framework.

The framework recognizes four interrelated and partially overlapping elements of: Availability, Accessibility, Acceptability and Quality that are necessary to be recognized and evaluated in national and international health policy for the implementation of the right to health (Schierenbeck, Johansson, Andersson, & Rooyen, 2013).

Figure 12- AAAQ Framework

"The right to health"

Underlying determinants
water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education, information, etc.

Health-care

AAAQ
Availability, Accessibility, Acceptability, Quality

(General Comment No. 14 of the Committee on Economic, Social and Cultural Rights)
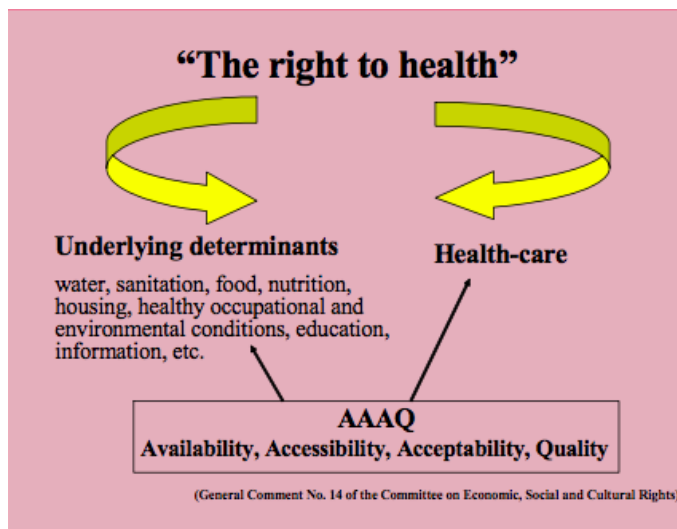
As cited in WHO (2007, p. 2)

This rights-based framework has been employed in studies that assessed barriers in health care in different socio-cultural contexts. One of the most notable studies that sparked interest in adopting this model was, "Barriers to accessing and receiving mental health care in Eastern Cape, South Africa" (Schierenbeck et al., 2013). This was recommended to me by a professor at the University of Gothenburg whose work on social medicine elicited interest in exploring this topic, and applying this framework to examine migrant maternal health services. However, after further research into its application and feedback from my supervisor and other academics, I realized that adopting this approach as my analytical framework which would require me to conduct a study of a greater magnitude to successfully fulfil its purpose. That not being feasible within the time frame granted for this project, I was advised by my supervisor to employ this approach as my conceptual framework. Nonetheless the variables inherent to this method, did guide the formulation of my research questions and did also act as one of the two major theories that influenced the reflections on my overall findings at the end of the dissertation.

The abbreviations of the AAAQ model according to WHO (2007) stand for the following:

Availability- primarily focuses on the physical aspects of health care within the community. This includes the saturation of hospitals or clinics that provide maternal health services.

Accessibility- has four overlapping dimensions: non-discrimination (health services must be accessible by law to all, especially the vulnerable without discrimination), physical accessibility (services must be physically accessible), economic accessibility (services must be affordable for all, especially disadvantaged groups), and information accessibility (everyone must have the right to information about health and have their health records protected by confidentiality).

Acceptability- requires all health facilities, goods and services respect medical ethics, to be culturally appropriate (respect individuals', and communities' culture), and to be sensitive to gender and life cycle requirements. It is important that health care professionals in this context are culturally aware and sensitive about traditions surrounding maternal care, abortion, and contraception etc.

Quality- necessitates that health facilities be scientifically and medically appropriate, and that services be of good quality.

The focus of my reflections in this study have mostly been on the Accessibility, Acceptability, and Quality elements of this framework, with a short discussion on the Availability of services, mainly because health care is a universal commodity in Norway. Nevertheless, there is a brief commentary on the right to health in Norway in the findings chapter.

Migration as a Social Determinant of Health (SDH)

The rights based conceptual framework discussed above, is very closely linked to the concept of SDH. In fact, the accessibility and acceptability elements of the AAAQ model are inherent components of the SDH framework. "The social determinants of health are based on universal processes" (Kirmayer, 2012, p. 150). They encompass conditions and factors that contribute to a population's inequality in health according the 'definition of social determinants of health' by WHO (n.d.-b). These include biological factors like age and sex, individual life style factors, social and community influences, living and working condition and finally, socioeconomic, cultural and environmental conditions. Furthermore, these conditions are influenced by an interplay of social economic, and political forces at local, national and global levels (Davies, Basten, & Frattini, 2006), hence "they take unique form in each society based on its cultural history, politics and economy" (Kirmayer, 2012, p. 150).

Figure 13-The Dahlgren and Whitehead model of social determinants of health
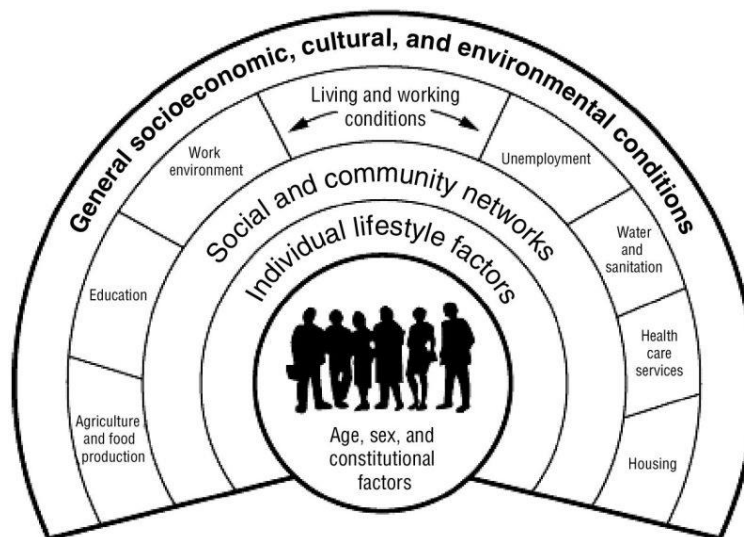
As cited in Dahlgren and Whitehead (1991)

Dahlgren and Whitehead's (1991) comprehensive representation of the main determinants of health within a social ecological model, has been a prominent framework in health policy. This illustration has been used to demonstrate the various relationships between an individual and their environment which contribute to their health, to understand and reduce health inequalities.

This topic and this concept can be studied and analyzed from an infinite number of approaches, with varying levels of complexity. A popular model I studied and later detected in several health policy studies, such as "Maternal and Perinatal Health of Refugees in Ontario: A Population-Based Approach" by Wanigaratne (2015), was the CSDH framework by WHO (2010).

The WHO offers a framework for action in studying health inequality titled: "Conceptual Framework for Action on the Social Determinants of Health" (CSDH) (WHO, 2010). The framework proposes a socio-economic focused structural approach to understanding and reducing social inequalities by organizing social determinants into three categories, which according to CSDH (WHO, 2010) are as follows:

1. Socio-economic and political context
2. Structural determinants and socioeconomic position
3. Intermediary determinants

Although this model is useful for action-based research, I did not employ it as a method of this study, because it did not fit the objectives or the scope of this policy analysis. My intention was to use this concept at a smaller scale, as a complimentary analysis model to interpret the findings of the study in relation to a specific set of determinants that affect migrant women's access to health.

Hence, with migration shaping the critical discourse of this study, I directed the focus of the original SDH framework to its implications on migrant health. Although this general model does not explicitly recognize migration as an SDH, some studies focusing migrant health have suggested that migration should be regarded as another component which intersects all the other layers of the model (Castañeda et al., 2015; Davies et al., 2006; International Organization for Migration, 2017). Even though migration on its own does not pose a health risk, it can exacerbate the implications of other SDH present in the model, and can therefore increase the vulnerability of the migrant population to illness (Davies et al., 2006).

This application has been further reinforced in international efforts to promote migrant health policies. "The Rio Political Declaration passed at the World Conference on Social Determinants of Health in 2011 and the 2008 World Health Assembly Resolution on Health of Migrants, recognized the need of migrant-inclusive health policies and inter-sectoral policy coherence to address health inequalities and vulnerabilities affecting migrants" (International Organization for Migration, 2017).

Health is an intricate topic and the health of migrants is an even more complex issue. Migrants are affected by an array of challenges that might act as barriers to attaining good health outcomes even in a society like Norway where services are universal. Socio-economic inequalities are the most prominent issues discussed in policy documents for overcoming barriers in accessing and utilizing health care, and though the availability and economic accessibility of health services, takes precedence in many societies like Norway (Ringard et al., 2013), it tends to overshadow other factors linked to migration such as, health beliefs, health seeking behaviors, and linguistic and ethno-cultural barriers(Nørredam & Krasnik, 2011) in targeting inequalities.

Therefore, the objective in applying this conceptual framework was to uncover whether Norwegian

health policy, which is underpinned by egalitarian values and driven by equality, takes into consideration wider ranging social contexts such as cultural knowledge and cultural competency that also play a critical role in defining health and well-being (Kirmayer, 2012).

"Social determinants play a critical role in health from the time of conception, through pregnancy, to the post- natal period, and beyond" (van den Heuvel et al., 2013, p. 2). The figure below offers a visual presentation of factors that affect migrant maternal health. The categorization of these factors, closely represents the ecological layout of the SDH framework, with the difference that migration is also considered as a determinant.

Figure 14- "Factors influencing perinatal outcomes among migrants"
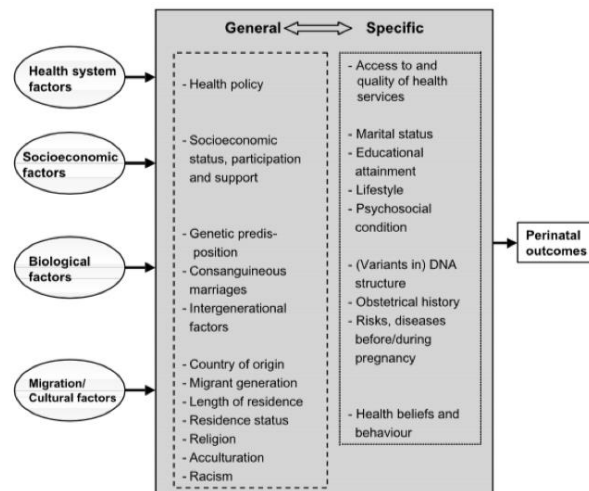
As cited in Reeske and Razum (2011, p. 140)

This offers an appropriate representation for my articulation of the usage of SDH as a conceptual framework to critique whether and how Norwegian health policy has taken accountability for micro level determinants, especially those pertaining to migration i.e. language and cultural barriers.

Subsidiary Conceptual Theories

In the process of reviewing further literature to interpret the implications of the findings, I came across two additional theories that became subsidiary to the critique on migration as an SDH. The discussion on the 'one dimensionality' of health services and 'universal policy' in Norway triggered the exploration of the concepts through the distinct, yet overlapping theories of: Whiteness Theory and Targeted Universalism. Although both theories are explained in greater detail within the context of the discussions chapter, I provide a brief commentary on them as components of the conceptual framework for this research here.

Whiteness Theory

The argument that prompted reference to this theory was the one-dimensionality of health care and health policy. Upon examination of literature from several fields such: as child protection, race studies and medicine about one dimensionality of services in predominantly white societies, the theory of Whiteness emerged. The theory addresses the nuanced concept of Whiteness Theory and its "pervasive yet invisibilised" (Young, 2008, p. 103) oppressing implications on defining privilege in policy and practice. Therefore, I found it most appropriate to lead a discussion on how Norway, as one of the most egalitarian societies, may exhibit unconscious prejudices against minorities through its policies.

"Whiteness does not have a universally accepted definition, to which the growing scholarship on Whiteness, mostly emerging from North America, attests" (Young, 2004, p. 104). The theory of Whiteness suggests that white privilege becomes the norm of practice and understanding through innate political processes that are founded upon white supremacy. therefore Young (2004) explains Whiteness has less to do with skin color, and is more a politicized term representing power interests.

"White workers automatically collectively embody White cultural norms in all their diversity in the work place, non-White minority workers are asked to speak specifically for the non-White minority in a conflation of the diversity that is present among even the smallest of groups, cementing the group and the worker as images of a single cultural dimension" (Young, 2004, p. 122).

White Theory emerged to address racisms, by emphasizing the reflection of White workers on their positionality and privileges in practice. This sets it apart from the antiracist approach in that, instead of turning to non-white workers to deal with race sensitive issues, it focuses on eliciting white practitioner's consciousness on their colorblindness.

This is an important approach to understanding health inequalities in Norway and the underpinnings of service provision to migrant women in Stavanger, considering its mostly white history until recently, and its dominantly white social policy. More on the application of this approach within the context of this study is analyzed in the discussions chapter.

Targeted Universalism

Last but not least, I came across the concept of Targeted Universalism whilst critiquing the weaknesses of the universal benefit systems, and searching for recommendations to reduce the health gap. Simply, Targeted Universalism promotes an equilibrium between: targeted benefits which are distributed according to needs-based assessment, and universal benefits which provide everyone with equal access to services. In other words, the argument for targeted universalism stems from the understanding that, universal access does not equal accessibility and hence a just society.

Leubolt et al. (2014) explain that targeting policy to a certain group, excludes a large population and is therefore often contested at the political level. Whereas, universal programs usually benefit

the middle classes and exclude the less advantaged. Which supports Powell's (2008) argument in that universalism further widens the inequality gap by disproportionately benefiting the privileged and turning a blind eye to the needs of the less advantaged population. He defines Targeted Universalism as an enhanced approach to universalism, whereby universal services are targeted through unique initiatives to minority groups (Powell, 2008), who would otherwise be overlooked by the system. Hence, "Targeting universal policy would avoid the pitfalls of a "false universalism" and the political liability that lies in limiting the scope of policy to a certain group or section of the population" (Leubolt et al., 2014, p. 89).

This is therefore an important concept to consider when analyzing the equitability of Norway's universal health approach to addressing migrant maternal health, as a discursive principle of findings in the findings chapter and further in the discussions chapter.

Summary

In summary, this chapter identifies and justifies the choice of theories used in the conceptual framework for analysis in this study. These four concepts are applied to the overall findings in the discussions chapter, and in their application, there is further reference to literature to contextualize within the milieu of this study.

Chapter 4
Methodology

Introduction

This chapter outlines the methodological framework used for this study beginning with the epistemological positioning to answer the research question. The research design incorporates the approach used, sources of data, selection, collection and analysis. Ethical considerations and limitations to the study end the chapter.

A qualitative exploratory research approach was chosen in order to answer the following research questions:

- How has health policy in Norway recognized and addressed barriers that affect migrant and refugee women's access to maternal health services?
- How have these policies enabled accessibility and acceptability of maternal health services to migrant and refugee women?

Qualitative research emphasizes the importance of exploring and understanding the context within which social events are examined (Bryman, 2016). Thus, a qualitative approach was adopted in this study to offer detailed and rich descriptions concerned with answering "how" and "why" questions (Bryman, 2016, p. 394). The emphasis of this approach was on the "description and interpretation of subjective meanings attributed to a social phenomenon" (Alfonso, 2016, p. 27) rather than on presenting results in numerical format (Alfonso, 2016). Additionally, this approach allowed for a more open-ended research strategy than quantitative methods (Bryman, 2016) , which was essential for studying "social life in terms of a process" (Bryman, 2016, p. 395).

Induction and Deduction

This consequently led to the adoption of induction as the principal theoretical orientation for the arrival to theories in this study. (Bryman, 2016). With an inductive approach, emphasis is placed on the emergence of patterns and theories from the data rather than the testing of already existing theories on the topic (Bryman, 2016). However, this is not to say that previous research and preexisting theories on this topic were neglected. According to Gray (2013) the inductive process is not completely exclusive from deductive reasoning. In fact, the selection of this topic, research questions, research methods and analysis was greatly influenced by pre-existing literature, research, theories and ideas. "Deduction and induction do not necessarily have to be seen as irreconcilable opposites, but can also be viewed as located on different ends of a continuum where qualitative studies tend to be inclined towards the inductive end" (Wiberg, 2015, p. 15). Therefore, despite the dominant adoption of an inductive approach to findings and analysis in this study, the process was not exempt from some degree of deduction.

Limitations of Qualitative Method

Although replication of social research is a challenging task, researchers argue that the issue is even more pertinent with qualitative research designs (Bryman, 2016). This is because the researcher is the primary "instrument of data collection" (Bryman, 2016, p. 398). The researcher's positionality and bias shape the views, observations, preferences and focus on what he or she considers to be significant and important in a qualitative study. Hence, qualitative research is often criticized as being "impressionistic and subjective" in comparison to quantitative research, which is more systematic and wary of bias (Bryman, 2016, p. 398).

Lincoln and Guba (1985), as cited in Noble and Smith (2015), advise use of rigor in qualitative research methodology for demonstrating trustworthiness and ensuring credibility of findings. Despite the lack of universal criteria to evaluate qualitative research, Noble and Smith (2015) recommend some strategies for applying rigor. They include: accounting for personal biases due to researcher positionality; biases in data collection, sampling and analysis; demonstration of decision making and thought process throughout the study for transparency; triangulation of data; and representation of multiple perspectives.

It is also important to note that qualitative studies are often done at a smaller scale than quantitative studies, hence results from a study that is bound rigidly by time, location and size, are not necessarily representative of a wider population and setting. For this reason, the results of qualitative studies are not intended to be generalizable. Rather the focus in this type of study is on the quality and the generalizability of theoretical inferences generated to theory than to a population or social setting (Bryman, 2016). This approach to generalization is referred to as, " 'analytic generalization' by Yin (2009) and 'theoretical generalization' by J.C. Mitchell (1983)" (Bryman, 2016, p. 399).

 Of course, foregoing any generalization of findings to a wider population and other studies in the field is inevitable. This is referred to as "Moderatum generalizations" by Williams (2000, p. 215; as cited in Bryman, 2016, p. 399) which allows for a modicum of generalization to extend the immediate findings of a study beyond the parameters of the case; hence enhancing its credibility (Bryman, 2016).

Guba and Lincoln (1982) state that "knowledge is best encapsulated in a series of 'working hypotheses' that describe the individual case" (p. 283), where generalizations are not possible since phenomena are bounded by context and time. However, a degree of transferability between hypotheses may be possible given that there is a "degree of temporal and contextual similarity" (Guba & Lincoln, 1982, p. 283).

Epistemological and Philosophical Underpinnings

According to (Gray, 2013, p. 19), the choice of methods is influenced by research methodology, which is affected by the theoretical perspectives adopted by the researcher and subsequently the researcher's philosophical stance.

Ontology is the study of being and what constitutes reality (Gray, 2013), whereas epistemology questions "what is (or should be) regarded as acceptable knowledge in a discipline" (Bryman, 2016, p. 28). The two main orientations of ontology are objectivism and constructionism, where the former is concerned with whether "social entities can and should be considered objective entities that have a reality external to social actors", or in the latter whether they "should be considered social constructions built up from the perceptions and actions of the social actors" (Bryman, 2016, p. 28). This research takes a constructivist stance.

Constructivism

Qualitative research is often connected with the constructivist paradigm (Baxter & Jack, 2008; Stake, 1995; Yin, 2003). This ontological position is frequently associated with research on the representation of social phenomena (Bryman, 2016), which affirms the suitability of this approach for studying how "migrant maternal health" is problematized in Norwegian health policy.

The constructivist ontological position asserts that social phenomena and our understandings of them are the result of how social actors frame or describe them (Bryman, 2016), and thus are dependent on one's perspectives. Furthermore, this approach to social understanding implies that "social phenomena are not produced by social interaction but are in a constant state of revision" (Bryman, 2016, p. 29); therefore, knowledge is intermediate and social realities are not definitive, they are a result of how social actors construct them, hence, emphasizing human subjectivity and pluralism over objectivity and relativism (Miller & Crabtree, 1999; as cited inBaxter & Jack, 2008).

Subsequently, by adopting this position the researcher becomes focused on interpreting the complexity of relationships between varied and multiple meanings, rather than being preoccupied with their subjection to definitive categories (Gray, 2013). It is important to note that in this process of induction, the researcher's positionality i.e. "their personal, cultural, and historical experiences" (Creswell, 2014, p. 8) plays a significant role in the way meanings are interpreted and explained (Creswell, 2014).

Interpretivism

An epistemological theoretical perspective often linked with constructionism in qualitative research is interpretivism (Bryman, 2016; Gray, 2013). Similar to the constructivist viewpoint, interpretivism is mainly concerned with understanding reality through "culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67; as cited in Gray, 2013, p. 23).

Interpretivism takes an anti- positivist stance by focusing on "culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67; as cited in Gray, 2013, p. 23). This stance imposes that our understanding of the world is interpreted through our construction of it (Williams and May, 1996; as cited Gray, 2013) and hence there is no singular "relationship between ourselves (subjects) and the world (object)" (Gray, 2013, p. 23).

The interpretivist approach has strong foundations in Max Weber's concept of 'verstehen' or

"understanding something in its context" (Rukwaru, 2015, p. 139). This position asserts that understanding natural reality and social reality require different methods because the interests in the two fields lie on opposite ends of a spectrum deducing quantifiable empirical data and inducing individualistic unique qualitative data (Crotty, 1998; as cited in Gray, 2013).

Research Design

Approach

In order to conduct a comprehensive study, I constructed an instrumental case study, the details of which are in this following section, to explore: how health policy in Norway recognizes and addresses barriers that affect migrant (refugee) women's access to maternal health services; and how these policies enable accessibility and acceptability of maternal health services to migrant women.

Case Study

"Case study is an interpretive-hermeneutic category of research that falls under the more general umbrella of qualitative methods, *hermeneutics* being 'the art and science of interpretation' (Yeaman, Hlynka, Anderson, Damarin, Muffoletto, 2001, p. 254)." (Gordin, 2006, p. 72). Crotty (1998, p. 91), states that hermeneutics "grounds the meaning of texts in more than their sheerly semantic significance". It is a method whereby implicit and multiple meanings of texts are studied through multiple perspectives and inquiry is made into how they "can and should be applied" (Crotty, 1998, p. 91).

Although different from my initial methodological intentions for this qualitative research, I soon realized that in order to explore my research questions thoroughly, I could not rely on one source of data or one method of data collection. Additionally, being confined by time, language and location upon other limitations, I discovered that constructing a case study would be the most suitable method of inquiry that would enable me to provide rich descriptions of my understandings and interpretations.

Case studies are "bounded by time and activity" over the course of which detailed information from various sources are collected (Stake, 1995; Yin, 2009, 2012; as cited Creswell, 2014, p. 14). Furthermore, the focus of this design of inquiry is on the in-depth examination of a phenomenon within a particular setting, which makes it an appropriate approach for understanding and constructing knowledge rather than discovering or explaining it (Stake, 1995).

Case studies allow the researcher to study complex phenomena within their context, and offer insight into the case by way of gathering and interpreting data from various sources to answer 'how' and 'why' questions (Baxter & Jack, 2008, p. 545).This feature, which is a hallmark of case study design, ensures that the topic is "not explored though one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood" (Baxter & Jack, 2008, p. 543). This strategy adds strength to the findings by way of data triangulation and

promotes a more holistic understanding of the topic in question. This further enhances the credibility of findings, and allows for the potential to "develop theory, evaluate programs, and develop interventions" (Baxter & Jack, 2008, p. 543).

There are several case study designs, but the selection of a specific type is determined by the purpose of the study (Baxter & Jack, 2008). There are two prominent approaches to case study research, one by Robert Yin and the other by Robert Stake. Although both scholars share the common aim of utilizing case studies as a tool to explore deep meaning and phenomena in research, their approaches to case study research methodology differ (Baxter & Jack, 2008). For example, in defining different types of case studies Yin categorizes studies as "explanatory, exploratory, or descriptive", whereas Stake describes cases as being intrinsic, instrumental, or collective (Baxter & Jack, 2008, p. 547).

I adopted Stake's (1995) instrumental case study design for this study. I selected an instrumental approach over an intrinsic one because my objective in the study was to promote understanding of specific issues in relation to a larger context I was interested in studying, rather than understanding a particular social setting or phenomenon (Stake, 1995). In other words, it allowed me to focus more on what can be learnt about Norwegian health policy as it pertains to migrant maternal health, by focusing on examples from Stavanger, as compared to merely exploring or describing Stavanger's experience.

In this instrumental case study, I explored and analyzed 'how' problem representation in policy determined the provision of maternal health services for migrant women in Stavanger. In this design, the case I constructed itself, "is of secondary interest"; instead the focus was on the in-depth examination on its contents to facilitate an external understanding of the situation and its implications (Stake 1995; as cited in Baxter & Jack, 2008, p. 549).

Generalizability and Limitations of Case Study Research

The purpose of this method of inquiry, or any qualitative design, is not on generating findings that can be formally "generalized to a wider universe" (Bryman, 2016, p. 64), since each study is constructed within its own world view (Bartlett, 2005; as cited in Gordin, 2006). However as (Flyvbjerg, 2006) argues, that it is incorrect to assume that the findings of a single case study are not at all generalizable and therefore insignificant in contributing to scientific development, which is a common misconception of case study research. In fact, he strongly supports that, "one can often generalize on the basis of a single case, and the case study may be central to scientific development via generalization as supplement or alternative to other methods" (Flyvbjerg, 2006, p. 228). The key to doing that is by enhancing the credibility and dependability of the study, and by focusing on how well theory is constructed from the findings (Bryman, 2016) which "relies upon triangulation, methods, and data sources" (Gordin, 2006, p. 75). This view on generalization is called 'analytics generalization' by Yin (2009) and 'theoretical generalization' by J.C. Mitchell (1983)" (Bryman, 2016, p. 64).

Nevertheless, this method of inquiry is not without its limitations. In addition to varying views on the degree of transferability as discussed above, the method has been criticized for weakness of methodological rigor and researcher subjectivity due to the absence of systematic procedures (Willis, 2014), and issues of credibility, dependability and replicability, which are all in a broader

sense interlaced with a wider critique of qualitative methods which are discussed in the previous section (Willis, 2014). The following section on data collection demonstrates the research process and methods of inquiry to demonstrate how these limitations were tried to be overcome.

Data and Data Collection

The data collection process for this research was both a great challenge, and a fulfilling learning experience. In fact, the limitations and possibilities imposed by this aspect of the project shaped and redirected my research into its current form.

After changing the perspective of the study to a policy analysis, to forgo the ethical approval process due to reasons explained in the limitations section of this chapter, I organized a meeting with a policy advisor at Stavanger Town Hall with whom I had established contact during an internship the previous year. After expressing my interest and research intentions by email and in a meeting to him and to one of his advisors to whom he introduced me, I received very positive feedback. I was highly encouraged to carry out this research in Stavanger, because they claimed that no similar study had been done on this topic in the region, and that my completed study could be of great value to them either on its own or as foundation to further research. Furthermore, they expressed their interest and inclination to cooperate and guide me in accessing information for this study.

I was further convinced to carry out my research in Stavanger, because it is the fourth largest city in Norway, has a significant migrant population, and resettles many refugees every year. Therefore, there was a higher likelihood of the existence of policies and interventions to address inequalities in migrant health, and the availability of richer data and information concerning migrants was more likely as opposed to a smaller municipality with a smaller migrant population. Hence these could enhance the transferability of findings beyond the time and location that bound this study, into a larger national or perhaps international policy setting to compare what is being done in other multicultural cities facing the same challenges.

With these factors considered, I was persuaded to move to Stavanger for the research semester in order to avoid any further delays in finding and establishing connections with members in the policy arena in Gothenburg with which I had no familiarity.

Access and sampling

Having started with a rather broad study objective, which was to analyze policies aimed at maternal health provision for migrant women in Norway, my focus gradually became more refined, and adopted new elements throughout my research journey. This journey was greatly influenced by the access and sampling process, a significant part of which involved networking with influential people. Consequently, the research progressed from doing a document analysis on policy papers, to a 'as inclusive as possible' instrumental case study that contained several data components. Below I provide an overview of the main sources of data that informed this study.

i) Policy Documents

Which I used to understand the health and policy setting in Norway, included:

- Norway: Health system review. *Health Systems in Transition* (Ringard et al., 2013) - English
- Helsesøstre – Helsesøstre (2007) - Norwegian
- ROGALAND NSF Lokalen (Sykepleierforbund, 2014)- Norwegian
- Setting the political agenda to tackle Health inequity in Norway (Strand, Brown, Torgersen, & Giaever, 2009)
- National guidance from Norwegian Health Directorate "Helsetjenester for flyktninger, asylsøkere og familiegjenforente": Health services for refugees, asylum seekers and family reunification (Helsedirektoratet, 2015)- Norwegian
- National strategy to reduce social inequalities in health -Report No. 20 (2006–2007) to the Storting (Ministry of Health and Care Services, 2007)- English
- ACT 24/06/2011 no. 30: Act relating to municipal health and care services, etc. (Health and Care Services Act) (Ministry of Health and Care Services, 2011a)- English
- ACT-2011-06-24-29 : The Norwegian Public Health Act (Ministry of Health and Care Services, 2011b)- English
- Local Government in Norway (Norwegian Ministry of Local Government and Modernisation, 2014)
- Financing the municipal sector and the sector's place in the Norwegian economy (Ministry of Local Government and Modernisation, 2011)-English

Although I had initially planned to translate and analyze one policy document, I ended up utilizing sections and sometimes the overall scope of these documents collectively to design my instrumental case study and interpret my findings. This method also reduced the limitations imposed by the language barrier. In cases where the documents were beyond my capacity to understand in Norwegian, I asked my contact persons and friends for help in translation. This proved to be a much more efficient and comprehensive approach to the incorporation of multiple perspectives into the study.

ii) Information from policy actors and health professionals

My discussions with policy makers and health care practitioners played a major role in my understanding. Their shared knowledge, experiences, and guidance provided extra depth to this study, which I would have otherwise had a difficult time gaining within the short time frame I had to complete this project.

a. Policy actors included:

- My conduit to Stavanger Town Hall who is a member of the Health and Social Welfare board, connected me with one of the consultants in his committee. She became my primary advisor on policy documents, and helped me retrieve documents explaining the Norwegian healthcare system and policy setting. Her knowledge and expertise saved me a lot of time in the long run, because instead of spending days like I did initially clarifying questions, she provided me with answers almost instantly. Furthermore, she

also introduced me to TEGRA and suggested that I contact the clinic responsible for the program to get more information. Although I am aware that not seeking to justify her views, though authoritative from other sources, is a source of limitation, it was justifiable given the time and exploratory nature of this research.

- The policy advisor later connected me with a public health coordinator at the Town Hall who supplied me with supplementary information on the organization and governance of health policy in the municipality

b. The health and allied health professionals in the municipality and workers involved with TEGRA included:

- My link into the health care system, with whom I coincidentally established contact through my interpersonal contacts. With her help, I established contact with the organizers of TEGRA, which ultimately made the micro-ethnographic study possible. Furthermore, she offered me crucial information about the OK project, the national guidelines for health of asylum seekers, and assisted me in retrieving charts from the intranet that were crucial to understanding channels of communication and hierarchies of the municipality's health reporting system. Finally, she helped me interpret multiple Norwegian documents.
- A public health nurse, who provided me with the opportunity to participate in the TEGRA workshops as an observer, and also helped me understand the program in much greater detail during our discussions in person, via email communication and also by giving me supplementary documents and statistics in relation to the courses.
- Two health professional involved with the founding of TEGRA. I had discussions with both of them in person about how and why they started the program, what their motivations and experiences were, and what they thought of its outcomes. I did also ask them for details on how the program received funding over the years and how it was sustained for more than a decade, but unfortunately, they could not recall this information and told me that none of them kept any records on this.

c. Advisor at the Health Directorate of Norway

- I contacted the Health Directorate by email describing my project, and seeking information about the provision of any national services targeting migrant maternal health. I was redirected to an advisor, who confirmed that there was no national program or policy addressing the issue. Furthermore, she confirmed my findings about the intertwined relationship of the municipalities with the central government and the hospitals.

iii) **Observations**

The opportunity I had in observing TEGRA workshops proved a great advantage for this study. By submerging myself in the social setting, I gained first hand insight into

the program, which would have otherwise not been possible through studying text alone. I had the chance to learn what was contained in the program designed for migrant women first hand, I learned more about the primary health care system and their services, the way the hospital operates. This opportunity also allowed me to observe more topical things in the context of the workshops, such as the participants, their reactions, the questions discussed and the role of interpreters.

In order to gather data for this aspect of my study, I engaged in what Wolcott 1990 (as cited in Bryman, 2016, p. 424) calls a "micro-ethnography". Bound by the time constraints of this dissertation, conducting a full- scale ethnographic study was not feasible. Thus, I narrowed my focus mainly on the birth preparatory workshops for migrant women offered by TEGRA at the Stavanger Sentrum Helsestasjon.

Hammersley and Atkinson (2007) define ethnography as a method of data collection whereby the researcher participates "overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews, collecting documents and artefacts" (Hammersley & Atkinson, 2007, p. 3).

Upon receiving permission to attend the workshops, I joined three pre-natal workshops and one post-natal workshop over the course of March and April 2017. I attended the courses as a non- participant observer and sat next to the English group so that I could benefit from the translations of their interpreter. I conducted an unstructured observation whereby I did not follow an observation schedule (Bryman, 2016) but instead collected as much detail as I could from the social setting and participants' behaviors and interactions in my field journal.

This method was the most appropriate for my study because my intention was to gain insight into the program and use it in an instrumental case study to analyze policy. Although I had informal discussions with the program organizers, I did not conduct nor include any conversations with participants regarding their experiences, as it was not within the objective or ethical scope of my study. However, this could provide a unique and fascinating dimension in a future study.

iv) **Demographic Information**

I incorporated some statistical information concerning the number of migrants, refugees and migrant women of childbearing age in Norway in the second chapter of this dissertation to put the study into context. I collected most of my general data by navigating through the English sections of the Statistic Norway Website. However, after futile efforts to find more specific data with multiple variables, and not knowing whether it was because of my search strategy or whether no record existed, I contacted the statistics bureau via email asking for help.

A few weeks later I got a very informative response to my questions, either with a link telling me where I could find them on the website and how to I could adjust the variables which were all in Norwegian, or that the bureau did not possess the data I had

requested (i.e. the number of refugee and/ or migrant women of childbearing age in Stavanger municipality). I also received clarification on what was considered as "childbearing" age for women in Norway, because I hadn't been able to find consistent numbers from my searches. This correspondence was of important value for filling in the limitations of my search as an English speaker through the Norwegian Statistics system. Without this, I believe my data would have been restricted to general statistics and therefore would have been incomplete.

v) Literature Review

Last but not least, I found it best fitting to include my literature search strategy in this section, since due to the nature of this study, literature review is spread across multiple chapters. To contextualize this research in the existing body of research and theories in and related to this field, I searched scientific databases for literature with intersections in: migrant health; migrant health Europe; migrant maternal health; migration and health; migrant health policy Europe; health and social work etc. Furthermore, I found additional literature through bibliographic references of works I studied and through automated database recommendations.

Researcher Positionality

Despite all efforts to enhance the credibility and dependability of results by incorporating the multiple data collection methods mentioned above, and applying the practice of triangulation (Deacon et. al, 1998; as cited in Bryman, 2016), all social research methods, including this study, are bound to have some limitations. I, as the researcher and the instrument of data collection, consciously and unconsciously influenced the design and development of this study. My positionality in this research process: provoked my interest in designing this study (i.e. my migrant background and experience with barriers to access); It determined my access (i.e. inter-personal connections with potential informants); informed my data collection process (i.e. my public health and social work academic backgrounds elicited and directed my data selection, and interpretation); framed the scope of this project (i.e. my language barrier which might have affected the quality of data I collected and the limitations it posed when information had to be translated for me); and finally, my gender might have had implicit implications on the entire project in terms of access which might have been more difficult for a male researcher (Hammersley & Atkinson, 2007).

Case Account

Below, I provide a pictorial representation which offers an overview of the positioning of TEGRA in the policy setting. It is also a demonstration of the boundaries that formed this study within which I collected and incorporated as much data as I could to provide a good account of how maternal migrant health care has been addressed in Stavanger municipality.

Figure 15- Case Account
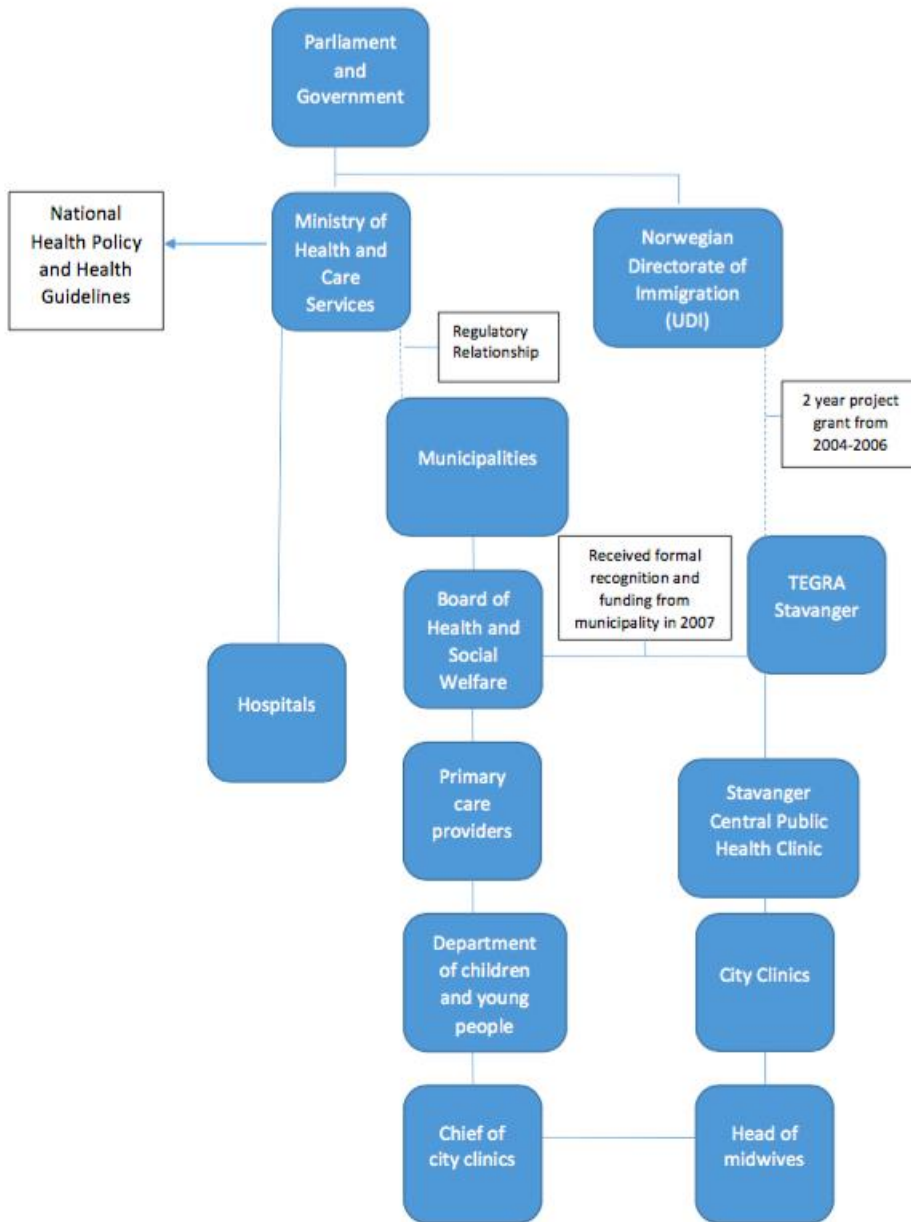
Adapted from Figure 2.1 in Ringard et al. (2013, p. 17); and Public health clinics and school health clinics organization in Stavanger municipality 2017 (available in appendix 3)

Data Analysis

Analytical Framework- Bacchi's WPR Approach to Policy Analysis

Bacchi's (2009) "What's the Problem represented to be" (WPR) approach was employed as the analytical framework for the findings of this study. This analytic strategy was introduced to me by my supervisor, and upon critical study and realization of its usefulness for this study, it was used to guide the organization and critical interrogation of data to understand the underlying factors to how policy recognizes and enables access to maternal health provisions by migrant women in Norway.

The "WPR can be positioned as a post-structuralist, social-constructionist contribution to policy analysis" (Cort, 2011, p. 22).This is due to the framework's inherent objective which aims to reveal the deep-rooted presumptions behind seemingly neutral social constructions (Cort, 2011).

The approach rests on "the premise that what one proposes to do about something reveals what one thinks is problematic (needs to change)" (Bacchi, 2012a, p. 21). Departing from this hypothesis , the model argues the possibility to 'work backwards' and deconstruct any public policy to deduce implicit discourses underlining the construction and representation of 'problems' (Bacchi, 2012b). To accomplish this 'critical scrutiny', Bacchi offers a set of six questions in her (2009) WPR model, that are intended to trigger reflection on the 'conceptual premises', 'genealogy', and the effects of these problematizations in a discursive, subjective and even lived life contexts (Bacchi, 2009, p. 2; as cited in Bacchi, 2012b, p. 5).

Bacchi's (2009, p. 48) WPR framework for policy discourse analysis rests on the following six questions, which I have applied in their entirety to analyze the representation of migrant maternal health in Norwegian health policy:

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

The goal of this approach to policy analysis is ''to intervene to challenge problem representations that have … deleterious effects, and to suggest that issues could be thought about in ways that might avoid at least some of these effects'' (Bacchi, 2009, p. 44; as cited in Pereira, 2014, p. 395). Deriving from the tenet that discourses in policy may benefit some members of the society at the cost of others (Cort, 2011; Pereira, 2014); her WPR methodology aims to empower marginalized and disadvantaged groups through "promoting political accountability" (Pereira, 2014, p. 394) by critiquing how discourses have been framed. Therefore, as she explains the objective goes beyond the evaluation of reflexivity or "rhetorical distance" (Bacchi, 2016, p. 11) between problems and recommendations, which is what is most commonly done in policy analyses; rather this approach

takes the level of critique further and "it begins with a postulated solution and identifies the problem representation implicit within it" (Bacchi, 2016, p. 11).

Subsequently, as Cort (2011) suggests, this framework of policy analysis requires more methods than just an analysis of policy documents because the model also places a great emphasis of the effects of the problem representations in policy. Therefore, interviews and ethnographical methods are often conducted in addition to accomplish the goals of the approach. These are also similar to the multiple methods of data collection I have used in this study.

Conceptual Framework

In the final stage of analysis, I subjected the overall findings from the WPR framework to my conceptual framework to understand and discuss the wider implications of the study outcomes. As previously mentioned, my conceptual framework that guided the interpretation and critique of the results in this study comprised four theories. The 'AAAQ model of right to health', and 'migration as a social determinant of health' were central theories to the development of this study. However, over the course of analysis, literature review on evolving discourses such as, culture and service provision, led to the emergence of 'Whiteness Theory' and 'Targeted Universalism' as subsidiary theories to the framework. The third chapter of this dissertation is dedicated to describing this framework.

Ethical Considerations

The deliberate change of my research design to a policy analysis, for reasons explained in the limitations section of this chapter, allowed me to avoid common ethical dilemmas associated with qualitative research involving interviews with participants. Nevertheless, I applied ethical considerations to every stage of my qualitative study. Because, although it did not involve direct participant participation for which an ethics approval was required, there was human involvement both as a result of interactions with my advisors and as an inherent component of the micro-ethnographic study. Hence, this section offers a summary of considerations applied.

Informed Consent

As with any type of research especially the qualitative kind, ethical challenges may arise. In order to carry out this research in accordance to suggested ethical guidelines by social science researchers, I ensured that all my contacts (advisors and health care personnel) were well informed about the purpose and significance of this study. My first point of contact with most of my advisors was through email, where I introduced myself and thoroughly described the purpose of my study. As for conducting the micro-ethnographic study on TEGRA, I informed and sought permission from both the administration and my contact at the clinic in person during a meeting.

Although it was not in my intentions to do a covert study, Hammersley and Atkinson (2007) support that doing a completely overt ethnography study is a common challenge of the method. "An ethnographer often does not know what will be involved, certainly not in any detail" (Hammersley & Atkinson, 2007, p. 210). Going into this branch of the study, my primary objective was to observe and learn more about the content of the workshops to gain a better understanding of the program. Therefore, I was not concerned with informing the participants of the courses about

my presence as a researcher.

But it was inevitable not to observe participants and their reactions within the social context I was in, even though my primary objective was to study the course. However, it was not possible for me to obtain informed consent from everyone without having disturbed the course and created confusion. As Bryman (2016) suggests "This is a common problem for ethnographers, who are likely to encounter people in the course of their research who form part of the social setting but whose involvement is fleeting and who therefore are not given the opportunity for informed consent" (p. 129). As a result I am fully aware that the micro-ethnographic study was not fully overt, however, "Rohn (1962) has argued that all research falls on a continuum between the completely covert and the completely open" (Hammersley & Atkinson, 2007, p. 211), which also pertains to my study falling along that spectrum.

Although in my findings, I refer to some responses from participants, and observations I made (i.e. the men's responses to the breast-feeding video), I did not refer to them than their gender, and thus made sure that none of them are identifiable

The other component of my information collection methods involved the study of documents. This was a non-reactive method, referred to as an "unobtrusive method" by Webb et al. (1996; as cited in Bryman, 2016, p. 303), and did not entail the involvement of any participants or need for consent.

Access

Although time consuming, I did not face too many bureaucratic challenges in reaching out to advisors. I relied on my previously established networks with politicians at Stavanger Town Hall during an internship I had there the previous year. I gained access to the health clinic by connecting with my gatekeeper through interpersonal networking and later by going to the clinic to meet the program organizers

Deception

I did not conduct any structured interviews or have any structured discussions with the participants I had encounters with over the course of the study, therefore aside from asking them questions to clarify topics, explain programs, or on a few occasions about their thoughts on the general program in natural conversation, I never intentionally asked them any questions that would be deceptive or that would purposefully limit their knowledge about my study to trigger a natural response about any aspect of the research. Furthermore, none of these conversations with course participants or personnel are cited or quoted in this research

Privacy

Furthermore, no private conversations were made note of, no images were taken, and no specific references or names of individuals who guided me or contributed to discussions in this study were included, to avoid their identification and maintain privacy.

Harm

Finally, this research method caused no harm to participants due to its non-invasive and passive nature. As for the micro-ethnographic, which involved a degree of participant observation, I defend that the study intended and cause no harm. My non- participant approach and limited interaction, and positionality as a female in maternal health workshops did not create any unusual situation whereby my actions elicited "anxiety" among participants which is a factor of harm in ethnographic research (Hammersley & Atkinson, 2007, p. 213) warns about.

Consequences for Future Research
Research that is "found objectionable by the people studied and/ or by gatekeepers may have the effect that these and other people refuse access in the future" (Hammersley & Atkinson, 2007, p. 218). Both the micro-ethnography, and the policy collection and interpretation components of this study, were enabled by gatekeepers who were fully informed about the purpose of my project and my research objectives. There was no objection from any party regarding any part of my study, in fact almost all of the reaction I received was positive and encouraging for undertaking this research because it was new and from a different perspective. Both the policy advisors and care providers I spoke with, considered this research as a positive initiative for further study in this field. Therefore, I do not believe that I have negatively affected future research prospects in this field; in fact I trust that I have paved the path and encouraged further research as my work only covers a snippet of an issue that has infinite potential for exploration.

Limitations

Location

My initial research objective for this dissertation was to conduct a comparative qualitative study on the experiences of asylum seeking women and the challenges faced by primary care providers in relation to maternal health services in Sweden at the University of Gothenburg, where I had established contact with my informants. However, after I was assigned to conduct my research at the University of Stavanger by administration, I had to re-evaluate my research plan to comply with the Norwegian institute's requirements.

The determining requirement that changed the perspective of this study, was being informed at the start of the research semester about having to obtain an ethical approval from the research committee (NSD) to conduct interviews with subjects, which was not a requirement for Masters level research in Sweden.

To avoid the long processing time and the risk of rejection/ reevaluation for wanting to study a vulnerable group, I changed the perspective and the scope of my topic with the guidance of my supervisor, while keeping it related to my area of interest (maternal health), to not include the involvement of participants.

Although this entire process postponed the commencement of the project, it took me on a new learning curve and subjected me to many rewarding personal and academic tests.

Knowledge

My supervisor influenced my research methods a great deal. Having never conducted a policy analysis of this scale, I required much guidance in structuring and organizing the study. The new study approach required the use of new research methods, theories and approaches to analysis, most of which I had a limited knowledge of restricted to the confinements of my Social Work program. Although I invested a lot of time and effort in learning new ways, her experience and knowledge in the field of health policy played a critical role in guiding me in the right direction and keeping me focused over the course of the study.

Time

Although having only one semester allocated to completing a Masters dissertation did not seem as daunting, time was one the most pressing if not the biggest limitation to this study in retrospect. Having to start anew with little relevant preliminary work left to depart from, it took me a significant period of time to readjust, find my position, and establish new connections. This was soon followed by further delays in correspondence with my advisors which slowed down the data collection process.

Language

Finally, language was another limitation to this study. I soon learned that most policy information was only available in Norwegian and that a lot of content in government websites either had no English translations (i.e. Helsedirektorat, helsenorge, nyinorge, etc) or were limited in the scope of translations they offered (i.e. Statistics Norway or the Kommune website); hence making navigating through their platforms challenging.

My basic knowledge of Norwegian was a great asset as it allowed me to browse through some general information, but of course I required help from some of my gatekeepers and local friends in accessing and understanding more information.

Lastly, although my advisors all spoke English relatively fluently, they did sometimes stutter or have trouble expressing their opinions or translating technical terms. I could not help wondering whether this affected the quality or depth of the conversations we had, or if I was always understood correctly.

Summary

In summary, this chapter offers a comprehensive overview of the research methodology including the philosophical underpinnings of the study and the researchers approach, description justifying the choice of research design, a thorough explanation of data and data collection, an argument for the analytical approach to the treatment of data, followed by a discussion on the ethical understandings, and finally an acknowledgment of the study limitations.

Chapter 5
Findings

Introduction

The following chapter presents the findings of this study, which have been organized under six sections following Carol Bacchi's (2009) WPR model for policy analysis. In answering the questions posed in this analytical framework (which has been described in the fourth chapter), I offer both a description of maternal health service provision for migrant women in Stavanger and a critical interrogation of data collected for the construction of this instrumental case study, in order to understand the underlying factors of how policy recognizes and enables migrant women in Norway to access maternal health services.

The chapter progresses through the framework, and begins by: exploring the presentation of this issue in policy; the underpinnings of its presentation; the processes involved in its emergence; its weaknesses and oversights; a reflection of its effects through different paradigms; and finally, a review of contestations resulting from its representation in policy.

"What's the problem represented to be?" – Question 1

The aim of the first Question in Bacchi's (2009) WPR model is to identify problem representations in a specific policy. In using the term 'problem representation', Bacchi refers to the form of a problematized phenomenon (Bacchi, 2012b). However, pinpointing the problem representation in policy is a far more complex task than one might imagine. Cort (2011) cleverly compares this process to, "opening up a babushka doll: there is not one problem representation but many, and analyzing one problem representation leads to other problem representations, as these are 'nested' within each other" (p. 24). It is very easy and tempting to become preoccupied with taking apart policies and analyzing their interconnectedness, however this never-ending task may prove impossible to analyze.

"The WPR approach rests on a basic premise - that what we say we want to do about something indicates what we think needs to change and hence how we constitute the problem" (Bacchi, 2012b, p. 4). In this case, the short answer to the first question of this framework is that 'migrant maternal health issues' have not been problematized in Norwegian health policy largely because of the assumption of equal access to universal services as will become clear later in the discussion.

This construction of the policy analysis framework, however, presents its own problems. For the underlying premise of the Norwegian welfare estate is that universal provision addresses any problems *because* provision does not discriminate in any way. Therefore, there is no problem to address. This assumption itself becomes the problem, as I will discuss. Hence, although 'problematizations' are a driving force behind policy interventions, because health provisions in Norwegian policy are not considered as such, there is no formal representation of issues affecting migrant maternal health in policy.

While it might come as a surprise, especially for a country whose social democratic purpose thrives on notions of equality, and which has a significant migrant population, Norway is not alone in lagging behind in addressing problems of health equity and inequality within its nation to ensure that the delivery of services does not disadvantage users and that they enhance users' ability to gain similar benefits (Culyer & Wagstaff, 1993) - (for a more detailed description of the terms, equity and equality, refer to sixth chapter). Developing health policies for improving migrant health in Europe is a relatively new phenomenon (Portugal et al., 2007). It is interesting that despite Europe's long and varying migration history, the theme of migrant health policy is still in its infancy, which is a stark contrast to the policy climate in traditional immigration countries such as Canada and Australia, where strategies pertaining to this area have been in place for decades (Portugal et al., 2007).

Europe's trend in addressing this issue, beyond legal requirements imposed by international organizations like the WHO and UN has thus far been strongly correlated with the concentration of migrants in each country (Portugal et al., 2007), and the attitude within the welfare state towards migrants, as discussed further in the second chapter. Thus, the scale of intervention addressing migrant health issues in general varies greatly across countries.

Nevertheless, there has been increasing international attention paid to recognizing migrant health needs and adapting health systems to serve increasingly diverse populations (Rechel, Mladovsky, & Devillé, 2012). For example, Sweden developed a health policy in 2005 to target the needs of migrants during their first 2-5 years in the country (Mladovsky, Rechel, Ingleby, & McKee, 2012). Similarly, Germany, another multicultural country with a long history of immigration passed a National Integration Plan at Federal level in 2007 which addressed migrant health needs and highlighted health issues affecting women and girls (Mladovsky et al., 2012).

Unlike the migration history of its neighbors, the ethnic and cultural background of Norway's population has only become highly diverse in the recent decade, as presented in chapter two. Yet despite being such a progressive, wealthy and generous country, there is a persisting lack of initiative in national health policy to improve the health of migrants beyond emphasizing their statutory entitlement to services. There is a difference between equality and equity, as stated earlier, and thus far the Norwegian health policy direction in favor of equality thereby fails to attend to equity, resulting in the disproportionate attention to ethnic Norwegians.

Consequently, with this foundation in national policies surrounding migrant health, policies targeting "migrant maternal health" are not present. To confidently arrive at this interpretation, I reviewed an extensive body of literature including: research articles; national reports; policy articles and white papers concerning migrant health policies; policies addressing health inequality in Norway and migrant maternal health; and furthermore, had correspondence with policy advisors and health care providers in the municipality of Stavanger, as described more elaborately in chapter four.

My review supported that the topic of migrant and refugee women's reproductive health and subsequently maternal health provisions are often addressed in policies as part of a collective discussion on migrant health, which is almost always in relation to equal and effective access. I also found that, there is still "no formulation of specific targets to reduce social inequalities in

health" (Dahl, 2009, p. 71), although there seems to be a greater awareness about migrant needs in comparison to older literature (Dahl, 2009). The only relevant national health initiative I found in relation to the general topic of migrant health policies was the entitlement of all migrants to qualified interpreters for overcoming language barriers in health care settings (The Norwegian Directorate of Health, 2015).

Furthermore, my reviews confirmed that beyond some guidelines referring to the legal rights of migrants to health services, the national government has minimal responsibility in devising policies targeting specific migrant needs. It is the municipalities' responsibility, as guided by the Act of Municipal Health and Care Services (Gjerstad, 2016), to ensure that all their residents have necessary access to services to which they are entitled (Dahl, 2009). Therefore, it is the municipalities who are principally responsible for recognizing the needs of their inhabitants and addressing them (Gjerstad, 2016).

As a result of this framework, and the realization of inequalities in health (Dahl, 2009; Mladovsky, 2009), especially among the migrant population, and the challenges faced by practitioners in having to adjust their services to make them more accessible to migrant women (Viken, Lyberg, & Severinsson, 2015), there have been local initiatives devised at 'grass-root' levels to improve migrant maternal health. The existence, structure, aim and expansiveness of these programs vary greatly across the country as I came to learn during my study. However, the purpose of this research is not to analyze this variance, rather it is on how the municipality of Stavanger has approached the problem or in other words has 'problematized' this issue, which leads this analysis to the next question in the WPR model.

Inequality in An Egalitarian Welfare State –Question 2

Bacchi's (2009, p. 48) second question asks: "What presuppositions or assumptions underpin this representation of the 'problem'?"

Having identified the problem in the previous question, this question seeks to undertake a historical discourse analysis of its representation, or as Bacchi puts it "this question involves a form of Foucauldian archaeology" (Bacchi 2009, p. 48; as cited in Pereira, 2014, p. 9), which is to be achieved by identifying the underlying assumptions and rationales. Therefore, as recommended by (Cort, 2011), this section will entail an analysis of assumptions underpinning key concepts in the representation of migrant health in policy.

The assumption of equality has proven to require some attention in policy, because there are groups in society who are not equally able to access provisions. To identify the presumptions underpinning this problem, an understanding of the health policy setting and the scope of service provision is fundamental to interpreting discourses underlying the realization and the response to society's changing needs, especially in relation to migrant health issues. Therefore, I begin this section with an overview of the foundations to Norway's universal policies, followed by a brief discussion on the realization of inequalities and how they are addressed, before finally arriving at where policy stands in addressing migrant health.

Foundations of Universalism and Coverage

As described in greater detail in the second chapter, Norway's social democratic welfare state was founded upon notions of community, mutual respect, trust, and most importantly, equality. To achieve this, high taxation was used to finance generous and universal public services (Pierson & Leimgruber, 2010).

The overall democratic purpose instils that everyone, regardless of their social or economic status and geographical location, should have equal access to the supports that make for a healthy and productive population (Ringard et al., 2013). Hence, the presumption in universal service provision which is a hallmark of the Norwegian welfare system, is that by enabling equal access equality will result.

As a result, all citizens and legal residents are covered by the National Insurance Scheme (Folketrygden, NIS), a publicly funded service, managed by the Norwegian Health Economics Administration (Ringard et al., 2013; Staten legemiddelverk, 2016). Furthermore, every person regardless of legal status, including undocumented migrants, has the right to emergency care (Ringard et al., 2013), and the same applies to all pregnant women and children who have the right to access primary health services regardless of their residency and citizenship (Ringard et al., 2013).

In order to access health services and benefit from the national insurance scheme, residents are required to have a social security number. Every person who plans to live in the country for more than six months, is listed in the civic register and receives a social security number (Gjerstad, 2016). Asylum seekers receive temporary social security numbers which grant them access to the same range of services (Gjerstad, 2016). The only special arrangement with regards to access to services is applied to asylum seekers in the transit phase (i.e. before they are moved to a reception center), and that is that they can only receive medical care at the transit center as a precautionary measure to detect and prevent the spread of infectious disease (i.e. tuberculosis) (Directorate of Health, 2010; as cited in Ringard et al., 2013). Which goes to show that one of the few health policies directed at refugees is mainly concerned with the control and prevention of infectious disease, and not much else.

Although undocumented immigrants are granted access to emergency services in national health policy, they are an underserved population and their health care needs are mainly addressed by two voluntary organizations: the Church City Mission and the Red Cross (Ringard et al., 2013). However, this is as far as I will take this discussion to point out the coverage of health services in Norway. Undocumented migrants are not the focus of this study, and their case in relation to health inequalities can consume the focus of an independent study.

Addressing Inequalities in a System Designed for Equality

However, these universal and inclusive policies have not been sufficient in ensuring equity among the whole population, and hence Norway has not been immune from problems of health inequality.

The first time health inequalities were addressed in Norwegian policy was in the White Paper on public health policies in 2003 (Ministry of Health, 2003; as cited in Ringard et al., 2013).

Following this, another White Paper titled 'The National Strategy to Reduce Social Inequalities in Health' was published in 2007 (Ringard et al., 2013). Although in the early 2000s Norway "used to be a laggard in recognizing health inequality as a social problem in need of political solutions" (van der Wel, Dahl, & Bergsli, 2016, p. 20). Now, the Public Health Act of 2011, explicitly promotes societal development to reduce health inequalities (Ministry of Health and Care Services, 2011b), and therefore, "health inequalities are currently high on the policy agenda" (Ringard et al., 2013, p. 27).

With health care being a shared responsibility between the national authorities and the local governments, they both play equally important roles in overcoming inequalities. Health inequalities are primarily addressed at the national level by the Ministry of Health, the Directorate of Health and the NIPH (Norwegian Institute of Public Health) (Ringard et al., 2013), who then try to assure universal access to a high quality services across all municipalities through funding arrangements and legislation i.e. via national guidelines and the Municipal Health Care Act (Ministry of Health and Care Services, 2011a; Ringard et al., 2013). Thereafter, the municipalities are "responsible for making their services accessible and understandable for the population, including the migrant population" (Gjerstad, 2016, p. 168), by designing their service provisions to best suit the needs of their populations. It will be shown that despite equality being a prominent health policy aim, in its delivery there are significant gaps which result in inequity (Culyer & Wagstaff, 1993).

Where Does Migrant Health Policy Stand

The way this process affects migrant women, especially in their access to maternal health services, is the subject of this dissertation and will be elaborated further below. However, Norwegian health policy still shows a limited recognition of specific migrant health issues, especially in relation to maternal health. A task now facing policy makers is to reevaluate policies to adapt the system, which was once suited to address the needs of its more or less homogenous and mono-cultural society, to a more plural population with more diverse needs and thereby attending to equity issues.

Realizing the Needs of Migrant Women – Question 3

Bacchi's third question in the WPR model enquires about the "contingent practices and processes through which this understanding of the 'problem' has emerged" (Bacchi, 2012a, p. 21). In order to address this question, Bacchi proposes a Foucauldian genealogical approach (Bacchi, 2009, p. 48; as cited inPereira, 2014, p. 9).

However, carrying out a full genealogical study on power organization and decision making with regards to problematizations in Norwegian health policy is beyond the scope of this study, as it could form a large study on its own. Nonetheless, in order to make suppositions about the 'problem representation' within the context of processes in which it is embedded, I reiterate in summary form the organization and governance of the health system which emerged from the establishment of the Norwegian welfare state, as outlined in the second chapter. Following that, I end the section by offering an overview of initiatives targeting migrant women's health issues that were enabled through these processes of change in health policy as an illustration to how the system has adapted.

Change and Adaptation

Processes of sociopolitical change over the course of past and recent history have shaped the welfare state and the policies contained within it.

From its early beginnings in the past century, the Norwegian welfare state has evolved from providing a basic safety net, to its current day form, where it is responsible for meeting a wide array of social societal needs. Today, the welfare state has become an important agent in ensuring health equality, and consequently has had to continuously adapt to sustain the ever-shifting needs of society. For instance, the onset of mass migration and the transformation of Norway's demography to a more heterogeneous society over the recent decades (as described in second chapter) has been a significant change that has imposed many challenges to the system. The timeline representing the formal recognition of inequalities in a 2003 White Paper, and their implementation in the 2011 Public Health Act (as described in the fifth chapter) coincides with this change.

These changes have resulted in the formation of a much more complex system, which is evident from: the multiple authorities, ministries, and subordinate agencies involved in the development and delivery of health services (refer to Appendix 1); to the distribution of duties and the two-tier system of governance that offers local governments more flexibility in distributing the national universal provisions more effectively with respect to their populations' needs (chapter two), the effects of which are analyzed within the frame of targeted universalism in the sixth chapter.

Finally, the emphasis on intersectoral cooperation and health in all policies is the evidence of this claim. "Intersectoral cooperation has become increasingly important over the past few years, especially as a means of preventing social inequalities in health" (Ringard et al., 2013, p. 15). The 2011 Public Health Act, "emphasizes intersectoral cooperation through 'health in all policies' initiatives" (Ringard et al., 2013, p. 27). This Act recognizes the impact of social determinants of health such as education, income, work conditions, and health behavior (Ministry of Health and Care Services, 2011b). Intersectoral cooperation between different ministries has been an important tool for the expansion of knowledge on the recognition and targeting of inequalities in health. National strategies and action plans that require the involvement of various bureaus rather than just the one directly responsible in implementing policies, have increased (Ringard et al., 2013). For example, the Ministry of Finance is responsible for the taxation of tobacco and alcohol to moderate the use of these harmful substances amongst the population/ promote better health, issues which were barely recognized at the beginning of the health portfolios of the new welfare state (Ringard et al., 2013). Or as further discussion in this chapter on TEGRA, a local initiative to target migrant maternal health goes to show, there is evidence for cooperation between the Norwegian Directorate of Immigration (UDI) and health services to address inequalities among the migrant population.

Recognizing Problems Affecting Migrant Women's Health

In the following section I present a summary of the O.K. project, a national initiative with a primary focus on preventing Female circumcision in Norway. In doing so, I aim to offer a better understanding of: when and why this issue affecting some groups of migrant women was

recognized at the national level; what efforts were made to address the issue; the important role of the community health clinics; and finally, how this proposal set the foundations for further initiatives that targeted the needs of migrant women by offering an illustration of a case on the municipality of Stavanger.

Most of the information I provide in this section on the O.K project and TEGRA is based on a triangulation of reports cited, my observations, and also accounts from my discussions with health personnel who assisted me in collecting and interpreting information about these programs. I especially had to rely on several sources of information for understanding TEGRA because it has not been studied, and there is extremely limited information available about it both in Norwegian and in English.

O.K Project a National Initiative to Tackle FGM in Norway

In 1995, Norway passed a law prohibiting female genital mutilation (FGM), and the government launched a national program called the O.K. project (Care and Knowledge against Female Circumcision) to prevent the practice of female circumcision in Norway, and to help those who had been affected by it (Norwegian Ministries, 2008). Anecdotally from talking to representatives in the health field, this was the first national effort to address a specific issue affecting migrant women's wellbeing. The main objective of the action plan was to raise awareness within communities of immigrants who practiced FGM, to inform them about its associated health risks, and to make them aware of its penal consequences as an illegal practice in Norway. Furthermore, another objective of the program was to educate care providers about the tradition, its prevalence among certain ethnic groups, and to increase their cultural sensitivity and efficiency in addressing and reporting the issue (FGM).

Community public health clinics have had a very important role in implementing this plan across Norway. It has now become one of the primary roles of midwives at clinics to screen for FGM, in women who seek their services, and also in babies during their primary years' period health checks. They have been an agent of change in communities by offering their patients information and resources to both promote better maternal health, and also to discourage them from carrying out the practice on their daughters. Moreover, through its initiative O.K. has also made it obligatory for health providers to report child FGM to social services as it is a form of child abuse in Norway.

During a conversation I had with a midwife, she explained how the national recognition of this issue has brought positive change to society. She recalled that the issue had been prevalent in the country for as long as she remembered, but that it was dealt with in silence by midwives until the call for its nation-wide recognition and demand for intervention. She said that they had very few tools and authoritative grounding before FGM's official recognition to discourage the practice when they were faced with a case.

Furthermore, additional concerns of families taking their daughters to their home countries to have the procedure performed were reported, but with greater policy and practice awareness practitioners feel more legally and practically supported to raise awareness and try to discourage this practice in a cultural sensitive yet persuasive way.

Finally, she emphasized the importance in formally recognizing inequalities and encouraging advocacy on hidden and often avoided concepts that affect the health of minority populations such as migrant women. She noted, that even though everything is not perfect about the health system now, Norway has come a long way over the past couple of decades, but still has some way to go to address the diverse needs of its society and to improve the quality and acceptability of its health services.

TEGRA- Addressing Migrant Maternal Health in Stavanger

The O.K project, coinciding with a period highlighting the recognition of health inequalities in Norway (as described earlier in this chapter), paved the way for numerous local initiatives targeted at migrant women's health, one of which was TEGRA in the municipality of Stavanger. Although I came to know about multiple local initiatives addressing different aspects of migrant women's health throughout my research, it would go beyond the scope of this study to analyse them all. Therefore, I offer a review of TEGRA in an instrumental case study (refer to fourth chapter) to illustrate the policy response to maternal health inequalities in one municipality, different examples of which may be happening elsewhere in Norway, and thus to answer broader questions about the recognition and representation of this problem in policy in this framework.

During my conversation with one of the founding members of TEGRA, she recalled that the idea sparked from the O.K conference in Oslo in the early 2000s, which inspired her and her colleagues to design another initiative that addressed what they had experienced throughout their practice to be beneficial in improving the quality of care and accessibility of services to migrant populations. She explained that the program which includes a rather comprehensive pre and post-natal course to women of migrant backgrounds for free, took its current day shape over the past decade through trial and error, feedback and experience. She explained that at the very initial stages, the program had not recognized nor did it address all the maternal needs of migrant women that it does today.

I had hoped that there would be some records of the project proposal or any official documents outlining the project to supporting what I gathered throughout my ethnographic research; however, despite TEGRA being an official government recognized and funded program, to my surprise no such document existed. I exhausted all my resources and connections in order to gain access to a comprehensive official documentation about the program, but my efforts were ineffective. No records of the initial proposals were kept at the clinic, and there was very little other than a very brief overview of the course for mothers on the course registration website on the municipality's webpage. The realization of the lack of any comprehensive information on the program on the internet, intranet or in hard copy brought along some degree of surprise among the founding members and personnel involved with the project.

Therefore, I had to take much of the information I received and collected for what it was. As mentioned in the beginning of this section, I was later able to cross check and confirm some of my findings with two Norwegian articles I found that included a few short excerpts on the TEGRA project. A more detailed account is as follows:

My research confirmed that the program was started in December 2002 by a team of Norwegian and non-Norwegian primary care providers at the central health clinic in Stavanger

(Sykepleierforbund, 2014). The program, which stands for 'inTEGRAtion', focuses on working with immigrant families, in particular with women and children to prevent their social isolation (Stavanger Kommune, 2016; Sykepleierforbund, 2014).

The initial focus of TEGRA was to carry out the national action plans against FGM more efficiently at a local level by offering informative courses to migrant populations. Furthermore, in line with O.K's initiative, TEGRA aimed to increase the cultural competency of healthcare professionals and other service providers working with immigrant women and families, on dealing with sensitive topics such as FGM (Helsesøstre, 2007). TEGRA's multicultural team which included members from the target communities for FGM practice, was a highlight of the importance of multicultural understanding in effectively addressing sensitive health issues (Helsesøstre, 2007).

Funding and Recognition

Until 2004, TEGRA did not have any formal grounding in the municipality, and as a result much of the work was carried out voluntarily by project team members (Helsesøstre, 2007). In 2004, the project was recognized by the UDI (The Norwegian Directorate of Immigration)- an illustration of intersectoral collaboration, and received funding for two years, until 2006, after which work was halted (Helsesøstre, 2007). In 2007, the project received formal recognition from the Municipality and was integrated into the public health system (Sykepleierforbund, 2014).

In addition to working on the national action plans against FGM in Norway, TEGRA also organizes free childbirth preparation (Fødselsforberedende kurs) and postnatal (Barselgrupper) group workshops for immigrant families living in Stavanger(Stavanger Kommune, 2016). The workshops are held several times throughout the year, and families can request to have interpreters free of charge (Stavanger Kommune, 2016).

Basic information about the program can be found online in both Norwegian and English on the municipality's website under "Children, Youth and Families- health clinics -courses and groups", and anyone interested can register online or by phoning the central clinic (Stavanger Kommune, 2016). However, on this website I found that even though descriptions are still limited in scope, the Norwegian webpage offers much more comprehensive information concerning what the program stands for in comparison to the English page which only offers information on the availability of pre and post-natal courses for migrant women and how to register. This is an interesting observation I discuss in the following question in answering Bacchi's fourth question.

In summary, the purpose of the topics discussed in this section were to offer a brief history of the processes that induced change, and to present through a description of a national and local program why and how policy targeting migrant women's health were developed in Norway. This discussion provides the grounding for leading the discussion to the next question posed in Bacchi's WPR framework, which is analyzing the limitations of this problem representation.

Ensuring Equality- Question 4

The next question posed by Bacchi deals with what remains unstated in policies (Cort, 2011), and encourages a critical reflection on the problematization to identify what factors have been "taken for granted" (Chien, 2015, p. 89), or overlooked in the policy making process. The question asks, "What is left unproblematic in this problem representation? Where are the silences? Can the 'problem' be thought about differently?" (Bacchi, 2012a, p. 21). In order to determine the silences and omissions surrounding the representation of migrant maternal health service, it is necessary to begin the discussion in this section by offering an overview of how this policy has enabled accessibility thus far, and from that progress into a discussion about the depiction of the limitations of the program. These discourses will be conveyed through the narrative of data I collected through my micro ethnographic study at TEGRA workshops at the Stavanger 'Sentrum Helsestasjon' (refer to chapter four).

The following section will entail an overview of maternal health service provision through data I have gathered in text and conversation, followed by an account of my micro-ethnographic observations on TEGRA, and ends with a reflection on the limitations of the program, which sets the foundations for a more critical discussion of its implications in the next question of the model.

Maternal Health Services

As illustrated in chapter two, maternal health services are offered through multiple channels. Women can choose to seek care from either their General Practitioner (GP), their midwife, or both during and after their pregnancy. The two health providers are separate entities and therefore their practices are not affiliated with one another. Unlike some countries, like Canada where I am from, gynecologists are not the primary health care providers during pregnancy. In fact, in Norway I have learned that gynecologists are only involved when a pregnancy is high risk or there are predisposed complications during pregnancy or at birth. Hence, midwives are the main providers of maternal health services.

All pregnant women, including refugees and even those in the asylum process, are entitled to free prenatal and postnatal health services at the public health clinics (Helsedirektoratet, 2017b). During the consultations women have with their midwives or GPs over the course of their pregnancy, they receive more than just medical checkups and advice. They also receive information about their social wellbeing; their rights; the birth process; and as protocol demands, service providers will address sensitive topics such as mental health, intimate partner violence, abuse, and other worries and fears that might affect the mother during and after pregnancy (Helsedirektoratet, 2017b). All these services intend to ensure that all mothers have equal access to maternal services, and information to obtain optimal pregnancy outcomes.

Furthermore, according to Helsedirektoratet (n.d), It is strongly recommended that all municipal health centers offer parents the opportunity to take part in group consultations. The purpose of a group-based initiative is so that parents in the same situation can share their knowledge and experience about child care and parenting with each other, and also have the chance to meet and create a social network with other parents in their community (Helsedirektoratet, 2017a).

All the health clinics in Stavanger offer these post-natal group workshops. These courses mainly focus on the post-natal health of the mother and baby, and as such they: discuss the importance of breastfeeding; demonstrate appropriate breastfeeding techniques; offer counselling services for new parents to help them understand and cope with the needs of their babies as well as everyday life challenges; promote gender equality and sharing of childcare responsibilities; and finally provide some information surrounding the topic of the baby's health and development, as I gathered from conversations with personnel, and from presentations is courses I attended.

According to discussions with health personnel during my observership, in addition to having a midwife and a GP, every pregnant woman is assigned a helsesøster (literal meaning health sister) or health visitor from their local public health clinic. After report of delivery, the woman's health visitor pays her a single home visit to check on how both mom and baby are doing, and if mom needs any help or has any questions i.e., about breast feeding. During this visit the health visitor provides the mother with information about the post-natal (Barselgrupper) group courses at her local health clinic, and if she has a migrant background and is not fluent in Norwegian, the health visitor also provides her with information about TEGRA at the central city health clinic. Since these courses are voluntary, it is the mom's responsibility to make an appointment and register her interest for attending either one of the courses.

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

 TEGRA

TEGRA offers not only post-natal courses but also pre-natal preparatory courses especially for women with a migrant background living in Stavanger. The pre and post-natal courses are held on Tuesdays from 9:00AM- 11:30AM and 1:30 PM- 3:00 PM respectively at the Sentrum Helsestasjon (Central Health Clinic) in Stavanger. The program is free of charge and open to everyone who wishes to register. Upon registering, participants can request to have a qualified interpreter during their attendance to the courses at no cost, which is really what makes this program unique and more accessible to non- Norwegian speakers.

The workshop content is designed by a public health nurse who is in charge of running the program in accordance to national public health guidelines and recommendations distributed by the health directorate (chapter 2). The courses are presented in Norwegian at the conference room of the clinic, where participants are invited to sit around a table in small groups with their translators. The courses are facilitated by PowerPoint presentations, videos, handouts, and props. Furthermore, the presenters pause regularly to allow for interpreters to translate the content and allow for questions to be asked and thoughts to be shared.

In the following sections, I provide an overview of the pre and post natal courses along with my observations under their respective subheadings.

Fødselsforberedende Kurs- **Birth Preparatory Courses**

These workshops are designed to offer pregnant women with migrant backgrounds, the best possible preparation for childbirth and the post-natal period (Stavanger Kommune, 2016). The pre-natal program consists of three sessions delivered by a public health nurse and a midwife (Stavanger Kommune, 2016)**,** to which women are encouraged to attend with their partners, or a friend.

Observations

This first session's content was mostly concerning the topic of delivery and familiarizing the women with the Norwegian health care system, the hospitals and the role of the community clinics. Some noteworthy discussions included: signs of labour followed by a basic demonstration of the birth process; signs of complications that might arise in later stages of pregnancy i.e. preeclampsia; post-natal care; and the role of the midwives as the primary care providers and persons in charge of delivering the baby. For some, this was new information and raised some questions about why gynecologists were not in charge of this like in their countries, to which the presenter explained that midwives in Norway are trained and qualified to assist in delivery and doctors are only involved in cases where complications arise. Another topic that sparked considerable discussion was about the Norwegian post-delivery care practices, which involves walking soon after birth, and being discharged after three days. This surprised some of the women, as for many it was unlike their practices at home.

The workshop also included a rather long segment on discouraging women from opting for caesarean delivery with some scientific backing, emphasising the benefits of natural birth. When I inquired about this discussion after the workshop, I was told that the emphasis is due to the significantly high number of migrant women wanting to deliver by caesarean section based on their cultural norms and the stigma against natural birth back home. Therefore, I was told that health providers try to equip women with as much information as possible to help them make the right decision and deliver naturally when they can. Further effort was made to familiarize women with the birth process, help them overcome their fears by answering their questions in the second workshop. This is also a consequence of universal services that some of these services are directed to some people, and therefore the others don't meet other people's needs.

Finally, the third workshop mostly focused on the after-birth period. Most of this session's time was spent addressing topics surrounding breastfeeding and how despite some traditional beliefs and cultural norms, the practice is beneficial for both mother and baby. A video demonstrating breastfeeding techniques was played and the nurse later repeated the techniques using props for the class. I observed that this made some men attending the course with their partners rather uncomfortable, as I saw them frequently glancing away during this part of the course.

Other topics addressed in this workshop included tips on: safe ways of holding and calming the baby; the importance of the father's participation in the baby's care and the sharing of responsibility with mom; the importance of attachment and communication in the development of

the baby; and finally, some information about the normality of mood swings, stress and depression after birth and the availability of help and support at the clinic via counsellors and psychiatrists.

What stood out to me in this course, was the genuine attempt portrayed by the organizer repeatedly to help and support migrant women and to encourage them to seek guidance and help whenever they needed it. This is one of the sayings that was said at the end of the last workshop, which amidst its humbling intentions, also shows a degree of stereotyping by the examples provided which do not apply to all women:

> *"We know in your country you might have family and friends to help you, but here we will guide you"*
> *...*
> *"in the old days, women used to go to watering wells and gather and talk to each other- they had a social support network, but now we at the sentrum helsestasjon and TEGRA have tried to make something similar to the "water-well", where you from all different backgrounds are welcome to come together and discuss your concerns and worries, share your needs and your experiences."*

Barselgrupper- Maternity Groups

Although it was not the intent of this study to focus on analysing the quality of post-natal care provided to migrant women, I believe that my findings would be incomplete without them. However, since the objective of TEGRA is to address the needs of migrant women and their babies both before and after birth, to improve their overall health outcomes by making fundamental information more accessible to them, neglecting an integral element of the program would therefore make this analysis incomplete.

My observations from participating in the one of the post-natal workshops, provided me with a more comprehensive overview of the types of needs the program recognizes and how it addresses them. This, I believe, enabled me to analyse the program from a more comprehensive vantage point and support a stronger position.

As previously mentioned, all Stavanger health clinics offer post-natal workshops in Norwegian, however according to (Sykepleierforbund, 2014), experience shows that immigrant women have a much lower turn up rate to the city-wide program. Several factors such as language barriers and lack of knowledge have been suggested as contributing factors for the difference (Sykepleierforbund, 2014).

TEGRA's post-natal program invites mothers and their newborns to attend five workshops over a period of time marked by the infants' key developmental stages (Stavanger Kommune, 2016). These workshops are delivered by a public health nurse, midwife, physical therapist, dental nurse and a doctor (Stavanger Kommune, 2016). The workshops cover topics such as sleep, nutrition, attachment and development, oral health, motor function and in the last session parents receive information on the kindergarten system in Stavanger (Stavanger Kommune, 2016).

Observations

My first observation was the difference in atmosphere in comparison to the pre-natal workshops. With the presence of a dozen infants, the room was obviously not as quiet or serious as in the birth preparatory courses. For example, on a couple of occasions, I saw mothers leave the room or turn away from the presenter to feed or to soothe their crying babies. Consequently, the mothers were not as focused on the course and the presenter, and hence naturally several missed out on parts of the course.

But aside from that, I found the course to be more interactive. There was communication between mothers sitting next to each other, and more participation in the course discussions. For example, on one occasion, the presenter went around the room and asked every mother where she was from and what the common traditional practices of feeding babies solid food were in their home country. Every mother shared her knowledge with the help of her translator and it made for a very interesting discussion among the multicultural group.

Another noteworthy observation I made, was on the recommendation of solid foods presented in the course material. During the segment where the presenter was making dietary recommendations for solid foods, she used "Leverpostei" which is a Norwegian brand of pork liver pâté, as an example of a nutritious and easy to digest food in her presentation.

I made note of this, because although there could not have been a negative intention behind using this item as an example, since it is a common food consumed by many Norwegians as I have observed during my stay here, I found it to be an inappropriate choice for this course.

Looking at the demographics of the participants which included a number of women wearing headscarves, a symbol of the Islamic faith, where pork is haram- forbidden, I found the example of 'Leverpostei' to be an insensitive and inappropriate choice, although it was not intentional. Especially because no other vegetarian or halal alternative was recommended in this crucial part of the program, which is supposed to cater to a diverse migrant population and encourage their utilization of Norwegian health services. The implications of this case are further analyzed in answering the fifth question, later in this chapter.

Last but not least, at the end of the workshop, mothers were encouraged to attend their community health clinic's post-natal group workshops in addition to attending TEGRA even if they only spoke very little Norwegian. There was an emphasis on the importance of networking with other mothers and their babies in their local communities which was explained to be beneficial for both their own and their children's integration into society. This is further described under 'secondary objectives of TEGRA' below.

This made me question the consistency of the course content. Therefore, after the workshop I asked one of the organizers whether the content of the post-natal TEGRA workshops is the same as the regular Norwegian post-natal workshops held at the other city clinics. I was told by a midwife that the general scope of the courses across the city is the same, with the difference that other city workshops were shorter in duration. When I asked if there was a regulatory body or anyone in charge of evaluating the programs to ensure that all women benefit from the same quality of

information, I was told that the program is regularly evaluated during weekly meetings at the clinic and also biweekly meetings with the other clinic leaders and higher up authorities (Appendix 3).

Appendix 4 contains documents presenting 2016 TEGRA statistics on the pre and post-natal workshops collected to put the scope of the course attendees in context. The data collected by the clinic are not published on any platform, and copies were provided to me by my contacts. It shows that there were 12 pre-natal groups, with a total of 172 pregnant women from 56 different nationalities; and 8 post-natal groups, with a total of 104 families from 46 different nationalities that participated in the workshops last year.

Secondary Objectives of TEGRA

Helsesøstre (2007)and Sykepleierforbund (2014) both state that based on experience, women with immigrant backgrounds tend to seek consultation from their doctor and midwife later and less frequently than Norwegian women. Therefore, in addition to the preparatory course content about childbirth, the city hospital, breastfeeding, and child care the program has a broader objective focused on promoting integration. TEGRA's workshops aim to provide a platform for immigrant women to create a network with other moms, which can otherwise be challenging in a new country with a different language and culture, furthermore this platform aims to encourage women to exchange their experiences, and share their questions and concerns (Sykepleierforbund, 2014).

Limitations of the program

Time

The time and location of this program can be considered a limiting factor. If the program is designed to cater to migrant mothers, and encourage their partner's participation, offering the course only on Tuesday mornings and afternoons may not be the most suitable time for some groups of immigrants who often occupy shift work and do not have much flexibility in their work schedule. Offering the course more than once a week and at different times could make the course more available.

Location

Although Stavanger Sentrum (the city center) is directly accessible by bus from many neighborhoods, offering the course at more locations across the city could make the course more physically accessible.

Attendance at this program is voluntary, but highly recommend. However, if women cannot attend the course due to either timing or location or both, there is no other extensive program that covers all the topics mentioned in TEGRA in detail, or provides a platform for them to express their needs and concerns over a long period of time. When I inquired about other ways this information was relayed to women who missed the course, I was told that the women briefly get most of this information from their midwives, their health visitor, at the hospital after birth, and that they are always welcome to call the health clinic to ask for help. I was also told the fashion in which the

information is delivered varies from one practitioner to the next depending on their "personal style", and how much time they have that day,

Span

TEGRA is only run at the central clinic in Stavanger. The services do not extend to the hospital, and the hospitals do not have any programs designed to address the needs of migrant women, expect for translation services when required.

As mentioned in chapter two, there is very little affiliation between the state-run hospitals and the primary care centers in Norway, as they are essentially separate entities. Subsequently, midwives and other care providers at the hospital are state employed and hence not associated with municipality run programs such as TEGRA. As a result, the quality of care, level of awareness, and sensitivity to culturally appropriate care (may) vary across these institutions, because the care providers are trained and experienced according to different guidelines. For example, although all patients have the right to qualified interpreters at all public health institutions (The Norwegian Directorate of Health, 2015), the quality of care they might receive from a primary provider who is a part of the TEGRA program may vary considerably (based on their knowledge, training and experience with handling culturally sensitive cases) in comparison to the care they might receive at from another service provider at another health clinic, or institution such as the hospital.

Quality and Consistency

During my observations, I observed some inconsistencies in the information relayed to mothers in different groups mainly because a strict dialogue is not followed. Although the PowerPoint presentation guides the general progression of the course, there can be discussion on new topics or emphasis on other topics from one courses to another based on what the nurse is talking about that day or based on what questions are brought up.

Furthermore, when I inquired about program audits or if there was any strategic method of evaluating the success and efficiency of the program, I was told by one of the organizers that participants are asked to complete a satisfaction survey in the last session of the pre and post-natal courses with the help of their interpreters. The results are then reviewed with the leader of the clinic, who then discusses it with her superiors. There are no formal national audits, but she claimed that the surveys had been very useful tool in evaluating and revising the program. Furthermore, the surveys are used to collect statistics on the numbers and nationality of women who attended the workshops per year as presented in Appendix 4.

Another scenario I observed related to inconsistencies, was linked to the interpreters. I observed that the interpreters were not always consistent. For example, the interpreter for a participant group (i.e. Polish, Russian, Afghan) would vary for every workshop over the course of the program. I found this to be a limitation because I compared the interactions between the participants and their translators with the English group I was sitting next to. The English interpreter facilitated both the pre and the post-natal course. She was consistent in her attendance to the workshops, and this in addition to the warm way she presented herself, created a more welcoming and trusting atmosphere for moms to talk and ask questions. Although an argument can be made about culture having an

impact on the degree of interaction or conversation, my counter argument is that the English group consisted of women from several nationalities from different cultures around the world, yet there was a lot of conversation and interaction compared to some of the other groups that had changing translators.

Cultural Sensitivity and Awareness

Another point about the interpreters was that, they were both males and females. Although this is considered mostly normal and acceptable by Norwegian culture, in other cultures around the world, for instance in more conservative cultures, it is not common for females to discuss maternity related issues which inevitably contain some intimate topics with men in general, and this can sometimes include their husbands too. Hence the participation of men in such discussions, or rather in relation to topics surrounding pregnancy and birth is not very common. Although I can appreciate the program's encouragement for the participation of fathers in these educational courses that cover health related topics, but also the importance of the fathers' participation in parenting, which is too often not emphasized in many cultures, I believe that having male interpreters at least for migrants from more conservative cultures is not culturally sensitive or considerate.

For instance, during one of the post-natal workshops I observed a Muslim couple and their newborn being assisted by a young man. The first thing that I observed was how far apart the couple was sitting from their interpreter whereas in comparison every other group was sitting very close to each other (either next to one another or in a small circle) to hear one another in the busy room. The second point I observed was the order in which the couple was sitting, with the father sitting closest to the interpreter (yet considerably far) and the mother sitting behind him almost in a row. The course facilitator asked the couple to switch seats and sit closer to the interpreter to hear better, but there was no reaction, so then the facilitator came over to them, and shifted some chairs and signaled them sit closer to the interpreter, and still they did not move, which made me think that this was not an issue of understanding Norwegian, rather and issue of culture. The mother made very little eye contact or conversation with the translator. This made me wonder, whether her experience and learning outcome would have been different should she have had a female interpreter.

Furthermore, I did not observe any initiative in the program that recognized and addressed issues concerning cultural sensitivity or acceptability of the content, the pork pâté being an example. The content presented in TEGRA has been selected and organized by Norwegian practitioners according to Norwegian notions of good practice. In other words, the program is founded upon a mono-cultural understanding of the issue. The focus is not on addressing any specific issues affecting migrant women or on making the Norwegian course content more culturally sensitive to the needs of women from diverse backgrounds. Rather, the main effort in the current program lies in making this information more accessible to migrant women by addressing the language barrier and not much more. This is discussed more thoroughly in the discussions chapter.

Outreach

Finally, information about the program is limited. Deducing from my own experience of trying to find information on a program for migrant maternal health, I believe that public knowledge about the course is limited as information about the availability of the course is rather restricted. Women can find out about TEGRA if their practitioners (GPs or Midwives) inform them about it, and only if they chose to follow up and contact the center. Otherwise, information available on the municipality's website is restricted to a very short outline about the course and instructions on how to register in Norwegian and English only, which in reference to the demographics of the migrant population (chapter two) is not an accurate representation of society's needs.

Although this is a free course, technically available to anyone who seeks maternal health services both during pregnancy and after delivery, there is very little awareness about the program, and access is restricted to those who can gain access to information to register their interest, and also to those who have the flexibility of time. During my observations, I did not see more than 15 or 20 women attend each sessions, and this was unsettling knowing that there are more than that many (refer to Appendix 4) migrant women who are likely in need of help and guidance at that time in Stavanger. Furthermore, even if awareness (availability of information), time and commute are not limiting factors, accommodating other possible children women have at the center is a great limiting factor. Many women in the workshops often referred to their other children as examples, meaning that many had children whom they had to leave behind to a babysitter while the mother attended the course.

How Are These Limitations Translated into Limitations in Policy?

To conclude this section, I now discuss how these limitations are a reflection of the limitations associated with how this problem has been represented in policy, which is what Bacchi (2009) asks in the fourth question of the WPR model. Departing from a speculative overview of the weaknesses observed in the program structure and delivery, I believe that an innovative approach to policy complies with the aim of this analytic approach. With no national recognition, specific national guidelines, formal audits or any research on the program, it is likely that the limitations I presented in this section about TEGRA are a similar illustration of limitations in other programs across the country that address migrant maternal health. This demonstrates a weakness not only in the individual programs, but in Norwegian health policy. However, raising awareness about these issues is not sufficient in inducing change. Instead of just pointing to what has been observed, it is important to discuss what can be improved in the problematization of this topic. To do that, the effects of these limitations need to be understood, in order to effectively address them in broader health policy, and not just 'fix' them at the local level. This is what Bacchi's next question in the WPR framework intrigues: an exploration of its broader effects and implications in peoples' lives.

Reflecting on The Implications of The Problem Representation- Question 5

The fifth question in Bacchi's WPR model asks, "What effects are produced by this representation of the 'problem'?" (Bacchi, 2009, p. 48). This question requires reflection on the discursive effects, subjectification effects and lived effects due to dividing practices (Cort, 2011; Bacchi, 2009, p. 48;

as cited in Pereira, 2014). Therefore, in this section I offer an analysis of the of the implications of the problem representation in policy based on the findings I have arrived at thus far, through the paradigms of reflection, recommended by Bacchi in this framework.

Discursive Effects

The emphasis of equality in health policy has been shown to overlook the ethos of equity. The presumption that all maternal health needs of women are the same, and that they can be addressed by the same standard provision, supports a universal discourse on policy representation.

Although policy makers have come to acknowledge inequality in Norway's universal healthcare, they have mainly addressed general challenges, such as socioeconomic barriers to accessibility which have implications for the entire population, in national policy. This study shows that policy has tended to leave the addressing of migrant women to local provision. The government has supported and continues to support many initiatives nation-wide designed to target these inequalities, and as described thoroughly in the previous sections, TEGRA is Stavanger's approach to making maternal health services more accessible to migrant women. However, as the findings of this study reflect, this provision is framed within a mono-cultural and 'white' oriented Norwegian perspective, which is further discussed in the sixth chapter.

In summary therefore, the general discursive principles are that: universal access will enable equal access which will ultimately lead to a just, equal and inclusive society. However, as the finding of this study suggest, the effects of these discursive principles are that, they ignore diversity by treating everyone the same (also refer to Whiteness critique in the sixth chapter). Migrant women are constructed as 'women' and 'mothers' with similar maternal health needs. The problem with this 'all inclusive' approach is that 'migration' is not accounted for in the co-construction of their needs and hence their representation in health policy. The consequences of this discursive effect further manifest themselves as subjective and lived effects, which are presented in the following sections.

Subjectification Effects

The subjective effects of these discourses are that, despite intentions to be inclusive, policies can lead to the exclusion of these women by disregarding their immigrant milieu.

The current policy realizations and representations of barriers to healthcare faced by migrant women are not an accurate depiction of nearly all the challenges they face. There are weaknesses in the current program that subjectifies all the women who attend, to a mono-cultural Norwegian ideal of pre-natal and post-natal care. In doing so, the program oversees the plurality that exist in the group labeled as 'migrant' and fails to acknowledge their different individual needs. Of course, this is not to say that the program should recognize each and every one of these women's different needs or to understand and be responsible for orienting care services in a way that respects or shows understanding of all of their individual cultures, because that is simply not feasible, rather, by showing awareness of these cultures norms, and acknowledgement of their differences, they can make the services more suitable and acceptable by a wider audience. This is further described within the context of cultural competency in chapter six.

After all, these health initiatives are all a part of a larger integration initiative. Acknowledging the needs of these migrant women through policy, and enhancing their relationship with a health system that is respectful of their cultures, their integration can be promoted in Norwegian society by way of increased trust and participation in the system. However, the opposite is highly likely as well, where their exclusion by disregarding their migrant milieus can lead to their isolation as described under 'lived effects'.

Lived Effects

Bacchi's WPR framework primarily focuses on policy analysis, and the representation of problems in policies, but she also emphasizes reflection on the "effects of a given policy in terms of 'lived life'" (Cort, 2011, p. 29). In this part of the model, Cort (2011) explains that this inclination is largely due to Bacchi's background in gender studies where her primary focus has been on "the effects of problem representations on the micro-level" (p. 29).

Although a meticulous reflection on lived effects, goes beyond the scope of this study, I provide a brief but significant postulations on this topic that was constructed based on my experiences, observations, and reflections during the micro-ethnographic component of this research.

Based on my observations at the TEGRA workshops, I believe that due to the structure of the course, and its complete lack of cultural awareness, it is possible that some participants will be less inclined to attend future courses. For example, scenarios that I described in response to question four above, such as the visible discomfort and embarrassment the extended breast feeding video had on one of the male participants, or the incident with the male translator and the conservative couple who almost completely avoided interacting with him, or most importantly the dietary recommendation for infants involving pork, are all examples that have implications for the lived effects of the participants of this program.

These situations can put some migrant women at crossroads, of whether they should assimilate and leave their cultural beliefs and practices surrounding pregnancy and birth behind, or excluding themselves from the mono-cultural Norwegian understanding of maternal services and relying on their own remedies and community practices.

In the case where lived effects of these scenarios cause participants to withdraw from this program, it would not only have negative implications for the health of the mother and her baby, but would further reinforce the discourse of individual responsibility which places the burden on the service user for failing to utilize the 'accessible' services available to them. When service users do not find anything to connect to in these programs, that also do not demonstrate much cultural awareness or alternatives to Norwegian ways of doing things, there is a high tendency that they will retreat to relying on their social networks or community whom they can relate with to some degree for help regarding maternal and child health issues. This could result in decreased utilization of health services, which would ultimately lead to inequality and marginalization.

The Truth About Universalism – Question 6

Finally, the last question in the WPR framework asks, "How/where has this representation of the 'problem' been produced, disseminated and defended? How has it been questioned, disrupted and replaced?"(Bacchi, 2012a). In other terms, the final step requires the researcher to summarize and provide an overview of "contestation surrounding representation of the 'problem'" (Bacchi, 2012a), which in this case are the consequences that result from adopting the principle of universalism in Norwegian Health policy, followed by suggestions of 're-problematization' based on discursive findings.

The progression through this policy analysis framework has simultaneously co-constructed the answer to this final question. Therefore, departing from the culminated knowledge cultivated from the preceding sections in this chapter, it can be construed that Norway's universalistic approach to health policy and focus on equality has undermined health equity. Equal provision has not resulted in equal access and utilization. In fact, the universal approach has disproportionately favored the privileged who are possibly like the program presenters (Powell, 2008), and has not done much in realizing the disadvantages of the minority population. Its generalist approaches to addressing population needs, have overlooked intricate determinants that are detrimental for ensuring health equity especially among the less advantaged migrant or refugee groups of its population. Because of this approach, the needs of a significant percentage of the population have been overlooked, posing greater challenges of inequity, deeper inequality, and segregation in the population.

What I have come to realize through this study is that the overly dominant notion of universalism overshadows the weaknesses of the system. There is a contradiction in the assumption that everybody is equal and therefore everybody should be treated the same. This hypothesis which implicitly infers that the needs of everybody can be addressed using the same general principles imposes a weakness on the principle of universalism. What I have come to learn is that people do not experience universalism and equality the same way because of their different cultural backgrounds, interpretations, aspirations, and expectations of the system. Not having policy that recognizes or targets differences breeds inequality, and results in people falling through the cracks.

The current representation of health policy in Norway is a representation of its social democratic ethos. However, its current universal approach to service delivery has proven inefficient in targeting minority groups in society. Therefore, its principles must be challenged and efforts need to be made to redefine service delivery to reach targeted groups of people who do not benefit from conventional strategies of provision within a universal context. Furthermore, "there is also the need to implement many of the initiatives on a more sustainable and coordinated basis; without public and government involvement, structural improvements are impossible to achieve (Ingleby 2006)" (Rechel et al., 2011a, p. 248).

Summary

In summary, this section concludes the findings of the policy analysis discourse facilitated by Bacchi's (2009) WPR framework, but also defines some critical points of departure for discussions which are expanded on in the following chapter. The next segment of this study, contains an in-

depth critique of the broader implications of this analytical model's findings through a carefully selected set of theories I have framed as the conceptual framework (explained in chapter three).

Chapter 6
Discussions

Introduction
Summary of Policy Analysis Findings

In summary, Bacchi's (2009) WPR policy analysis framework served not only as an organization tool for the raw data, but also elicited a progressive and in depth reflection on the Norwegian approach to addressing social determinants of health in policy, through an example of its enactment in Stavanger.

The first, second and third questions of the framework drew attention to the policy setting by exploring the representation of the problem, which I described as being 'migrant maternal health'. The results supported the proposition that universal provision did not ensure equal access. Despite the emphasis on universalism, and recognition of fundamental determinants of health such as availability, physical, economic and legal accessibility, the discussion of more implicit social determinants linked to migration were absent in national policies targeting health inequalities. In fact, the responsibility of recognizing and addressing micro-level determinants of health appeared to have been passed down to municipalities, who have a high degree of autonomy from the central government. This decentralization of responsibility supports the suggestion that there has been a recognition that in order to cater for universal health services equally across the nation, communities require more flexibility in shaping their health services with respect to their populations' needs.

In the fourth question, I presented my micro-ethnographic findings on a local program in the municipality of Stavanger which aims to make maternal and child health services more accessible to migrant women, by focusing on overcoming language barriers. My observations enriched my understandings of the policy environment at the local level, and the program served as an illustration of how one municipality with a high migrant population has recognized and addressed inequalities in maternal health service provision at the grass-root level. This case, as mentioned earlier, demonstrated how health policy in light of this issue has been enacted in Stavanger, and although it does not serve to show what is happening in the rest of Norway, it does offer a representation of what is likely to be in response to the same pressures and under the same governance.

Although the program is a demonstration of progression towards addressing more nuanced health inequalities that are overseen by current policy at both national and local levels, I found that it had a multitude of limitations, the consequences of which I reflected upon in the fifth question. In responding to this question, I discussed the implications of this problem representation from discursive, subjective and lived perspectives to offer an all-rounded view of its effects.

Finally, in the last section of the model, I summarized these findings within the context of Norwegian health policy which is underpinned by the ethos of equality and is driven by the principle of universalism. I suggested an alternative re- representation of the problem in policy by

targeting services to ensure equitable access by migrant women to maternal health services, which is further developed in this chapter. Nonetheless, the last question concluded discussions guided by the analytical framework, and served as a point of departure for critiquing the broader implications of the case through the conceptual framework in this chapter.

Zooming Out - What Does This Mean for Policy?

As described in the third chapter of this dissertation, I developed a framework to interpret the findings of this study and their wider implication on health policy from multiple perspectives by selecting different yet overlapping theoretical concepts. The two primary theories that guided both the development of this study and the analysis of its findings were the AAAQ framework and the SDH model. However, as subsequent result of discussions that arose from their application in this section the two concepts of Whiteness Theory and Targeted Universalism emerged, which I incorporated into the framework to further develop the understandings generated by the study. Hence, the following chapter will entail an in-depth discussion on the current policy setting, and a comprehensive review on the study's overall findings articulated by my interpretations of theories encompassed in the conceptual framework.

Current Policy Setting

The AAAQ framework recognizes four interrelated elements of: Availability, Accessibility, Acceptability and Quality that are necessary for the implementation of the right to health (Schierenbeck et al., 2013; WHO, 2007). Interpreting the study findings through this lens, supports a belief that Norwegian health policy recognizes the fundamental macro-level, social determinants of health that enable legal, physical and economic accessibility to general primary health services.

Furthermore, the ethos of social democracy reflected in policy through the principle of universalism in Norway promotes a high degree of citizen autonomy and welfare state responsibility for social benefits such as health insurance rather than the market and their social network (i.e. family, or community). This principle, which is a hallmark of the Norwegian welfare state, accounts for addressing the meso-level determinants of health, that are frequently deemed as individual responsibility in communitarian welfare models i.e. Germany that rely more on the market and the family unit.

Finally, having one of the highest health care expenditures in the world (OECD, 2015), the Norwegian health system has the structures and policies in place to ensure high quality of care and equal coverage for the whole population across the country through its governance scheme as described in the second and fourth chapters. For example, as demonstrated in the second chapter, there is one state run hospital and six public health clinics offering maternal health services to the population in the municipality of Stavanger, located in Rogaland County which is home to 19,791 migrant women of childbearing age. Moreover, Norway has maintained one of the lowest maternal mortality rates (The World Bank, 2015).

Hence, it can be deduced that Norwegian health policy is reasonably effective in attending to primary meso and macro level social determinants of health and consequently ensures the right to

health by addressing the fundamental aspects of availability, accessibility and quality of health services as a result.
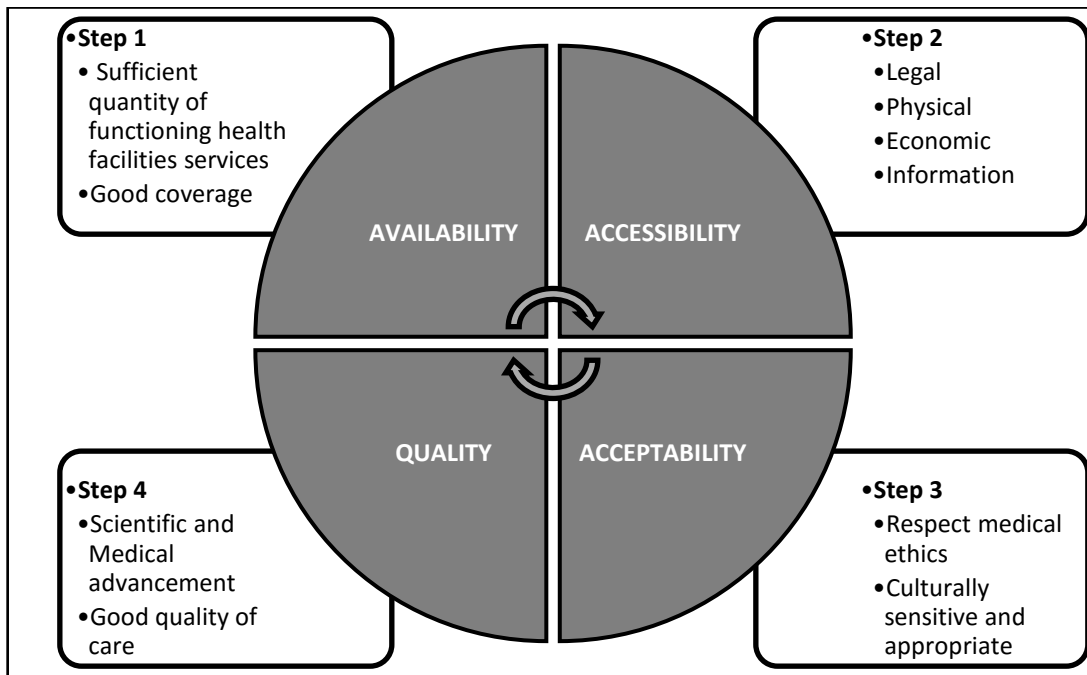
However, addressing the formal barriers of health such as the ones mentioned above, are not sufficient for ensuring equity. As described within the context of the conceptual framework in the third chapter, migration itself is not a risk factor to health, but it has implications for social determinants of health and vice versa. Access to health services by migrants will be affected by a complex interplay of informal barriers such as language, religion, ethnicity, culture and "newness" (Nørredam & Krasnik, 2011, p. 71) both on their own, and as a result of their consequences for formal determinants such as socioeconomic factors. Although there is significant evidence for the importance of these factors in inhibiting migrants from utilizing and benefiting from health services available to them (Nørredam & Krasnik, 2011), there seems to be a prominent absence of their recognition in health policy.

Language barriers are one of the main obstacles in providing care to migrants. They affect both service users and service providers and can pose challenges in accessing information, interpreting information, recognizing problems, adherence to treatment and of course lead to misunderstandings and less effective treatment (van Wieringen et al. 2002; Harmsen et al. 2003; as cited in Nørredam & Krasnik, 2011, p. 72).

Norway has recognized the need for interpreters to assist in the delivery of health services to the migrant population in its national health policy. As mentioned in the fifth chapter, everyone is entitled to the right to request a translator, which is not a sufficient solution to overcoming language barriers and thus access to health as demonstrated through some observations in the findings chapter. However, what I found in this study was that the recognition of other informal determinants, especially cultural awareness and sensitivity, which are more nuanced and complex to address than language barriers, are predominantly absent from policy and subsequently in practice.

This poses a challenge for the rights based model of health, that has four intertwined components. "Reducing health inequities is important because health is a fundamental human right and its progressive realization will eliminate inequalities that result from differences" (WHO, n.d.-a). All elements of this framework must therefore work in unison to ensure migrant women's equitable right to maternal health care. However, without the recognition of critical components, the system becomes faulty.

Figure 16- Policy development framework for enabling right to health

- **Step 1**
  - Sufficient quantity of functioning health facilities services
  - Good coverage

- **Step 2**
  - Legal
  - Physical
  - Economic
  - Information

AVAILABILITY ACCESSIBILITY

QUALITY ACCEPTABILITY

- **Step 4**
  - Scientific and Medical advancement
  - Good quality of care

- **Step 3**
  - Respect medical ethics
  - Culturally sensitive and appropriate

Adapted from: JOINT FACT SHEET WHO/OHCHR/323 on "The Right to Health" (WHO, 2007)

Equity in health is a critical aspect of accessibility, and it differs from equality in that it "concerns fairness" (Nørredam & Krasnik, 2011, p. 67). "*Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (WHO, n.d.-a). Applying horizontal equity to health policy implies that everyone's needs are equal and that they can be addressed by the same set of provisions, whereas vertical equity recognizes differences and allocates access accordingly (Oliver and Mossialos 2004; as cited in Nørredam & Krasnik, 2011).

The findings of this study suggest that Norway's health policy falls within the horizontal definition of equity. However, the problem with this approach is that it fails to recognize differences in needs of migrant women seeking to have their maternal health addressed, and hence fails at ensuring equity. The policy analysis conducted in this study suggests that there is an emphasis on steps one, two and four of the model in developing policy to overcome general health inequalities that could affect the entire population, migrants included. However not much discussion is available concerning the acceptability or cultural appropriateness of services beyond topics surrounding medical ethics such as patient rights, and confidentiality in policy.

This element of the framework requires the acknowledgment of more subtle determinants at the individual level inhibiting access and usage of health services. I conclude from Rechel et al. (2011c) that the following factors impact access: race, ethnicity, religion, sex, women's social position, health behaviors, cultural beliefs, traditional customs in health care, and last but not least practices and attitude towards care, which are also supported by Higginbottom, Hadziabdic,

Yohani, and Paton (2014). The absence of critical discussion on these issues in health policy indicates perhaps that reliance on a universal framework of provision is considered sufficient to ensure access. I will argue later that this illustrates a monocultural frame of reference which may be understood by using Whiteness Theory. The lack of attention to this element can have negative implications for the 'cogwheel' function of the AAAQ rights based model, and could in fact deepen inequality by presuming that current services are exempt from enquiring into their acceptability as satisfying a rights based provision.

Although the elements of the model are distinct concepts, they overlap and are also interrelated. Access is influenced by both quality and acceptability. "Lack of confidence in the quality of services will deter people from accessing them" (Salt, 2011, p. 30), and hence ignoring the different needs of the population by adopting a blanket approach to universalism in addressing needs is a form of inequity (Salt, 2011).

Norwegian health policy, and its lack of concern for acceptability supports a one-dimensional understanding and approach to addressing health inequalities, which as discussed in the previous chapter, overlooks the needs of minority groups. My observations suggest that the health information delivered during the workshops was heavily based on mono-cultural Norwegian understandings of health and good practice, and there were several remarkable examples as described in fifth chapter such as the recommendation of pork pâté, to support it.

One important contributing factor to this issue is how migrants are defined in policy. Migrants constitute a very diverse group of people with different needs and different challenges. Yet the lack of consensus on a single definition of 'migrant', and the interchangeability of the term with other interlinked notions associated with migration, causes ambiguity. The generalization of the term 'migrants' to refer to a largely heterogeneous population as one group in policy poses a problem of inconsistency when discussing the impacts of migration and leads to the inadequate recognition of the different challenges and risks associated with different groups and generations of 'migrants' in a nation. Currently the needs of 'migrants' in Norwegian health policy have been defined mostly in the context of legal rights and economic accessibility, which barely accomplishes the primary stage of addressing their equitable access to health services.

Whiteness Theory and Privilege

The critical theory of Whiteness is used in social sciences to demonstrate White privilege. "Whiteness theory treats Whiteness not as a biological category but as a social construction" (Thompson, 2001), where White worldviews and discourses on policy making and practice become normalized and naturalized (Thompson, 2001). Consequently, whiteness as a race privilege becomes "pervasive yet invisibilised" (Young, 2008, p. 103). The invisible prejudice imposed by Whiteness in defining privilege, equality, and access furthers discrimination and imposes inequity through its oppressive discursive effects.

This argument shows resemblance to a critique by Young (2008) whose paper discusses a more extreme example of the utilization of Whiteness Theory criticize the imbuement of White privilege in Australia's social policy history with regards to practices of child protection in indigenous communities, whereby their cultural values and practices are dismissed. The paper shows how Whiteness Theory explains the events of a social history affecting Aboriginal children and families

in Australia, through the use of invisibilised and unacknowledged norm and privilege derived from a mono-cultural view of the world. While applied to an extreme example, in the Norwegian health context the concept is applicable to understand how policy replicates a monocultural norm in its belief that a universal approach will address all needs, but in fact fails to recognize cultural differences.

The blindness I observed towards acknowledging cultural differences in the municipality's program for migrant women, resembles how policy makers and practitioners in Norway view and understand multiculturalism. Young (2008) argues that, claiming universal equity "but ignoring the realities of race" (p. 103), and ethnicity for non-white people resemble behaviors which "reinforce race privilege" (p. 103). This is a contradiction to the Norwegian ethos of social democracy and equality, which indicates that the cultural mishaps I observed during my study of TEGRA were likely not deliberate, which is a feature of white privilege, that it is unintentional and unrecognized. Of course, to overcome this policy makers and practitioners need to make a conscious decision to step out of their own worldview, to acknowledge other cultures' worldviews, and realize that not everyone experiences universalism equally.

In order to understand this differential experience a precept of Whiteness theory is that it is important that as a starting point policy makers and practitioners implementing policy deliberately enquire into and articulate their own positionality and its influence on their understanding and contribution to defining privileges in order to realize and target different needs of a multicultural society. Practitioners thereby also become policy actors in influencing policy through their practice.

While it is not feasible to gain knowledge about all the cultures that coexist in society in order to offer culturally sensitive and competent care, as Ingleby (2011) states, "only by first exploring one's own preconceptions and values could one learn to recognize and accept those of others" (p. 236). In this case, this would translate to the recognition of less formal barriers that affect migrant women's access to maternal health services, and to have more inclusive and respectful progressive policies.

 "For decades it has been almost an axiom that matching health services to the needs of migrant users involves bridging 'cultural gaps'" (Ingleby, 2011, p. 235). Kirmayer (2012), states that, current approaches to developing culturally competent health systems to respond to diversity have further marginalized minority groups by "essentializing, commodifying and appropriating culture, leading to stereotyping and further disempowerment of patients" (Kirmayer, 2012, p. 160). An added consideration is the current realization that culture is not a fixed attribute and so differential provisions are to be less based on presumed cultural attributes and more on an understanding of culture being one of many factors which require attention (Carpenter- Song et al. 2007; as cited in Ingleby, 2011). A whiteness theoretical approach requires that service providers reflect on their own cultural being and expressions which may negatively impact on culturally different others. Sensitivity to different cultural norms, such as being mindful of dietary prohibitions, is just one of many necessary considerations. This makes the provision of health, and other, services, a complex undertaking.

Furthermore, although it may seem that migrants come from many and varied backgrounds, statistics from the second chapter support the claim that "large migrant communities tend to gravitate to specific locations" (Ingleby, 2011, p. 236). As a secondary step to recognizing differences, this could make it possible for service providers to focus on needs of a more manageable number of communities to familiarize themselves with cultural norms and practices to avoid the overgeneralization of migrants' cultures, or as Ingleby (2011, p. 236) states, to avoid "pigeon-holing them into rigid stereotypes". This is analyzed in the following section under Targeted Universalism.

Targeted Universalism

In summary of the discussion thus far, I have come to realize through this study that the blanketed approach to universalism overshadows the gaps in the system. There is a contradiction in the assumption that everybody is equal and therefore everybody should be treated the same. This hypothesis implicitly infers that the needs of everybody can be addressed using the same general principles, however this thinking imposes a weakness in the principle of universalism and further deepens inequality in migrant maternal health which can lead to women's further marginalization.

Although this system might have been sufficient at a point in Norwegian welfare history, it is time to challenge the principles underlying policy making and enhance the notions of equality to be equitable and truly inclusive.

As described in the above sections, the first step to change is the realization of differences among the vulnerable (refugee population) is to reevaluate the acceptability of maternal health services and develop more culturally competent programs. But understanding these issues alone will not solve the bigger problem of inequality and close the gap, there needs to be action. Therefore, upon realization, these changes need to be systematically applied to policy and practice. This should then be followed by a reevaluation of interventions to make services more accessible to those whose needs were overlooked. Hence, in order to close the health gap and make provisions more equitable, the system must become more plural in recognizing the population's diverse needs and furthermore, universalism should be targeted to reach out to and benefit marginalized groups.

The argument for targeted universalism stems from the fact that, "social conditions vary significantly between ethnic groups and across regions" (Perry, 2011, p. 571). Therefore, for universal provisions to benefit the whole population equally, services must be targeted at those who are typically overlooked by common policy.

"Policies that are designed to be universal too often fail to acknowledge that different people are situated differently" (Perry, 2011, pp. 571-572). Powell (2008), argues that universalism will by and large disproportionately benefit the already privileged. This, as described earlier, is due to the advantaged groups in society often having dominance over defining privilege and inequality in policy (refer to Whiteness critique). Although these policies might offer some benefits to the majority of the population, they are not effective in meeting the needs of the less advantaged (Perry, 2011), which extend beyond migrants, and includes other vulnerable groups as well.

Powell (2008) proposes that, "a targeted universal strategy is one that is inclusive of the needs of

both the dominant and the marginal groups, but pays particular attention to the situation of the marginal group" (p. 802). Furthermore, his political strategy to overcome inequality states that, "targeted universalism rejects a blanket universal which is likely to be indifferent to the reality that different groups are situated differently relative to the institutions and resources of society" (Powell, 2008, p. 803).

Finally, his rhetorical strategy on targeted universalism requires that policies be "evaluated by their outcome, not just the intent" (Powell, 2008, p. 803), wherein output is determined by how well the universal policies benefit the entire population, especially the targeted groups. For example, in this case targeted universalism would involve interventions that would increase the participation, satisfaction and birth outcomes of migrant women, particularly refugees, who are a vulnerable and often marginalized group, by making maternal health services more accessible and acceptable to them.

The decentralized system of health governance and division of health care responsibility in Norway as explained the second chapter, serves as an excellent example of how the state has attempted to target its universal provisions through community based initiatives. The great bureaucratic autonomy and financial flexibility municipalities have in catering for primary health services based on their population's needs (as described in chapter), demonstrates the efforts in place to mobilize universal health policy in different communities. Although a positive first step towards targeted universalism, the categories are too broad. My study findings suggested that, despite initiatives like TEGRA, the needs of communities are still generalized and a blanketed universal approach is still applied to service provisions, which as described above overlooks the needs of minority populations such as migrants. Nonetheless, I strongly believe that adopting a targeted universal approach to health service provision can be most efficient method to overcoming inequity.

Summary

Through the thorough application of the conceptual theories defined for this study in the third chapter, this chapter provided an analysis of the greater implications of the findings. Departing from a rights based framework for understanding, the discussions incorporated the consequences of overlooking migration as a social determinant of health in the provision of maternal health services; further this critique adopted the politicized theory of whiteness to demonstrate the one-dimensionality of health policy and provision, which then led to a criticism of the universal approach to health in ensuring equity.

Chapter 7
Conclusions

Following a lifelong fascination with health, I pursued a degree in life sciences where I majored in Global Health and Physiology, two contrasting yet overlapping health sciences. Over the course of my undergraduate degree I became acquainted with both the biomedical aspects of health and its social definitions. However, it was not until I took an intellectually intriguing course on the "Political Economy of Health" in my last year of study, that I realized my tireless passion and abiding interest in approaching health from a socio-political angle.

Subsequently, I commenced my Masters studies in Social Work with Families and Children, where I gained a deeper understanding of the intertwined relationships of social policy, and wellbeing in different European countries within a family centered module. With profound interest in both: the versatile and multidisciplinary nature of social work as a practice-based profession underpinned by disciplines targeted at understanding inequality and improving wellbeing (International Federation of Social Workers, 2014), and the encompassing definition of health by the WHO which goes beyond the "absence of disease and infirmity", and incorporates a series of determinants to ensure a state of "complete physical, mental, and social well-begin" (WHO, 1948), I was determined to reflect their critical interconnections in my dissertation .

I worked determinedly to develop a study that offered a representation of this intersection, and its importance in contributing to knowledge for overcoming health inequalities. However, in searching for a point of departure, I realized there was a gap in the literature adopting a similar approach to understanding health inequalities among vulnerable populations such as migrants, even more so on the topic of migrant maternal health in Norway. Therefore, with guidance from my supervisor I designed a study to reflect my interests, and to contribute to the gap in knowledge by conducting a policy analysis on maternal health service provisions for migrant women in Norway. This study is not only critical for reducing health inequalities and enhancing the wellbeing of migrant women, but serves to emphasize that a universal approach has not addressed the needs of various groups within the migrant population. This implies possible consequences not only for a larger group, and thus should intrigue further exploration of the topic.

The purpose of this study was to explore:

1. How has health policy in Norway recognized and addressed barriers that affect migrant and refugee women's access to maternal health services?
2. How have these policies enabled accessibility and acceptability of maternal health services to migrant and refugee women?

To investigate these questions, I adopted a qualitative research design and developed an instrumental case study composed of data from several sources including: policy documents; a micro-ethnographic study on TEGRA, a maternity workshop developed for migrant women in the municipality of Stavanger; and information from several policy advisors and health practitioners (as described in the fourth chapter).

I reviewed the data I had gathered using Bacchi's (2009) WPR policy analysis framework in the fifth chapter. This analytic strategy guided the organization and critical interrogation of data to recognize the underlying influences of how policy enables access to maternal health provisions by migrant women in Stavanger as an illustration of the policy setting and enactment in Norway. I then applied my conceptual framework to the findings generated from this framework. This, consists of four theories: the AAAQ, SDH, Whiteness Theory and Targeted Universalism (all of which are described in the third chapter), for a more in depth critique of their broader implications in the sixth chapter.

My overall findings suggested that Norway's universal approach to health is inadequate in addressing population specific determinants of health. Although TEGRA is a representation of progress in addressing inequality, the underpinnings and processes involved in the problem representation at policy level pose many limitations to its effectiveness. There is a contradiction in the assumption that everybody is equal and therefore everybody should be treated the same. Norway's universalistic approach to health policy has inadvertently resulted in a degree of ambiguity in the ethos of equity and equality, which has overseen intricate determinants of health at the micro level of society. Consequently, this has led to the formation of loopholes in the theoretically equitable healthcare system, through which a fraction of the population, particularly people from migrant and refugee backgrounds fall. Hence, this approach to equity imposes a weakness of the principle of universalism and further deepens inequality.

In the sixth chapter, I emphasized the importance for policy to recognize and acknowledge 'informal' micro level determinants that affect migrant women's access to maternal health services. Furthermore, I discussed the importance of making health services more culturally sensitive and plural in response to Norway's growing population diversity. Finally, I suggested adopting targeted universalism as a refined political strategy to transitional universalism to overcome inequality, by making it a priority to reach the needs of more marginal groups of society through universal interventions.

In summary of this chapter and in response to research questions, the findings of this study, as discussed throughout chapters five and six, suggested that:

1. That national health policy in Norway has not formally recognized any specific barriers that impact migrant women's access to maternal health services beyond their statutory rights and free access to interpreters. However, the central government has strategically given local governments a degree of autonomy in developing community based programs to cater for universal health services more effectively based on their population's specific needs. An example of such an initiative is TEGRA in the municipality of Stavanger that offers maternal and child health workshops to migrant women.
2. However, despite this, the service still does not recognize the plurality of migrant women, their diverse needs, and their implicit determinants to access maternal health services. Therefore, with a disregard for cultural sensitivity in their content, and a lack of realization of the challenges associated with acceptability and utilization specifically due to these women's migrant backgrounds, it serves as a demonstration for the mono-cultural understanding of maternal health services. This is a reflection of weaknesses associated with the problem representation in policy and thus illustration of the weaknesses imposed

by the assumption that equality can be ensured by universal access in a multicultural society. More simply, it is a representation that equality has not guaranteed equity.

Recommendations

This dissertation is an overarching realization that policy is not a straightforward decision making process. It is a complex field with complex interests in which multi-sectoral cooperation is required at every level of policy making, both local and national, for the appropriate responses to migrant health issues. Furthermore, cooperation is needed from policy makers and practitioners from different fields to contribute to knowledge expansion not only on this issue, but others that affect vulnerable groups such as: the elderly, children, disabled people etc.

"The task of monitoring health problems and identifying risk factors is not only carried out by health service providers, but also by public health agencies, municipal or government departments, research institutes, NGOs and universities" (Salt, 2011, p. 30). Multi-sectoral cooperation between different government agencies is crucial in understanding, targeting and monitoring disparities in health. This is highlighted in "equity and health in all policies" by the "Council of the European Union (Council of the EU 2010)" (Ingleby, 2011, p. 231). Without a synergy of evidence, and research from different viewpoints of actors who influence the social political economy, the scope of interventions will be limited, and their outcomes inadequate in overcoming inequality or in addressing the needs of the population they target.

There are three principle dogmas used to theorize health inequity in research and in practice. Although each of the three medical, political and social standpoints contribute to significant understandings about health inequalities, and can each offer convincing solutions for overcoming these disparities, I believe that none can achieve this successfully alone. For example, clinical research although significant, is insufficient on its own in addressing inequalities in health by medicalizing people and their treatments. The same is true from a sociopolitical perspective where needs are often generalized to economic barriers, and lastly, health inequalities cannot be comprehensively addressed through a purely sociological lens without recognition of other factors. This is because social determinants do not exist in isolation from one's health, their environment or position. Hence, the design and provision of equitable health services involves collaboration from different sectors addressing the issue to ensure that the access to services is not only equal but also equitable.

This is where the multidisciplinary role of social work and social workers as policy makers and policy players, which is present in all those fields, should be emphasized. Although social work discourses addressing this issue in policy are often outnumbered and thus overshadowed by the more traditionally 'scientific' viewpoints, the role and diverse knowledge of social workers both at policy and practice levels is fundamental to understanding social determinants. The unique positioning of social workers is essential to assessing the immediate and broader implications of policies on people's lives as reviewed in the fifth chapter. Therefore, I believe that having social workers as a part of multidisciplinary teams to develop effective, holistic, and sustainable interventions to reduce inequality and overcome inequity is crucial.

Implications for Future Research

In conclusion, this analysis offers an essential contribution to understanding migrant health policy in Norway by offering an illustration of its enactment in addressing maternal health services in Stavanger. However, in addition to contributing to the knowledge base in this field, this study serves as an equally important departing point for further research on the inadequately explored field in Norway, where migration is a visible problem.

There is an immediate need for more extensive research analyzing migrant health policies and their effects in Norway. This, as mentioned before was a great limitation I was faced with in this study. There was very little foundational information, statistical and comparable research available on and surrounding this topic. Yet the select few documents that were available, as discussed in the fourth chapter, were in Norwegian.

This is an extremely limiting circumstance that makes Norwegian health policy, renowned in the world, inaccessible to international evaluation, which is a critical component to both national and international progress in the globalized world. Nonetheless, I hope that this study has offered the foundations for further inquiry on this topic.

Recommended Future Research Options and Directions

- Further qualitative inquiry on the experiences and perceptions of both service users and service providers- this can add to the richness of this policy analysis by providing a much more comprehensive overview of how migrant and refugee women experience maternal health services
- Systematic evaluation of current programs and policies i.e. program audits- since no formal documentation on this matter exist at the moment, it would be useful for programs such as TEGRA to illuminate and what can be improved both at the practice level which could contribute to policy improvement
- Comparative research between other similar programs offered at the local level in Norway- because by sharing knowledge and experience, the different localities can learn from one another, and this could contribute to the enhancement of existing initiatives
- Cross country comparative studies to examine how this problem has been represented and addressed in neighboring countries with similar welfare states and migratory flows- again both interstate and intrastate comparative studies are important to share knowledge, and contribute to the development of better programs and policies.
- Qualitative study on the awareness, and understanding about health equity and perceptions of cultural competency in relation to migrant maternal health among policy makers and health practitioners- this can again offer a rich and critical dimension to the policy analysis, or on its own as an individual study perhaps in comparison to other European countries.
- Inquiry about cultural responsiveness training can enrich understandings of why and how Norwegian policy is where it is at and why services are structured the way they are.

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Appendices

Appendix 1

Figure 17- Subordinate agencies to the ministry of health

Agencies subordinate to the Ministry of Health and Care Services

Name of agency	Key responsibilities
Directorate of Health (Directorate)	• Implements national health policy through integrated and targeted activities across services, sectors and administrative levels
	• Advises central authorities, municipalities, RHAs and the voluntary sector
	• Is responsible for direct payments to various health service providers (e.g. through the system of activity-based financing and the HELFO)
	• Prepares ordinances, national guidelines and campaigns
	• Is responsible for the work of the Health and Social Services Ombudsmen (POBO)
National Board of Health Supervision (National Board)	• Provides general supervision of health and social services at national and local levels (through Offices of the County Governors)
	• Monitors the population's need for health and social services
National Institute of Public Health (NIPH)	• Provides monitoring, expertise and research in the areas of epidemiology, infectious disease control, environmental medicine, forensic toxicology and drug abuse
Norwegian Medicines Agency (NoMA)	• Supervises new and existing medicines and the supply chain, including production, trials and marketing
	• Grants/withdraws market authorizations
	• Monitors and ensures cost efficient, effective, documented use of medicines
	• Regulates prices and trade conditions for pharmacies
	• Provides advice on reimbursement of drugs outside specialist care
Norwegian Radiation Protection Authority	• Monitors the use of radioactive substances and fissile material
	• Coordinates contingency plans against nuclear accidents and radioactive fallout
	• Monitors natural and artificial radiation in the environment and workplace
	• Disseminates information about the occurrence, risk and effects of radiation
	• Provides assistance to all ministries on matters related to radiation, radiation protection and nuclear safety
Norwegian Biotechnical Advisory Board	• Evaluates the social and ethical consequences of modern biotechnology and supports usage that promotes sustainable development
Norwegian System for Patient Injury Compensation (NPE)	• Handles compensation claims for patients who have sustained an injury while receiving health-care services
	• Collects and collates data on such injuries with the aim of providing a statistical basis for quality improvement and injury prevention work
	• Works to inform the public, patients and health service workers about the patient injury compensation scheme
Norwegian Registration Authority for Health Personnel (SAK)	• Provides work authorizations/licences for 29 categories of health-care personnel
Norwegian Knowledge Centre for the Health Services (NOKC)	• Provides decision-makers and health personnel with synthesized research evidence on the effects of health interventions
	• Promotes and monitors patient safety and quality of services

Source: Agencies' websites.

As cited in Ringard et al. (2013, p. 21)

Appendix 2

Figure 18- Immigrant and Norwegian-born migrant women of childbearing age in Rogaland County

**Statistisk sentralbyrå**
Statistics Norway

Immigrants and Norwegian-born to immigrant parents etter region, age, sex, country background, time og contents

	2017	
	Immigrants and Norwegian-born to immigrant parents	**Total**
11 Rogaland		
20-44 years		
Females		
Europe except Turkey	10 426	10 426
Africa	1 996	1 996
Asia including Turkey	6 264	6 264
North America	231	231
South- and Central-America	825	825
Oceania	49	49
Stateless	0	0
Uoppgitt	0	0
Total	19 791	19 791

Retrieved from SSB (2016a)

Appendix 3

Figure 19- Public health clinics and school health clinics organization in Stavanger municipality 2017
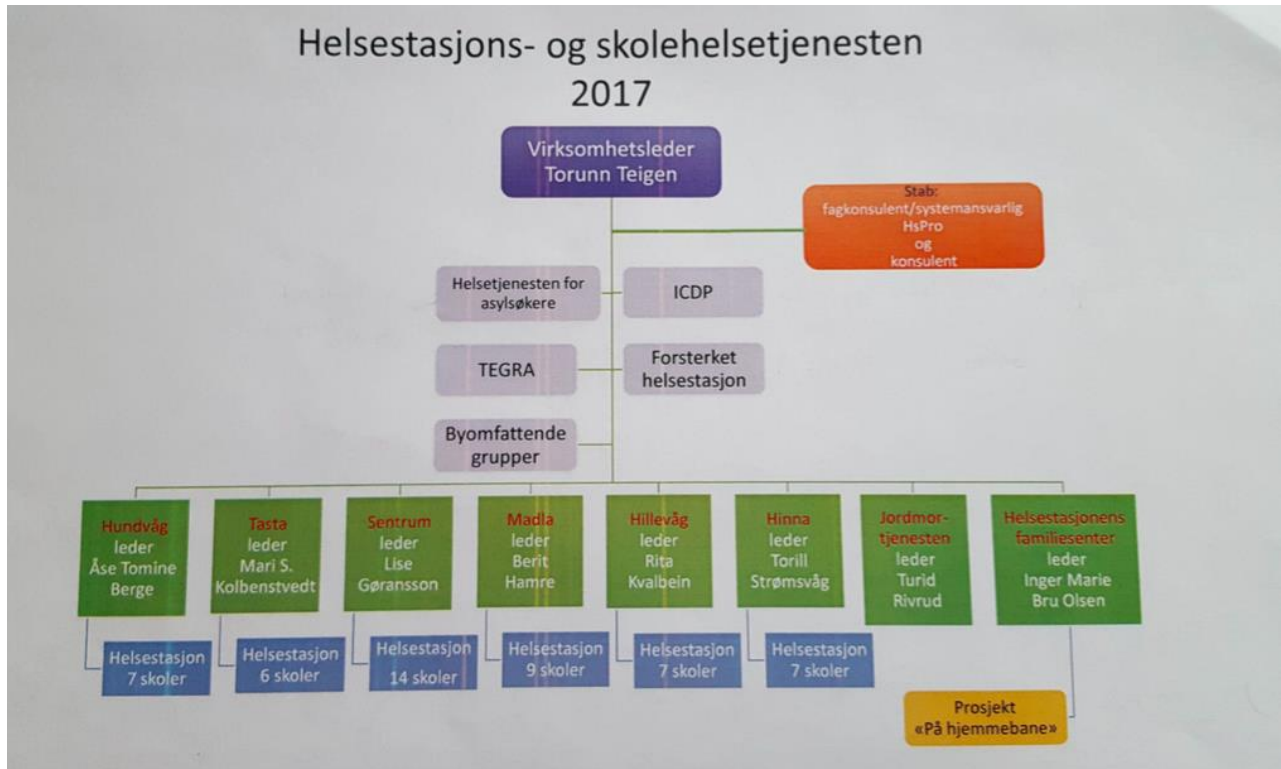
Source: Retrieved from internal municipality database (Municipality Intranet) and provided to me by my contact person

Appendix 4

Figure 20- 2016 TEGRA Statistics provided by clinic

Tegra Statistikk 2016

Fødselsforberedende kurs 2016

Vi hadde 12 kurs i 2016. Totalt har vi hatt 172 gravide som har deltatt, (de fleste har hatt med ektefelle). Vi har hatt 56 nasjonaliteter representert. Kurset går over 3 tirsdager a` 1 ½ time.

Polen er sterkest representert med 13 deltakere, deretter India med 12, Filipinene med 9 Afghanistan, Litauen, og Iran med 6, Tyrkia og Syria med 5, Thailand, Pakistan, Etiopia med 4, Indonesia, Russland, Eritrea, Kina, Romania, Sudan og Somalia med 3, Bulgaria, Tunis, Tjekkia, Nigeria, Venezuela, Sør-Korea, Østerrike og Serbia med 2, Sri-Lanka, Ecuador, Dominikansk Republikk, Danmark, Irak, Hellas, Brasil, Marokko, Ghana, Peru, Palestina, Ukraina, Ungarn, England, Jordan, Yemen, Uganda, Burma, Argentina, Saudi Arabia, Algerie, Colombia, Libya, Kosovo, Bosnia, Mexico, Hvite Russland og Kenya med 1.

Europeiske land er representert ved: Polen, Russland, Hellas, England, Danmark, Østerrike, Serbia, Ukraina, Tsjekkia, Tyrkia, Litauen, Romania, Kosovo, Bulgaria, Bosnia, Ungarn, Hvite Russland.

Asiatiske land: India, Fillippinene, Iran, Irak, Kina, Pakistan, Thailand, Indonesia, Sør-Korea, Afghanistan, Syria, Palestina, Jordan, Yemen, Burma, Saudi-Arabia, Sri-Lanka.

Sør-Amerikanske land: Brasil, Venezuela, Argentina, Colombia, Mexico, Ecuador, Den Dominikanske republikk, Peru, Burma.

Afrikanske land: Tunis, Nigeria, Eritrea, Somalia, Marokko, Sudan, Ghana, Etiopia, Uganda, Algerie, Libya, Kenya.
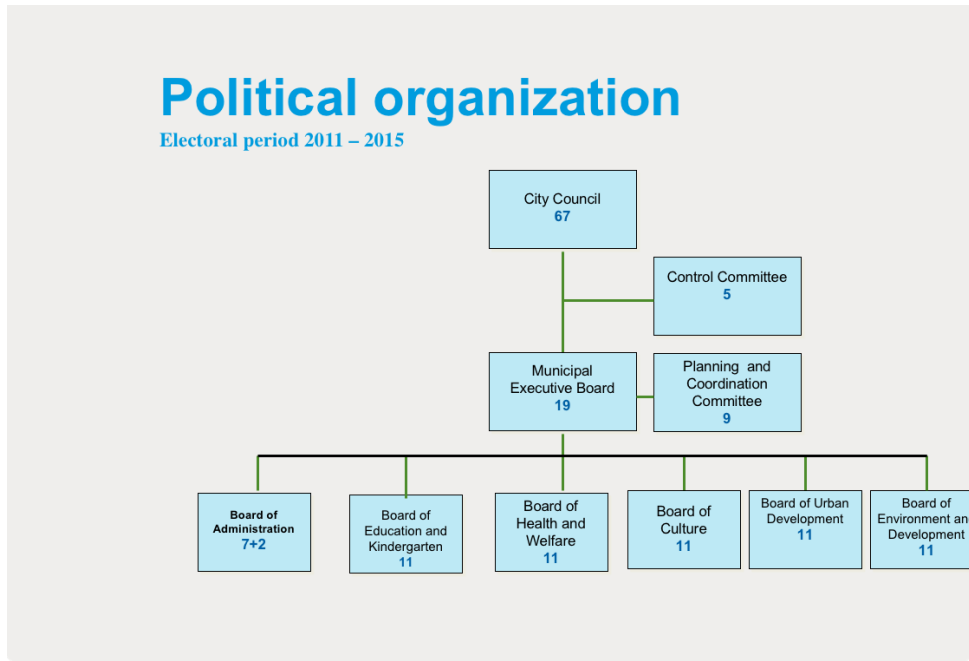
Barselgrupper 2016

Vi har arrangert 8 barselgrupper. 104 familier er representert. Totalt 46 nasjonaliteter. Mange har hatt med seg ektefelle.

Hver barselgruppe har 5 ukentlige samlinger på tirsdager a` 1 ½ time.

Foruten jordmor og helsesøster inviterer vi inn tannpleier, fysioterapeut, lege og besøker Storhaug åpen barnehage.

Appendix 5

Figure 21- Political Organization Stavanger

Political organization

Electoral period 2011 – 2015

City Council
67

Control Committee
5

Municipal Executive Board
19

Planning and Coordination Committee
9

Board of Administration
7+2

Board of Education and Kindergarten
11

Board of Health and Welfare
11

Board of Culture
11

Board of Urban Development
11

Board of Environment and Development
11

Source: Source: Retrieved from internal municipality database (Municipality Intranet) and provided to me by my contact person

Appendix 6

Non-Plagiarism Declaration

I hereby declare that the Dissertation titled **"Imperfections of a Perfect State: A social policy analysis of the provisions of maternal health services for migrant women in Norway- A case study on Stavanger"** submitted to the Erasmus Mundus Master's Program in Social Work with Families and Children:

- Has not been submitted to any other Institute/University/College

- Contains proper references and citations for other scholarly work

- Contains proper citation and references from my own prior scholarly work

- Has listed all citations in a list of references.

I am aware that violation of this code of conduct is regarded as an attempt to plagiarize, and will result in a failing grade (F) in the program.

Date (dd/mm/yyyy): **01/06/2017**

Signature:

Name (in block letters): **LYDIA MEHRARA**