

Cultural Diversity in Perinatal Care: Somali New Mothers' Experiences with Health Care in Norway

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Abstract

Objective: To explore Somali new mothers' experiences with the Norwegian health care system and their experienced needs during the hospital stay and the postpartum period.

Methods: A qualitative design with individual semistructured interviews. Qualitative content analysis was used to analyze the transcripts from the interviews.

Results: Ten women aged 25 to 34 years were interviewed. The women had lived in Norway 4-16 years and had 1-4 children. Analyses of the interviews indicated that there were cultural differences between Somalia and Norway, and that these affected the women during pregnancy and childbirth. Four main categories were central in the women's stories: (1) inadequate integration into Norwegian society; (2) need for and fear of a caesarean delivery; (3) family support around the postpartum period; and (4) support from health services.

Conclusion: Even though these women lived in Norway, their language skills were poor and they were poorly integrated into Norwegian society. Health professionals should use an interpreter when dealing with Somali women with poor language skills, especially when discussing issues relating to birth and the hospital stay. To help integrate these women into society, they should be encouraged to learn the Norwegian language. Well-child clinics should offer immigrant mothers the opportunity to participate in maternity groups to strengthen their social relationships and to integrate better. Public health nurses play an important role in supporting immigrant mothers. The findings of this study will help broaden the understanding of the support immigrant women need during the hospital stay and the postpartum period.

Keywords: Somali immigrant mothers; Postpartum period; Birth experience; Qualitative design; Public health nurse

Introduction

The transition to motherhood can be stressful and may lead to feelings of vulnerability and challenge [1-3]. Even when the circumstances, such as first-time parenting, are similar, the transitions are experienced in different ways by different mothers [1]. Events such as pregnancy and birth lead to a process of transition. Women need help and support to feel safe in parenting and to develop the skills needed for motherhood, and first-time mothers need greater confirmation and support because they are more uncertain [4-6]. Social support can help a mother's transition to motherhood [3,4,7]. The provision of psychological support and information to parents during both pregnancy and the childbirth period is recommended [3,8].

Women who are away from their support system in the postpartum period are likely to feel vulnerable. Most cultures have rituals associated with birth and the postpartum period. For example, within Islam, women are mandated 40 days of rest. During this time, postpartum women are considered to be "unclean" and are not allowed to wash or cook in the belief that this may result in contamination. Housework must therefore be performed by others. One consequence is that the woman is allowed to rest [9]. In a systematic literature review of 20 original research papers, Lee et al. [10] found that immigrant women have a higher incidence of postpartum depression than the overall population. This incidence was even higher among immigrant women from minority groups. Another systematic review found that, even though immigrant women in Canada are provided the opportunity to receive necessary services, there are barriers such as a lack of information about the services, lack of support or help to access these services, and differences in expectations between the women and their service providers [11].

Cultural aspects are important for integration, especially in view of the growing immigrant population in Norway. Immigrants in Norway come from 222 different countries and autonomous regions, and comprise people who have immigrated as refugees or labor immigrants, for education, or to join a family member already in Norway. Presently, there are about 698,600 persons living in Norway who are immigrants and 149,700 Norwegians born to immigrant parents. Together these groups constitute 16.3% of the population. Many immigrants live in Oslo, where immigrants

make up about 33% of the population. The extent of immigration contributes to a complex pattern of integration, education, religion, employment, and equality [12].

The largest groups of immigrants come from Poland, Lithuania, Sweden, Somalia, Pakistan, and Iraq [12]. Somalis comprise the largest non-Western immigrant group in Norway. In 2014, there were about 36,000 Somali immigrants living in Norway [13], which represents a large increase from the 22,000 Somalis living in Norway at the beginning of 2008 [14]. The first Somalis came to Norway in the 1970s [15]. The civil war in Somalia broke out in 1991, and the number of asylum seekers increased significantly thereafter. Almost all Somalis are Muslims, but the significance of religion in their society varies between individuals and different communities.

Another important political–organizational system is the clan system. There are no religious differences between the clans [16]. Both women and men belong to a particular clan from birth to death, and one has both rights and duties in relation to the clan. For newly arrived refugees, clans provide an important opportunity for developing networks and obtaining information [17]. According to the Norwegian Ministry of Labour and Social Inclusion [18], most Somalis seeking asylum in Norway before 1991 belonged to the Issaq clan, which is the dominant clan family in northwest Somalia. From 1991 until about 2000, most asylum seekers stated that they belonged to the Hawiye clan from the southern parts of Somalia. Clan affiliation seems to have less impact with increasing time spent living in Norway.

Most Somalis have come to Norway as refugees, and have had a relatively short period of residence in Norway; most have come since 1998 with a record year of intake in 2002. Forty-four percent of Somali immigrants in Norway live in Oslo. Many of the Somalis are in secondary education, which reflects the collapse of the education system in Somalia in 1991 [17]. The Somali immigrant population in Norway is very young. In 2006, 83% of first-generation immigrants were younger than 40 years, and 30% were younger than 20 years. Of their descendants, 86% were younger than 10 years at the time [15]. Somali women in Norway give birth to more children than the average among Norwegian women. In 2004, the average number of children among first-generation immigrant women with a Somali background was 3.7. There are many single parents, especially single mothers, with 29% of all Somalis in Norway living in a one-parent household [17].

Norwegian public health services cover all pregnant women and families with children [19]. The prevention of ill health is a key principle of the new Public Health Act [20]. The national goal to provide inhabitants with good opportunities for quality of life and coping skills requires a greater emphasis on early prevention. Municipalities are responsible for managing the services within Norwegian laws and regulations. Child health professionals offer routine child health examinations free of charge at a universal level, including detection of a range of environmental and family issues that influence children's safety and health. The goal of preventive childcare is to foster an optimal trajectory for growth and development in children and to provide guidance to parents and communities [19]. All

Norwegian municipalities are required to provide health services in maternity care, well-child clinics (WCCs) for the 0-5-year-old population, school health services, and youth health centers. Publicly organized services are offered to pregnant women and to all parents with children and adolescents aged 0-20 years. The service keeps a record of physical, mental, and social health status, and other matters of concern for children's health and welfare [19]. Public health nurses (PHNs) play a central role in this service and are the health care workers who meet with families most frequently [21]. For a woman who does not speak or read Norwegian, the information provided must be sufficient for a woman to participate and make choices about her own and her child's health. Information is tailored to each woman according to her age, maturity, experience, and cultural and linguistic background. Health professionals are obliged to use an interpreter if there are language barriers [22].

Studies have focused on Somali immigrant women in the USA [23-30] and in the UK [31-33]. The Nordic countries Finland and Sweden have similar health care systems to Norway. Two studies from Finland explored health care providers' experience in meeting Somali women's needs and Somali-born immigrant women's experiences with maternity care services [34,35]. One Swedish study described Somali women's use of maternity health services and the outcomes of their pregnancies [36]. A few Norwegian studies have focused on Somali immigrant women during the perinatal period: one study focused on women undergoing caesarean delivery [37], another on perinatal complications [38], and another on perinatal care experience to explore how perinatal care practice may influence labor outcomes among circumcised women [39]. However, no studies have explored the experiences of Somali new mothers during the postpartum period even though this is the largest non-Western immigrant group in Norway. Immigrant women's experiences in the postpartum period may help broaden the understanding of the type of support women need and may help inform the practice of health care professionals.

The objective of this study was to explore Somali new mothers' experiences with the Norwegian health care system and the mothers' experienced needs during their hospital stay and the postpartum period.

Methods

A qualitative design with individual interviews was chosen. This form seeks to understand more than explain individual experiences [40]. A semistructured interview guide was developed. The guide was open and contained follow-up questions that allowed the interviewer to explore the material in greater depth [41].

Data collection

The interviews were conducted between January 2014 and August 2015. The mothers were recruited by PHNs from two WCCs located in urban districts in Norway. The inclusion criteria were first-generation Somali immigrant women not

born in Norway who had delivered a healthy child 6 weeks to 18 months before the interview, were aged 18-40 years, had a normal or caesarean delivery, were married, unmarried, or divorced, and were living in Oslo or its suburbs.

The first author conducted all the interviews, and the second author participated in three of them. The interviews were audiotaped and lasted 24-48 minutes. The interview took place at the WCC where the woman was seen regularly. The sample size was assessed on the basis that saturation can be achieved when there seems to be no new information [42]. In this study, we interviewed 10 women.

Data analysis

Soundtracks and transcriptions were available to both authors. Graneheim and Lundman's [41] method for analysis was used to identify similarities and differences in the text. Because the purpose of this study was to understand and describe the informants' perspectives, this method was considered to be appropriate. The transcribed text was first read several times to obtain a sense of the whole. Meaningful units were extracted from the text material, condensed, and coded. Codes with similar content were assembled into subcategories and categories. The transcript was then read through to ensure that no codes had been ignored [42].

Ethical considerations

The study was assessed by the Regional Committees for Medical and Health Research Ethics (reference number

2013/1056), and the study was reported to the Data Protection Official for Research, Norwegian Social Science Data Services (reference number 35055). The participants received written information about the study, and the information letter was translated into Somali to ensure that the women were well informed. The women gave written consent to participate. They were told that the study was voluntary and that they could withdraw from the study at any time and without giving a reason. The data were treated as confidential. During the interviews, in recognition of the cultural differences, we consciously tried to show respect.

Results

The women were aged 25-34 years (Table 1). They had lived in Norway 4-16 years and had 1-4 children. The children were aged 2 months to 7 years, and there were 25 children in total between all 10 women. All children but one was born in Norway, and that child was born in Somalia. All except one of the women were married, but she was going to marry when her children's father had finished his education. Five of the 10 women had been in another country before they came to Norway. Five of the women were working; three had permanent employment, and two were working as interns in a kindergarten. Seven of the women had family members other than their husband living in Norway.

Table 1 Participants in the study.

Participant number	Age	Years lived in Norway	Lived in another country before Norway	Number of children	Number of children born in Norway	Age of the youngest child (months)	Married	Working or studying	Other family members living in Norway
1	28	11	No	3	3	1	Yes	Working	Yes
2	29	12	No	4	4	8	Yes	No	No
3	30	8	Yes	2	2	4	Yes	Working	No
4	27	14	No	2	2	11	No	No	Yes
5	25	12	Yes	1	1	10	Yes	Working	Yes
6	25	6	Yes	2	2	9	Yes	No	Yes
7	34	6	Yes	4	3	5	Yes	No	Yes
8	34	16	No	2	2	17	Yes	Working	Yes
9	25	12	Yes	2	2	12	Yes	Working	Yes
10	27	4	No	3	3	2	Yes	No	No

Analyses of the material from the 10 interviews identified cultural differences between Somalia and Norway, and the significance these differences had for the women during pregnancy and childbirth. Four main categories were central in the women's stories: (1) inadequate integration into Norwegian society; (2) need for and fear of a caesarean

delivery; (3) family support around the postpartum period; and (4) support from health services. Each of these categories and the results are presented below with quotations from the women.

Inadequate integration into Norwegian society

Language barrier: Although many of the women had been in Norway for a number of years, their command of the Norwegian language was limited. One woman noted that she spent most of her time at home with her children and had little or no social contact with people who speak Norwegian. Some argued that it was difficult to become acquainted with Norwegian women. Cohesion between Somalis, both family and friends, was considered positively but there were few opportunities to talk with Norwegians and share in the Norwegian way of life. Some of the women were invited to maternity groups, but declined. Several said they did not feel this was needed because they had enough family and friends around them; however, surrounding themselves only with family and friends from Somalia did not help them learn the Norwegian language. One of the informants attributed her desire not to participate in a maternity group directly to the language barrier:

“One does not know how to behave when with others. Maybe if I go there and so I am (full of) dread... I do not know how (proficient) my Norwegian language is if I speak with Norwegian women, and I do not know what will happen. I’m a little unsure.”

The interviews showed that language difficulties meant that many of the women did not receive the necessary information relating to childbirth and the postpartum period. This led the women to feel that they did not get the help they needed during labor. One of the women had worked as an interpreter, and she expressed very strongly the need for these women to understand the Norwegian language to be able to understand what was happening around birth and to communicate with their children as they learned Norwegian in kindergarten and school:

“They didn’t understand anything when midwives told them that we should do this and that. They understood nothing. I think it is important to learn the Norwegian language before you get married! Yes, I recommend those who give birth or women who are from another country that they must learn the language.”

Problems in educational and work environments: All of the women expressed the desire to obtain work. Several had not completed high school and some had completed high school but needed to enroll in further study to obtain work. It was difficult to find a job. They wrote applications, but heard nothing back. Those who were unemployed lost out on the opportunity to learn the Norwegian language through work. One said: “it’s difficult to find a job when one is from abroad”. Those who had an education experienced this differently.

Need for and fear of caesarean delivery

Despite not being mentioned as a topic by the researchers, the women expressed their strong resistance to having a caesarean delivery. All women except two had given birth to at least one of their babies by caesarean delivery. They had argued strongly about their desire to give birth vaginally, but

they had been advised to have a caesarean for their baby’s safety. They meant that caesarean delivery far too quickly was introduced in relation to birth in Norway. Some of these women had been circumcised before they came to Norway. One of the informants talked very openly about this. Before she was married, she made an appointment “to get opened up.” She went on: “it’s difficult with childbirth and normal sexual intercourse also when you are circumcised.” One woman said that she was not circumcised in Somalia and explained that this was because of education. She said: “if you have education, for instance, my father had been given a college education by his father”. They noted that, in Somalia, no one wanted to have a caesarean delivery, which was perceived as something negative because of the risk to the mother and baby:

“No, because they do not survive, the women who give birth by caesarean delivery in Somalia. You are not okay when having surgery. I’ve heard from a lady who had given birth here in Norway that the doctors are good because they’ve studied. It’s not like that in Somalia, the doctors there are bad. If I have a caesarean delivery in Somalia, I do not know if it will work well.”

Fears about a caesarean delivery seemed to be deeply rooted in these women. They believed that giving vaginal birth was a natural and positive experience, and that they recovered sooner after a vaginal delivery.

Family support around the postpartum period

The interviews revealed large cultural differences between Somalia and Norway in terms of attitudes to birth and the postpartum period. In Norway, the focus is largely directed toward the child; in Somalia, it is aimed more at the mother. The women in Somalia do not work, and they remain at home where they take care of family and neighbours. According to the informants, they are very intent on helping one another, even financially if needed. After delivery, many family members offer support and advice, and after birth, women are supposed to rest and eat a healthy high-energy diet for up to 40 days after birth:

“You’ve done a huge work [refers to birth]. In Somalia... for 1 month, the woman does nothing, you only breastfeed the baby and there are others who take care of the child and care for the mom; you just rest for a month.”

Some participants implied that the Norwegian way had its advantages:

“In Somalia, when you give birth, you have to be in the house for 40 days. But here it is very different. I think that is good, because you get out and get some fresh air. I think the body needs to move too.”

Several of the women had family around them also in Norway and they described the help and support they received from family and friends as very important. The family and friends helped with cooking and cleaning, and gave them a respite by taking care of the new baby and any other children. Importantly, family and friends offered guidance and

assistance about being a new mother and taking responsibility for the baby.

Not all of the women had family members in Norway. Some described the loneliness they felt in the new situation of being pregnant and giving birth for the first time. One of the women, who had only her husband, felt isolated in the beginning after being discharged from hospital:

"It was a little... quite lonely... sometimes when my husband was at work... then I think more... but the situation became better with time."

Some of the women were young and had to interrupt their high school studies. In addition, they did not speak the Norwegian language fluently:

"I was in my last year of high school, but sometimes when you're angry when you have pain and you cannot speak any other language, it is better to speak the same language."

Some also highlighted the cultural differences in terms of a new mother's diet. In Somalia, new mothers are encouraged to eat fatty foods and to drink tea with milk to facilitate breastfeeding. In Norway, there was no specific emphasis on diet for postpartum women. Other cultural differences were also mentioned such as the importance of praying to God every day and teaching this to one's children. The women also noted that they have many children because they love children and they considered it an honor to have several children:

"In Somalia, everyone loves, loves children very much. Some say you have to give birth every year. It's nice to have many children, but in Norway it is very difficult to have many children."

Support from health services

Before and during labor: Several of the women seemed unprepared for the birth; they felt that they received little or no information about how to prepare for the birth and they received very little support. This was particularly evident in relation to the first childbirth, but also for subsequent births. One woman said that when she was pregnant with her third child, she had asked for help, but the midwife said:

"You are going to give birth to your third child. You do not need help, you can manage alone."

All participants were concerned about their birth experiences. All of the women were discharged from hospital after 2-4 days. They had diverse experiences during their stay at the hospital. Many women described the delivery and stay in the maternity ward as traumatic. They did not feel that they were seen and taken seriously. Many described that they were tired after the delivery, but even if they asked for help and support, no one responded. One Somali woman said:

"At the maternity ward, they said I had to get up and take care of the baby myself and find my food and freshen up, but I just wanted to lie in my bed. I had done a big job, I had given birth to a baby and I needed rest."

In contrast, others noted that they had received good help during childbirth and useful guidance after birth about how to breastfeed and take care of their child:

"I got a lot of information at the hospital. And the first time they helped me (learn) how to breastfeed the baby and how to shower him and so on in the hospital. I had three days there."

Several of the women felt that they also perceived negative attitudes from health workers because they gave birth to so many children:

"It's me who decides, and if I want to have 10 children so it's not your problem. Women in Somalia give birth to many children."

After birth: All mothers had a positive experience with the WCCs and especially the PHNs after discharge from hospital. Most of the women had home visits by a PHN and were very happy with these. It was especially important for the first childbirth, but several had been offered a home visit at subsequent births, although they declined the home visit and instead went to the WCC and met the PHN there. Home visits by the PHNs gave the mothers confidence and confirmation that what they were doing was good. The meeting with the PHNs was described predominantly as positive. Several informants said that the PHNs were available, they felt they could call a PHN when they had questions, and received satisfactory answers. The PHN was described as a kind, good person:

"She's very direct and she explains everything we don't understand. You should do this and this and that. And you know, I feel in a way that she is my sister. I feel like I've known her for many years."

They described the content of the help they received from the PHN as related to information and practical assistance about breastfeeding and nutrition, accident prevention, psychological support, and encouragement for being a mother. Several of the women said that they were grateful for the free health care in Norway. Many noted the differences between health care in Norway and Somalia, and the benefit that that it was free for all in Norway. In Somalia, good health care is expensive and difficult for most people to access.

Discussion

In this study, we interviewed 10 Somali women living in Norway who had recently given birth. Cultural differences and the significance of these differences for these women during pregnancy and childbirth emerged as central themes from the interviews. The key findings are discussed and the strengths and limitations of the study are addressed here.

Although the women had lived in Norway for a number of years, they still struggled with the Norwegian language. This is a barrier to integrating into Norwegian society and to finding appropriate information and support. A recent systematic review identified and analyzed studies of immigrant women's perspectives on prenatal and postpartum health care and found that the language barrier is a main negative factor that

interferes in the communication between women and health professionals [43]. Another study that estimated the effects of language proficiency on the economic and social integration of immigrants in Australia found health benefits for women and several social outcomes [44]. This underscores the importance of supporting women in learning the language as soon as possible when they arrive in Norway. The women in our study had little contact with Norwegians. Good language skills will likely help the women to become integrated and to increase the chances of finding paid work and participating in activities such as maternity groups, which in turn promotes the development of networks [45-47].

All but two of the women in this study had a caesarean delivery for at least one of their children. They commented that this option was decided all too quickly in Norway and that they had wanted to give birth "naturally." In a study involving 34 Somali immigrant women, Brown et al. [48] found that a common fear of caesarean delivery stemmed from their fear of death and resistance to obstetrical interventions in general. The women in the current study also were afraid of complications arising during a caesarean delivery and were afraid to die. They said death during caesarean delivery was common in Somalia, as has been reported elsewhere [48]. The 10 women believed that doctors in Norway decided too quickly to use a caesarean delivery and that they could have had a vaginal delivery if they had been allowed to wait. According to Tollånes [49], there has been an increase in the rate of caesarean delivery in most parts of the developed world in the past decades, which is explained by both medical and nonmedical factors. In Norway, the percentage has increased from 1.8% of all births in 1967 to 16.4% in 2006. However, the rate of caesarean delivery in Norway is moderate compared with other countries such as the USA and UK [49]. In Norway, caesarean delivery is safe even if there are more complications than with vaginal delivery [49]. The need for a caesarean delivery is assessed by the obstetrician and is based on clear medical indications, so the women's perception that a caesarean delivery was offered too quickly is probably based on their fear of this procedure, as noted in other studies [31,48]. The fear of caesarean delivery is understandable for these Somali women given the lack of medical care for pregnant women in Somalia, which contributes to high maternal mortality [48].

Some of the women in the current study had been circumcised before they came to Norway. According to Vangen et al. [38], most Somali women in Norway have undergone circumcision. Such knowledge may affect the obstetrician's decision about the need for a caesarean delivery, but the women in the current study felt that they were not informed or had not understood the information they received about the reason for the choice of delivery method. Vangen et al. [39] found that Norwegian health care professionals did not recognize circumcision as an important delivery issue and the topic was not discussed with Somali women during pregnancy, which may have contributed to the fear of the delivery process, in particular caesarean delivery, reported by the Somali women in this study. The health care professionals also believed that this lack of communication led to unnecessary

caesarean sections [39]. A US study that explored Somali immigrant women's health care experiences found that they felt they lacked control over and familiarity with delivery options [50]. The authors suggested that prenatal education sessions are needed to address immigrant women's needs. There seems to be a similar need for information for pregnant immigrant women in Norway. Health authorities should consider this need seriously, and health care workers should ensure that this information is given to pregnant immigrant women in a way that they can understand and, if necessary, use an interpreter.

The participants in the current study were concerned about their birth experiences and described the delivery and stay in the maternity ward as difficult. They felt they were not heard or did not receive the help they wanted. Straus et al. [32] found that Somali women in the UK felt that midwives had negative and stereotyped attitudes toward them. Other studies also have found that Somali immigrant women feel vulnerable, uninformed, and misunderstood during the perinatal period and that health care providers have an important role in considering the women's culture-based expectations [51]. The women in the current study expressed the need to rest during the postpartum period and to consume energy-rich food; however, they felt that these needs were not supported by health care workers. Straus et al. [32] emphasized that, in addressing potential communication barriers, it was important to recognize the Somali oral tradition. Health care workers' lack of cultural sensitivity can lead to women becoming reluctant to seek help [43]. Herrel et al. [27] found that refugee Somali women wanted more information about what happens at the hospital stay and their preference was to obtain this information by videotape, audiotape, printed materials, and birth center tours. In a Finnish study, health care workers described difficulties with cultural traditions and religious beliefs when working with Somali women [34]. Wissink et al. [25] described the need for qualified interpreters and cultural competency training for health care workers in the USA. Health care workers' cultural sensitivity and knowledge are necessary for meeting Somali women's needs during the hospital stay, and negative attitudes about the number of children these women have should be discussed. The results from the current study indicate that educational programs for health care workers should be implemented in Norway.

However, all women in the current study felt that they received good support from the WCC and the PHN after their discharge from hospital. They felt supported and that they could contact the PHN any time when needed. They received information about accident prevention, breastfeeding, and introducing solid food to their infant. Degni et al. [35] also found that Somali immigrant women in Finland experienced quality care from maternity health care services. The health care services in the Nordic countries have many similarities and are universal, which may be one reason for the different experiences of Somali mothers in the USA, where women have reported unmet needs [26]. The frequency of informational support received from social services is important [52]. The health care services for women after birth in Norway are

frequent and supportive. The findings of our study support this conclusion but also suggest that the use of interpreters may help improve the Somali women's communication skills.

The women in the current study had help and support from family and friends after their discharge from hospital. These family members and friends helped with everything and ensured that the mother was able to rest. Among immigrant women, the best predictors of happiness are emotional support from the family and instrumental support from the local population and associations [52]. However, those who did not have any family in Norway felt lonely and isolated. These women should be identified by health care providers and be offered help to connect with other mothers because participation in a maternity group can help immigrant women to develop language skills and to create a social network [45-47].

Strengths and Limitations

The interviews provided rich data material. Despite the small sample size, this study obtained information that should be interesting to health personnel working with Somali women, especially because there has been little research in Norway about immigrant women's experiences in perinatal care.

It was difficult to recruit women for the study, partly because the PHNs were so busy and often forgot to ask the women who met the inclusion criteria. Most of the women who were asked agreed to participate in the study. Four women who did not want to participate refused because of a lack of time or because they did not want to be interviewed. Three women who had agreed to participate were not included in the study: one because of a lack of time, one did not answer the phone when the researcher called her, and one because her husband answered the phone and said that she did not want to participate in the study.

The language barrier was a limitation. Aside from one interview conducted in English, all others were in Norwegian. Most of the women had problems understanding and expressing themselves in Norwegian even if they had lived here for some time. It is possible that we would have obtained more detailed and correct information had we used an interpreter. On the other hand, that may have raised other problems. The positive aspect of the interviews was that they provided the opportunity for the women and researchers to meet and talk directly without any intermediary. There are large differences between the cultures of Norway and Somalia, and the Somali population typically does not have a high status in Norway. The fact that the researchers were Norwegian health personnel may have made the women reticent to talk about any negative experiences related to cultural differences and possible racial discrimination.

Conclusions

Language skills are essential to the integration of immigrants into society. In this study, we found that, even

though the women had lived in Norway for a number of years, their language skills were poor and they were poorly integrated into Norwegian society. The use of an interpreter is necessary when language skills are poor, especially to inform women about the birth and hospital stay. PHNs play an important role in providing support to immigrant mothers. The women had good experiences with PHNs and these professionals are in a good position to develop good relationships with these mothers. To help integrate immigrant women, they should be encouraged to learn the language and WCCs should offer immigrant mothers the opportunity to participate in maternity groups to strengthen their social relationships and their integration. The findings of this study may help broaden our understanding of the types of support immigrant women need during their hospital stay and the postpartum period, and will help inform the practice of health care for new mothers.

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