

# Injured in Child Birth and Doubly Vulnerable:

## *Experiences of Obstetric Anal Sphincter Injuries (OASIS) among women whose mother tongue is not Norwegian*

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If you talk to a man in a language he understands,  
that goes to his head. If you talk to him in his  
language, that goes to his heart.

- Nelson Mandela

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IV

# Abstract

**Background:** Obstetric Anal Sphincter Injuries (OASIS) are injuries to the perineum sustained during childbirth. It occurs in 1,8% of all births in Norway, with great institutional variations. Symptoms of OASIS include anal incontinence, dyspareunia and pain. The emotional consequences can lead to isolation and an altered sense of self. Interactions with caretakers largely influence how women cope with and perceive their injury. Immigrant women are deemed a vulnerable patient group. However, none of the previous studies on women's experiences of living with OASIS have included women who are non-native speakers. This study attempts to contribute to covering this research gap.

**Aim:** The thesis aimed to find out how women whose mother tongue is not Norwegian experience sustaining and living with OASIS. The objectives were to inquire into how these women perceive and cope with OASIS, and further go on to identify factors contributing to and influencing their understanding of OASIS. Lastly it wanted to explore views on care and communication in the health services from the perspective of these women.

**Methods:** Qualitative methods with a phenomenological perspective was used, and the findings are based on the analysis of seven in-depth interviews with five women. The women were recruited from a mother and child public health care center, social media or the researchers' network, and all lived in Oslo. Theories of embodiment, coping, identity and communication have influenced the findings and discussion of this thesis.

**Findings:** Through the themes "coming to terms with the injury", "reshaping their identity" and "interaction with health personnel" the findings confirm that women struggle in the postpartum period to come to terms and cope with their injury due to physical and emotional consequences of the OASI. These consequences are challenging, especially as new mothers, and could mean having to redefine their identity as someone injured. The struggle to come to terms with the injury was influenced positively or negatively by perceived helpful or dismissive caretakers. Language is identified as a barrier to receiving information, get emotional support and access to appropriate care for these women.

**Conclusion:** Women whose mother tongue is not Norwegian is doubly vulnerable to the effects of the OASI; both through the possibly isolating effects of the symptoms, but also due to their inability to reach appropriate information and emotional care in the health services.

# Acknowledgements

My biggest thank you goes out to all mothers who so openly shared their stories with me. I remember leaving your homes with a sense of awe – your courage and your smiles through this experience are truly inspirational. Thank you for agreeing to be a part of this study. I wish you all the best.

The quote by Nelson Mandela on p. II was sent to me by one of the participants, as she felt it illustrated her experiences. Thank you for agreeing to let me use your favorite quote.

I would also like to send my thoughts to all the mothers I have come in contact with who did not fit the inclusion criteria and who continue to live with their untold stories. You are not alone. Let your voices be heard!

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# Abbreviations

EAS: External Anal Sphincter

IAS: Internal Anal Sphincter

GP: General Practitioner

OASI: Obstetric Anal Sphincter Injury (singular)

OASIS: Obstetric Anal Sphincter Injuries (plural)

PFMT: Pelvic Floor Muscle Training

WHO: World Health Organization

# Glossary:

**Barselavdeling:** a Norwegian word for the maternity ward at the hospital

**Doula:** a non-medical birth-companion assisting a woman before, during or after birth both emotionally and/or for practical help.

**Helsestasjon:** a Norwegian word for the Mother and Child Public Health Care Clinic, a public service offering maternity and child health care services.

**Immigrant:** The term “immigrant” encompass many different individuals. In this thesis, following the definition of Statistics Norway, it is defined as a collective name for people with foreign citizenships residing in Norway, immigrants with Norwegian citizenship, or Norwegian citizens born in Norway with immigrant parents (1).

**Mother tongue:** the language which a person has grown up speaking from early childhood.

**Obstetric Anal Sphincter Injury:** an injury sustained to the perineal area of the woman during birth. In literature, many terms are used for this injury, such as: obstetric/perineal (and/or) tear/rupture/laceration/trauma.

**Tolkesentralen:** An interpreter-service provider, servicing the Oslo University Hospitals.



# Table of contents

- 1 Introduction ..... 1
  - 1.1 Structure of the thesis ..... 1
  - 1.2 Thematic Introduction ..... 2
  - 1.3 Rationale for the study..... 5
  - 1.4 Research Question and Objectives ..... 6
- 2 Background and Literature Review..... 7
  - 2.1 Understanding OASIS ..... 7
    - 2.1.1 An OASI is an injury to the pelvic floor and the perineum ..... 7
    - 2.1.2 Classification and diagnosis of OASIS ..... 9
    - 2.1.3 Incidence and prevention of OASIS..... 10
    - 2.1.4 Management and treatment of OASIS ..... 11
    - 2.1.5 Possible postpartum problems after OASIS..... 14
    - 2.1.6 Risk factors for OASIS ..... 14
  - 2.2 Living with OASIS..... 17
    - 2.2.1 A changed every-day life ..... 18
    - 2.2.2 Experiencing isolation..... 18
    - 2.2.3 Sexuality and future pregnancies ..... 19
    - 2.2.4 Interaction with health care professionals..... 20
    - 2.2.5 OASIS from the viewpoint of midwives..... 22
  - 2.3 Immigrant women’s needs and expectations of maternity care ..... 24
    - 2.3.1 Immigrant women want the same from their maternity care as native women . 24
    - 2.3.2 Communication is a key challenge to attain proper health care..... 24
    - 2.3.3 Level of care needed and possible prejudice interferes with health care ..... 26
    - 2.3.4 Meeting the needs of immigrant women..... 27
  - 2.4 Conceptual Framework..... 28
- 3 Methodology ..... 31
  - 3.1 Research design ..... 31
    - 3.1.1 A phenomenological perspective ..... 31
    - 3.1.2 Triangulation ..... 32
    - 3.1.3 Reflections on reflexivity and role ..... 33
  - 3.2 Study site, access and sampling..... 35

3.2.1	Gaining access and recruitment.....	36
3.2.2	Reflections on sampling and the final sample.....	37
3.3	Data collection and analysis .....	38
3.3.1	Carrying out the interviews .....	38
3.3.2	Applying systematic text condensation for analysis .....	42
3.4	Trustworthiness .....	44
3.4.1	Reflections on credibility, transferability and language.....	44
3.4.2	Dependability and confirmability.....	45
3.5	Ethical considerations.....	46
3.6	Strengths and limitations of the study .....	47
4	Findings.....	49
4.1	Introduction to the women.....	49
4.2	Themes and Subthemes .....	50
4.3	Coming to terms with the injury.....	50
4.3.1	The birth: unexpected turn of events.....	50
4.3.2	The OASI: more serious than they thought.....	52
4.3.3	Managing the consequences of OASIS .....	54
4.3.4	Dealing with stressful experiences .....	55
4.4	Reshaping their identity.....	57
4.4.1	Uncertain prognosis.....	57
4.4.2	Worrying about a possible next birth and being intimate .....	58
4.4.3	Body image and doing exercises .....	60
4.4.4	Being in a new country.....	61
4.5	Care and caring in the health services .....	63
4.5.1	Feeling cared for during birth and surgery.....	63
4.5.2	Seeking care after discharge.....	66
4.5.3	Role of Language .....	68
5	Discussion .....	73
5.1	Care and communication in the health services .....	73
5.2	Embodiment and coping.....	79
5.3	Reshaping their identity – intrinsic to coping and embodiment.....	84
6	Methodological Considerations.....	89
7	Conclusion.....	94

8	References .....	97
	Appendix A: REC Exemption .....	104
	Appendix B: NSD receipt .....	105
	Appendix C: Informed Consent .....	106
	Appendix D: Interview guide .....	109
	Appendix E: Facebook invitation.....	111
	Appendix F: NSD confirmation of delay .....	112

	Figure 1: Left: The superficial muscle structures. Right: Muscles of the pelvic diaphragm. The figure is reproduced with permission from Kari C. Toverud MS CMI Certified Medical Illustrator www.karitoverud.com .....	8
	Table 1.....	9
	Figure 2: Degrees of perineal injury. ....	9
	The figure is reproduced with permission from Kari C.Toverud MS CMI Certified Medical Illustrator www.karitoverud.com .....	9



# 1 Introduction

## 1.1 Structure of the thesis

Within this first chapter, an introduction to the study, the rationale for the study and description of the research questions lay the foundation for what is to come.

The thesis follows with a second chapter, devoted to describing the background and literature review relevant for the study. It attempts to shed light on what an OASI entail and how women with an OASI are cared for within the Norwegian health care system. Available knowledge on how women experience living with an OASIS will be presented, showing how OASIS are affecting women's lives. Immigrant women's experiences with maternity care will be presented. Finally, a presentation of the conceptual framework for the study will provide a frame for the further discussion.

Following the background is a third chapter with description of how qualitative methodology with a phenomenological perspective shaped and guided the data collection and analysis of the study.

In the fourth chapter, the research findings of how women with a mother tongue that is not Norwegian experience sustaining and living with an OASIS are presented through analysis of seven in-depth interviews with five women. It shows there are factors pertaining to language and being from a non-Norwegian background impacting on their experience and understanding of the injury.

Methodological considerations are presented in the fifth chapter.

These factors and experiences are further discussed in the sixth chapter, where theories of embodiment and coping, identity and communication are juxtaposed with the women's experiences and illustrate the effect of this injury on their lives.

In the final and seventh chapter, the thesis concludes on the findings of the previous chapters and give some suggestions for the future.

## 1.2 Thematic Introduction

Immigrants in Norway constitute 14 % of the population, and the largest group of immigrants and Norwegian-born children with immigrant parents come from Poland, Lithuania, Somalia, Sweden and Pakistan (1). There are large difference in duration of residency, varying from on average less than 5 years in Syrian and Eritrean immigrants, and up to and surpassing over 20 years in immigrants from Bosnia-Hercegovina, Pakistan and Vietnam (1).

The birth demography is changing. Women are giving birth at higher age and more people live in cities. The mean age of women giving birth was 29,2 years in 2017 (2). In 2016 in Norway, 58 900 children were born. Of these children 11 200, or 19%, had two immigrant parents (2). Approximately 27% - one in four - children born in Norway had a mother with an immigrant background. Most of the children born to two migrant parents, had parents from Asian countries, and almost as many had parents from Central and Eastern Europe (2). It is thus safe to say that immigrant women who give birth and become pregnant in Norway represent a diverse group.

Health equity is, according to the WHO, a concept that implies that everyone should have “a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential” (3). Immigrants giving birth in Norway are defined as a vulnerable patient group within health care, and a national strategy to ensure equity in health care aim to settle differences in care provision and outcomes (4). It has been shown that immigrant women within Norwegian maternity care have more unplanned caesarian sections (5), are more likely to see perinatal deaths (6, 7) and are more likely to suffer from depression in pregnancy (8). The reasons for this are thought to be due to barriers these women experience towards their maternity care. These barriers relate to the accessibility of ordinary antenatal check-ups, where the first contact with the mother and child public health care clinic or general practitioner (GP) is often postponed or deemed inaccessible. The delay in care-provision relates to difficulties for the immigrant women to access information about the services, understand terminology in information provided, attain effective communication with health professionals or it could be due to facing practical barriers such as transportation or funding issues (9-11). Despite this, regardless of migration status, immigrant women want the same and have the same needs of their care as native women. However, immigrant women

were less likely to have their needs met and were subsequently less positive towards their maternity care (12).

The Norwegian maternity care is professionally rooted in national guidelines published by the Norwegian Directory of Health (13, 14). These guidelines follow the intentions of White Paper 12 developed by the Norwegian parliament. Freely translated this white paper interprets as “A joyous occasion –a coherent pregnancy-, birth- and postnatal care” (15). The main vision for the maternity care as presented in the white paper is to create a care characterized by continuity: users should feel that the service provision is coherent and safe. According to the white paper, this presupposes services of high professional standards, a safe pregnancy- and birth experience and a family friendly postnatal care. The white paper brings to the surface the challenging situation faced by immigrant new mothers, and highlight that they are a vulnerable group that should be prioritized (15).

During the pregnancy, women have the opportunity to schedule visits with either the general practitioner or a midwife at the Maternity and Child Health Care Center, the “helsestasjon” in Norwegian. It is recommended in national guidelines that the woman have eight scheduled visits with a health professional during her pregnancy (16). Historically in Norway, almost all births took place at home in the late 1800’s, but by 1947 nearly all women gave birth at hospitals (17). Today, most babies in Norway are delivered at larger hospital facilities with a midwife as the primary birth attendant in uncomplicated deliveries (14).

The Norwegian postnatal care is a collaboration between regional health authorities and the municipal primary health care. The “National Clinical Guideline for Antenatal Care” was published by the Norwegian Directory of Health in 2014 and guides the organization of the services (13). The postnatal care comprise the time spent at the hospital after birth and the time spent in the home after discharge from the hospital. It includes all relevant hospital staff and municipal health personnel such as general practitioners, midwives, public health nurses, physiotherapists and other relevant staff.

In the 1950’s the normal time spent at the maternity ward was 14 days (17). On average, women today spend 1-3 days in the hospital before returning home (13). This is also seen for those who have complications during birth (14). It has been recognized that the shorter time spent in hospital has not been accommodated by a change in service provision or by an increase in competent staff in the municipalities (18). Having home-visits with a municipal

midwife within 1-2 days after returning home from hospital are established as an important tool to bridge the gap of early return to the home and subsequent presentation at the public health station (13). This service is regarded as advantageous, is not connected to adverse outcomes and was connected to higher user satisfaction (13, 19). Due to lack of financial- and human resources, a report by the organization “Ammehjelpen” found that only one in ten families live in a municipality where they can expect a visit from a midwife in the days following the birth (20). The conclusion of the report is that as of today, the postnatal care guidelines are not being followed and the service provision is not up to desired standard (20). In the municipality of Oslo, the Norwegian Association of Midwives are concerned for the well-being of mothers and describes a situation where the recommendations in the guideline are not a priority. They explain that due to a lack of human resources, women are not realistically given an option to see a midwife for her antenatal checkups and also are unlikely to meet a midwife at the post-natal home visit (21).

This discussion taps into an ongoing debate in the Norwegian political and professional climate, where a prospective decision to reduce the number of maternity beds to release women as early as 6 hours after birth have spurred a discussion on priorities for postnatal care in the future (22). According to different health-care actors, the decision to release women even earlier than they are today are a cause of concern for the health and well-being of mothers and babies, as the municipalities are not prepared and do not have enough resources to take on the increased work-load (23-25).

Women who sustain an OASIS have thus given birth in a system where they are possibly faced with a short stay in the post-natal ward at the hospital and risk insufficient service provision in the municipality they live in when returning home from the hospital. All women are offered a post-partum follow-up with their GP after six weeks, and hospitals offer controls after six months or a year (26). The practice varies between hospitals. The OASI has potential detrimental effects to women's health due to the possible symptoms of pain, dyspareunia and incontinence (27). The injury impacts greatly on women's lives, and women have described the effects of the tear as isolating, stigmatizing and impacting on how they view themselves and interact with others (28-30).

Knowing immigrant women are considered vulnerable within the current maternity care system, the question arise how they experience sustaining and living with an OASI. The possible barriers they face to access maternity care both ante-and postnatally might influence



how they experience their situation of living with OASIS. In addition, possible language barriers might interfere with the understanding of and their adherence to treatment for the symptoms of the injury. This question is especially relevant seeing as factors within the birthing room, such as interaction with the midwives or doctor, is considered important to prevent OASIS (31, 32).

## **1.3 Rationale for the study**

The rationale for this study is based on there being no previous literature exploring how women who are not native speakers experience sustaining and living an OASIS.

This study aim to understand more about the experiences of OASIS among women whose mother tongue is not Norwegian. The study will inquire into how these women cope with and perceive their injury. For women whose mother tongue is not Norwegian, information given about the injury and what is needed to recover might be confusing, which potentially exacerbates her vulnerability. The possibly confusing information might influence how a woman understands her injury, and this study will explore factors influencing the understanding of the injury when the woman is not a native speaker. For many immigrant women, the maternity and postnatal ward is the first meeting with the Norwegian specialist health care services, adding additional confusion as to how to navigate and understand the routines in the maternity ward and grasp important aspects of their postnatal care. The study is carried out in the Oslo region. There is a need to understand more about how women with an OASI whose mother tongue is not Norwegian understands the information she is given, and how the communication between health professionals and a patient whose mother tongue is not Norwegian influences recovery in order to improve current services and ultimately enhance treatment and rehabilitation outcomes.

## 1.4 Research Question and Objectives

The research question guiding this study is:

How do women whose mother tongue is not Norwegian experience living with an Obstetric Anal Sphincter Injury (OASI)?

The objectives of this study are to:

- Inquire into how women whose mother tongue is not Norwegian perceive and cope with an OASI
- Identify factors contributing to and influencing the understanding of OASIS in women whose mother tongue is not Norwegian
- Explore views on care and communication in the health services from the perspective of women whose mother tongue is not Norwegian following OASIS

## 2 Background and Literature Review

This chapter attempts to provide an understanding of what OASIS are, and show how OASIS affect women's lives in both the short- and long term. Further, it describes women's own experiences of living with OASIS based on previous qualitative studies. The last section before a presentation of the conceptual framework attempts to give insight into how immigrant patients are potentially vulnerable in the current maternity health care system and to the effects of OASIS on everyday life.

### 2.1 Understanding OASIS

#### 2.1.1 An OASI is an injury to the pelvic floor and the perineum

The pelvic floor is a complex structure of four layers that comprise an endopelvic fascia, the muscular pelvic diaphragm, the perineal membrane and a superficial layer of muscles called the superficial transverse perineal muscles (33). This definition and way of explaining the pelvic floor is chosen here because it resonates with important points drawn in Bø (34). She references Wall and DeLancey (35) in pointing out that historically, the pelvic floor has been poorly understood and professionally compartmentalized into three 'holes' - the urethra, the vagina and the rectum - each of which has its own doctor and own medical specialty. Instead of looking at the systems isolated, a unified and cross-disciplinary approach will contribute to progress in treating pelvic floor dysfunctions (35).

The endopelvic fascia sits on top of the pelvic diaphragm and is important for the passive support of visceral organs (33). The pelvic diaphragm is composed by a central group of muscles called the levator ani functioning as a supporting system for the vagina, uterus, ovaries, bladder and rectum. Another muscle called the puborectalis muscle, forms a sling surrounding the anal canal and is connected to the anal sphincter muscles. The external sphincter (EAS) is a muscle we control voluntarily to close and open the anal canal. The EAS is a part of the anal sphincter complex; a multilayered cylindrical structure that envelops the anal canal (33). In addition to the EAS it also consists of the internal anal sphincter muscle (IAS). The IAS is controlled by reflex, and it maintains the sphincter resting pressure (36). The anal mucosa lines the anal canal (33).

The levator ani and puborectalis muscle are shown in figure 1, left side. These muscles contract to help maintain urinary and fecal continence, but also relax in order to help with defecation and expulsion of urine(37). When jumping, sneezing or coughing, these muscles will help maintain intra-abdominal pressure by contracting to increase pelvic floor closure. The levator ani muscles are also central during childbirth – having to extend considerably to allow passage of the fetus’ head and then contract again postpartum to maintain all of its normal functions (37).

The function of the pelvic floor depends on different factors, such as an intact supply of nerves, injuries and strength of pelvic floor muscles and also hormonal changes (38). In the case of a rupture of these muscles, the high level of resting tone means that these muscles will retract more than muscles with less tone. They will not be able to spontaneously heal, and must therefore be sewn back together (36).

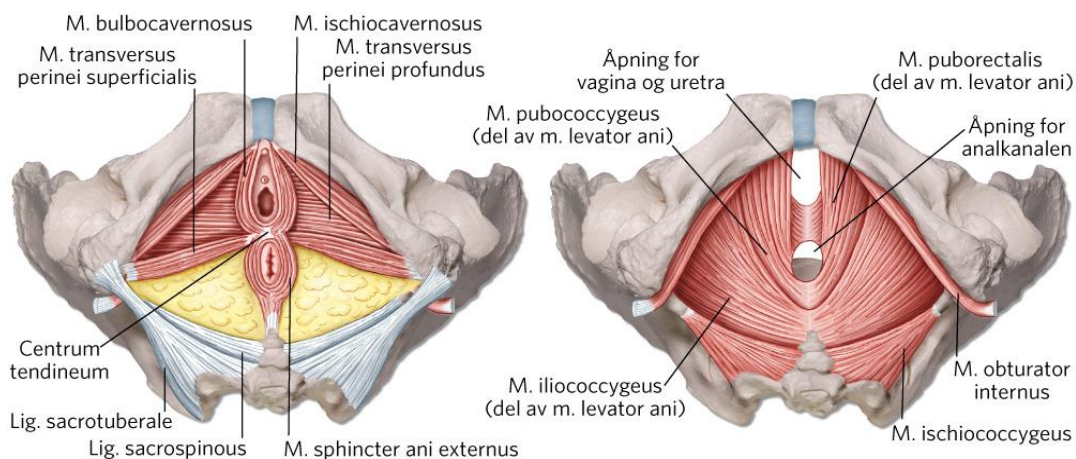


Figure 1: Left: The superficial muscle structures. Right: Muscles of the pelvic diaphragm. The figure is reproduced with permission from Kari C. Toverud MS CMI Certified Medical Illustrator [www.karitoverud.com](http://www.karitoverud.com)

The most superficial component of the pelvic floor is the external genital muscles, shown in figure 1, right side. These superficial perineal muscles have a supportive function and contributes to the closing of the vagina, and the latter two also play a role in sexual function (33). These muscles insert in what is called the perineal body. When defining what the *perineum* is, it is often referred to as the region of the perineal body and the overlying skin (33). In women, it comprises the pyramid shaped area between the vulva and the anus. Because of the many muscles and structures that join in the perineal body, this area is vulnerable in case of tearing during childbirth.

## 2.1.2 Classification and diagnosis of OASIS

An accurate classification is important because it is essential to correctly define the damaged anatomical structures to ensure proper management of the injury. Sultan proposed a system where description of anatomical structures is essential, shown in table 1(39). Setting a clinical diagnosis by inspection and palpation has a high detection rate and is described as the cornerstone of diagnosis (40). The first-degree tears are superficial, and involves injury to the perineal skin and/or vaginal mucosa. The second degree-tears are deeper, and involves injury to perineal muscles. According to national recommendations, these injuries should be sutured by a midwife or a doctor under local anesthesia (26).

Classification of perineal trauma	
Degree	Definition
<b>First-degree tear</b>	Injury to perineal skin and/or vaginal mucosa.
<b>Second-degree tear</b>	Injury to perineum involving perineal muscles but not involving the anal sphincter.
<b>Third-degree tear</b>	Injury to perineum involving the anal sphincter complex: <b>Grade 3a:</b> Less than 50% of external anal sphincter (EAS) thickness torn. <b>Grade 3b:</b> More than 50% of EAS thickness torn. <b>Grade 3c:</b> Both EAS and internal anal sphincter (IAS) torn.
<b>Fourth-degree tear</b>	Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

Table 1.

When the rupture extend to involve tearing of the anal sphincter complex – the IAS or EAS muscle and possibly the anal mucosa – it is classified as third- or fourth degree tears. The different degrees of tearing are illustrated in Figure 2. Together, the third-and fourth degree tears are referred to as Obstetric Anal Sphincter Injuries (OASIS). These are the injuries connected to the most adverse outcomes and are the injuries in focus for this study.

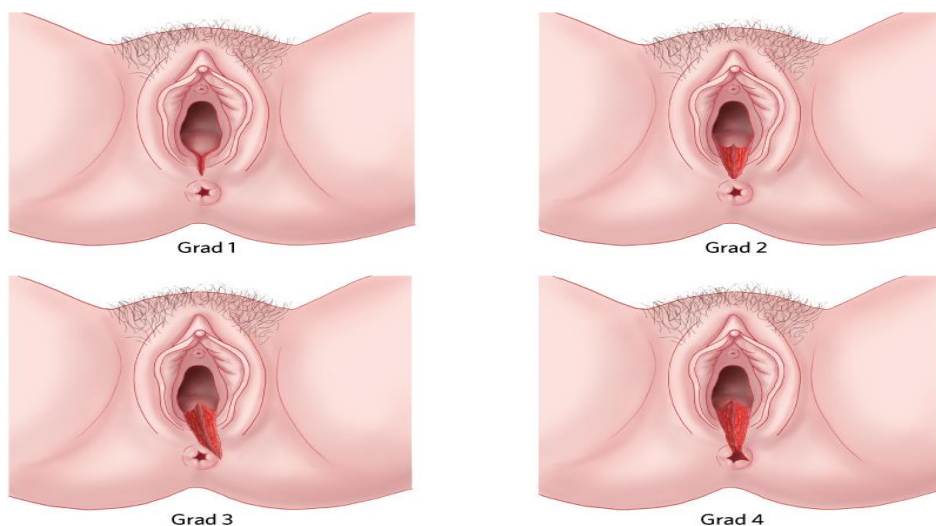


Figure 2: Degrees of perineal injury.

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### 2.1.3 Incidence and prevention of OASIS

It is recognized as common for women to sustain some kind of perineal damage during childbirth. It is frequently reported that globally, up to 85% of women sustain some degree of perineal tearing, and that 60-70% of these will need suturing (41, 42).<sup>1</sup> It is recognized that global rates are difficult to ascertain, and these numbers will vary significantly according to policies of institutions and practitioners throughout the world (27). The difficulty described include determining rates specifically for OASIS. A multi-country study including seven African, nine Asian and eight Latin-American countries found varying rates of OASIS from 0.1% to 15%. The conclusion of this study is that misdiagnosis, as well as over- and under-diagnosis in developing countries may be common (43).

The most recent numbers from 2016 in the Medical Birth Registry in Norway show the incidence of OASIS is at a national average of 1,8% (44). The incidence varies between institutions. A short introduction of how researchers and clinicians have made prevention of OASIS a priority in Norwegian obstetric care is needed to understand the background for the reported incidence.

In the decades leading up to 2004 there had been an increase in the incidence of OASIS, and a report from the Norwegian Board of Health stated that the incidence in 2004 of 4,2% was a sign of severe perineal ruptures occurring too often (45). As a follow-up of the report, a commission was established and a new action plan launched, focusing on education and training of health personnel, updated research and proper registration of cases (46). Laine et.al (47) explains how midwives management of the second stage of birth had in the 1980's gone from a "hands on" to a more "hands off" approach, and that the leading assumption up until 2004 was that women should give birth with as little interference and as natural as possible. The action plan recognized that in Finland, the incidence of OASIS had remained low and stable over many years and this was thought to be due to Finnish midwives' active role in applying manual perineal support – a "hands on" approach - during the second stage of labor (46).

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<sup>1</sup> When traced back, these numbers stem from two randomized control studies published in the UK in 1998 and 1984, respectively. No recent numbers have been found for worldwide or Norwegian prevalence of perineal tears.

A successful training program for doctors and midwives based at a hospital in Eastern Norway was expanded with the new action plan to prevent and reduce the occurrence of OASIS (46). The training program consisted of four steps; improving communication between the midwife and the delivering woman, midwives' applying manual perineal support— often called the Finnish intervention- to the perineum, a birthing position allowing the midwife to see the perineum and use of episiotomy only on indication (31). The results of the intervention showed a reduction in OASIS in the study period from 2004 – 2009; the incidence decreased from 4.16-5.25% to 1.73% during the last year of the intervention (31). The same training program was subsequently successful at other hospitals: Oslo University Hospital registered a reduction in incidence of OASIS from 4.0% to 1,9% after implementing the training program, a reduction attributed to manual perineal support (48).

Laine et.al (47) studied the difference in incidence of OASIS between the Nordic countries; Finland, Denmark, Sweden and Norway. This study found that Finland had notably lower incidence than the other countries, something the study expected. However, they found that of the other three countries only Norway saw a significant and constant reduction in incidence of OASIS (47). The changes occurred at the same time as the implementation of the mentioned training program for manual perineal protection. Further, within Norway, the units with a structured and documented perineal protection program had lower rates of OASIS than the mean Norwegian OASIS rates (47). Since then, the mentioned training program has been implemented at hospitals abroad, with a successful result in reducing the incidence of OASIS (49-51).

## **2.1.4 Management and treatment of OASIS**

The management of an OASIS described here is mainly sourced from the guidelines of the “Veileder i fødselshjelp”, a national handbook of birth management developed by the Norwegian Medical Association (26). This is seen as most relevant in the Norwegian setting.

### **Hospital management and treatment**

Within Oslo University Hospital, the practice of having two midwives present during the final stages of the birth has been presented as a strategy to ensure manual perineal support and prevent OASIS (52). If an OASIS occur, it is recommended that the repair is performed in the operation theater by a specialized doctor or surgeon, where lighting and equipment is optimal

(26). The operation is performed with anesthesia, either in regional- or general narcosis (26). After suturing, women are transferred to the maternity ward. Further management consist of adequate pain-relief, a two week regiment of the laxative lactulose and for women with fourth degree tears; a prophylactic antibiotic treatment (26).

The guideline does not mention specifically how or when the woman should be informed about the injury. It is suggested that women get all the information in written, and a template of the patient information is provided within the medical birth handbook (26). In this template, women are given information about what an OASI is and entails and what to do if they experience a worsening in pain or symptoms. They are given practical advice about hygiene, diet and exercise and are advised where and how to seek help if symptoms are worsened before the control checkup (26). Within the national guidelines for antenatal care, there are recommendations for the structure and the frequency of talks with new mothers (13). These guidelines explain that after a birth experienced as difficult, a formal de-briefing is not recommended, but instead a conversation about the events of the birth should be provided by the midwife or doctor that were present during the birth. A post-partum conversation is centered on the event of the birth and any concerns the mother might have, whereas other informational conversations about the post-natal period and preparing the new parents for arriving home are separate and can be given individually or in groups (13).

The care at the maternity ward for women with OASIS is other than the mentioned information and practical advice following the same standards as that of other women. The mother should at the maternity ward be able to rest and get to know her baby (53). Depending on how long she stayed in the delivery room, she is now urged by health staff to go to the bathroom, eat a nutritious meal, take a shower and get some movement (53). Breastfeeding is initiated and the mother is helped by nurses or trained health workers to facilitate this. If the baby is having trouble calming, staff can take care of the baby whilst the mother gets some sleep (53). The father is always welcome, but has to leave around ten in the evening, unless they are provided with a family room (54). Family is welcome during visiting hours, usually a few hours in the afternoon. If there is a wish to have additional visits they will have to be received outside the ward (54). The practice may be different throughout the country.



## **Post-natal checkups**

After discharge, a post-natal checkup with a general practitioner approximately 4-6 weeks after birth is standard for all women after having given birth in Norway, and this is the same for women with an OASI (13). It is recommended in the guidelines that women are called back to the hospital for a control after 6-12 months, with some variation between hospitals. In this consultation, symptoms are screened using St. Mark's score, a validated scoring system to determine the severity of anal incontinence. The anal sphincter muscle is visualized with ultrasound to determine the mobility of the perineal body and the function of the involved muscles. Advice concerning the next birth is given. In case of any symptoms, such as anal incontinence, the woman is referred to further specialized treatment (26). This specialized treatment is not described within this thesis as it is beyond the scope of the project.

## **Physiotherapy**

A referral to treatment with physiotherapy after OASIS is recommended in the national handbook for management of perineal rupture to "improve chances of continence" (26). For the hospitals included in this study, all provide list of therapists to contact, but not all give physiotherapy in the maternity ward. The decision of why some hospitals do not offer physiotherapy and some do have not been found in the literature search.

There are few studies on physiotherapy and its direct effect on perineal injuries. A systematic review of available literature published in 2017 attempted to evaluate level of evidence for physiotherapy treatment and also provide treatment recommendations (55). They included 8 studies in the review, and the studies represented various physiotherapy treatment practices such as pelvic floor muscle training (PFMT), biofeedback and electrical stimulation. Electrical stimulation through an external skin electrode or via an anal plug has been suggested to enhance the effect of exercises alone (27). There are however no evidence of it giving additional benefits to biofeedback treatment (55). Biofeedback is a treatment option considered to be the first-line conservative intervention for fecal incontinence in adults (27). This review concluded that the level of evidence for each treatment and its efficacy in treating consequences of OASIS is low, and thus it is difficult to determine the best treatment option. They believe that the low evidence is due to the large variety of treatment duration and intensity described in the studies. The review state that the limited evidence does not mean that the treatment is ineffective and that studies with a well-defined setting should be used in

the future to evaluate different treatment options (55). Although not specific to OASIS, a 2017 review of incontinence after pregnancy reached the same conclusion; the studies had limited details and poor reporting of measurements, highlighting the need for validated treatment measurements in future studies (56).

### **2.1.5 Possible postpartum problems after OASIS**

OASIS are the single highest predictor for anal incontinence (57). Anal incontinence is a collective name for incontinence of feces or flatulence, and encompass any involuntary loss of solid or liquid feces (fecal incontinence) or inability to control flatulence (flatus incontinence) (27). For people living with anal incontinence it may appear as much of a social, emotional, psychological and physical burden as any other chronic illness (58). Other possible postpartum problems related to the bowel could be anal fissures or hemorrhoids (27).

Pain after OASIS is common due to soft tissue trauma with or without suturing, and can be exaggerated if there is an inflammatory process in the sutured area (27). The pain is often followed by dyspareunia – pain during intercourse. Postponed resumption of intercourse or dyspareunia has been found to be strongly connected to OASIS (59). Childbirth in general is an established risk factor for urinary incontinence (27). With a further injury to the pelvic floor muscles the symptoms of urine incontinence can be exacerbated (38). The higher degree of perineal trauma, the more consequences a woman is likely to suffer from (27).

### **2.1.6 Risk factors for OASIS**

An Obstetric Anal Sphincter Injury is a complication that can occur suddenly in otherwise uncomplicated deliveries (47). Extensive research focus has been given to risk factors of OASIS. The risk factors can be divided into maternal, fetal and obstetric risk factors, and some of these are described below. Particular attention is given to the suggestion that maternal ethnicity is a risk factor for OASIS and possible factors influencing this assumption is explored. Some of the risk factors described, such as maternal and fetal factors, are non-modifiable, whereas others, such as factors relating to obstetric interventions, are modifiable (36).

#### **Maternal, fetal and obstetric risk factors**

The main maternal risk factors include first and foremost primiparity, meaning women giving birth for the first time. Reasons for this may be physiological; the muscles may have stretched and are more resilient in multiparous women, or it may be due to that an OASIS in the first birth may cause a woman to not have a second child (60). Further, it is suggested that maternal age over 30 years can also play a role (61). Body Mass Index (BMI) and its role in OASIS is discussed, and some suggest a high BMI might have a protective factor (62), whilst others find it not to be associated with OASIS (63). Maternal birthing position can be a factor in OASIS, especially in positions where the birth midwife is unable to see and manually support the perineum (38). As for the fetal factors; a high birth weight in the infant over 3500 g is found to be a risk factor (61).

It has been consistently shown that women who have vaginal births that are delivered operatively, meaning delivered with forceps or vacuum, have a higher risk of OASIS (64). In Norway, it was found that women who had a forceps delivery were at fourfold higher risk and with vacuum-delivery they had a two-fold higher risk of OASIS compared with non-instrumental deliveries (61). It has also been discussed if induction of labor with oxytocin plays a role in developing an OASIS (65). These are examples of obstetric risk factors.

The role of episiotomy as either a tool to prevent or be a cause of OASIS have been discussed (66). A midline episiotomy is thought to increase the risk of further tearing towards the anal sphincter and should be avoided, whilst a medio-lateral or lateral episiotomy is thought to be protective in some cases (67).

The risk of a recurrent sphincter injury in subsequent births are found to be four times as high in women with one previous OASIS and ten times higher in women with two previous OASIS compared to women with no previous sphincter injury in a study based on the Norwegian birth registry (68). Women with a previous sphincter injury have a higher rate of elective caesarean section (64, 68). It is advised that all women with a prior OASIS receive counselling about her subsequent birth and mode of delivery at the follow-up control visit (26).

### **Maternal ethnicity**

A 2010 review study shows how some studies have found ethnicity, and in particular Asian ethnicity, to be a factor in sustaining OASIS (69). The review found that across literature the research on this topic was conflicting. On one hand, several studies included in the review

confirmed Asian ethnicity to be considered to be a risk factor for OASIS (69). These studies all originated in Western countries. It remains discussed if anatomical variations such as angle of the pelvis, a shorter perineum, qualities of perineal muscles and characteristics of the skin, can be a possible explanation for these differences in risk for perineal trauma (69-71). On the other hand, the review found no conclusive evidence of Asian ethnicity as an *independent* risk factor (69). Rather, the review saw factors within the birthing room as possibly contributing to the unknown factors influencing the impact of severe perineal trauma specifically for Asian women in Western countries. Wheeler et.al summarize that in addition to anatomical differences and management techniques; communication, cultural differences and the skill and influence of the doctor or midwife can be part of these unknown factors (69). The idea of communication and language playing a role in sustaining perineal trauma is supported by Davies-Tuck et.al, who found that the need for an interpreter was significantly associated with anal sphincter trauma (71). Although they were unable to see if those needing an interpreter actually had one, they suggest that having a childbirth educator in the native language addressing the prevention of severe perineal trauma may be beneficial.

Dahlen et.al (32) found that midwives thought the risk for mothers with of Asian ethnicity was due to a shorter perineum, but midwives also saw communication with the woman as one of the most important ways of minimizing perineal trauma Midwives saw a setting where the woman was unable to understand as possibly leading to a greater chance of perineal trauma. It could for example lead to her pushing excessively when being told to breathe during the birthing of the baby's head (32).

Language as a factor in obstetric care has been examined further in the U.S. One study examining the role of language and ethnicity in hospital outcomes found having a non-English or non-White background did not put patients at higher risk for inpatient mortality – except in the case of obstetric trauma (72). In the Norwegian study setting, Baghestan et.al found that women born in Africa or Asia had a higher risk of OASIS than European women and states: “one may speculate that the higher risk in African and Asian women is also caused by difficult communication with the birth attendants”(61). Another U.S study compared maternal language with adverse outcomes and found that Non-English speakers had approximately two times higher risk of having an obstetric trauma during a vaginal birth when other factors, including race/ethnicity, were controlled (73). These results strongly highlights why a broader research focus is needed where ethnicity is not part of the equation, but rather

factors within the birthing room are the focal point in determining if patients who are not familiar with the language have a higher risk of OASIS.

### **Female Circumcision**

Some studies have suggested female circumcision to be a risk factor for OASIS (61, 74, 75). These studies have been done in western countries, and Balachandran et.al suggest that the role of experience and knowledge in the health care professionals about circumcision might contribute to the poorer outcomes seen in western settings (76). With good antenatal and intrapartum care, as well as training and education for health professionals, FGM was not associated with adverse obstetric and fetal morbidity and mortality (76).

## **2.2 Living with OASIS**

The earliest study found exclusively looking at experiences of women after perineal trauma following birth, is by Salmon and was conducted in the UK in 1999 (77). She based her study on the impression of women discussing the topic of pelvic floor difficulties as taboo, and said there was missing recognition of the social and psychological impact perineal trauma can have. She argued that the quantitative research traditions had dominated the medical research agenda, thus rendering the women's subjective experiences invisible. The most recent article from 2018 present the same observation as its predecessor 19 years earlier - that the majority of research to date focus on risk factors and morbidities, with little research exploring women's own experiences with OASIS (78).

The studies on how women experience sustaining and living with an OASI have several commonalities, although it is worth noting that some include women with perineal injury without specifying the degree of trauma (77, 79-82), whilst others focus on OASI in general (28, 30, 78, 83-85) and others yet again concentrate on women living with anal incontinence as a consequence of OASI (29, 86-88). Women in the studies represented different age groups and had varying symptoms. The time since the injury occurred ranged from four weeks to 27 years. Participants in the mentioned studies are primarily Caucasian and from high-income countries. One study included women with different ethnicities, though they were few and their responses were not analyzed separately or discussed, as well as their language

proficiency not being mentioned (88). Two studies mention the relevance and importance of including women with different cultural backgrounds in future research (81, 82).

Below is a presentation of how women experienced living with an OASIS as presented in the mentioned studies, occasionally illustrated by quotes.

### **2.2.1 A changed every-day life**

From the studies, it is clear that women make changes in their lives according to their symptoms. The first weeks post-partum is described as difficult, and two studies explain that first-time mothers felt confusion as to whether the pain or symptoms they experienced was due to normal sensations after vaginal birth or due to the perineal trauma (28, 77).

*“I couldn’t go to the toilet. I couldn’t sit in the car. And I basically couldn’t do anything – I was standing up and I was so tired, I could barely even lie down, it hurt that much that I just couldn’t think of anything”*

(28).

Women made several changes to their lifestyle in order to accommodate their symptoms or ‘keep up appearances’. One example of this is always using pads or bringing spare underwear as a necessary way of dealing with incontinence. Some women changed their diet, and several women explained that when planning for a day outside they made sure that there was at all times restrooms available should they need it (29, 80). Others avoided activities that could evoke feelings of anxiety in relation to symptoms, such as swimming or going to dinner parties (79).

Some women felt they had to “put up” with their symptoms, or minimized their symptoms and tried to see the consequences as a normal occurrence for women, and placed it secondary to the needs of their baby (79, 80). Other women chose to be happy that they managed to give birth vaginally, as this was seen as “the gold standard” and compensated them for the feelings of trauma experienced (28).

### **2.2.2 Experiencing isolation**

The consequences of making changes to their lifestyle was often feeling isolated (29). Lindqvist et.al say that women compared their situation to that of a child – dependent,

insecure, and incapable of fulfilling their own needs and the needs of others (78). Rasmussen and Ringsberg describe that whilst some women avoided talking to others about their problems in an attempt to remain some sense of normalcy, others felt that talking to their network about their symptoms was a hurdle – but when traversed they felt relief if they were met with respect and understanding(29). When their worries was not met with understanding, it exacerbated their feelings of frustration (29).

*“And you know what really annoys me, really to the point where I just want to scream is that if you try and talk to someone about it including your mum or even some of your friends, especially the older women. They say like, ‘women have been doing it for many years, you know, they have managed so, can’t you?’(79)”*

The difficulty of talking to others includes also their partner. Some women felt alone at home due to lack of support (30, 80). Some women described their husbands as “not interested” (30, 80) whilst others emphasized that they felt their partner understood and supported them both psychologically by acknowledging them and practically by helping them carry things and attend to the child (29). In either situations of feeling supported or not; often the full story were kept from their husbands. The reason for doing so was that they did not want to burden him or be seen as less womanly. Women acknowledged that speaking to their significant other would probably be beneficial but they hadn’t, and this led to feelings of insufficiency and inability to fulfill their roles (29).

### **2.2.3 Sexuality and future pregnancies**

The consequences and symptoms of OASI extended into intimacy and sexual relationships. Future pregnancies were also a source of worry, and several women felt anxiety towards a possible next birth (28, 30, 77, 78, 85). Sexuality and regaining sexual intercourse was difficult for the women, and a topic raised to some extent in all the studies available. Perineal pain, loss of interest or sensation, change in sexual identity or in some cases a strong association with the suturing-experience and the traumatic experience of the birth affected their own view of their sexuality and their intimate relationships with their partner. This led to avoidance of the act or pretending to their partner that everything was all right (29, 30, 78, 79, 85, 86).

*“You continually worry that you need to go to the toilet in the middle of sex, it is not exactly the best turn on and then if you’re not enjoying it because you’re sort of trying to tense yourself up in case something happens”*(86).

Some women described this worry as being constantly aware of their bodies and ‘on guard’, trying to hold in gas (85). Sometimes, the effort of dealing with the physical and emotional symptoms of OASIS led to a feeling of not being able to fulfill their role as mothers and partners. Having to live with unfulfilled expectations was also reported to interfere with breastfeeding and connecting with the infant (78).

#### **2.2.4 Interaction with health care professionals**

Feeling devalued and dismissed are prominent for women in all of the studies. Nearly all the studies found relate this in some way to the treatment the women experienced in the health services. These feelings arose from various experiences, such as from the birth itself and extending to several years after the birth when women sought out treatment.

The feelings of being dismissed by health personnel started immediately after the birth. Priddis et.al (28) describe how the level of compassion and companion women felt or did not feel during labor and birth influenced how they reflected on and dealt with their experience of perineal trauma.

*“And (the doctor) didn’t really want to talk, she just had this disgusted look on her face when she was doing it. It was horrible. She could have said ‘look, it’s not that bad’ or something. There was none of that. She just looked like she was someone doing her job and not really enjoying it, like ‘oh (sighed), I can’t believe I have to do this’”* (28).

Women used coping mechanisms such as focusing on the baby, using humor or dissociating to deal with the experience (28). Feeling that the suturing experience was ‘brutal’ and ‘torture’ is described by Salmon (77), and she explains how women felt they were given inadequate pain relief and left feeling out of control.

Women across the literature described communication and information from the early stages as an issue. Williams et.al (30) describe that timing and content of information given were crucial to women’s understanding of the outcome of the perineal rupture. Priddis et.al (28)



also found that the majority of women participating in their study experienced that they did not receive sufficient information about the extent of their perineal trauma. Rushed communication, and the perception of health personnel as ‘reticent to supply information’ put them in an unfavorable light and made women think health providers had a lack of knowledge (30). Poor communication demonstrated by rushed delivery of information or a perceived lack of provider knowledge was together with lack of information recognized as the most important components of women’s unmet needs (30).

Challenges arose also when women presented with symptoms after returning home from the hospital. The feelings that health professionals were dismissive of their problems, or was reluctant to listen to them is found in several of the studies (29, 30, 77-80, 86). The feeling that health professionals were reluctant and didn’t give appropriate advice led to women having to present multiple times with their problems before action was taken (30, 79). O’reilly et.al (79) explains that health professionals led women to believe that their symptoms could be expected after birth, and were as such within their control. Failure to heal led to having to either accept and manage symptoms themselves or having to be assertive and demand a second or even third opinion. This claim is supported by Herron-Marx et.al (80), who found that women’s problems had been dismissed as trivial until they were eventually led to believe that their problems were insignificant.

*“(…) Two months later I was still in pain only to be told at a consultation with a midwife ‘you’re bound to be sore you’ve just had a baby what do you expect?’”(77)*

This normalization of their symptoms and dismissal of their worries intensified the feeling that perineal problems were something the women had to live with, and often led to self-blame (77, 79). Similarly, another study found that the stigma, shame and isolation women felt towards their anal incontinence was perpetuated by the silence they were met with by health professionals (86). Instead of providing relieving care, health professionals caused further suffering of a similar strength as the suffering caused by the fecal incontinence (29).

The topic of doing pelvic floor exercises after OASIS is not frequently mentioned in previous literature. Elden et.al (85) explains that women hoped that the more they trained, the more their musculature would improve. Herron-Marx et.al (80) explains that women found pelvic floor exercises to be important, but blamed themselves if they forgot to do them. In addition to the mentioned articles, there is a student thesis done by two Swedish physiotherapy

students on how women experience following advice and instructions regarding pelvic floor exercises after OASIS (89). No other found studies focus solely on this issue in relation to OASIS. The main findings is that the information about exercises was not sufficient, due to either timing or content of information. It took time for women to process the injury and prioritize exercise, and this was also based on their previous knowledge of doing pelvic floor exercises (89).

Together, the body of literature paints a picture that the effects of OASIS are complex and intertwined. Feelings of shame, anxiety and being devalued arise from different experiences and are as such affecting each other. Societal stigma is present and felt deeply by women, especially those with anal incontinence. Women try to navigate the health care system, but suffers under the weight of a health care system where perineal problems are normalized and overlooked. Feeling dismissed, and being led by society and health care professionals to believe that their symptoms are to be expected after birth contribute to the shame women feel. Normalizing their problems maintain the notion that they are supposed to live with their symptoms. The consequence is that women are less likely to seek help, and less likely to confide in others. The reluctance to share their symptoms contribute to sustain the idea that women actually do ‘get on with it’ after birth and perpetuates the stigma around the effects of OASIS.

### **2.2.5 OASIS from the viewpoint of midwives**

The search for articles involving the perspective of health personnel led to finding two Scandinavian studies that look into the experiences of midwives following a birth where the outcome is OASI.

The newest study found is a Swedish study from 2014, where 13 midwives were interviewed and spoke about their experiences with birth and OASI (90). Edqvist et.al’s main finding is that midwives described feelings of being in a “deadlock” position where they had to navigate between a perceived truth that a good midwife can prevent an OASI from happening, and the more complex belief that sometimes an OASI is inevitable and that it can’t always be prevented (90). The deadlock described occurred when midwives were doubting what to believe was the cause of the injury. Midwives in this study felt guilt and shame having delivered a baby where the mother sustained an OASI because they felt the perceived truth that a good midwife can prevent an OASI from happening. The guilt and shame was directed

towards themselves, and they felt fear towards appearing vulnerable and incompetent and a fear of being judged by colleagues. Some described it as a “professional failure”. When there was a valid explanation for why the tear happened, the midwives found there was a way out of the deadlock. If there was no explanation, they ultimately accepted what happened and moved on without definite answers (90).

Through four focus group discussions with 14 midwives a Norwegian study from 2007 describe that midwives had similar feelings as its Swedish colleagues although not verbalized in the same way (91). Brunstad et.al acknowledged that a birth with an OASI as outcome was unfortunate, but not always preventable (91). When the concern for the baby’s wellbeing was at stake, an OASI was maybe not avoidable. Avoiding sphincter injuries was seen to be related to the midwives work experience and competency. This competency related to how they solved certain challenges that arose, such as choosing one birthing position over another and heeding the signs of a perineum about to tear (91).

The clinical experience of midwives was held in high esteem in both studies, and experienced midwives were respected and listened too. Both studies discuss how midwives interact with their colleagues, but take different approaches. Edquist et.al suggest that midwives, in the context of the study, work in a continuous relationship with her colleagues, rather than with the birthing woman she only sees once (90). They link this relationship to how midwives reported feeling not having only failed the woman, but also having failed professionally if a tear occurred. According to this study, the risk of being seen as incompetent might explain why there was hesitancy to share feelings of guilt and failure with colleagues (90). The other study propose that midwives are in a close relationship with the birthing woman, and work alone in the birthing room for a substantial amount of their work day. There is a reluctance to take difficult experiences out of the birthing room, making the birthing room a “closed” room. Taking experiences and reflections out of the closed room and share them with their colleagues was seen as important, but to do this made high demands of co-operation and openness in the department and between colleagues (91).

## **2.3 Immigrant women's needs and expectations of maternity care**

As mentioned in the previous section on how women experience living with OASIS, none of the studies discussed this with focus on how a woman who are not a native speaker might experience an OASIS. In this section, literature of how immigrant women experience their maternity care in general will be presented.

### **2.3.1 Immigrant women want the same from their maternity care as native women**

A 2012 review assessed 16 articles from within Europe found immigrant women to be experiencing challenges pertaining to communication and interaction with health professionals, accessing the health services and dealing with situations of possible prejudice (10). Small et.al shed further light on how native and immigrant women experience their care in a review of qualitative studies from five Western countries, where they also recognize these three barriers as the factors influencing immigrant women's feelings towards their maternity care (12). Small et.al found that regardless of migration status, women want the same and have the same needs of their care. However, immigrant women were less likely to have their needs met and were subsequently less positive towards the maternity care (12).

### **2.3.2 Communication is a key challenge to attain proper health care**

Communication was recognized as a key challenge to attain proper maternity care by immigrant women in the review by Balaam et.al (10). Balaam et.al explains that women described a lack of connection to health personnel, and unsuccessful communication had practical and emotional implications. The practical implications could on the one hand be lack of information leading to them not accessing the services in time and not following up with antenatal check-ups. On the other hand, the western medical philosophy and terminology were unknown to the immigrant women, making it difficult to understand all aspects of the care. If the women were unfamiliar with the care system or had a bad experience with a health professional, they tended to avoid using the services (10).

Small et.al found that immigrant women experienced a lack of information provided in a language they could understand, an insufficient access to interpreters and they were not receiving adequate information about what options for care they had (12). Other authors confirm this view; Fisher and Hinchliff describe that women wanted information, but it was often unavailable in different formats and languages due to a lack of resources (11). Even when material was available, women were frequently not directed to it due to health workers being unaware of its existence (11). In Norway, The Norwegian Directorate of Health offers brochures on the pregnancy-, birth- and postnatal care in several languages other than English and Norwegian to accommodate non-Norwegian speakers (92). It is unknown if these are routinely handed out by health workers.

From the perspective of health care workers, the challenges immigrant women faced when having gained access to health care related to the same factors as described by the women; establishing effective communication with health providers, navigating within an unknown system and how to effectively receive the necessary care and support when facing possible prejudice (93). At the forefront, communication and language was deemed essential to receive and give appropriate care (94). Binder et.al elaborates that language was cited as the main problem against establishing adequate communication between women and their providers. This language discordance among immigrants were according to the authors usually dealt with by providing an interpreter (94).

In regards to interpreter services, although seen as essential to overcome the language barriers as described by both women and health providers, they are in practice a more complex issue. In the Norwegian setting, The Norwegian Law of Patients' Rights, "Pasientrettighetsloven", declare that all patients have the right to complicity and information on their own health and the content of the health services received (95). In the Norwegian Guidelines on the Use of Interpreter Services it is said that "using qualified interpreters is crucial to be able to give justifiable health care services when there is a language barrier involved" (96). Despite this, there is an underutilization of interpreter services in the Norwegian public health care system (97). In Oslo, the Oslo University Hospital has its own central –"Tolkesentralen" – specifically providing interpreter-services to the hospitals (98). Others can turn to the National Register for Interpreters, where individual interpreters are registered and ranked according to qualifications (99). It is important to note that family and children should never be used as interpreters for a patient (96).

### **2.3.3 Level of care needed and possible prejudice interferes with health care**

Through interviews with 63 health workers involved in maternity care for migrant women Pelaez et.al (93) explains how the reasons women for moving were highly relevant; those having moved from countries of similar standard had gone through similar processes as were expected in the new country, such as job hunting. Women having fled or escaped from politically unstable or dangerous countries were considered to have the additional challenge of past traumatic events and being unprepared for the challenges to come. Pelaez et.al show how where in the process of ensuring their basic needs were met in the new country when they became pregnant would influence the level of care they needed or were provided, and their wellbeing was associated with how different levels of care responded to these challenges (93).

From the perspective of immigrant women themselves, accessing health care was found to be difficult due to lack of transport, funding, awareness of services and competing obligations such as work or having to care for children (11). Women have also described having small networks, and feeling isolated in their new country (10, 100). Episodes of discrimination were reported, with women describing that staff were insensitive towards their experiences of pain in labor and sometimes had negative attitudes towards them (12). They reported that it was difficult to follow their traditional cultural practices, but this was not as big a concern to them as problems with communication, lack of information and negative attitudes (12).

Binder et.al explain that in addition to the use of interpreters, there are cultural- and sociocultural influences on communication (94). The study found that providers sometimes felt restricted by cultural features such as women having strong religious beliefs, or they assumed that women had strong feelings toward gender preference of providers. This assumption turned out to be misconstrued, as the women interviewed found competence more important than gender- preference (94). Small et.al points out that although they found in their review that immigrant women preferred female care-givers, this question was rarely asked in studies of non-immigrant women and thus they are effectively demonstrating how assumptions can blind the provision of care (12)

Binder et.al concluded that in the quest of providing culturally sensitive care, providers may be blinded by these presumed cultural factors and thus obscure the appropriate management

of the woman's obstetric care (94). Small et.al further argue that culture and cultural practices are not a static phenomenon and stress the importance of seeing the women as diverse and not a homogenous group. Women themselves acknowledged that health workers could not know every culture, and they were more concerned with receiving respectful care, assistance with communication difficulties and information about care provision (12).

Pelaez et.al raise in their study that the dynamic between women and their providers is also connected to the role of the health care system (93). Within the Canadian health care system where the study took place, the providers showed empathy towards the women when they tried to fit in to the health care system, but also questioned those who refused to adopt or follow proposed standards of care. This, they argue, is a sign that the norms underlying medical culture is such a deeply ingrained practice that those who question it are seen as outsiders that do not align with the norms (93).

### **2.3.4 Meeting the needs of immigrant women**

Binder et.al conclude that understanding these sociocultural clashes and translating the needs of women into practice becomes of vital importance (94). Small et.al reach the same conclusion, and states that in order to empower women and make them feel less anxious of giving birth, an enhanced focus on promoting equity and non-discriminatory attitudes is, together with strategies to improve communication, the most important focus for health services going forward (12). An example of how to meet the needs of immigrant women is to provide a multicultural doula to guide women through childbirth, as described in a Swedish study as "enhancing security and facilitating communication" from health care workers perspective (101), and as providing "important information and continuity of care" from women's perspective (102). A similar project is currently piloted at Oslo University Hospital (103).

To summarize, it is clear from the literature that immigrant women are a diverse and individual group. Immigrant women are less likely to have their needs of maternity care met, although having the same expectations of the care as other women. Structural and interpersonal challenges affect the access to and utilization of the health care services, making immigrant women vulnerable and less likely to achieve equity in the health care. The majority of literature presented have focused on maternity health care in relation to care in pregnancy, with some comments to care during birth. Immigrant women experience physical and

emotional barriers to achieve appropriate maternity care, and language and communication are barriers to receiving information needed to make decisions relating to their own health.

## 2.4 Conceptual Framework

Concepts of embodiment, coping and identity have shaped the analysis and discussion in this thesis. These concepts are presented below along with some additional attention given to intercultural communication.

### Embodiment

Embodiment is a concept incorporating the nature of physical experience as mediated through the body. The body shapes the experience and the social world, and is in return shaped by it. Embodiment was a topic within the phenomenological approaches that grew out of a reaction to the mind/body dualism brought forward by Descartes in the 1600's. (104) The Cartesian dualism and the Enlightenment period it operated within, viewed bodies – and particularly female 'unpredictable' bodies in childbirth- as a machine. This is exemplified within today's medicalized view of birth, where the diagnostic terms "failure to progress" and "incompetent cervix" signal a breakdown in the machinery. (105).

In the 20<sup>th</sup> century, post-modernist thinkers, such as Foucault, started to view the body as shaped and bounded by external social effects. Merleau-Ponty argued intentionality of the body, meaning the way of the body of acting and being in the world – the lived body -, is the sum of bodily experience, physicality and emotions. In relation to pregnancy and childbirth, women might struggle to make sense of the bodily experiences they go through and thus view their 'embodied' selves differently after the birth. (104-106) Walsh argues that the labor experience is foregrounding both external and internal bodily processes, and the pain experienced is a universal manifestation of these processes (105). She further explains that childbirth is unique in the sense that the pain does not generally represent pathology. The effect is that the experience forms a personal narrative that will stay with the women for a long time. (105). Pain or an overwhelming amount of procedures can lead to a loss of control and a resignation of agency. Agency can mean different things during childbirth, such as letting go of control and giving in to the body's primal responses or disembodying as a way of coping with pain (105). It is when the loss of control is perceived as being alienated from the



body - unable to appropriate a subjective embodiment, that the agency is truly compromised and it becomes central to later achieve some sort of grounding in order to achieve a meaningful subjective embodiment (105).

## **Coping**

Coping is defined as ongoing cognitive and behavioral efforts by a person to manage psychological stress. Lazarus and Folkman conceptualized coping through their Transactional Model of Stress and Coping; explaining how when faced with a potential threat, people will evaluate the significance of the stressor based on how they perceive it as impacting on their lives. Coping is also seen as a process, where it is thought that coping changes over time and in accordance with the situational contexts it occurs in. This implies that what a person does to cope, changes the relational meaning of the perceived threat. (107)

The view of coping as a process introduces two major functions of coping; problem-focused and emotion-focused coping. Problem-focused coping involves attempting to change the environment or oneself when faced with a stressor. Examples of how women used problem-focused coping described in the literature review on how women experience OASIS is for example always wearing pads, planning their day around toilets and changing their diets. Emotion-focused coping involves the aim of managing the intensity of emotions a stressor has caused, either by changing the way one acts towards the environment or by changing the relational meaning of what happened. For women with OASIS, as described earlier in the chapter, this could for example mean isolating themselves from perceived stressful interactions with the environment; such as dinner parties or going to the gym. In regards to changing the relational meaning, this could mean focusing on the baby or minimizing the effect of their symptoms. When a stressful situation is seen as impossible to manage, often emotion-focused strategies are employed. When the stressful situation is manageable, problem-focused coping predominates. (29, 108)

## **Identity**

Identity is the set of meanings that define who one is when one is an occupant of a particular role in society, a member of a particular group, or claims particular characteristics that identify him or her as a unique person. People have multiple identities, because they occupy multiple roles, are members of multiple groups and claim multiple personal characteristics,

yet the meanings of these identities are shared by members of society. The identities people hold influence their behavior, thoughts, feelings or emotions; and how their identities tie them to society at large. The individual and the society are thought to be mutually influencing each other. (109, 110) Identity theory assume that identity is always changing, implying that people change the meaning of a situation to align with the meaning held in their identity standards. It can also mean that people change their identity as a whole. There are thought to be three factors that influence change in identity, and these are: first, changes in the situation that alter the meaning of the self, second; conflict between two identities in the person, and third; a conflict between a person's behavior and their identity standard. An injury might impact on women's sense of self and how they view themselves in relation to the roles they identify with. (109, 110)

In the discussion, the concept of embodiment was used to look at how women experienced the birth and subsequently also how the injury was seen as a continuation of the pain experienced during birth. The concept of coping was applied to considerations of how women used problem-focused and emotion-focused coping strategies to cope with the effects of the tear on their lives. These previous concepts were seen as intrinsic to how women related to their identity after birth, and this concept was used to explore how women saw themselves and understood their injury.

## **Communication**

Language, culture and communication are largely inseparable, and always intertwined (111). Some might question why concepts of intercultural communication will not be discussed in length throughout this thesis. Culture and its influence on communication is undeniable. Even though we know the content of the words spoken, it is not a given to understand its full meaning in the context they are given in (112). The risk of misinterpretation and misunderstanding can also be based in different values and ideals in culture (112). Applying an intercultural communication approach to a health related interaction is also considered the responsibility of the health care professional, as a tool to help the patient understand how to navigate within the new culture (112). As the background of this thesis showed, immigrant women presented with less emphasis on receiving culturally correct care in the maternity services, and rather valued correct information and access to appropriate services (12). This thesis chose to focus on experiences with communication women voice themselves.

# 3 Methodology

In the following chapter the methodological journey of the project will be accounted for. The research design is presented before describing the recruitment of participants. The approach to data collection and analysis is presented before giving reflections on trustworthiness and describing ethical considerations. The chapter ends with thoughts on strengths and limitations of the project.

## 3.1 Research design

### 3.1.1 A phenomenological perspective

When wanting to understand how women understand and experience their situation after obstetric sphincter injuries, I am seeking to derive meaning from the experiences of others. I want to look behind the perspective that meaning and reality is quantitatively measurable and graspable by the means of numbers. This is in line with this research taking a qualitative phenomenological perspective in its approach to the research subjects.

The core inquiry question in phenomenology is described by Patton as to ask what is the meaning, structure and essence of the lived experience of this phenomenon for this person or group of people (113). Phenomenology entails capturing and describing how people make sense of a phenomena, and it can do so by in-depth interviews with people who have first-hand experience with what we want to study. The phenomenological reflection is not introspective, but retrospective in that it looks back at the experience and reflects on what is already lived through. (113)

In-depth interviews are for this reason chosen for this study, as it is considered the best method for capturing the experience of women whose mother tongue is not Norwegian after an OASI. Interviews are useful for getting the story behind a participant's experience, and get in-depth information around the topic. The events following birth are individual to each woman, and her experiences are valued greatly. The very goal of qualitative methodology is to explore the meanings of social phenomena as experienced by individuals themselves, in their natural context (114).

More specifically; a qualitative approach with in-depth interviews is appropriate when trying to understand the experiences of women with OASIS because qualitative methods in public health research can lead us to underlying behaviors, attitudes and perceptions that determine health outcomes. It can also shed light on the success of our interventions; and it can facilitate better understanding of the contexts in which health choices are made (115).

As mentioned, this project takes on a phenomenological *perspective*, where the essence is the individual experience. This study is not a pure phenomenological study, where the goal is to create a reality based on shared essence. It is not within the scope of this section to describe thoroughly the vast phenomenological traditions, but this project wishes to be inspired by its views on essence. The philosophical nature of phenomenology was first applied to social science by Edmund Husserl, and the basic focus of phenomenologists is on how we put together our experiences in such a way as to make sense of the world, and in so doing, develop a worldview (113). Making meaning out of our experience is the essence of a person's reality. In addition, there is an essence to shared experiences. By trying to understand how women whose mother tongue is not Norwegian experience sustaining and living with an OASI I am not seeking to create an essence of the experience, but rather study the experience and opinions of a group of women who have a similar obstetric injury.

### **3.1.2 Triangulation**

Triangulation to further enrich the data is considered a valuable tool to test for and discover inconsistencies in the data (113).

Follow-up interviews were decided to be the best opportunity to provide rich accounts of women's experiences. Having follow up interviews allowed for more time to explore topics after the interviewer and participant have gotten to know each other in the first interview (116). It also allowed some time to pass and thus provided an opportunity to reflect upon issues and questions that arose in the first interview. All participants were asked to share, if they wanted, any documents or written information they had been given. This provided an opportunity to see what information they had been given and had access too.

Theory triangulation involves examining the data through different theoretical lenses to see what theoretical framework fit (113). During the building of the conceptual framework, several concepts were considered and positioned in relation to the research questions,

background and, later, the findings. Especially concepts such as health literacy, power relations and empowerment were explored, but later not actively incorporated as these did not fit with the direction the study was taking. In the end, the theories of embodiment, coping and identity were found through a combination of seeing which theories and concepts fit with previous literature and which were able to shed light on the findings.

Patton further describes the Rigour Attribute Model; where eight steps of critical thinking and analysis ensures a rigorous approach to deepen the triangulation of the study (113). These steps have all been taken into consideration, and of particular importance for this study was specialist collaboration, where the perspectives of experts and key knowledgeable have been incorporated into the assessment of the study (113). Through personal communication via email or phone, informal meetings over coffee, formal meetings in offices and spontaneous conversations at meetings and a conference various physiotherapists, doctors, researchers, anthropologists and other professionals have been consulted and their views have been taken into account going forward. Further, the step of information synthesis with thorough consideration and integration of information have shaped the work of this study (113).

Possible other triangulation approaches was considered and is described in chapter 5, methodological considerations.

### **3.1.3 Reflections on reflexivity and role**

The quote below in Patton's book on qualitative research (113) meant a lot to me in order to start understanding the complexity of qualitative research.

*Innovators are told, "Think outside the box." Qualitative scholars tell their students, "Study the box. Observe it. Inside. Outside. From inside to outside, and from outside to inside. Where is it? How did it get there? What's around it? Who says it's a 'box'? What do they mean? Why does it matter? Or does it? What is not a box? Ask the box questions. Question others about the box. What's the perspective from inside? From outside? Study diagrams of the box. Find documents related to the box. What does thinking have to do with the box anyway? Understand this box. Study another box. And another. Understand box. Understand. Then, you can think inside and outside the box. Perhaps. For awhile. Until it changes. Until you change. Until outside becomes inside – again. Then, start over. Study the box."*

Having never understood what people meant when they told me to think outside the box, this resonated with me. Time and time again throughout this project I had to go back and figuratively “study the box”. The quote of the box resonates with the reflections a researcher has to consider about his or her own role. These reflections are closely tied to the reflexivity of the study. Reflexivity means to actively maintain an open mind with room for doubt, reflections and unexpected conclusions throughout the research (117). The trustworthiness of the study will also depend on making this process clear for the reader, and let the whole thesis be a proof of reflexivity throughout the process.

Qualitative research is unique in the way that the researchers own perspective and position influences the research process (117). I found myself asking “who am I in relation to the box?” The answer is that I have held many roles in this project: student, physiotherapist, investigator, interviewer, collaborator and woman. I am also childless and a Norwegian. Especially my background as a physiotherapist was a role it was difficult to put to the side. Sometimes, the role opened doors. For instance when meeting possible contacts who were also health personnel. In meeting the participants, I did not wish to let this role influence the interaction. What I did when I noticed that I put on my ‘physiotherapy hat’ was to try and accept the thought and let it go, not say anything and just focus on what the woman was saying. An example of such a thought is when a participant mentioned what kind of physiotherapy she received, I was tempted to assess the treatment in my mind in a clinical way, instead of listen to her descriptions. I tried to not mention that I was a physiotherapist unless they asked. The topic often came up after the interview was over, and I could sometimes find myself talking a little bit as a physiotherapist if we were talking about pelvic floor exercises. I did my best not to, and I do not believe this influenced the interaction greatly. Perhaps it made it easier to talk about pelvic floor problems, as they knew I would be able to understand what they meant when they described their issues and had heard about such problems before.

Malterud says that it is when we believe that we have removed our own abilities to influence the research process that the real bias occur – that is when bias threatens our ability to critically reflect (118). Dahlgren explains that the researcher in qualitative methods is referred to as “the human research instrument”. He says that knowledge is generated in interaction between people, and the researcher will influence the participants and vice versa (119). I tried to let being a physiotherapist take a background position, acknowledging that I was a

researcher and instrument in this process. Once, I crossed this line and actively found myself consciously giving advice as a physiotherapist. A participant talked to me about her experience of talking about exercises at the hospital. She spoke about how often to do “it”, and how important “it” was. I probed further on her understanding of the exercises, and it became clear that “it” was unknown to her. She had not grasped the concept of the exercises. I then showed with my hands and explained what the function of the pelvic floor was. As I was explaining to her I realized I went beyond my role. On the one hand, she had given birth quite recently and would maybe be instructed to do the exercises at her next visit at the health station. On the other hand, there were circumstances that made it relevant to explain these exercises to her at this point in time. It serves as an illustration that as a new researcher this process of positioning yourself in relation to the participants has to be an active process. If I were in the same situation again perhaps I would have waited, and given her the information after the interview was finished, if she had wanted it.

Another role that influenced the whole process is being a student in academia. I had little experience with academia from before. I found it a challenge in the beginning to structure myself and to actively reach out to collaborators. As the days went on I changed and became more pro-active. Positioning myself in relation to the methodological approach of the study became central due to sample size of the project. If I hadn't applied as much energy as I did into researching the background for the project, I would feel as if the experiences of the women did not have a solid foundation.

I saw being a woman as beneficial in the interview process. From my background literature I got the impression that women preferred to discuss sensitive issues like this with someone of the same sex. If I had children maybe I could have related more to the process of the birth. Although being childless can also mean that I did not influence the conversation with my own experiences of giving birth and as such left more room for the participant's experiences.

## **3.2 Study site, access and sampling**

This study is based on seven interviews with five women whose mother tongue is not Norwegian. It took place in the context of maternity care services for women with OASIS, where the final sample was recruited from Facebook, through the researchers' network or

through a “helsestasjon”. Following is a presentation of the process of recruitment and considerations of sampling.

### **3.2.1 Gaining access and recruitment**

The process of establishing contacts that could be of help in the recruitment period started in the spring and summer of 2016, when I contacted the head of department at the women’s clinic or head nurse at five different hospitals in the Oslo region. Three of these were positive to helping me. Due to challenges to recruit participants, several approaches to recruitment was attempted and is described further in chapter 5, “Methodological Considerations”.

I contacted the moderators of a closed Facebook group where the majority of the members were international mothers in Oslo. I concluded, and was given advice from staff and head of department at my faculty, that if I posted an invitation to participate in the group through one of the moderators and was never a member in the group, women’s anonymity would be protected. To further protect the anonymity of the participants, details about the Facebook group is not described. The group moderator was happy to post my invitation, and possible interested participants were given my contact information. The invitation can be seen in Appendix E. In April 2017 I had set up and conducted interviews with two women who had responded to my invitation. I interviewed a third woman who had contacted me due to the Facebook invitation, but it turned out she did not meet the inclusion criteria of having a third or fourth degree tear and this interview was omitted.

I was contacted by a friend in May 2017 who knew someone eligible to participate. This woman contacted me and I interviewed her in early June 2017. I also attempted the process of snowballing, where you ask relevant interviewees for additional relevant contacts (113). Through snowballing I had two leads, but these women turned out to not meet the inclusion criteria or declined participation due to personal reasons. In addition, through my network of fellow students, I was contacted by three women who could be eligible to participate in an interview. It turned out they lived on opposite sides of the country and were not included due to the geographical bounds of the project or did not meet the inclusion criteria of a third or fourth degree tear.

At a conference in early November 2017 I met a midwife I recognized as coming from a “helsestasjon” where I had previously spoken to the department leader. The midwife was a



key note speaker and I approached her and asked her for help. In the following two weeks she had invited two women to participate, and the interviews were conducted shortly after. The helsestasjon is in Oslo, but is not described further to protect the anonymity of the women.

I also had follow-up interviews with two women during this period.

I kept all research contacts open until the final deadline of May 2018 was fast approaching, but did not manage to recruit more participants.

### **3.2.2 Reflections on sampling and the final sample**

This study aimed to include women who had given birth in the eastern part of Norway, and had sustained a third or fourth degree perineal tear during the birth. A purposeful sampling, where recruitment is based on preselected determinants, ensured that I examined the research questions in sufficient breadth and depth (117).

The inclusion criteria for this study were women who had sustained a third or fourth degree tear during birth at a hospital in the Eastern region of Norway after 2004. Ideally the women had given birth recently, but had to have given birth after 2004 when there was increased awareness of prevention and repair of the injuries in Norwegian hospitals. Further, the inclusion criteria were women with a mother tongue other than Norwegian.

Exclusion criteria were women who had a first- or second degree tear, had not given birth at one of the hospitals in the Eastern region of Norway and had Norwegian as their mother tongue.

Ideally, the final sample size is based on reaching saturation, meaning to end data collection when new cases do not add new knowledge (117). Patton explains that striving for broad involvement in order to maximize variation is essential to give descriptions, and also to challenge those very same descriptions (113). Originally, this study aimed to have 10-15 participants. Although a fixed number is rarely defined in literature, this amount is suggested to be able to make comparisons. As the sample in this study is small, seven interviews with five women, the presentations of the findings are not making in-depth comparisons between the participants, but rather describe the variety of experiences the women presented.

Malterud (117) explain how in an exploratory study, instead of saturation, we should be content if we have succeeded in opening a few doors to a new field by showing some relevant examples that can contribute to new thinking. She also states that with a meticulous theoretical preparation, a knowledge of the field and a strategy to approach analysis, then a low number of informants (4-7) can be sufficient to provide a rich material (117). Instead of fixating on a specific number, it is more important, Malterud argues, to ask ourselves if we have enough empirical data to enlighten our research question, rather than to have explained all the possible sides to it (117).

## **3.3 Data collection and analysis**

### **3.3.1 Carrying out the interviews**

#### **Interview guide**

The interview guide guiding the data collection had predefined questions and themes. It covered their background, pregnancy, birth experience, postnatal stay, the OASIS itself, pelvic floor exercises and different aspects of their care, as well as communication. The interview-guide is appended in Appendix D. Although I had a detailed interview guide, I chose an informal interview style where I had my interview guide and questions available, but did not rely on it slavishly during the interview. Such a semi-structured interview style can be seen as similar to an everyday conversation, but has as a professional interview a premeditated purpose (120). It becomes a “conversation with a purpose”.

#### **Pilot testing**

Prior to starting the interviews with the participants I conducted two interviews to pre-test my interview guide. This was done with two non-Norwegian speaking women who had sustained a perineal tear degree one or two. They were accessed through my network. I made some tweaks to the order of some questions in the interview-guide after the pre-testing, but kept most of the questions as they were. It was a good experience to get to know how I myself act during the interview situation, and allowed me to explore my own responses. I noticed how I was quick to ask questions during a lull in conversation, and that I could benefit by not attempting to fill the silence with more questions. I also noticed how the two women wished

to speak more about their birth than I had thought, and decided to leave more room for this in the interviews with the participants.

### **Interview considerations**

The participants were able to choose the location of the interview, and I offered to see them at their home if they preferred, or another location of their choice. Four out of five women preferred to be interviewed at home. One woman I met at a café, as she preferred to get out of the house. I suggested a café at her request, and this turned out to be a good alternative. It did not seem to be hindering her to be open about her experiences and there was a good flow of conversation. With the women I met at home, they always offered me tea or coffee, and I had brought some sweets or baked goods to share for the interview or gift her at an appropriate time as a token of appreciation.

All the interviews started with an informal conversation to get to know each other a little bit. Before the interview I made sure to meet and greet the baby if he or she was awake or present. After the informal conversation, the informed consent form was signed and permission to record asked.

All interviews were recorded. I chose not to take notes during the interview, but kept my focus on the conversation. We were most often situated facing each other at an angle, as this can be more comfortable in such a situation as it does not force eye contact, and give multiple other areas to focus on if needed. Right after the interview (and also before) I made notes of my initial thoughts and impressions from the interview. Looking back, this was useful to capture some of my reflections on what they focused on, giving me a chance to see if it concurred with what I later found.

### **Ensuring an open interview situation**

Prior to meeting I spoke to the participants on the phone to be able to explain my project in more detail and answer any questions. All women were offered an interpreter, and one woman wished to have an interpreter present. I always got in touch the day before via text or phone to confirm our appointment and to let them know that if something came up they should let me know. This also gave them an opportunity to retract from the interview if they wanted.

I noticed, as I had also experienced in the test-interviews, that all the women had a wish to discuss their birth experience in greater detail than I had anticipated. It was clear that it was a profound experience for them. I tried to let them explain it with as much or little detail as they wanted. I could then go forward with my questions about their experience of the OASI and what came with it. Patton (113) explains the importance of making the purpose of the interview clear, and I chose to turn the conversation to the effects of OASIS by saying “an important part of this interview is also the tear you had during birth, can you (...)”. Meta-communication in form of explaining why one is bringing up a certain issue or requesting more detailed information can contribute to making the participants informed partners of the study (116). I attempted to do this by saying variations of “yes, exactly that, and the reason why I also want to know is (...)” or “I am not entirely familiar with this process, but would like to know because (...)”.

I tried to mostly ask open questions, and follow up with appropriate probes. I attempted to clarify any misunderstanding by summing up and asking some version of the question “is it correct if I understood what you meant as (...)”. This becomes especially important in a cross cultural interview to avoid false assumptions and misunderstandings.

### **Discussing emotional topics and having a good end to the interviews**

Several times we ventured into topics that were considered difficult by the participants, and occasionally they showed their emotions by crying. This was a powerful expression of their feelings. I chose to let her cry, and ask after a while if she found it difficult. If she confirmed I chose to say some version of “that is very understandable, given what you just told me” and that she was in charge of what she wanted to share. In line with Patton’s (113) reflections on this, I thought that giving the woman control of what she chose to share was central to her feeling safe in the interview. An interview has by default a power asymmetry, and the participant might already feel that she relinquishes power by signing an informed consent form. To give her autonomy to decide what she felt comfortable sharing was seen as crucial to maintain a conversation as equals. I sometimes found that if we left the difficult topic and talked about other, safer topics, it was reassuring to her. It made it easier to talk about if we reverted the conversation back to the difficult topic later in the interview. I took it as a sign of them being comfortable and feeling safe that they could walk around, breastfeed, talk to the baby, or ask me to hold the baby during the interview. We never had interruptions other than

for them to accommodate the baby. We always ended the interviews with discussing simpler and less personal topics. They were asked if they had any further topics they wanted to discuss. This is seen as a crucial question that can take the researcher in new directions and expose flaws in the interview guide (113). Sometimes they wanted to clarify some points, but mostly they had shared all they wished. I turned off the recording and we either went through the written information she had received and discussed this a little, or we talked informally until it was time to leave. The interviews lasted between one hour and 10 minutes and one hour and 45 minutes.

### **Accuracy of the interviews**

The interviews were transcribed within short time after returning home. The recording were listened to three times, where I in the first just wrote down as much as possible and arranged a structure. I then listened with the sound on half speed. The last time I listened I made corrections to spelling and word-positioning. Some conversational fillers were left out if they did not seem of importance to the context. The transcription gave approximately 20-25 pages of text for each interview.

All of the women were offered to read through and comment on the transcript of the interviews. To give participants a chance to comment on the transcript of the interview can contribute to the trustworthiness of the study by clearing potential misunderstandings or errors in the interview (117). At the same time, to read through a transcribed verbal interview can be difficult for the participants, especially if the topic is sensitive (120). Two women commented and gave feedback on how the transcripts conveyed what they had said accurately.

Four participants were requested to have a second interview. I was able to do follow up interviews with two participants. The other two participants was either travelling for a prolonged time or did not wish to participate again at this point. In the repeat interview, the women had new reflections that gave further insight into their experiences. They were perceived as emotionally lighter, smiling more and seeming more uplifted. This could also be due to us having met once before. They had new experiences and new viewpoints that seemed to have come with some distance to the difficult event of the birth and the postnatal period. They seemed more comfortable discussing intimacy, and in my case as interviewer, I felt more inclined to ask sensitive questions. During these interviews we had more time to discuss

what they wanted from their care, possibly because we had covered more introductory topics during the first interview.

### **3.3.2 Applying systematic text condensation for analysis**

For the analysis of the interviews I adapted some parts of Malterud's description of Systematic Text Condensation. This approach is deemed appropriate for beginners as it gives a step by step tactic to analyze the material. It is based on phenomenological analysis. As mentioned in the introduction of this chapter, this project is inspired by phenomenological research traditions, but does not strictly follow the phenomenology school of thought. Choosing systematic text condensations is in line with this approach, as it does not require extensive knowledge of phenomenology as such (117). The four steps in Systematic Text Condensation are named by Malterud as: 1) total impression - from chaos to themes; 2) identifying and sorting meaning units - from themes to codes; 3) condensation - from code to meaning; 4) synthesizing - from condensation to descriptions and concepts (121).

#### **Getting to know the material**

The first, and integral step in the analysis was to read through the material to get to know it. To treat the analysis process as a continuous venture throughout the research process is central (116). The continuous analysis shaped the considerations and reflections of the researcher. At this stage, the predetermined views was set aside and the material was viewed from a bird's eye perspective (121).

I occasionally made instinctive notes in the margin of the transcriptions. I chose to write a summary of each interview, too see what I instinctively remembered and focused on. This proved handy for later in the analysis, when I could look back and see if my original focal points were skewed or accurate.

#### **Finding themes through trial and error**

An analytic reduction means to filter and reduce the amount of material, but in a way that is true to the original content (121). In this second step of Systematic Text Condensation, my initial analysis became a cloud of well-intended, but chaotic codes. I tried to apply an inductive approach where I let the material determine the themes and codes. At this point I

was attempting to capture everything the participants conveyed. This led to something similar to a language analysis, a misguided (albeit colorful, judging by the different shades of highlighters) approach.

I reassessed the material, and instead of trying to define every sentence into a theme, I lifted my perspective and tried to discover broader topics. At this stage I had not taken into account that my theoretical foundation could be a tool to guide me through the process. I was also in the process of interviewing two more women, and having follow-up interviews and thought that maybe it was the lack of variance in the material that made it difficult to analyze. I decided to take a few steps back, work more on my conceptual background and then learn more about the process of analysis.

This time around I approached the analysis with both an inductive and deductive approach. Inductive in the sense that I first coded and then saw what this resulted in, such as when I noticed that the women were describing insecurity towards knowing if the tear had healed or not. It was deductive in the sense that I extracted meaning based on a predetermined code based on what I had read in the literature. This was for instance when I looked for descriptions of intimacy and next birth. The extensive literature search I had made gave new insight into what possible challenges they might have faced. I then spent time redefining the themes and codes. For example the codes within the theme “finding yourself a new mother while suffering” was better captured by the term “reshaping your identity”.

### **Making meaningful inferences**

Initially three themes emerged: ‘coming to terms with the injury’, ‘feelings of a changed identity’ and ‘interaction with healthcare’.

The third step of Systematic Text Condensation implies systematic abstraction of meaning units within each of the code groups established (121). Each participant’s transcript was given a color, and all the tentative codes were organized within one specific theme in a document. I then had four different documents, one for each theme. I then went on to organize and analyze further in the ‘old-school’ way, by cutting and sorting the sections by hand into subthemes based on the codes. I now had four piles of “text elements” representing each of the themes, and then further organized these text elements into subthemes based on the codes. This time, only occasionally did I double-code.

Next, the excerpts were arranged to make what Malterud calls a text condensate – an artificial quote based on all of the interviews, written in first person (121). This proved useful, as it gave understanding of how the themes and subthemes were interlinked. I was also able to see where my thoughts had been influenced by the responses of only one or two of the participants, and were not really representative. I could take these out and consider if they belonged somewhere else or had to be discarded.

### **Reconceptualizing the experiences**

With the text condensate and the clip outs arranged next to me I started to write out the analysis in full. In this fourth step of the analysis process; the data are reconceptualized, and the pieces are put together again (121). I noticed that some parts of the text condensate were a bit skewed to represent one person, and had to make a decision on whether or not to keep them, put them somewhere else or discard them. Some stories represented unique experiences, and although they represented one person, others might be able to recognize themselves in parts of the stories. Quotes are used throughout to exemplify the themes and subthemes. The analysis was written with the goal that if every one of the participants read it, they would be able to feel that the text as a whole represented their own feelings and experiences, even though the story was not their own. It is very important that the women could feel represented, respected and valued in this shared story. Finally, I went over the themes and codes again, putting them in context with the transcribed material to see if I had missed important statements.

## **3.4 Trustworthiness**

### **3.4.1 Reflections on credibility, transferability and language**

This study sets out to describe how women whose mother tongue is not Norwegian experience an obstetric anal sphincter injury. Trustworthiness is essential to determine if the results of the study is credible, transferable, dependable and confirmable (113) . This study has attempted to show in various ways its credibility – meaning to determine what the results are true about (117). First, as is recommended practice to increase credibility, this study offered all the women to perform a “validity check” by reading through the transcripts of the interview (117). This is important, especially pertaining to the possible misunderstandings



posed by language barriers. Further, having second interviews is seen as strengthening the credibility as the participants were able to reflect on the last visit, discuss in detail, elaborate on earlier thoughts and so on. Credibility is also determined by the reflexivity of the researcher, described previously in relation to the researchers' role.

Language is a factor that influenced in one way or another all of the interviews. Only one of the women had English as a mother tongue, whereas the rest had other language backgrounds. As a consequence, in the rest of the interviews either both or one of us did not speak her mother tongue. This created possible barriers. Being aware of possible barriers due to language and realizing that different cultural backgrounds implies different ways of understanding, using words and body-language, made the barriers more visible. Rarely did I feel we misunderstood each other, and if we did we managed to clear it up quite quickly. It might be that I misinterpreted something a participant said or meant due to these barriers; I believe it would be naïve to think this didn't influence the conversation.

Another possible insight into the credibility of the study can be made by looking back to the interviews. A transcript with assumptions, leading questions and little response from the participants can make us believe the researcher has influenced the interview too much (117).

The study's transferability relates to the study's ability to transfer to other settings (117). This study is based on seven interviews with five women, and the results are as such not generalizable to other setting. The findings can however, provide some new insight into how non-native speakers experience their care. To generalize the findings to hold truth for all women whose mother tongue is not Norwegian in this situation has never been the aim of this thesis. Rather, it has attempted to describe and shed light on how five of these women experience their situation. Patton explains that research with small samples cannot be generalizable, but one can learn – often a great deal – from them and open up new territory for future research (113).

### **3.4.2 Dependability and confirmability**

One of the best ways to ensure the dependability – the consistency and ability of findings to be repeated – is to have another researcher perform an audit of the research process (117). This has not been done in this study, although the supervisors have been informed of the direction of the research process. The amount of time spent on analysis, where the coding

process was done in several stages and adjusted as needed, could also speak for the dependability of this study. The objectivity of the researcher – the confirmability – has been attempted to be described also under the heading of reflexivity. To let the experiences of the women speak for themselves without the influence of my opinions has been an active process. An audit trail of all my notes, interview- and correspondence logs and field diary have contributed to the confirmability.

### **3.5 Ethical considerations**

The project was not considered direct medical research and I did not need to apply for ethical clearance with the Regional Ethical Committee. This was confirmed in an exemption letter, see appendix A. An application to the Norwegian Center for Research Data (NSD) was submitted and approved, as seen in Appendix B. NSD extension permission was received when necessary, as seen in Appendix F.

Ethical issues pertaining to informed consent, confidentiality and anonymity of the women in this study have followed the directions given by the NSD. Providing the informed consent form has ensured a professional and ethical start to the interviews. The informed consent form can be seen in Appendix C. The sensitive nature of the topics discussed during the interviews required trust, and proper handling of material was prioritized throughout. Care was taken to ensure the women understood what they were signing on the informed consent form by going through it orally and let them read it. This was especially important seeing as there was a possible language barrier in the interviews.

All research material, such as code-sheets, interview recordings and transcriptions, as well as all other notes and materials connecting participants' identity to the study was stored in a locked location when in a material form, and in a designated password-protected external hard disk when in electronic form. All transcriptions were anonymized prior to starting analysis, also by leaving out larger sections of the material that could possibly reveal their background. Women were requested to be recorded, and all of them agreed after being explained how it would be stored safely, and only be used for transcription of the interview. Recordings of the interviews were done on a mobile phone in flight mode, but immediately after the interview was transferred to the mentioned password-protected external hard disk. All data has been, and still is, only accessible by the researcher.

I took great care in anonymizing the transcriptions and coded all sensitive information in a separate document kept secured in a password protected external storage unit. In the one interview where there was an interpreter present I chose not to get help in transcribing the interpreted part. The interpreter was only active for a small part of the interview and served to correct misunderstandings and help with occasional words. Had she been more active I would have seen the need for transcribing and translating these parts to be able to double check the translations.

Women's anonymity has been ensured throughout the thesis by not providing their country of birth, age or mother-tongue. This is especially important when the sample size is small. The hospital where they have given birth, any distinct features or details of their lives have been excluded to protect their anonymity. The names used in this thesis are pseudonyms and in no way resemble their real names.

The power-dynamic that is inevitably a factor in the interviews due to the researcher's role and women's potential vulnerability has actively been considered throughout. The important concept of "do no harm" has acknowledged how the women have been potentially vulnerable to stressors in the interview situation. A friendly, compassionate and genuinely interested approach to the interview setting, together with professionalism in the conduct of the study and the interviews have contributed to acknowledging these concepts.

### **3.6 Strengths and limitations of the study**

A limitation of the study is its small sample size. Despite efforts to include more women, the recruitment process did not yield more participants. The five women interviewed are representing their own viewpoints and stands, and naturally cannot speak for all women whose mother tongue is not Norwegian. Three of the participants represented Western cultural backgrounds, and it is possible this has influenced the findings. It is possible that a sample size with women from other cultural backgrounds would have different findings. At the same time, many of the viewpoints shared in the findings represented similar experiences to those described in previous literature, and the experiences might be similar for women across cultural backgrounds. The interviews were rich and the participants shared many experiences, and this is a strength despite the small sample size.

This study has attempted to build a strong foundation in its literature review and background, a strength that I believe have made the experiences of the participants more visible and contextualized OASIS. Further, the number of expert opinions and viewpoints have influenced the study in a positive way, creating a thesis having explored OASIS as a concept thoroughly. Possible method-triangulations could have given further perspectives into the experiences of these women, either through exploring the experiences of these women from other angles, or by interviewing other actors playing an active role in the women's lives. It is as such a limitation of the study that it did not include these additional viewpoints.

# 4 Findings

## 4.1 Introduction to the women

The five women interviewed represented different backgrounds, beliefs and reasons for coming to Norway. Their stories were rich, varied and they were open to sharing their experiences. They had chosen to participate for various reasons: wanting to make the situation better for other women, wanting to help out, or they were curious as to what would be discussed. Two women were from Europe, two from Africa and one from Asia. The reasons they had for coming to Norway included moving here for work either by themselves prior to meeting their partner or together with their partner and family reunion. They has stayed in Norway between 2 and 10 years. They all had partners they either lived with or were married to, and their partners were also from a foreign country. The names; Olivia, Maya, Sara, Emma and Nora are pseudonyms given to the women, taken from the list of top ten most popular names in Norway in the previous year.

The women represented various educational backgrounds: two had completed their secondary education in Norway and gone on to work or complete a University College degree. Others were university educated, specialists within their field and/or self-employed. They all held jobs that they were on leave from at the moment. They represented various symptoms; ranging from discomfort to dyspareunia to urine and/or anal incontinence. Further, they were at various points in their recovery. Sara and Emma had given birth approximately six months before the interview, Maya approximately three months before, whilst Nora had given birth as recent as four weeks before the interview. Olivia had given birth two years prior. Maya and Emma were interviewed twice, at nearly six months and one year after the birth, respectively. All had different levels of formal Norwegian courses, ranging from none at all to completing the “Bergenstest”. The hospitals where they had given birth is left out to protect women’s anonymity.

Their stories are shared through representation of the themes described in the table below.

## 4.2 Themes and Subthemes

The main theme and subthemes are presented in the table below.

<i>Main theme</i>	<i>Themes</i>	<i>Subthemes</i>
Doubly vulnerable	Coming to terms with the injury	The birth: unexpected turn of events The OASI: it was more serious than they thought Managing the consequences of OASIS Dealing with stressful experiences
	Reshaping their identity	Uncertain prognosis Being intimate and worrying about next birth Body image and doing exercises Being in a new country
	Care and caring in the health services	Feeling cared for during birth and surgery Needing rest at the barselavdeling Seeking care after discharge Role of language

## 4.3 Coming to terms with the injury

### 4.3.1 The birth: unexpected turn of events

Giving birth was an important milestone in the lives of the women. This was manifested in a need to discuss the events of the birth and tell their experience. The events of the birth, and the sometimes dramatic turn it took, was an experience several of the women said they were not prepared for. Sara explained how she had felt prepared for the birth, but had to be induced and give birth in a different way than planned:

*“It’s not the birth I would have wanted, and it really turned out not to be”.*

An unbearable pain that was so much worse than expected made the women request pain relief. Pain relief was not always attainable for them, either because the birth had progressed or the chosen pain-relief did not have the desired effect. The combination of having a long pushing phase, having been up for several hours longer than normal, and then this excruciating pain made three women feel like the baby was never arriving. They felt very tired and exhausted. Their pain was a source of feelings of loss of control, described by Olivia as being “sort of in a daze” and “so not with it”, and by Emma, who had been induced with oxytocin, as “I felt like I kept on losing it (...) I was a bit out of it”.

Nora is the only woman who had given birth before, and she sees this birth as better than the last one as she knew more of what was happening this time. She explains that her last birth was “unforgettable” in terms of the pain. She still describes this birth as really painful, and explain that she just could not take it although she originally wanted to give birth without ‘medicine’ and requested more pain relief. She says she just needed something, as she felt she was unable to endure it and could not even speak anymore.

The birth took a much unexpected turn for some of the women as the baby started showing signs of distress or was “stuck”. Two of the women subsequently had instrumental deliveries, whilst the other three describe a quick turn of events ending in that the baby “eventually just shot out”. For several of the women, and especially for the two who had instrumental deliveries, the unexpected turn was felt as a sudden change in the atmosphere in the delivery room. They perceived the situation as dramatic. The midwives who had up until this point been in control took a step back to give room for, as one woman described it, “a rush” of doctors. Emma’s feelings at this point is illustrative of how this change was perceived:

*“The vibe in the room changed, and she explained quickly what I had to do, and I didn’t see anything, but it felt unbelievably violent”.*

Having the baby out, and having him or her on their chest felt like a relief. Like the birth was done and they could relax a little. However, as we will see, most of them at this point were unaware of the tear and what this meant.

Prior to the birth Maya had been concerned whether her small frame would be able to birth a large child. She thought that in her country the weight of the baby was measured more often and more closely, and elective C-section was performed if the baby was big. Here in Norway,

as the baby was thought to be smaller than the limit of 3000 gram she was not given an elective caesarean. The baby turned out to be a bit of a surprise weight-wise, weighing over 3 kg, causing a fourth degree tear. On the other hand, she reasoned, she had learned that healing from a C-section could also be complex, and was in the end glad she had given birth vaginally.

Being back on a gynecological chair for a checkup after the injury also brought back difficult memories of the birth and one woman said she was scared before going for a check-up. She reflected back to her birth and found her contractions and long pushing phase what she thought about more than the tear itself. It felt difficult letting anyone back in that area. She illustrated her unresolved feelings about the birth in this powerful image:

*“If I think about giving birth I am scared of having long time contractions. Like, (...) it sounds horrible what I say now, but I read this crime-book where some woman got raped, and they used like some metal pipe. And I – not that I know what it is like to be raped - but I can picture a little what she must have felt afterwards.”*

#### **4.3.2 The OASI: more serious than they thought**

The awareness that they had been injured and sustained a tear came from listening to health workers talk amongst themselves or being given direct information about the injury. A common marker was that they knew that something had happened from the start, but did not know or realize the extent of it. After the birth all described focusing on the baby, and some explained how in that moment they were so happy to have a child that they didn't care if their bodies were 'a mess'. Immediately following the birth, some of the women understood that something had happened due to either the pain they experienced, or they picked up on cues from the health workers. Maya explains what happened;

*“I could hear them [midwives] talking, or, like, they said ‘oh, it’s a’ – like something had happened, a tear or something, but I didn’t really know what was happening”.*

Sara had a similar experience and remembers when she heard them talking in Norwegian about a 'complex tear' she thought 'uh oh, that doesn't sound good'. Olivia explains that the amount of blood she saw was worrying. However, at this point the women were feeling tired and 'beaten up' after birth and a few considered it 'just another thing on top' of what had already happened. Emma said:



*“I knew that I had one, but didn’t know the – like is it second degree? I didn’t know how bad it was”.*

Being sutured or wheeled to the operation theatre was experienced in different ways. Those who had had an instrumental delivery was wheeled to an operation room and the others were sutured in another room due to circumstantial events such as the theatres being occupied. Arriving in the operation theatre made Emma realize that something was going on:

*“I was thinking: ‘okay, what the hell happened’, like, ‘you need four people to stitch me up’?”*

Others had an impression that tears were a normal part of giving birth, and as they were sutured remember not feeling scared at all, just thinking that this was a normal part of the process of giving birth or finally finding an opportunity to relax. For these women, the realization that the tear meant more than they had thought came after being wheeled to the “barselavdeling”. They explain that they had some questions to the nurses as it was quite painful and there had been so many people present during the final stages of the birth. Nora explains these early thoughts:

*“I thought (...) that you get a tear and get some stitches and then it is okay. So I thought it was totally normal, not serious at all”.*

When consequences were explained they realized that this could have more effects on them than they had realized and that it was more serious than expected. Sara remembers feeling worried that this would cause possible embarrassment in the future, if she could not hold any farts in. Nora felt worried that something severe had happened to her, that it would affect her health in a serious way.

For some of the women, this realization that they had a more serious tear than expected came from their significant others who had been present during birth or from the reactions of others. When her partner told her the extent of her injury, Maya was surprised and more worried. She explains that her boyfriend phoned his family and his brother’s wife reacted with surprise, shock and worry at her tear. This made them realize that it could be potentially more serious than they had thought, and her boyfriend started reading a lot about what this tear could mean for her.

The realization that it was more serious than expected also came with the arrival of symptoms. They started thinking more about what it could mean, as the area was sore and

painful. Being incontinent, and having severe pain or no feeling when going to the toilet were early symptoms that concerned them. Olivia went to do pelvic floor exercises in a Pilates class arranged at the hospital and recalls when she realized her lack of sensation was not just a normal part of having given birth;

*“When I should’ve been pulling the physiotherapist felt nothing. I thought this is normal, but the other four women [in the hospital pilates class] could feel it and then (...) I felt a bit nervous that this is gonna take a long time, you know?”*

### **4.3.3 Managing the consequences of OASIS**

The initial period after birth was characterized by descriptions of pain in the area that had been sutured. Going to the bathroom was described as a difficult and painful task, especially for defecation. Nearly all of the women spoke of taking Lactulose or Dufalac to prevent constipation, and they continued this for a long time because they were afraid of what would happen if they didn’t. Maya explains how important she feels taking this has been for her:

*“To drink Dufalac, that is important. It is a drink that makes it easier to go to the bathroom, because it is important – very important – as it is really, really painful.”*

Some felt that they were not able to hold in urine or faeces, and ‘when they had to go they had to go’. Others could not hold it all, and experienced difficult situations of not being able to have control over when they defecated. This meant having to wear adult diapers at all times in the beginning. The women took care to avoid pain during defecation by not pushing when they were sitting on the toilet. They also took pain killers in the beginning. For some the pain subsided a few days to weeks after birth, for others it could last up until six weeks. Many of them described some level of pain during sitting down, and an uncomfortable sensation that came when they put pressure on the sutured area. Nora explains what she did when it became too uncomfortable:

*“When I sit down for a long time I can feel that I need to move, or kind of do something. I have to move. I can’t just sit still in a hard chair, I can’t do that.”*

They solved this uncomfortable feeling by moving around a lot, alternating sitting, standing and lying down. To rest a lot was described as important to feel improvement. Moving around outside was painful, and a few described not really going outside for the first weeks. Lifting heavy things was also avoided, for some also including reducing the amount of time spent

carrying the baby. Two of the women talked about changing their diets to accommodate their symptoms. Olivia describes what she had to change:

*“I changed the way I ate, because eating carbohydrates isn’t good when you have incontinence and can’t control anything”.*

Maya also ate more vegetables and meat to become more regular in her toilet habits. Imodeum was seen as a good alternative when having to go out and exercise to avoid uncontrolled leakage of faeces.

The women spoke about breastfeeding and said it was an important activity for them. They had a wish to do what was best for their child and thought it was a good way to connect to their child. They were told that due to breastfeeding, their body could feel ‘loose’ and that when they stopped breastfeeding the control over their pelvic floor muscles would improve. One of the women chose to stop breastfeeding altogether as the symptoms of the tear became too much for her to cope with. The women also tried to improve the function of their pelvic floor muscles with commencing to do exercises daily. They placed various emphasis on this, but four of the five women had started doing exercises within the first days or weeks after the birth. Three of these described doing rigorous pelvic floor exercises daily, and one did them when she remembered. The one woman who did not do pelvic floor exercises had not been taught how to do them and did not know what the exercises entailed.

Reading and looking for information on the internet was a strategy used to learn more about the tear, what it meant for them and how to care for the area that had been sutured. In Mayas case, her boyfriend had read a lot and passed on to her what he found. Emma says that “a lot of the information I got, I definitely got from the internet”.

#### **4.3.4 Dealing with stressful experiences**

*“In the beginning I was thinking a lot, like ‘will it ever improve? (...) it was very difficult, like; ‘will it be like this always?’” Maya*

These worries Maya presented were typical feelings for the women. Talking about the tear, the events surrounding it and the changes it had brought to their lives was a reminder of the tough experiences they had. The pain of the birth and the pain they experienced afterwards, both physically and emotionally, represented feelings some described as wanting to forget. Two women spoke of wanting to forget the memory of the birth as an active approach they

took to dealing with it. Often, the focus was kept on the baby, and thinking how grateful they were for their child. Those who did not attempt to forget the experience dealt by trying to accept what had happened. Sara, for instance, explains how she chose to trust the gynecologists involved in the birth:

*“(...) it is better to believe the gynecologist, and believe that it was unavoidable rather than get upset. Like this was not necessary and could have been prevented. I think it’s better to accept it and stick to that story, even though it might have been preventable, I don’t know”.*

Others chose to believe what had happened to them was a bad mix, just having bad luck. They realized that it took time to heal, and some believed that healing would happen naturally as time progressed. To help with this process some described having to rest a lot. Maya, who after 6 months feels healthy again, said:

*“Time heals. It doesn’t help to stress – it is stressful – but it doesn’t help. Stressing about it just makes it worse”.*

Some took an active approach, and found doing exercises and/or going to the gym a way of dealing with the stress. Three of the women described this. At the same time, not seeing progression made Olivia think about making some changes:

*“I have been working with this machine up until now, but (...) doing my normal exercises is actually better because I will never get the strength they [the physiotherapist and the settings on the machine] want me to on the machine and it sort of makes me worry more. If I just do my daily exercises I can cope with it every day”.*

The women felt sometimes that there was an emotional aspect to having the tear that surpassed the physical symptoms. The events surrounding the tear, such as the birth and their experiences with care, also impacted on how they dealt emotionally with the tear. Some remembered fondly health personnel who gave encouraging advice. Although the birth and the events surrounding it were difficult, they felt that the experience also gave them their child. One woman stated that she realized others might not be as lucky, so she felt grateful for her family. Maya, who initially had attempted to forget her experiences, said that after having some time to process she was able to consciously see the birth in a new light:

*“In a way I am happy that I gave birth vaginally too, that I gave birth naturally – that I could do it. It hurts, but it turned out okay. It is a child I have put into life, sort of. Giving birth naturally – you kind of get very proud of yourself too!”*

All of the women commented on how the support of their partner was important. They spoke of having the partner there to share the experience, and have him support them emotionally during the birth. The partner was for some of the women also a source of information, as he was the one who took over the communication with the midwives and the nurses when they themselves felt unable to due to pain and feeling tired. Those who themselves tried to forget the bad experience of birth said that they thought their partner also used this approach. Even though her partner was not a talkative person, Olivia felt that her husband realized how bad it had been based on his reaction when the topic of birth was brought up. Their families were involved in various way. Nora's mother had travelled from her country to stay with her after birth, and the mother in law of Maya had also visited her a lot in the beginning after birth. Others chose to involve their family less, although they knew what had happened.

## **4.4 Reshaping their identity**

### **4.4.1 Uncertain prognosis**

The women saw having the tear as a new mother as something that added an extra layer of stress to an already stressful situation. Their new situation was seen as overwhelming. Some didn't understand what was normal in terms of pain and continence after birth and what was expected to be due to the tear. Having known more about what problems would be expected to be due to the tear was seen as something that would have eased their worries.

Some experienced their new situation more difficult than others, and described it as a 'sort of sad, or weird feeling', that they now had a child and had to do things they weren't used to. Lack of sleep, breastfeeding and soothing their child were activities demanding their attention. Emma wished that she could sleep more, as she saw sleep as a good way to subconsciously work on difficult thoughts. Others mentioned crying at various points because they felt overwhelmed, tired or like they didn't understand their new situation. Finding time for themselves was a challenge – and sometimes they felt that all they did was breastfeed, care for their child or do pelvic floor exercises. Not having time for themselves at all was seen as something that made their day difficult.

Not knowing what causes a rupture, or what happened during their birth to cause the tear was also causing uncertainty. They sometimes had to reason with themselves to explain why the tear happened, like Nora does, illustrated below:

*“I had to push – push too hard, not only the head but also the hand, so that could be what caused the tear, but I don’t know that. (...) They [health professionals at the hospital] didn’t tell me why I got the tear, the only thing they said was that they hadn’t been told that I had had a tear before, but they didn’t say why I got it. (...) I didn’t know that that was something I had to tell them, and no one asked me either (...) I have been thinking inside, that I pushed too hard, I have thought that I don’t know why you get a tear. (...) I thought maybe I have used the wrong technique to push, or pushed too hard, but you have to push as well, and they tell you to push, so...”*

For those who were aware why they had teared, they had found out either early on at the hospital or had to seek the information at controls later on. They also struggled with insecurity about the state of the sutures or scar. As one woman said: *“I didn’t study medicine, I don’t know how it’s supposed to look”*. Wishing that someone had looked and done a thorough check early on was expressed by some of the women. Sara, especially, expressed this; she was surprised that she hadn’t been examined at the hospital, nor at the control with the general practitioner at six weeks. Olivia, who suffered from quite extensive symptoms, did not have a thorough vaginal check until she was seen by a physiotherapist a few months after birth, something that *“was basically what I needed”* to receive a referral to see a specialist. The three other women describe receiving vaginal checks at the hospital or with their midwife at their *“helsestasjon”* or their GP. Having a trained professional see the scar and say that it looked good eased their feelings of uncertainty and reassured them that they were healing properly.

#### **4.4.2 Worrying about a possible next birth and being intimate**

The possibility of a next birth and second child was a topic that concerned all the women. They experienced uncertainty as to whether or not they could give birth vaginally a second time; if their muscles would be able to accommodate a second birth. When becoming pregnant, Emma had always thought she only wanted one child. She reflected on how, now, facing a possible reoccurring tear if she ever wanted to give birth again, she had started to think more about a second child:

*“I think if I knew I only want one kid it’s fine, I could put it in a box and think, okay this chapter is over. But this box is still open if I want another kid”.*

They discussed the possibility of a scheduled C-section, and not all of them were sure that was an option for them. Maya had been told that next time she would definitely need a C-section, and was comforted by the news. Sara was given the same information early on at the hospital after her surgery and felt alarmed, as this was not her preference. She was later able to discuss it with health personnel and found it would depend on her symptoms, and her own wishes. This news comforted her. As it was quite early after birth for many of them, they did not voice specific plans for a next pregnancy. However they appreciated greatly to be able to discuss a possible next birth with health personnel already at an early stage.

Resuming an intimate relationship with their partner was a topic they spoke about with unresolved melancholy and solemnity. The OASI and its consequences was considered an injury that affected their partner more than any other injury would. Olivia spoke of what it was like for her:

*“I hardly had any sex life because I didn’t want to be near my husband, and also because I was worried that something would go wrong you know? And also because I feel I can’t use those muscles. And you kind of need them to have sex. And I ask my husband, and he goes ‘no it feels exactly the same’. So I thought ‘oh that’s good then’, but for me it felt different. So yeah.”*

It also took some time to let someone emotionally back into ‘that area’. The feelings of not having sensation in their vaginal area was described by all of the women who commented on their sex life. In total three of the women commented on sex and intimacy, and two of them did so during the second interview. Having hemorrhoids contributed to why one woman saw the area differently than before the birth. One woman who spoke about sex said she and her partner had not tried having sex yet, due to her not having sensation, and feeling like the area was not the same in terms of feeling very dry. Two women had been advised to use lubricants during sex, and all of them had been informed by a physiotherapist or read on the internet that when they stopped breastfeeding it would feel less dry. Olivia remembers when being asked by her physiotherapist if she and her husband had sex, she started crying, as it was so hard to start having it. Having sex again felt easier for one woman when the overall surrounding for the scar improved, as she had more feeling in the area and was less dry due to breastfeeding.

### 4.4.3 Body image and doing exercises

The tear was not the only thing that changed their body. After the pregnancy their bodies changed from having a big belly to it suddenly being gone, and their core felt weak in general. Emma felt that between the weak core and the weak pelvic floor that the whole area was, in other words, ‘a bit of a mess’. The three women who knew about yoga before saw this as a benefit, as it increased their body awareness and it helped them having some experience in how to do the pelvic floor exercises. At the same time they all said that doing the exercises did not feel the same as before. They had been told about doing the exercises by various people, some had been told by the midwives or nurses at the hospital, others by the physiotherapist and others again by professionals that they met in social situations. Two of them commented on feeling surprised about the emphasis doing exercises was given after returning home from the hospital. They felt that pelvic floor exercises were important to manage or prevent symptoms of incontinence.

Nora had been told of the importance of the exercises, and could recite how many she should do, but found she did not understand what the ‘pelvic floor’ entailed and said:

*“When I was leaving the hospital I was told I have to see a physiotherapist, because you have to practice it, have the technique, and I have to make an appointment. I thought (...) doing exercises might hurt the wound a bit, that you – I don’t know what kind of exercises they meant, but I thought you needed to be well again to do it. But I haven’t been told - I mean, this is my opinion, but it hasn’t been checked”.*

Others had gone to the physiotherapist and had gotten help in how to do the exercises and how often to do them. How to do them correctly was a concern when they could not feel properly and compare to the way it felt before. The extent to which they did the exercises varied from “I do them when I think about them” to “I do/did them three times every day”. Sara mentioned how useful she found using an app to get daily reminders and aid her in doing the exercises. The physiotherapist had also helped Olivia with adjusting the way she walked and used her muscles in her back, as they would contract and spasm when she tried to hold in gas, but could not. She had also, as the woman with the most severe symptoms, received a device to start treatment at home with electrical stimulation.

The women described several barriers to doing the exercises and one of the hardest factors was finding the time to do it. Especially prioritizing exercise while caring for a newborn was a challenge. Sara described how motivation and finding time impacted her:



*“The motivation I think is the main thing. Feeling like I can’t do this, feeling like I can’t hold it long enough, can’t do it properly, so I might as well – and not seeing improvement in terms of incontinence. So I find it very difficult, even now when the baby is more independent, but especially with a newborn, to find the time during the day to put the baby down and focus on doing exercises, I find that very difficult.”*

When not feeling improvement or having stagnated at a certain level, the women were discouraged from doing the exercises. Sometimes it felt like all they did was do pelvic floor exercises. At the same time, many of them recognized they had to continue doing them still, and with not doing the exercises came a feeling of further reduction in function. Taking their time, and believing they would improve eventually was a hope for them. When experiencing improvement, it was a great feeling that encouraged them. Emma describes what happened for her:

*“I don’t know if I was ambitious or what, but I did these exercises every day and I was really on it. I could feel myself it was just going up, and (...) there was just this moment where it felt like \*snaps\* it works better and also I can do like back and front now. That was like for me, great wow.”*

For two women, pelvic floor exercises was seen as something they would have to continue for the rest of their lives.

#### **4.4.4 Being in a new country**

The women felt the care they received in Norway was different from the care they were familiar with from their home country. One of the main differences mentioned by nearly all of the women was that in Norway you saw your general practitioner during your pregnancy and not a gynecologist. They were also unfamiliar with midwives delivering babies instead of gynecologists/obstetricians. Olivia shared what she thought in the beginning:

*“In my country we have gynecologists that deliver babies, so at first I was a bit nervous about the whole midwife thing. But then I was speaking to her about it, like, if you are not a doctor then how can you do this? (...) But she was really amazing and I trusted her.”*

Accessing the care was a source of confusion in the beginning. Emma explains that she had to see her general practitioner for some additional tests, but without the scheduled tests she “would have no idea how often to go”. Sara relates to this feeling, and explain that trying to find a physiotherapist after returning home from hospital was difficult:

*“I had no idea how that [finding a physiotherapist] worked. In the end I found out by googling, and I know enough Norwegian, or am good enough at Googling to find out who offer support for women.”*

The comments regarding physiotherapists also related to confusion as to who was private and who was funded by the municipality. In the end, several of them ended up or considered going to private practitioners despite feeling the price was too steep.

Two women reflected on Norwegians' views on pregnancy and motherhood. One woman commented on how she perceived Norwegian health professionals as handling the pregnancy like it was not a disease. Also, they had perceived that Norwegian women wanted to give birth as naturally as possible.

Nora had given birth once before, right after arriving in Norway many years ago, and saw the experience this time as completely different. Her being new to Norway back then meant that she had not understood as much as she did this time. In relation to the most recent birth, she spoke about several traditions in her home country in Africa she more or less adapted. One of the traditions was to not leave the house for forty days, as the baby was not baptized. Nora is the only woman who mentioned religion. She explained how her Christian faith meant that the babies in her home country could not leave the house for forty days, as they were susceptible to illness. After the baptism at forty days the baby could leave the house. She had decided not to follow this tradition and to leave the house. She explained that if she had been in her country she might have followed it, but not here in Norway. Her mother had to accept it – she was going out to get fresh air, not sitting indoors. She also explained that a special porridge was prepared for and eaten by new mothers, and they were also encouraged to drink milk for its nutritional value. The porridge was to help for back pain and to heal faster. She enjoyed the porridge, but thought it was calorie rich and she wanted to not gain too much weight.

Emma reflected that it felt that Norwegians are so tough, that she had the feeling she had to be strong. Being away from her family and always having a language barrier contributed to this feeling. She said;

*“Often so much is expected of mothers, being in shape right away and working out right away, and sometimes when I see videos on Facebook that there is some woman who did the marathon three months after birth. (...) But then again, if you are a foreigner you are stuck at home, and all you see are these kinds of videos on Facebook”.*

## 4.5 Care and caring in the health services

### 4.5.1 Feeling cared for during birth and surgery

Although the birth had been difficult for the women, they had good memories of certain midwives who were perceived as caring, motherly and helpful. Warm touches, encouraging words and a safe demeanor was important for them in order to feel cared for during birth.

Looking back at her birth, Olivia recollected:

*“My midwife, she was really good. She was the one deciding everything actually, the doctors just stood back in case they had to do something. (...). But she was really amazing, and I sort of trusted her and felt she was very in control. I felt very safe and she was just very in control”.*

For Maya, having the midwives supporting her emotionally and physically, giving her encouragements like “you can do it” and “come on” was considered helpful for her when going through the pushing phase. In the end she had held on to a rope held by the midwives, and pushed with all her might. Olivia wondered if she had kept to quiet during birth, and noticed that her midwife really couldn't tell how she was doing. She herself felt she wanted to save her energy and the midwife was, “like, save your energy for what?”

The midwives were often seen as “*a mother there, very caring and in control*”. This feeling is shared by the women, but two had a change of shift during birth and did not have the same perception of all the midwives they had met. When the midwife had seemed insecure, Emma felt that it affected their interaction, and was more on guard. When her birth took a more dramatic turn, the atmosphere changed along with her perception of the caretakers. Sara and Olivia also present a sudden change of atmosphere where orders were being called and midwives and doctors were speaking amongst themselves. Not all of them had a doctor present during birth, and Nora remembers:

*“When I gave birth they [midwives] had to check – like how big a tear it was, and they were talking together and I didn't understand their language then, but they were talking together and said that first – the doctor have to check the tear, they couldn't do it themselves”.*

Being wheeled to the operation theatre or transferred to another room to be sutured in was either a situation where women were made to feel safe or had experiences that scared them. At this point, none of them had realized the extent of their injury. To illustrate this situation,

two women had complete opposite experiences of the same situation. Emma's feelings are presented first:

*“I said to my boyfriend afterwards, when they rolled me into that theater, I said to him, I think I have a trauma. Just seeing this, and being there seeing the ceiling rolling above me, you are so out of it. And when I came into the surgery room – I was like “shit, this is really a surgery room”.*”

Her recollection of the events is feeling traumatized and scared. Sara, on the other hand illustrates that the part of this process that also made other women feel safe had a lot to do with the interaction with the caretakers. She recalls:

*“And what was really good is that this midwife - I remember being wheeled out – she actually held my hand the entire way to the operation theatre. That was very nice, to have her face above me.”*

Other women also remember having the midwives and doctors reassuring them that everything will be fine, and this made them feel calm and safe. Both women who had been wheeled to an operation theatre remember the staff there as nice, professional, accommodating and skilled. The other women had been sutured by their midwife or doctors present at birth. All of them spent some time, varying from a few to twenty-four hours, at a post operation room. Their partner and baby was allowed to visit and this was a joyful reunion. Needing rest at the barselavdeling

Being at the “barselavdeling” was a bag of mixed experiences. Nora sums it up as “quite okay, but not really”, effectively voicing the experiences of the other women as well. All of them voiced some dissatisfaction with their care and had negative experiences at the “barselavdeling”, but the extent of it varied greatly. Three of them had their partner able to stay with them, and this was considered vital by Emma:

*“Then I was brought to my room, and the good thing is that my boyfriend was allowed to stay with me. So we stayed in our room, and they said we were lucky, because normally they didn't have that space. And I was thinking; honestly, if my boyfriend couldn't stay with me I would have a nervous breakdown, and luckily he got to stay there.”*

The two who didn't have their partner there to stay felt alone, vulnerable and like it was too much to handle. As within the birthing room, those who experienced staff they perceived as caring, motherly and helpful and as “seeing the whole picture” had more positive perceptions of their stay. The sterile, dramatic and acute medical situation some had experienced during

birth was difficult to deal with, and the bad feelings this gave them were exacerbated by staff at the “barselavdeling” who acted busy, dismissive or were perceived as rude when they asked for help. Nora recalls how she, without her husband there, felt that she spent her first night alone:

*“And the baby was crying. I didn’t have that much experience with breastfeeding from before so I needed help with that too. I tried, but the baby just wouldn’t calm. So I asked them [the nurses] if they could take the baby because I was so exhausted, and I couldn’t endure it anymore, I just wanted to sleep. And she [the nurse she asked] said that if she was crying ‘we will bring her back’. And I was thinking ‘oookay, but do you not realize that I just gave birth and am so tired’. And they brought her back almost right away. And she didn’t say it in a nice way either, so I was just, I don’t know what to say, I was just a little disappointed. I understand they are busy and everything, but she could have said it in a nicer way.”*

For the rest of her stay she refrained from asking for help to care for the child, but she received help with practical issues. Except for this first night she felt that the staff was helpful and friendly. The women were in general feeling “completely exhausted” and “so tired” during their stay at the “barselavdeling”. Nora is not alone in feeling that she did not receive the care she needed in the beginning. Maya was also alone the first night, and she struggled with sharing her experience there and just wished to forget it altogether. She cried as she explained how she felt:

*“I was in so much pain and it was hard to – because they had said I shouldn’t carry the baby, but there I had to carry the baby. And I had never changed a diaper. And I asked them for help but they said I had to do it on my own. And they didn’t stay there with me (...) and I couldn’t walk properly. I was in pain. And then I had to care for the baby. The first night (...) she said ‘you have to get up yourself and then walk yourself’ and I just felt I couldn’t walk and she just stood there, and I had to ask again ‘please can you help me get up’. I think it’s a, it’s a bad memory.”*

The other women felt that they could ask for help, and got sufficient assistance in how to commence breastfeeding, and also experienced that the nurses offered to look after their child while they rested. For Maya and Nora, when their partner could come back the next day they felt that they finally had an opportunity to rest and receive help with caring for the baby. A constant change in staff at the “barselavdeling” made the women feel that although the staff was nice and friendly perhaps sometimes something was missed about their care. Emma explained that she had to be observant the first night:

*“I asked again about breastfeeding situation and they said “don’t worry they gave him something”. (...)said to my boyfriend, sorry this doesn’t make sense, and I asked him; “okay so if you were with the baby the whole time then when did they give him food?” (...) And he got up to go ask and right that moment someone came in and said like “oh, oh we had the wrong baby, yours didn’t get anything”. And then we got the breastfeeding started.”*

This perception that they were understaffed or busy was shared by several of the women. In regards to the tear, the women were approached with information about this at various points of their stay. Some were informed and explained as they arrived at the ward for a “welcome conversation”, and others had someone come and inform them after several days. They stayed in the ward for approximately 3-4 days. The content of the information was often limited to “they said that I had a big tear, but didn’t say anything more about what it could be” and informing them about possible consequences and give painkillers and Lactulose/Dufalac. One of them had a visit with a physiotherapist who explained a bit more in detail what it meant, and introduced her to exercises. They thought it was good to be able to talk to the midwife or doctor who had been present during birth and discuss the birth and the tear. Emma experienced that a different doctor than the one who had been there during birth came into her room and said “I heard you wanted to speak, so you have some questions?” She remembers feeling silly during this meeting, trying to come up with a good question, and was just left feeling perplexed. She had the following to say about how much it would mean to her if she was able to talk to her midwife or doctor again:

*“And I still describe this moment, since the doctor didn’t talk to me afterwards, at least not the day afterwards and I never saw the midwife again, it felt like: It felt like the light is turned on, and the cockroaches are disappearing – it’s like oh shit – a third degree – off and away! That’s how I felt a little bit, no one wanted to be confronted with this again.”*

In summary the stay at the “barselavdeling” was a place they needed rest and care, but were not always able to get it due to a perceived busy or dismissive staff. When staff was warm and kind, and offering to help they were left with a more positive impression of the care and felt better equipped to deal with their baby and themselves.

#### **4.5.2 Seeking care after discharge**

Two women mentioned that they had a visit from the “helsestasjon” a few days after returning home. This question was not asked specifically, so some of the other women might also have had this. The two who mentioned it saw it as a positive thing. The nurse visiting informed

them and “basically did what the hospital should have done” in regards to providing information and translating difficult medical terms.

Olivia was the one of the five with the most extensive symptoms. She spoke to the staff at the hospital about her concern but was told to give it some time and that her symptoms of incontinence of urine and feces were normal ‘once or twice’ after birth. She goes on:

*“But even when I told my GP the first time she said like ‘oh yeah this happens’, but I had to keep on because I don’t think they realized how bad it was, so I had to really push to get them to hear me. And also it’s embarrassing to try and explain it all over and over, so I found it difficult, you know.”*

She finally had her problems taken seriously when seeing a physiotherapist after about two months, and receiving a referral to a specialist.

Four of the five women had sought out treatment with a physiotherapist. They had varied experiences. Sara felt that the physiotherapist “did little more than to tell her how to do ‘knipeøvelser’”, which she could have thought of herself. Maya went back after six weeks to a control with the physiotherapist at the hospital. Before going she was dreading it a bit, but she saw the physiotherapist as good, taking care to explain to her everything she was doing and told her she need not worry. To have a physiotherapist do an internal check was perceived as weird, but they understood its relevance after being explained the importance of checking the function of the muscles properly. Not all of them had the physiotherapist check their muscles internally, but rather just on top of the underwear or not at all. Olivia felt her physiotherapist was mostly concerned with getting her body stronger again. Most of them had few health professional outlets to discuss their emotions with, rather choosing to do that with family or friends. Not all of them had this opportunity to share with family and friends.

To have caretakers give professional advice, telling them what to do and don’t do and follow up with them in controls was considered important. “Being kind” was described by Maya as the most important quality a caretaker could have. When asked what “being kind” entailed she described a caretaker who asked her how she was doing, listened to her and gave her professional advice on how to move forward. Olivia felt her physiotherapist was mostly concerned with getting her body stronger again, and had few opportunities to discuss how she was doing emotionally. She said she would have benefited from talking to someone about her feelings around the six-month mark of her injury, but felt that this was not initiated by any of

the health professionals she met. Sara described how she, when feeling unmotivated at the lack of improvement of symptoms, had a need to discuss her emotions, but rarely got the words out the way she wanted due to language barriers.

The follow-up controls they had at the hospital in regards to the tear varied from 6 weeks, and a scheduled control at six months for the one who gave birth at AHUS and those who gave birth at Oslo University Hospital received a control after one year. Several were confused as to when and how the controls were happening. They also had the six week control with their general practitioner as scheduled for all women after birth. A few of them, when they felt uninformed considered or decided to see specialists; either by insisting on referrals from their general practitioner or by seeking private care in Norway or when visiting their home country.

### **4.5.3 Role of Language**

Topics on information, language and connection with the health services were discussed during all the interviews. Having different backgrounds, and different needs for information, their experiences varied accordingly. Collectively, they did not mention that they saw themselves as immigrant women, although this question was not asked directly. Rather they reflected after the fact on their experiences with language, and a great deal of focus was given to how language could be perceived as a barrier to both receiving information and also to be able to emotionally connect to health personnel. Some seemed to not have reflected that much over language. If that was the case, discussing the role of language was easier to talk about when asked how other women in the same situation might perceive the situation.

Two of the women described experiences pertaining to language that occurred already in their pregnancy, causing them to miss out on relevant information. Both events occurred at the “helsestasjon”. Olivia had all the information at the “helsestasjon” being given to her in Norwegian. She was told by her midwife there that they did in fact have English material:

*“(…) but then she couldn't find it, so I never got the book on breastfeeding. Cause when I got to the hospital and they put the baby on me I asked if they were going to teach me how to breastfeed, and they said 'well, didn't you get the book', but I never did because they never had the one in English”.*

In Emma's situation, she had some trouble with mutual understanding with the substitute who covered for her assigned midwife. To overcome the language barriers they tried speaking a



mix of English and Norwegian and as she said “a looooot of silence”. She needed some further blood samples, and explains what happened:

*“I did not understand what that means [reason for having to have additional blood samples], and I tried to ask ‘what does it mean?’ And yeah, it didn’t work out. I ended up googling it, what that meant. (...) and it’s such a funny story to tell, but that moment sucks. Its still- you’re pregnant, and it’s your health.”*

The women thought their fluency in either English or Norwegian would be sufficient for communicating with their midwives during birth. They figured ‘it would be fine’. This preconceived thought that it would work out turned out to only be partly true. Olivia, who does not speak Norwegian herself, but understands basic conversation, had a nurse speak to her in Norwegian and found that “I sort of understood basically what she was saying so I sort of got by”. They expressed greater satisfaction with personnel who spoke English fluently, as compared to those who were perceived as more reluctant to speak English. Emma experienced this and said:

*“I’m fine if they don’t speak English fluently, but the problem I had with for example the midwife was that I felt it definitely stopped her a little bit, that she felt like ‘oh, my English is not good enough’. It doesn’t matter if the grammar is not good enough, it doesn’t matter to me.”*

Three of the women were more fluent in Norwegian than the rest, and they had also varying experiences. Those who spoke some Norwegian appreciated those who gave them an option to speak either Norwegian or English. Sara explains why:

*“With me, if people start in Norwegian, I won’t ask them to switch to English. Whereas I probably should. (...) if I switch to English I find often that the health personnel is not quite comfortable in English, and then I don’t push it either. (...) we start in Norwegian, and we speak Norwegian until we get stuck altogether.”*

This perception that health personnel was uncomfortable speaking English was a general feeling. This had implications for the connection they felt to health professionals, and their ability to discuss their emotional concerns. They often thought it would have been a nicer atmosphere or they felt like they would have received more information if they were fluent in Norwegian.

Sara had reflected over her position as someone who spoke quite well Norwegian, but preferred English in a health setting. She said that although it was her preference to practice

Norwegian in any other setting, this did not apply to the health services. She felt that it was quickly assumed by others that she spoke Norwegian well, and that this made health personnel believe they had someone across from them who was managing just fine. She explained why talking about the psychological and emotional effects of the tear in Norwegian did not manage to pick up on the nuances of her emotions:

*“I found it very difficult to talk in Norwegian about how I was feeling. Its’s like “jeg er ikke veldig motivert”<sup>2</sup> æææh “det er vanskelig”<sup>3</sup> æææh \*signaling words get stuck in her throat\*. (...) Understanding is not the problem, it’s the speaking and the communication. Especially the emotional part, how you actually feel about it. And if you only know two words, ‘det går bra, det går ikke bra’<sup>4</sup>, then you don’t have any nuance in between.”*

Emma also found that sometimes she felt like patient from a lower class, always having to ask if health personnel spoke English. It left a barrier between her and the person she was speaking to that made it feel like she would have gotten more information if she spoke Norwegian.

As the only participant who had given birth before, Nora was in a good position to compare the situation of giving birth from when she was new to the language, and now nearly ten years later when she felt fluent. She said that the experience this time was completely different, as she the first time lacked the language to understand what having a tear entailed. She said:

*“I was new to Norway at that time so I didn’t speak that much Norwegian. I don’t remember that much, but I can’t recall if they offered any pain relief. They might have asked, and I might have just said no because I didn’t understand. (...) They have probably told me that I had had a tear and was sutured, but what – like what I could have done then and such, I haven’t picked up on”.*

Nora further went on to talk about how she had felt confused and uncertain if she had understood everything correctly at that time, and how she now made sure to ask if she didn’t understand. She highlighted the importance of mutual understanding, and emphasized how important it was for health care workers to make sure the patient understood by asking follow up questions. She said that this was of great importance, because sometimes it was easy to say “yes” when you didn’t understand something. Maya was of the same opinion, she felt that she connected best with health personnel that understood her, as she thought herself that her

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<sup>2</sup> English translation: I am not very motivated

<sup>3</sup> English translation: It is hard

<sup>4</sup> English translation: I am fine/I am not fine

Norwegian was not that good. She noticed that when she asked questions, the health workers were not used to explaining concepts in different and thorough ways, so it was best when they understood each other right away.

Nora also mentioned that her husband had functioned as an interpreter at the previous birth because she did not understand the information given. Having their husband relay information or translate information was experienced by nearly all of the women. Those whose husband interpreted for them did not problematize this, but saw it as helpful to have their partner there to translate. Maya illustrates the important role her boyfriend took:

*“The doctor came and talked about – actually, it’s hard to say because I didn’t understand everything, but my boyfriend told me. (...) They said, as far as I know – they said a lot that I didn’t quite get. But my boyfriend knows everything.”*

Others had help from their husband interpreting and translating when their own understanding fell short. This extended to translating written information in regards to the tear. When questioned about the amount of Norwegian papers and information she had - among other papers one instructing her to fast before a control - Olivia said:

*“Yeah I didn’t understand any of that. Usually when I get a letter I just give it to my husband. He usually just says if I have an appointment or not, and I can see that. (...) Yeah I didn’t do any of that. Because I didn’t, see, I didn’t really read all of it very well. And that’s the thing. It’s the same now, I get all these letters in the post and I don’t understand them. The general stuff I understand, but the medical stuff I have no idea what they’re trying to tell me.”*

The notion that medical language was hard to understand was commented on by nearly all the women. They did not understand what was communicated when doctors used medical language, and then trusted that the partner who spoke more Norwegian would convey the contents to them.

When asked what was important for someone not speaking the language when meeting health professionals the three who commented on this said the most important was to have someone interpret. They said the best interpreter was someone who spoke the language well, but simultaneously was someone they trusted. The partner or someone close to them was ideal. At the same time; two of the women would not consider interpreting for their family in the health services as it was seen as difficult to interpret for someone. Without being aware of this contradiction Emma presented a solution that she would consider for her next birth:

*“For my next birth I would definitely consider having a doula, so that I’m not alone in that situation. Someone that has more birth experience and is perhaps good in English and Norwegian and can be in between.”*

Sara also recognized that caring for someone not able to communicate properly required an extra level of empathy. To understand that this was a really tough situation for someone to be in, required more of the health personnel. She explained further:

*“I can’t imagine being a nurse or a midwife and having a patient that you cannot communicate with. It makes it difficult. It makes your job more difficult, so it’s maybe a birth you would not want to be assigned to in that sense.”*

In regards to written information, the women had mostly been given information in Norwegian. Sometimes the information had answers to questions they had towards management of the tear, but had not been given the answer to orally. Nearly all received a version of the written patient information recommended in the guidelines of the Norwegian Medical Association. They had rarely read this, as they either didn’t understand it or had not been able to process the information. Two of them had received a list of suggested physiotherapists to call after discharge. Some of them received help by health personnel to go through written information and explain the medical concepts to them.

# 5 Discussion

This project set out to describe how women experience sustaining an injury during birth in the context of having a different mother tongue than the resident language. The main issue that emerged from the material is how sustaining an OASIS is described similarly for women across literature, countries – and now also across language barriers. The women in this study came from three continents and all of them had unique experiences. However, some of what they said align with already established knowledge; OASIS impacts and changes physical and psychological everyday life. Following is a discussion of the findings starting with a discussion of communication, language and the role of the health care workers. These topics attempt to illuminate the objective of the study of exploring these women’s views on care and communication in the health services. Further, a discussion of women’s experiences in the light of the conceptual framework attempts to show how women started the process of coming to terms with their injury and how it related to their bodily experiences and sense of self. By doing so, the discussion attempts to illustrate the objectives of inquiring into how these women perceive and cope with the OASIS and what factors contribute and influence their understanding.

## 5.1 Care and communication in the health services

In this section, the experiences women had with care and caring from their midwives and doctors during birth, nurses and staff at the postnatal ward, general practitioners and other health professionals after returning home will be discussed. Their views on communication linked to these topics. In the end of the section is an appraisal of how language was a central actor in their experiences of connecting with health care workers.

### Care during birth

Despite some of the women seeing their birth as a traumatic experience, several recall feeling safe during birth and felt taken care of by caring midwives. In cases where they didn’t feel a connection to the midwives, the experiences were contrasting as the desired partnership between midwife and woman was absent. A shift in atmosphere is described when midwives had to step back to give room for obstetricians, and the picture of the caring midwife is replaced with the “career-woman” doctor. Instead of a partnership, it became a matter of

being told what is going to happen to ensure a speedy and safe delivery. In the acute setting, it is perhaps understandable to view communication as a lower priority when there is a risk for mother or baby. For the woman, however, it can make a great difference to have the information and the support needed to retain her agency.

When discussing experiences of embodiment and disembodiment during the birth, it has been concluded that an inter-personal connection with a caretaker could be crucial to avoid alienation, and instead achieve grounding (105). One of the most prominent examples in this study of how a midwife could contribute to this grounding experience is the experience two women had of being wheeled to the operation theatre. Where one recall a safe hand to hold and a friendly face above her, the other present seeing the ceiling roll above her without any firm fixation points, left to feel “out of it”. This illustrate what Walsh refers to as the role of the midwife as someone having so much more to offer than her clinical skills (105).

Some women describe how midwives and doctors talked over their head, sometimes using a medical language they didn't quite understand. They picked up on cues of being injured from these conversations, but as previously described did not understand the extent of their injury or thought of it as normal. In previous descriptions of the same situation, women described feeling left vulnerable, uncomfortable and exposed as a consequence of not being communicated to directly (28). These findings are partially in contrast to this study, where some describe thinking the tear was normal, and others describing how this was a time to finally get some rest after the birth. Some women were at this stage unable to understand what had happened to them, and if information was provided at this stage, they were unlikely to retain it. For some, this meant a risk of not understanding subsequent information given at the postnatal ward, because it was assumed they had understood at the birthing room, operation theatre or post-operation room the extent of their injury. This was not always the case due to pain, tiredness or feeling overwhelmed.

### **“Barselavdeling”**

The “barselavdeling” was a place women needed to rest, but were not always able to get it. Women in this study spoke highly of health care personnel they perceived as warm and empathic. They made them feel safe, calm, and cared for. Those who had a good experience of the birth in total, felt more at ease and adjusted more easily to the news of the tear. The health care workers thus played a large role in providing emotional support and accurate

information. If staff at the postnatal ward responded to their questions in ways they felt were dismissive or rude, women felt alone and the stressful emotions was made stronger. In general, the experience at the postnatal ward reflect the views of a national survey on service-satisfaction (122). This survey rated the postnatal stay as the least satisfactory of the maternity care services. The postnatal stay were described as more difficult by the two women who did not have the opportunity to have their husband there, and they also described feelings of not being given empathic care. For those women, it was the stay at the postnatal ward they attempted to forget, rather than the birth.

One woman in this study said she felt as if the “light was turned on and the cockroaches disappeared” when talking about how she perceived health workers as not taking responsibility for following up with her after the tear during her stay at the hospital. This statement can imply what midwives themselves have described as being in a “deadlock” position of knowing that a tear is not always preventable, but at the same time feeling as if a good midwife could sway the outcome and avoid a tear. This deadlock position led to internalized shame and guilt for midwives and might impact on their interaction with the woman (90).

The women in the study of Priddis et.al describe they were often not told about the extent of their injury, and the great variation in how women were told about symptoms of, caring for, or available treatment for their perineal injury contributed to a sense of abandonment (28). Continuity of care, is like some of the women in this study mentioned, connected to feeling supported in Priddis et.al’s study (28). Williams et.al, who discuss what they refer to as deficiencies in information-giving and show how women reported timing and content of information to be inappropriate or inadequate, contributing to feelings of anxiety (30). Williams et.al goes on to discuss how these feelings lead to isolation from health care services due to perceived lack of interest. Further literature support these statements on information giving and continuity of care (29, 123). In general, it was perceived that midwives were caring and interested, but seemed busy and occupied. The focus was often on breastfeeding and caring for their child, not the woman.

It could be relevant to discuss cultural influences on the perceptions of women of their care during the postnatal stay at the “barselavdeling”. However, the women did not voice any particular concerns that could be construed as distinct cultural preferences. This is in line with previous research showing how immigrant women want the same from their maternity care as

native women, but are less likely to get it due to language difficulties and issues concerning access (12).

### **Care after returning home**

Some of the women described having a home-visit with a nurse or midwife after returning home. The visit was a positive experience and a chance to get information they “should have gotten earlier”. This signals that the intention of the home-visits, as described in official post-natal care strategies, is fulfilled (13). However, not all women received this visit, and some felt they had to struggle to find information. This struggle is described in previous studies, where Priddis et.al describe the situation for women as a “patchwork of services” to navigate (123). In the context of Sweden, the country perhaps representing the most similar care as the Norwegian, the care after returning home was described as a long and winding road of inconsistent advice and not being listened to when asked for help (78). This inconsistent advice was described by one of the women in this study, who had to consistently present her issues to her GP and hospital to be heard. She was also the one with the most extensive symptoms.

Many of the women sought the recommended care with physiotherapy. This provided them with information they needed, but wished they had been presented sooner. The role of physiotherapy is not described to a large extent in previous literature, but Herron-Marx et.al have suggested the need for a specialized health care professional for perineal morbidity, as women felt their GP was for more acute illness (80). Perhaps the physiotherapist can represent these specialized services. Women described in previous literature felt that the importance of receiving specialized care was sometimes downplayed by health personnel, as their symptoms were often attempted to be normalized and they were not taken seriously (29, 78, 86). Some studies even present direct dismissal of women’s concerns presented after returning home (77, 79). One woman in this study received an individual visit with a physiotherapist at the hospital, and she presented with less confusion in her initial postnatal period. She also described the physiotherapist as someone at the hospital a little less involved with the direct medical concerns, but was caring, had time to listen and gave her concrete advice. This speaks for seeing an initial visit with a physiotherapist as a possible benefit for women. For those who saw the physiotherapist later, there was some confusion as to how to reach contact, and the specialists suggested by the hospital were often private and more



costly. They had not been told when to start physiotherapy, and some wished they had gone sooner. Making a clear pathway to the services seem to be the missing link in current information provided to the women about services postnatally (78).

Another aspect of care after returning home is the six week postnatal check up with a GP all women receive. For some this meeting did not provide sufficient information and reassurance. One woman had not had her perineum looked at during this meeting. Insufficient support and advice at the general practitioners made some women want further controls with a specialist. In the Swedish study of women's experiences, the meeting with the GP is also presented as happening too late, as women wished information earlier (78). Perhaps is this another hint at how a specialized health care professional such as the physiotherapist can provide holistic care.

### **Language – key to understanding and obstacle to healing**

None of the existing articles on women's experiences after perineal trauma have factored in language, and this discussion is based on the women's own descriptions of the role of language. Language played a key role in the interaction women in this study had with health care professionals; they reported feeling that if they had known the language better it would have made them connect better with health personnel, possibly received more information and felt the services to be more accessible.

First, Terui explains that language can contribute to decreased access of services due to available resources and health literacy (124). Health literacy as a concept is relevant, but not chosen to be discussed in-depth in the context of this study. This is because several of the women had higher education, represented western cultural backgrounds or had gone to Norwegian schools. The women were in large part aware of what they didn't understand and when they found difficulty in gaining access to services they often solved the problem by being "good enough at googling to figure it out".

The women appreciated greatly health personnel who offered to speak their second language, in this case English, and it didn't matter to them if the grammar was "bad" as long as it got the meaning across. They saw the health care setting as an inappropriate time to practice their Norwegian, which in any other setting would be their preference. In her review of language disparities in the health setting, Terui found evidence for patients having higher rates of

satisfaction, better adherence to treatment and more control of their health visits if they were offered to speak a language they were fluent in (124). In the situations where women were offered this accommodation of language in this study, they did in fact report greater satisfaction with the services. It should however be pointed out how a possible language discordance could occur because English was not the mother tongue of the patient nor the provider. In these cases, it would perhaps be more beneficial to utilize an interpreter service. Neither of the women had been offered interpreters during their visits with maternity care. This was not expressed as important to them, as they either felt it “would be fine” or their husbands interpreted for them. Having their husband interpret is against recommended policies and could have potential detrimental consequences for their health (96). Relying on a husband to inform his wife about the state of her perineum, when he himself is not a health professional, might cause medical language to be misconstrued, or essential meaning might be missed. This is especially the case if he himself is not a native speaker. However, the women themselves did not see this as a problem, and were grateful to their husbands. They wanted someone they trusted to interpret.

Terui further showed how even though patients were considered fluent in the language, patients tended to misunderstand written hospital instructions (124). This is illustrated by women in this study returning home to find instructions they wanted about how to care for their perineum, suddenly available when written Norwegian instructions were translated. Another example of how lack of information in their mother tongue, or otherwise preferred language, can cause an inability to adhere to treatment, is how written information was often not read due to an inability to understand both the Norwegian words and the medical language. For one woman, this meant not showing up to controls having fasted, because she didn't understand the instructions in her referral- letter. Not having access to understandable oral or written information also meant less satisfaction of services provided, as shown in the findings of women not getting their informational needs met at the “Helsestasjon”. These examples might all be hindering the women in their process of coping, because information on how to accommodate their lives to the tear is not only insufficient, as presented in previous literature of women's experience with OASIS, but also unavailable because of the language barrier.

One of the most important effects language had on women's interaction with health care workers was its ability to make them feel a distance to building inter-personal relationships

with health care providers. Not knowing the language left them with an inability to express their emotions regarding the tear. The concept of emotional communication indicates that emotional support is an important dimension to the inter-personal relationship between the provider and the patient, and also contributes to a positive treatment outcome (125). Women in this study expressed a need to discuss emotional effects of the tear with health personnel, and felt distress when they were unable to. Patients, both native and non-native, convey distress indirectly as cues, instead of clearly expressing them verbally (126). It may well be that the women have attempted to provide clues on their emotional status, but when this was not picked up and brought forward they were left to their own.

For non-fluent patients, expressing complaints in a language they did not know was found to be a source of discomfort (126). This statement is apparent in this study through women commenting on how they feel it is expected for them to speak Norwegian in health encounters if they are perceived as fluent, and how the struggle to converse can contribute to feeling “stuck” in the conversation and unable to achieve an emotional connection to the health care professional. It could be said that this barrier to expressing their emotions are causing women to become isolated from health care. This illustrates how language can be seen as a key to either lifting these women up from the confusing state of coming to terms with the injury or pushing them further down into a prolonged state of uncertainty.

## **5.2 Embodiment and coping**

The first theme of the findings of this thesis is called “coming to terms with the injury”. Within this thesis, ‘coming to terms’ with something implies beginning to understand, accept and deal with a difficult situation. “Coming to terms” is sometimes likened with reconciliation – the act of accepting or agreeing with one’s fate or an event. It is not the point of this section to discuss being reconciled with the injury, but rather to look at the birth and the early period after as a process of beginning to understand, accept and deal with the situation. It does not attempt to treat ‘coming to terms’ with the injury as implying women “forget” their experience and have a definite conclusion, as this would diminish the depth of feelings the women in this study described.

### **A traumatic birth is in the eye of the beholder**

It was clear from the beginning that several of the women experienced their birth as a traumatic event. The experience of birth trauma is subjective, described in literature as being “in the eye of the beholder” as there is no consistent definition on what a traumatic birth entails (127). It is likely that the dramatic events of the birth would interfere with the women’s ability to come to terms with their injury, as a traumatic birth can lead to serious consequences such as post-traumatic stress or postnatal depression. One of the women likened her birth experience to that of a rape she had read about in a crime book. Feeling violated and bereaved of autonomy can be consequences of a traumatic birth, and the rape-analogy is one that has been used before by women describing traumatic births (127).

### **Pain and embodiment**

All of the women described intense pain during birth. How people perceive and respond to pain, and also how they communicate their pain to health care professionals can be influenced by cultural background (128). In some cultural groups, the pain during childbirth is welcomed as it is thought to increase the regenerative spiritual power of females. This is in contrast to other, predominantly Western, cultures (128). The women in this study welcomed pain-relief during the birth.

It is of relevance to see the birth in a cultural view, and recognize that health care professionals operate within an established culture of medicalized birth. Being by some criticized for medicalizing a natural procedure, modern obstetrics represent new technologies and medical interventions applied to birth. Building on this it naturally follows that a modern obstetric birth includes the possibility of a medical intervention. In the case of sphincter injuries, this is reflected in midwives saying that sometimes a tear can’t be avoided where there is a risk involved for mother and child, implying that some kind of intervention has to be applied (90).

The fact that women in this study described feeling that their birth experience was unexpected, signals that they were unprepared for the scope of medical interventions they were exposed to. It becomes relevant to draw parallels to Walsh’s discussions of embodiment during childbirth. She argues that an ingrained dichotomous views of birth, either as inherently medicalized or entirely natural, are in conflict and leave little room for uncertainty (105). She further goes on to explain how these ingrained views are thus effectively contributing to ambivalence towards the birth. It enforces the Cartesian dualistic view of the

mind and body as separated, not attentive to the perceptions of the individual (104). For the women, who have to navigate the balance between a natural and medical birth, and losing and regaining control, the result is often an ambivalence when birth does not conform to prior expectations, sometimes leaving them disappointed or distressed (105).

The women in this study report feeling “out of it” and having “a pain I couldn’t endure” during birth. One of the women said the tear felt as if “it was just another thing on top”. These statements are signaling a possible disembodiment during the birth. Earlier in this discussion, the situation where the midwife held the woman’s hand to the operation theatre illustrated how achieving grounding in such a situation can be crucially linked to interpersonal connection with a caretaker or companion.

### **An OASI further influences embodiment**

In previous literature, Priddis explains how perineal trauma can be seen as a continuation of the trauma of the birth itself (83). This resonates with how women in this study talked about their bodies as “a mess”. Priddis exemplifies this through showing how culturally the childbirth is seen as a conclusion, where women undergo a transition to a new self. When women suffers symptoms such as incontinence or prolonged perineal pain, the boundaries between the external and the internal body is altered and women struggle to reach closure both emotionally and physically (83).

Few of the other studies on experiences of women after OASIS dwell on, or describe how women experience the birth. Priddis et.al is one of the studies taking this into account, and sees the birth and the postpartum period as an intertwined process, where all elements impact on each other and created an initial period of confusion for the women (28). This is supported by the findings in this thesis where separating the two - the birth and the tear - can be difficult and is exacerbated by feelings of uncertainty in the post-partum period. The consequence is a continuous reminder of the traumatic events of the birth, and a possibly altered view of themselves.

### **Coping responses**

After returning home, the women had both emotion-focused and problem-focused responses and strategies to overcome the initial confusion and worry that their injury presented.

All of them had a strategy for managing their pain, taking medication as needed and avoiding to sit for an extended period of time. Especially taking dufalac/lactulose to make it easier to go to the bathroom. Descriptions of pain and pain management was also prominent in the study by Lindqvist et.al (78), explaining how pain was a source of frustration and a constant reminder of the trauma. Way (82) describes pain as one of the main obstacles for a women to regain a sense of normalcy. Women in this study further described having to accommodate time spent in the bathroom, not push excessively during defecation, wash their perineum carefully, change their diet and develop strategies to manage incontinence issues. These are all approaches that have been explored and described thoroughly in previous literature (29, 80, 82, 85, 88).

The women did not speak extensively of emotion-focused coping related to self-controlling or avoidance-responses that involved keeping to themselves. Occasionally, they avoided social situations because they were uncomfortable, but it was not a prominent coping-response in this study. This is in contrast to findings in literature, and could perhaps be due to women in this study, except for one who had anal incontinence, had less extensive symptoms than what is presented in the literature. In previous studies, accommodating what is referred to as an “unpredictable” or “uncontrollable” perineum led women to emotion-focused coping responses of isolation or avoidance of situations that could exacerbate stressful feelings (79, 80, 84, 88). These stressful feelings were often linked to women describing themselves as feeling old before their time or hideous (28, 29, 79, 85). The response of isolation or avoidance that followed were described by Priddis et.al (84) as women attempting to manage a cultural perception that leaking bodies should be hidden. This can be seen as internalizing feelings of shame related to physical symptoms, causing them to view themselves as “a shabby model”, “hideous” or as an “incomplete woman” (28, 29, 85).

Women described in this study and in other research shows how focusing on their baby, and being grateful for their child and family was meaningful to them in order to take focus away from their own body (79, 88). One woman commented on how she was proud to have given birth vaginally, also presented in the study by Priddis et.al as a feeling of being compensated for the trauma they had experienced (28).

Further, the women in this study put a great emphasis on the role of their significant other. Their husband/boyfriend was by all the women described as important for them to cope with the injury, both in terms of practical help and emotional support. Other literature both support

and contradict this finding, either through showing how women felt their husband was supportive, or by portraying that women felt their husbands were disinterested and chose not to confide in him (29, 30, 80, 88). Some of the women in this study chose to let friends in on their struggle to come to terms with the injury, whilst others chose not to. The common finding across literature is that it felt good to talk to other women in the same situation (29, 30, 80).

The emotion-focused coping response of distancing themselves by “trying to forget” the experience was presented by women in this study. Two of them spoke of it as a conscious effort they took to deal with the experience. This coping response is not apparent in literature looking at experiences of women with OASIS, although some studies have spoken of distancing through using humor (88) and denial (29). Trying to forget the experience and actively push it away can serve as a useful coping strategy when awaiting results (108). For the women in this study who “tried to forget”, it can seem as if it was used in the “waiting period” between sustaining the injury and awaiting its final results and effects on the body, being exchanged for another coping-response when they were ready to face the consequences of the injury.

Attempting to change the relational meaning of what happened is a second emotion-focused coping response seen in this study not described explicitly in previous literature. By thinking that the injury was unavoidable, or explaining how their negative experiences were due to busy staff, the women in this study managed to change the initial response of anger to one of acceptance. This response is thought of as a positive response to eliminate a threat (108). As we will see when later discussing identity, the obstacle to this coping response was women not knowing the reason for why they had sustained the OASIS. If they did not know the reason to why their perineum tore, they were not able to change the meaning of what happened. Instead they had other emotional coping responses of trying to accept responsibility of the injury, and this made them criticize or blame themselves. According to previous literature, self-blame served only to “turning women against themselves” (29). This implies correctly that women are not the only actor in ensuring a satisfactory process of coming to terms with the injury, and that health personell plays a role in meeting women with acceptance and understanding.

The “end-goal” of coping is based on the individual’s needs and expectations (108). Some women in this study saw their situation as manageable, others described a still ongoing

process of sorting out their symptoms and feelings. Others again saw the experience as something they had found personal growth from or even saw themselves as fully healed. The common finding is the use of many different coping strategies simultaneously in an initial period after birth characterized by confused feelings.

## **5.3 Reshaping their identity – intrinsic to coping and embodiment**

The discussion of how the OASI affected women's identity revolves around how motherhood, sexuality and body image are parts of their identity women have to redefine – or reshape, after the injury. The concept of identity is a wide field, and this discussion will only scratch the surface of established knowledge on identity. The following discussion of identity moves from a view of identity as the ability of the self to identify with certain roles. It does not explore the findings to a large degree in relation to social identity, although often the borders between these two approaches are fluid (129). Some of the points presented will attempt to draw lines back to the previous section on embodiment and coping as these concepts are found to be intrinsically linked and influencing each other within this the topic of this thesis. Language and interaction with health workers are key facilitators to women's process of reshaping their identities.

### **Being a new mother**

Women in this study represented role-identities connected to being a woman, spouse, parent and employee to name a few. It is common to identify with multiple roles at a time, and a conflict between two or more identities can occur when a person take on a new role-identity (130). This new role can in this context mean the transition to motherhood. Becoming a mother involves moving from a known, current reality to an unknown, new reality (131). Navigating this new role-identity was in and by itself difficult. Having to go through the process of coming to terms with the tear and to start understanding the extent of their injury added a second layer they had to attribute meaning to and begin the process of incorporating into their new identity as a mother.

As presented in the previous section on the discussion on coping it was clear how not knowing the extent of their injury meant not being able to apply meaning to their situation.



Coupled with having a need for someone take a look at the state of their perineum to confirm if they were healing, this meant an added disturbance in the already difficult process of adapting to their new reality. Women presented confusion as to what symptoms were due to the tear, also found in Priddis et.al who states that women were unsure as to what level of pain after birth was expected (28). To have information on which challenges could be attributed to the tear and which were expected consequences of giving birth meant the difference of having a smooth transition to their new identity of being a mother versus spending time worrying if their new identity meant being someone injured. Women did spend considerable time in this state of searching to attribute meaning, referred to in this thesis as having to reshape their identity. From literature it was clear how those who saw themselves as injured, old, or otherwise defect as women coped by isolating themselves, having serious consequences which in turn altered their identity in larger scale (28).

### **Intimacy and the next birth**

Difficulties connected to having sex again after sustaining the OASIS was described by women in this study. Avoidance of the act due to fear of bodily leakages is the most prominent cause of avoidance in previous studies, following thereafter lack of desire or sensation, perineal pain and difficult memories of birth as topics found in this thesis that have been described before (28, 30, 77, 78, 84, 85). Their sexual relationships, or lack thereof, are presented in these mentioned studies as affecting their sexuality, their identity and their view of themselves as women. These implications for the woman's identity is not explored in depth in previous studies.

In contrast to previous studies, the women in this study did not mention fear of leakage as the main cause of postponing or avoiding intercourse, but rather the lack of sensation and diminished muscle strength. To not have sensation during intercourse can possibly be seen as a form of disembodiment, where women are exposed to loss of control due to not being able to feel what is happening within their bodies. It can also be connected back to the recent difficult experience of the birth and the injury, bringing back memories of painful feelings.

It was recognized by the women how the tear was an injury that involved their partner to a larger degree than any other injury would. To use the term intimacy instead of sex in the heading of this section is a conscious choice. The word intimacy, instead of sex, implies that intercourse is an exchange between two people, taking emotions into larger account than just

describing the act of having sex. Further, being intimate with someone involves embodiment; it involves a self who sees, smells, touches and has the capacity to feel emotions and sensations connected to desire and sensual pleasure (132). To be intimate with someone can also mean to incorporate the other's perspectives, and incorporate these perspectives into our own ways of perceiving – seeing others as becoming an extended form of our embodiment (133). These descriptions of what intimacy entails are irreconcilable with the words women used when talking about their experiences surrounding the tear; “exhausted”, “unforgettable”, “violent”, “worried”, “painful”, “overwhelming”, “difficult”, “stupid”. The choice of keeping sexual intimacy at a distance, especially in the early postpartum period, is perhaps a way of protecting their “embodied self” while still attempting to come to terms with the injury.

Women voiced worrying about a next birth. They worried for their perineum during a second birth, and also thought about possibly having C-sections. These concerns are all presented in previous studies, but not explored in-depth (28, 30, 77, 78, 85). The concerns they had towards a next birth can be said to have expressed meanings and perceptions related to their gender-identity role of being women, seen as, simply put, valuing being fertile and reproducing. The concern women had regarding a possible next birth can perhaps more fittingly be seen through coping theory. Lazarus suggest that if there is a likelihood of recurrence of a traumatic event, then the danger of reoccurrence will be the center of attention (108). He further goes on to say that the closer in time the reoccurring event is, the more it craves attention (108). For most of the women, thoughts of a next birth was prominent. The choice of keeping the door open for a next birth was likely to be a constant reminder of the tear and the birth. Tying this together with embodiment, it exemplifies what was discussed previously of how the boundaries between the external and internal body is fluent for women with OASIS, and serves as a constant reminder of the trauma. To be informed of possible risks, to be reassured of strategies for preventing a reoccurring tear, as well as being given a validation of their worries and fears in relation to a next birth might contribute to women being able to attain the agency of their own bodies needed to move on and cope. This can be seen as further influencing the process of reshaping their identities, contributing to their view of themselves as being someone injured or not.

## **Body image and pelvic floor exercises**

Doing pelvic floor exercises diligently emerged as another illustration of how the women navigated the possibility of a changed identity. Doing exercises became a way for some women to attempt to “control” the consequences of the injury on their bodies, and by doing so keeping with their identity as healthy women. When successful, this brought tremendous relief that their effort had paid off. When unsuccessful, it served as a further reminder of their injury and led to feeling demotivated. In previous literature, pelvic floor exercises has been described similarly as in this study, as time-consuming and guilt inducing when they were not able to find or make time to do them (80, 85). The statement of pelvic floor exercises as something they had to continue for the rest of their lives is also previously described in literature (85).

A traumatic event can disrupt the plans and values attached to a person’s identity, and possibly change lives in unpredictable, sometimes permanent ways (134). It is also suggested that our identity before the trauma can shape the way we interpret and perceive the trauma (134). This could mean perceptions women had of their bodies from before the injury might exacerbate the demotivation arising when not seeing progress to the exercises. A previous role-identity as athletic and/or healthy young women may be difficult to unite with experiences of leakage, pain and lack of progress.

Some of the women expressed how they valued their previous experience with pelvic floor exercise and yoga, and verbalized how this had positively influenced their body awareness. The others did not have previous experience with pelvic floor exercises and valued other ways of problem focused coping, such as resting or taking walks. What stood out is how one of the women knew about the exercises, but had not understood what the pelvic floor entailed. This misunderstanding could signal a different way of viewing the body and understanding its functions. For women representing other cultural backgrounds, the definition of what is considered the internal and external body can represent something different than what is comprised in a western cultural context (128). The cultural view of what is “inside-the-body” influences people’s perception and representation of bodily complaints (128). This view can extend to the awareness of their pelvic floor. Having either a cultural view of their genital area as something less spoken about, or not having had any opportunities to learn pelvic floor awareness, might explain why doing the exercises are not chosen as an area to focus on. Knowing why someone chooses to do the pelvic floor exercises or not can be especially relevant if they are not informed about the importance of the exercises, nor have been taught

how to carry them out. Being uninformed about exercises, and not being sufficiently taught how to do them correctly was presented by a few women in this study, and thought to be a main concern for women in a previous study (80).

### **Cultural identity**

The women did not describe cultural traditions and customs after birth at length. Their cultural and ethnic identity was not a highly noticeable topic, nor were they explicitly asked about matters of cultural identity. The exception is Nora, who talked about eating a special porridge and the tradition from her home country of staying indoors for forty days after birth. From literature, it's noted that to receive culturally sensitive care is not as big a concern for women as receiving proper information and communication (12). It has been suggested that ethnic identity change in a new country is related to maintenance of ethnic cultural involvement and largely independent of orientation towards the dominant culture (135). This is illustrated in Sara's case by her talking about her countries traditions in a positive way, but herself choosing to not follow the custom of staying indoors for forty days. It is highly possible to have a positive attitude towards maintenance of once heritage culture, yet not endorse that culture oneself (135). Although cultural identity is of relevance, it is not explored further as a topic of discussion. This is due to women in this study having either a western cultural background, or having stayed in Norway for a long time. If they had presented more culturally oriented perspectives, it would have been appropriate to present an in depth discussion of cultural identity.

## 6 Methodological Considerations

*Today I got another response from a physical therapist saying that I have “an interesting project”, but that “they don’t see patients who don’t speak Norwegian”. I feel like this is happening a lot, and am getting frustrated. Where are they? Do they not seek help? Have I just not found the right place to look?*

The quote above is an excerpt from my field notes, and it shows how the qualitative fieldwork was a fluctuating process, where feedback from collaborators added new dimensions to the project. Here, I will give insight into the processes having shaped this thesis.

### **Entering the field**

Moen and Middelthon (116) says flexibility in the field work is a fundamental requirement of research that set out to discover and understand. A strength of the study is the great deal of flexibility applied to recruiting for this project. To listen and to learn from others I met in my fieldwork and adopt my strategies of recruitment thereafter was crucial. The field work felt ever-changing, meaning that it took several directions I had not anticipated, and often did so simultaneously. In the end, the amount of insight I gained on where and how these women are cared for, and also of what services are offered to immigrant women is of great substance. This insight have shaped the background of this thesis and also left me with an extensive knowledge of what is moving in the community in terms of services catering to the needs immigrant women.

My application to the NSD was expected to be administered by September 2016. In September it emerged that there had been a processing error, and clearance was subsequently received in early November 2016. To be able to recruit from hospitals, which was the original recruitment method, there was another clearance process with the hospital Data Protection Officer. I also needed permission from other research responsible leaders and head of departments, leading to final clearance being given in early January 2017.

By early March the recruiting process from hospitals had not yielded any results. I had started to think alternatively and had contacted physiotherapists working with women’s health issues. General practitioners were also contacted. The majority of these said that they did not see, or

rarely saw, patients with OASIS whose mother tongue was not Norwegian. They were positive towards the project, and would help if they came in contact with such patients.

I contacted all of the “helsestasjoner” in Oslo. Most of them declined, and the reason for declining was midwives and nurses having heavy workloads, lack of both human and financial resources to see these women or having to prioritize internal projects. The reasons they gave reflect the current politically charged debate on resources and funding of the midwife services in Norway, as presented in the background chapter of this thesis.

I further contacted nurses at asylum centers and reached out to ideal organizations who worked with immigrant women. I offered these to give a talk on women’s health or affiliated topics in exchange for the opportunity to present my project. I did so at one ideal organization offering a variety of courses and services primarily to women with a minority background, and the women were interested but did not know of anyone who met the criteria.

I was given the opportunity to meet with a doctor responsible for performing controls on these women at one hospital, and after this meeting women who met for controls at the hospital were given a written invitation to participate in the project.

I contacted profiled persons whom I knew had an interest in the topic. One of these profiled persons put up a request for me on their private Facebook page. I was consequently contacted by approximately 20 women – all Norwegian – from North to South in Norway. All spoke of a story they wished to share. None of them met the inclusion criteria of language, and approximately seven of the women had also given birth in the period before 2004 when the care for these women were different. Having given birth before 2004 was an exclusion criteria, and will be described below. I will never forget the volume of women who contacted me in the span of a few hours, and also not the stories some of them volunteered of lives altered due to their perineal injury.

## **Pre-understanding**

Our pre-understanding is the backpack of previous experiences, knowledge, theories and hypotheses we bring with us into the field (117). Upon starting the data collection I had thought that culture would be more palpable in our interactions than what it was. I also thought the women would comment more on their own position as immigrants than they did. I had reflected so much on what it meant to be an immigrant woman and in need of health care

that I thought this was something they had in the forefront of their mind, too. When conducting the interviews I quickly laid this aside and during the interview I felt first and foremost that I was talking to a woman with a unique story to tell.

A cross-cultural interview setting means there are added layers of complexity increasing the possibility of misunderstanding (113). I had thought that language would play a more obvious role in our interaction, making misunderstandings noticeable. I was less prepared for the more subtle misunderstandings that occurred. An example of such a subtle misunderstanding is when a participant said 'yes' to confirm that she had heard my question, and I thought she answered yes to the question and continued probing. It took some clarifying to sort out the misunderstanding that followed. Whether or not such misunderstandings were related to language, or to our way of interacting, is not discernable. Patton explains that globalization, far from reducing the likelihood of misunderstandings, simply makes miscommunication more nuanced and harder to detect because of false assumptions of shared meaning (113). This was in line with my own experiences and became important for me to keep in mind. In addition, our preunderstanding is related to the roles we have had or have during data collection.

### **Language and interpreters**

Language and the possible use of interpreters was a topic that took a lot of consideration during the development of this study. At that point in time, it was thought that an interpreter would be necessary during the interviews. This turned out to only apply to one of the interviews. She functioned to clear a few misunderstandings and also help in explaining a few words. The interpreter was recruited through the official interpreter registry, was professional and felt trustworthy. Her presence did not seem to interfere with the level of openness from the participant, but it could have had a hidden impact on the dynamic of the interview.

In the beginning women who had little proficiency of the Norwegian language were to be included in the study. It was later decided to not predefine language proficiency, as it was clear that the women I came in contact with spoke varying degrees of Norwegian. I held the view that you can converse fluently in a language, but not be fluent in matters pertaining to health and chose to let the participants define their own level of fluency. The criteria of having a mother tongue other than Norwegian was deemed easy to understand and could possibly include many definitions of fluency.

## **Considered approaches to triangulation**

Several approaches to triangulation were considered. For instance, observation at the “barselavdeling” could have rendered beneficial insight into the experiences of these women. On the one hand, it would contribute to the understanding of the treatment of OASIS in its context at a Norwegian hospital. On the other hand, it could give the researchers observation data a larger influence on the findings and discussion. There are ethical implications to conducting such observations, such as women feeling exposed and not wishing to have a researcher present when they are at their most vulnerable. As the incidence of OASIS is low, and the time when women receive information at the “barselavdeling” is not predetermined during their stay, coordinating a time to meet would require a lot of organizing that would be dependent on several actors; midwives/nurses, the women, the researcher, and interpreter etc. The patients in the hospitals are protected by strict directions for outside researchers, and ethical clearance, access to a hospital ward to observe from and time-constraints emerged as valid reasons for not choosing this approach.

Further triangulation possibilities was considered. Having focus group discussions with women after OASIS would perhaps have shed light on common experiences these women have, and could have given insight in to new ideas that only a group discussion could bring forward. It could possibly have felt like a relief for the women to hear similar experiences to their own. At the same time, the topic is considered sensitive, and they could also have been unwilling to share in a group. There is also an added challenge of language in this case, and lack of shared language could pose as an obstacle to discussion. Group-interpreting could have been a solution to this. However, it was decided to not do this due to the financial cost, other practical issues in terms of organizing and recruiting, and the resources it would take to coordinate a meeting with the women and interpreters.

To investigate the experience of OASIS from the viewpoint of other actors would give an integrated and nuanced perspective of how these women are cared for. Focus group discussions with health care professionals and interpreters were considered, but turned out to be difficult to organize in terms of finding available practitioners. It was in the end ruled out. Interviews with health care professionals were considered a good alternative, and would shed light on the perspective of health care workers on care, caring and communication in the health services in regards to OASIS. This was actually commenced, and two interviews with health care workers were conducted. The recruitment of health care workers was discontinued



due to difficulty getting in contact with staff at clinics, or having to go through additional ethical clearance that at this point in data collection there was not time for. The two health care workers interviewed, although knowledgeable and highly respected in their field, had little direct experience or viewpoints on OASIS in this patient group. They did however, give valuable insight into matters that became important for the work on the background for the project.

### **Further consideration of sample size**

Despite striving for flexibility in the recruitment process, the study recruited relatively few participants. It would have perhaps generated more participants if I was able to meet and interact with women with a non-Norwegian background and explain directly what my project was about. There has been relatively little direct contact with women in the community, and I have had little opportunity to know what have been said to women who might have been eligible to participate. Possible skepticism to participating in research or language difficulties might also have impacted on recruitment. In the cases where a written request was given, it perhaps became just one of many other papers to consider and evaluate for the women. I have also come across other studies and master theses that comment on the difficulty of recruiting immigrants for similar research. For me, as a native Norwegian female with few access points into social arenas where immigrant mothers meet, these women are for me a “hidden population” and the accessibility of their social world would perhaps be greater if I had a different entry point (136). Further, from the literature it is clear that with OASIS follows stigma and taboo topics of incontinence, and women might have not wanted to participate due to this perceived barrier. Lastly, from talking to various actors and other women, the questions of whether or not women actually knew what kind of tear they had was raised. I cannot conclude on this, but it’s a worthwhile suggestion that some women might not understand the extent of their injury.

# 7 Conclusion

## Summary of the thesis

The aim of this thesis was to understand more about how women whose mother tongue is not Norwegian experience sustaining and living with an OASIS. By doing so it has attempted to bridge the research gap of there being no previous studies having taken non-native speakers experiences of OASIS into consideration. The study has attempted to answer the research question and objectives by analyzing the findings from seven interviews with five women using a phenomenological perspective and the approach of Systematic Text Condensation. The main theme emerging from the analysis “Doubly vulnerable” describe how women who do not speak the language are facing challenges relating to the OASIS, and have additional barriers in relation to language.

The findings was further analyzed and presented in the three subthemes; “coming to terms with the injury”, “reshaping their identity” and “care and caring in the health services”. The findings of the interviews and the research objectives have been discussed by exploring how women in this study viewed the communication they experienced in the health services with special attention to their views on how language influenced the interaction. Womens experiences are discussed in relation to concepts of embodiment, coping, and identity. Following is a conclusion of the findings and discussion, ending with some recommendations for practice and future research.

## Conclusion

This study confirms that OASIS have a large impact on the lives of women. Although women in this study presented experiences described in previous literature, the findings gave new insight into how these women experience living with their injury.

An important finding was the effect of perceived empathetic and caring health professionals on the women’s experiences. Receiving perceived empathetic care meant women felt supported, accepted and informed. This study confirmed previous findings in literature describing how dismissive, busy or perceived rude health care professionals exacerbated stressful and painful experiences. The findings in this study signal that health care

professionals are not sufficiently taking women's needs into account, and women are subsequently vulnerable to not receive perceived helpful or empathetic care.

Language further impacted on the women's access to information either by lack of material in their preferred language or through a feeling of not receiving the same information as they would have if they spoke the language. To have an emotional connection to health care workers was a challenge and language was seen as a barrier for these women to express their emotions and start a healing process. They are as such "doubly" vulnerable to the possible effects of the tear; both through the possibly isolating effects of the symptoms, but also due to their inability to reach appropriate information and emotional care in the health services.

The partners of the women potentially played a large role in their understanding of the OASI. This is due to the role the partner took for some women of translating both written and oral information. The women themselves did not see this as an issue, but if applied to situations where the husband translating is undesirable, this might interfere with women's ability to retain agency and take control over their own bodies.

The findings highlight how, for the women, the birth and the OASI were seen as an integrated experience. A central concept for women to be able to embody the experience of the birth and the perineal trauma was to understand why and to what extent they had been injured. Furthermore, the findings of this study suggest how pain and lack of sensation in their perineum impacted on women's intimate lives with their partner and on thoughts of a possible next birth. Paired with the extent to which their efforts of doing pelvic floor exercises were seen as successful or not, the amount of symptoms they experienced faced them with the decision of whether they had to reshape their identity to one of being an injured person.

Not knowing if their symptoms of pain, dyspareunia and pain were a normal part of having given birth or if their perineum had healed correctly enhanced the initial feeling of confusion women described. This confusion could potentially lead to self-blame if women were not able understand why they had been injured. Health workers were central to enhance women's understanding of their injury, but the timing and content of information was often not adapted to their needs.

## **Recommendations for further research**

Further research is needed to assess the need for making changes in the health system which could ensure that women who have sustained an OASIS receive more consistent care both during their stay at the hospital and in the postnatal period. The research should include looking at the role of the health professionals caring for these women, and especially the effects of them being attentive to the emotional needs of women and being proactive in asking them how they are coping with the injury.

Furthermore, future studies should assess the health professionals' awareness of patients' language barriers and how these can influence women's abilities to perceive correctly and clearly the state of their injury and what they need to do to move forward after the injury.

This study supports previous research having considered a need for one specialized perineal health professional for women to approach with their symptoms and concerns. In addition, this study suggests that providing a visit with a physiotherapist during the stay at the maternity ward could potentially provide women with information targeted specifically to healing from and coping with OASIS. Being well-informed early is central to understanding their situation for these women whose mother tongue is not Norwegian. It could be that native speakers could also potentially benefit from such information. Further studies should be conducted to look into these issues with a larger group of respondents.

Future studies might also benefit from including more women whose mother tongue is not Norwegian to show greater variance in experiences. Further, future studies could compare experiences of native speakers to the women who have a different mother tongue and by doing so illustrate key differences in experiences and focal areas for care-provision.

## 8 References

1. Dzamarija MT, Steinkellner A. 14 prosent av befolkningen er innvandrere: Statistics Norway; 2018 [Available from: <https://www.ssb.no/befolkning/artikler-og-publikasjoner/14-prosent-av-befolkningen-er-innvandrere>].
2. Dzamarija MT. Stadig flere som fødes i Norge har innvandrerbakgrunn: Statistics Norway; 2017 [Available from: <https://www.ssb.no/befolkning/artikler-og-publikasjoner/stadig-flere-som-fodes-i-norge-har-innvandrerbakgrunn>].
3. Organization WH. Health equity 2018 [Available from: [http://www.who.int/topics/health\\_equity/en/](http://www.who.int/topics/health_equity/en/)].
4. Likeverdige helse- og omsorgstjenester – god helse for alle : Nasjonal strategi om innvandreres helse 2013-2017. In: omsorgsdepartementet H-o, editor. 2013.
5. Sorbye IK, Daltveit AK, Sundby J, Stoltenberg C, Vangen S. Caesarean section by immigrants' length of residence in Norway: a population-based study. *European journal of public health*. 2015;25(1):78-84.
6. De Rosa M. 44 dødfødsler kunne vært unngått. *Dagsavisen*. 2018.
7. Vangen S, Stoltenberg C, Skjaerven R, Magnus P, Harris JR, Stray-Pedersen B. The heavier the better? Birthweight and perinatal mortality in different ethnic groups. *International journal of epidemiology*. 2002;31(3):654-60.
8. Shakeel N, Eberhard-Gran M, Sletner L, Slinning K, Martinsen EW, Holme I, et al. A prospective cohort study of depression in pregnancy, prevalence and risk factors in a multi-ethnic population. *BMC pregnancy and childbirth*. 2015;15:5.
9. Ahlberg N, Vangen S. Svangerskap og fødsel i et flerkulturelt Norge. *Tidsskrift for Den norske legeförening*. 2005(125):586 - 8.
10. Balaam MC, Akerjordet K, Lyberg A, Kaiser B, Schoening E, Fredriksen AM, et al. A qualitative review of migrant women's perceptions of their needs and experiences related to pregnancy and childbirth. *Journal of advanced nursing*. 2013;69(9):1919-30.
11. Fisher J, Hinchliff S. Immigrant women's perceptions of their maternity care: a review of the literature part 1. *The practising midwife*. 2013;16(1):20-2.
12. Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries. *BMC pregnancy and childbirth*. 2014;14:152.
13. Nytt liv og trygg barseltid for familien : Nasjonal faglig retningslinje for barselomsorgen. Oslo: Helsedirektoratet; 2014.
14. Helsedirektoratet. Et trygt fødetilbud : kvalitetskrav for fødeinstitusjoner. Oslo: Helsedirektoratet; 2010.
15. En gledelig begivenhet : om en sammenhengende svangerskaps- fødselsog barselomsorg. Oslo: Departementet; 2009.
16. Klovning A. Retningslinjer for svangerskapsomsorgen. Oslo: Sosial- og helsedirektoratet; 2005.
17. Eberhard-Gran M, Nordhagen R, Heiberg E, Bergsjø P, Eskil A. Barselomsorg i et tverrkulturelt og historisk perspektiv. *Tidsskrift for Den norske legeförening*. 2003;123(24):3553-6.
18. Statens h. Korleis tek fødeinstitusjonen og kommunen vare på behova til barselkvinnar og det nyfødde barnet i barseltida? : rapport frå tilsyn med barselomsorga. Oslo: Helsetilsynet; 2011.

19. Hjälmhult E. Skal helsesøster tilby hjemmebesøk til alle foreldre med nyfødt barn? *Sykepleien Forskning*. 2009;4(1):18-26.
20. Tromsø A. Jordmor hjem etter fødsel - skjer det? En undersøkelse av norske kommuners etterfølgelse av Helsedirektoratets anbefaling om hjemmebesøk av jordmor etter fødsel. *Ammehjelpen*; 2017.
21. Association TNM. Den norske jordmorforening er bekymret for at gravide ikke får den oppfølgingen de skal i Oslo kommune 2017 [Available from: <http://www.jordmorforeningen.no/om-oss/nyhetsarkiv/den-norske-jordmorforening-er-bekymret-for-at-gravide-ikke-faar-den-oppfoelgingen-de-skal-i-oslo-kommune>].
22. Vest H. Regional plan for svangerskaps-, fødsels- og barselomsorga i Helse Vest 2017-2022. 2017.
23. Schjelderup HC. Sett ikke fødende og spedbarns helse i spill! 25.02.2018 [Available from: <https://www.dagensmedisin.no/artikler/2018/02/25/sett-ikke-fodende-og-spedbarns-helse-i-spill/>].
24. Saugstad OD. Tidlig hjemreise etter fødsel betyr at noen risikobarn ikke fanges opp i tide: *Aftenposten*; 01.03.2018 [Available from: <https://www.aftenposten.no/meninger/debatt/i/G158p6/Tidlig-hjemreise-etter-fodsel-betyr-at-noen-risikobarn-ikke-fanges-opp-i-tide--Ola-Didrik-Saugstad>].
25. De Rosa M, Fladberg KL, Andreassen T. Ordførere gjør opprør mot dårlig tilbud til nyfødte: *Dagsavisen*; 01.03.2018 [Available from: <https://www.dagsavisen.no/innenriks/ordforere-gjor-oppror-mot-darlig-tilbud-til-nyfodte-1.1108050>].
26. Spydslaug AE, Baghestan E, Laine K, Norderval S, Olsen IP. Perinealruptur. In: Øian P, Jacobsen AF, Kessler J, editors. *Veileder i fødselshjelp: Den Norske Legeforening*; 2014.
27. Sultan AH, Thakar R, Fenner DE. *Perineal and Anal Sphincter Trauma*. London: Springer 2007.
28. Priddis H, Schmied V, Dahlen H. Women's experiences following severe perineal trauma: a qualitative study. *BMC women's health*. 2014;14(1):32.
29. Rasmussen JL, Ringsberg KC. Being involved in an everlasting fight--a life with postnatal faecal incontinence. A qualitative study. *Scandinavian journal of caring sciences*. 2010;24(1):108-15.
30. Williams A, Lavender T, Richmond DH, Tincello DG. Women's experiences after a third-degree obstetric anal sphincter tear: a qualitative study. *Birth (Berkeley, Calif)*. 2005;32(2):129-36.
31. Hals E, Oian P, Pirhonen T, Gissler M, Hjelle S, Nilsen EB, et al. A multicenter interventional program to reduce the incidence of anal sphincter tears. *Obstetrics and gynecology*. 2010;116(4):901-8.
32. Dahlen HG, Ryan M, Homer CS, Cooke M. An Australian prospective cohort study of risk factors for severe perineal trauma during childbirth. *Midwifery*. 2007;23(2):196-203.
33. Stoker J. Anorectal and pelvic floor anatomy. *Best Practice & Research Clinical Gastroenterology*. 2009;23(4):463-75.
34. Bø K. *Evidence-based physical therapy for the pelvic floor*. Edinburgh: Churchill Livingstone Elsevier; 2007.
35. Wall LL, Delancey JOL. The Politics of Prolapse: A Revisionist Approach to Disorders of the Pelvic Floor in Women. *Perspectives in Biology and Medicine*. 1991;34(4):486-96.
36. Hagberg H, Maršál K, Westgren M. *Obstetrik*. 2. uppl. ed. Lund: Studentlitteratur; 2014.

37. Wall L. THE MUSCLES OF THE PELVIC FLOOR. *Clin Obstet Gynecol.* 1993;36(4):910-25.
38. Brunstad A, Tegnander E. *Jordmorboka : ansvar, funksjon og arbeidsområde. 2.* [rev.] utg. ed. Oslo: Cappelen Damm akademisk; 2017.
39. Sultan HA. Editorial: Obstetrical perineal injury and anal incontinence. *Clinical Risk.* 1999;5(6):3.
40. Andrews V, Sultan AH, Thakar R, Jones PW. Occult anal sphincter injuries--myth or reality? *BJOG : an international journal of obstetrics and gynaecology.* 2006;113(2):195-200.
41. McCandlish R, Bowler U, Asten H, Berridge G, Winter C, Sames L, et al. A randomised controlled trial of care of the perineum during second stage of normal labour. *BJOG: An International Journal of Obstetrics & Gynaecology.* 1998;105(12):1262-72.
42. Sleep J, Grant A, Garcia J, Elbourne D, Spencer J, Chalmers I. West Berkshire perineal management trial. *British Medical Journal.* 1984;289(6445):587-90.
43. Hirayama F, Koyanagi A, Mori R, Zhang J, Souza J, Gülmezoglu A. Prevalence and risk factors for third- and fourth-degree perineal lacerations during vaginal delivery: a multi-country study. *BJOG: An International Journal of Obstetrics & Gynaecology.* 2012;119(3):340-7.
44. Medisinsk fødselsregister og abortregisteret - statistikkbanker [Internet]. 2016. Available from: <http://statistikkbank.fhi.no/mfr/>.
45. Oppsummering av landsomfattende tilsyn med fødeinstitusjoner i 2004. Oslo: Helsetilsynet; 2004.
46. fødselsomsorg Nrf. Sfinckerskader ved fødsel bør reduseres i Norge: Nasjonal handlingsplan In: helsedirektoratet S-o, editor. Januar 2006.
47. Laine K, Rotvold W, Staff AC. Are obstetric anal sphincter ruptures preventable?--large and consistent rupture rate variations between the Nordic countries and between delivery units in Norway. *Acta obstetrica et gynecologica Scandinavica.* 2013;92(1):94-100.
48. Laine K, Skjeldestad FE, Sandvik L, Staff AC. Incidence of obstetric anal sphincter injuries after training to protect the perineum: cohort study. *BMJ open.* 2012;2(5).
49. Naidu M, Sultan AH, Thakar R. Reducing obstetric anal sphincter injuries using perineal support: our preliminary experience. *International urogynecology journal.* 2017;28(3):381-9.
50. Yeung J, Stecher A, Crisp CC, Mazloomdoost D, Smith B, Kleeman SD, et al. Incidence of Obstetric Anal Sphincter Injuries After Training to Protect the Perineum. *Female pelvic medicine & reconstructive surgery.* 2018;24(2):126-9.
51. Rasmussen OB, Yding A, Anh OJ, Sander Andersen C, Boris J. Reducing the incidence of Obstetric Sphincter Injuries using a hands-on technique: an interventional quality improvement project. *BMJ quality improvement reports.* 2016;5(1).
52. Fodstad K, Laine K, Staff AC. Different episiotomy techniques, postpartum perineal pain, and blood loss: an observational study. *International urogynecology journal.* 2013;24(5):865-72.
53. Roland B. Nytt liv og trygg barseltid for familien: Nasjonal faglig retningslinje for barselomsorgen. In: Helsedirektoratet, editor. Oslo: Helsedirektoratet; 2014.
54. Holan S. Pregnancy, birth and the postnatal period in Norway. Sosial- og helsedirektoratet; 2006.
55. Arkel E, Torell K, Rydhög S, Rikner Å, Neymark Bachmeier H, Gutke A, et al. Effects of physiotherapy treatment for patients with obstetric anal sphincter rupture: a systematic review. *European Journal of Physiotherapy.* 2017;19(2):90-6.
56. Woodley SJ, Boyle R, Cody JD, Morkved S, Hay-Smith EJC. Pelvic floor muscle training for prevention and treatment of urinary and faecal incontinence in antenatal and postnatal women. *The Cochrane database of systematic reviews.* 2017;12:Cd007471.

57. Laine K, Skjeldestad FE, Sanda B, Horne H, Spydslaug A, Staff AC. Prevalence and risk factors for anal incontinence after obstetric anal sphincter rupture. *Acta obstetrica et gynecologica Scandinavica*. 2011;90(4):319-24.
58. Collings S, Norton C. Women's experiences of faecal incontinence: a study. *British Journal of Community Nursing*. 2004;9(12):520-3.
59. Fodstad K, Staff AC, Laine K. Sexual activity and dyspareunia the first year postpartum in relation to degree of perineal trauma. *International urogynecology journal*. 2016;27(10):1513-23.
60. Waldenstrom U, Ekeus C. Risk of obstetric anal sphincter injury increases with maternal age irrespective of parity: a population-based register study. *BMC pregnancy and childbirth*. 2017;17(1):306.
61. Baghestan E, Irgens LM, Bordahl PE, Rasmussen S. Trends in risk factors for obstetric anal sphincter injuries in Norway. *Obstetrics and gynecology*. 2010;116(1):25-34.
62. Kapaya H, Hashim S, Jha S. OASI: a preventable injury? *European journal of obstetrics, gynecology, and reproductive biology*. 2015;185:9-12.
63. Durnea CM, Jaffery AE, Gauthaman N, Doumouchsis SK. Effect of body mass index on the incidence of perineal trauma. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics*. 2017.
64. Gurol-Urganci I, Cromwell DA, Edozien LC, Mahmood TA, Adams EJ, Richmond DH, et al. Third- and fourth-degree perineal tears among primiparous women in England between 2000 and 2012: time trends and risk factors. *BJOG : an international journal of obstetrics and gynaecology*. 2013;120(12):1516-25.
65. Rygh AB, Skjeldestad FE, Korner H, Eggebo TM. Assessing the association of oxytocin augmentation with obstetric anal sphincter injury in nulliparous women: a population-based, case-control study. *BMJ open*. 2014;4(7):e004592.
66. Muhleman MA, Aly I, Walters A, Topale N, Tubbs RS, Loukas M. To cut or not to cut, that is the question: A review of the anatomy, the technique, risks, and benefits of an episiotomy. *Clinical anatomy (New York, NY)*. 2017;30(3):362-72.
67. Fodstad K, Staff AC, Laine K. Effect of different episiotomy techniques on perineal pain and sexual activity 3 months after delivery. *International urogynecology journal*. 2014;25(12):1629-37.
68. Baghestan E, Irgens LM, Bordahl PE, Rasmussen S. Risk of recurrence and subsequent delivery after obstetric anal sphincter injuries. *BJOG : an international journal of obstetrics and gynaecology*. 2012;119(1):62-9.
69. Wheeler J, Davis D, Fry M, Brodie P, Homer CS. Is Asian ethnicity an independent risk factor for severe perineal trauma in childbirth? A systematic review of the literature. *Women and birth : journal of the Australian College of Midwives*. 2012;25(3):107-13.
70. Brown J, Kapurubandara S, Gibbs E, King J. The Great Divide: Country of birth as a risk factor for obstetric anal sphincter injuries. *The Australian & New Zealand journal of obstetrics & gynaecology*. 2018;58(1):79-85.
71. Davies-Tuck M, Biro MA, Mockler J, Stewart L, Wallace EM, East C. Maternal Asian ethnicity and the risk of anal sphincter injury. *Acta obstetrica et gynecologica Scandinavica*. 2015;94(3):308-15.
72. Hines AL, Andrews RM, Moy E, Barrett ML, Coffey RM. Disparities in rates of inpatient mortality and adverse events: race/ethnicity and language as independent contributors. *International journal of environmental research and public health*. 2014;11(12):13017-34.
73. Sentell T, Chang A, Ahn HJ, Miyamura J. Maternal language and adverse birth outcomes in a statewide analysis. *Women & health*. 2016;56(3):257-80.



74. Berggren V, Gottvall K, Isman E, Bergstrom S, Ekeus C. Infibulated women have an increased risk of anal sphincter tears at delivery: a population-based Swedish register study of 250 000 births. *Acta obstetrica et gynecologica Scandinavica*. 2013;92(1):101-8.
75. Wuest S, Raio L, Wyssmueller D, Mueller MD, Stadlmayr W, Surbek DV, et al. Effects of female genital mutilation on birth outcomes in Switzerland. *BJOG : an international journal of obstetrics and gynaecology*. 2009;116(9):1204-9.
76. Balachandran AA, Duvalla S, Sultan AH, Thakar R. Are obstetric outcomes affected by female genital mutilation? *International urogynecology journal*. 2018;29(3):339-44.
77. Salmon D. A feminist analysis of women's experiences of perineal trauma in the immediate post-delivery period. *Midwifery*. 1999;15(4):247-56.
78. Lindqvist M, Persson M, Nilsson M, Uustal E, Lindberg I. 'A worse nightmare than expected' - a Swedish qualitative study of women's experiences two months after obstetric anal sphincter muscle injury. *Midwifery*. 2018;61:22-8.
79. O'Reilly R, Peters K, Beale B, Jackson D. Women's experiences of recovery from childbirth: focus on pelvis problems that extend beyond the puerperium. *Journal of clinical nursing*. 2009;18(14):2013-9.
80. Herron-Marx S, Williams A, Hicks C. A Q methodology study of women's experience of enduring postnatal perineal and pelvic floor morbidity. *Midwifery*. 2007;23(3):322-34.
81. Dudley L, Kettle C, Waterfield J, Ismail KM. Perineal resuturing versus expectant management following vaginal delivery complicated by a dehisced wound (PREVIEW): a nested qualitative study. *BMJ open*. 2017;7(2):e013008.
82. Way S. A qualitative study exploring women's personal experiences of their perineum after childbirth: expectations, reality and returning to normality. *Midwifery*. 2012;28(5):e712-9.
83. Priddis HS. Autoethnography and severe perineal trauma--an unexpected journey from disembodiment to embodiment. *BMC women's health*. 2015;15:88.
84. Priddis H, Dahlen H, Schmied V. Women's experiences following severe perineal trauma: a meta-ethnographic synthesis. *Journal of advanced nursing*. 2013;69(4):748-59.
85. Elden H, Olesen A, Svahn L, Lindgren H. Feeling old in a young body: Women's experiences of living with severe consequences of an obstetric anal sphincter rupture: An interview study. *Clinical Nursing Studies*. 2014;3(1).
86. Tucker J, Clifton V, Wilson A. Teetering near the edge; women's experiences of anal incontinence following obstetric anal sphincter injury: an interpretive phenomenological research study. *The Australian & New Zealand journal of obstetrics & gynaecology*. 2014;54(4):377-81.
87. Tucker J, Wilson A, Clifton V. Women's experience of anal incontinence following a history of obstetric anal sphincter injury: a literature review. 2013. p. 181-6.
88. Keighley MR, Perston Y, Bradshaw E, Hayes J, Keighley DM, Webb S. The social, psychological, emotional morbidity and adjustment techniques for women with anal incontinence following Obstetric Anal Sphincter Injury: use of a word picture to identify a hidden syndrome. *BMC pregnancy and childbirth*. 2016;16(1):275.
89. Skottheim J, Wahlqvist U, Thunborg C, Sandborgh M. Upplevelsen av att följa råd och träningsanvisningar vid obstetrisk sfinkterruptur: En kvalitativ intervjustudie. 2016.
90. Edqvist M, Lindgren H, Lundgren I. Midwives' lived experience of a birth where the woman suffers an obstetric anal sphincter injury--a phenomenological study. *BMC pregnancy and childbirth*. 2014;14:258.
91. Brunstad A, Nilsen ABV, Aasheim V. Forløsningspraksis og fødselsrifter: Jordmødres erfaringer. *Nordic Journal of Nursing Research*. 2007;27(2):9-13.
92. Helsedirektoratet. Are you pregnant? Are you expecting a child? Pregnancy, birth and the postnatal period in Norway 2013 [Available from:

<https://helsedirektoratet.no/publikasjoner/er-du-gravid-venter-dere-barn-graviditet-fodsel-og-barseltid-i-norge>.

93. Pelaez S, Hendricks KN, Merry LA, Gagnon AJ. Challenges newly-arrived migrant women in Montreal face when needing maternity care: Health care professionals' perspectives. *Globalization and health*. 2017;13(1):5.
94. Binder P, Borne Y, Johnsdotter S, Essen B. Shared language is essential: communication in a multiethnic obstetric care setting. *Journal of health communication*. 2012;17(10):1171-86.
95. Lov om pasient- og brukerrettigheter (pasient- og brukerrettighetsloven).
96. Helsedirektoratet. Veileder om kommunikasjon via tolk for ledere og personell i helse- og omsorgstjenestene. Oslo: Helsedirektoratet; 2011.
97. Kale E, Syed HR. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient education and counseling*. 2010;81(2):187-91.
98. Tolkesentralen. Tolkesentralen Oslo: Oslo universitetssykehus HF [Available from: [http://www.oslo-universitetssykehus.no/omoss\\_/avdelinger\\_/tolkesentralen\\_](http://www.oslo-universitetssykehus.no/omoss_/avdelinger_/tolkesentralen_) .
99. Tolkeportalen. Nasjonalt tolkeregister Oslo: Integrerings- og mangfoldsdirektoratet (IMDi); [Available from: <https://www.tolkeportalen.no/>.
100. Fisher J, Hinchliff S. Immigrant women's perceptions of their maternity care: a review of the literature. Part 2. The practising midwife. 2013;16(2):32-4.
101. Akhavan S, Lundgren I. Midwives' experiences of doula support for immigrant women in Sweden--a qualitative study. *Midwifery*. 2012;28(1):80-5.
102. Akhavan S, Edge D. Foreign-born women's experiences of Community-Based Doulas in Sweden--a qualitative study. *Health care for women international*. 2012;33(9):833-48.
103. Flerkulturell doula: Oslo universitetssykehus; 2018 [Available from: <https://oslo-universitetssykehus.no/likeverd-og-mangfold/flerkulturell-doula>.
104. Shilling C. *The body and social theory*. London: SAGE; 2003.
105. Walsh DJ. *Childbirth embodiment: problematic aspects of current understandings*. Oxford, UK 2010. p. 486-501.
106. Lupton D, Schmied V. Splitting bodies/selves: women's concepts of embodiment at the moment of birth. *Sociology of Health & Illness*. 2013;35(6):828-41.
107. Lazarus RS, Folkman S. *Stress, appraisal, and coping*. New York: Springer; 1984.
108. Lazarus RS. Coping theory and research: past, present, and future. *Psychosomatic medicine*. 1993;55(3):234-47.
109. Burkitt I. *Bodies of thought : embodiment, identity and modernity*. London: Sage; 1999.
110. Burke PJ, Stets JE. *Identity theory*. New York: Oxford University Press; 2009.
111. Porter RE, McDaniel ER, Samovar LA. *Intercultural communication : a reader*. 13th ed. ed. S.I.: Wadsworth Cengage Learning; 2012.
112. Eide H, Eide T. *Kommunikasjon i relasjoner : samhandling, konfliktløsning, etikk*. 2. rev. og utv. utg. ed. Oslo: Gyldendal akademisk; 2007.
113. Patton MQ. *Qualitative research & evaluation methods : integrating theory and practice*. 4th ed. ed. Los Angeles, Calif: Sage; 2015.
114. Malterud K. Qualitative Research: standards, challenges and guidelines. *The Lancet*. 2001;358:483-8.
115. Ulin PR, Robinson ET, Tolley EE. *Qualitative Methods in Public Health: A Field Guide for Applied Research*. San Fransisco: Jossey-Bass; 2005.
116. Moen K, Middelthon AL. *Qualitative Research Methods* 2015. 321-78 p.
117. Malterud K. *Kvalitative metoder i medisinsk forskning : en innføring*. 3. utg. ed. Oslo: Universitetsforl.; 2011.

118. Malterud K. Kvalitative metoder i medisinsk forskning. Oslo: Universitetsforlaget; 2003.
119. Dahlgren L, Emmelin M, Winkvist A. Qualitative Methodology for International Public Health. Umeå: Print och Media; 2004.
120. Brinkmann S, Kvale S. InterViews : learning the craft of qualitative research interviewing. 3rd ed. ed. Thousand Oaks, Calif: Sage; 2015.
121. Malterud K. Systematic text condensation: a strategy for qualitative analysis. Scandinavian journal of public health. 2012;40(8):795-805.
122. Sjetne IS, Holmboe O. Brukererfaringer med fødsels- og barselomsorgen i 2016 (PasOpp-rapporter). Folkehelseinstituttet; 2017.
123. Priddis HS, Schmied V, Kettle C, Sneddon A, Dahlen HG. "A patchwork of services"--caring for women who sustain severe perineal trauma in New South Wales--from the perspective of women and midwives. BMC pregnancy and childbirth. 2014;14:236.
124. Terui S. Conceptualizing the Pathways and Processes Between Language Barriers and Health Disparities: Review, Synthesis, and Extension. Journal of immigrant and minority health / Center for Minority Public Health. 2015.
125. Stewart MA. EFFECTIVE PHYSICIAN-PATIENT COMMUNICATION AND HEALTH OUTCOMES - A REVIEW. Can Med Assoc J1995. p. 1423-33.
126. Kale E, Skjeldestad K, Finset A. Emotional communication in medical consultations with native and non-native patients applying two different methodological approaches. Patient education and counseling. 2013;92(3):366-74.
127. Elmir R, Schmied V, Wilkes L, Jackson D. Women's perceptions and experiences of a traumatic birth: a meta-ethnography. Journal of advanced nursing. 2010;66(10):2142-53.
128. Helman CG. Culture, health and illness. 5th ed. ed. London: Hodder Arnold; 2007.
129. Stets J, Burke P, Stets J. Identity Theory and Social Identity Theory. Social Psychology Quarterly. 2000;63(3):224-37.
130. Burke PJ, Burke PSJE. Identity Theory. New York: New York, US: Oxford University Press; 2009.
131. Mercer RT. Becoming a Mother Versus Maternal Role Attainment. Journal of Nursing Scholarship. 2004;36(3):226-32.
132. Jackson S, Scott S. Theorizing sexuality. Maidenhead: Open University Press; 2010.
133. Maclaren K. Intimacy and embodiment: An introduction. 2014. p. 55-64.
134. Berman SL. Identity and trauma. J Trauma Stress Disor Treat. 2016;5(2).
135. Mähönen TA, Jasinskaja-Lahti I. Identities, intergroup relations and acculturation : the cornerstones of intercultural encounters. Helsinki: Gaudeamus; 2009.
136. Holloway I. Qualitative research in health care. Maidenhead: Open University Press; 2005.

# Appendix A: REC Exemption



Viva Combs Thorsen  
Institute of Health & Society  
The University of Oslo

**Regional Committee for Medical  
& Health Research Ethics**  
**South East Norway, Section D**  
Postbox 1130 Blindern  
NO-0318 Oslo  
Norway

Phone: + 47 22 84 55 23

E-mail: [ingrid.donasen@medisin.uio.no](mailto:ingrid.donasen@medisin.uio.no)

Webportal: <http://helseforskning.etikkom.no>

Our ref.: 2016/1555d  
IRB ref.: IRB00006245

Date: 19<sup>th</sup> September 2016

To whom it may concern,

**Re: REC Letter of Exemption**

Review

The Chairperson for the Regional Committee for Medical & Health Research Ethics, Section D, South East Norway, has reviewed the Remit Assessment Form received on the 7<sup>th</sup> September 2016 for the Research Project "Communication between physiotherapist and non-Norwegian speaking women following an Obstetric Anal Sphincter Injury" (*Norwegian title: Kommunikasjon mellom fysioterapeuter og ikke-norsktalende kvinner med tredje- eller fjerdegrads perinealruptur*). The Project Manager is Viva Combs Thorsen and the Institution Responsible for Research is the University of Oslo. The Review was carried out on behalf of the Committee on the 16<sup>th</sup> of September 2016.

The application was assessed accordance with the Norwegian Research Ethics Act (2006) and Act on Medical and Health Research (2008).

The Decision

The Chairperson for the Regional Committee for Medical & Health Research Ethics, Section D, South East Norway, found the Research Project to be outside the remit of the Act on Medical and Health Research (2008) and therefore can be implemented without its approval.

Ethics Committee System

The Ethics Committee System in Norway consists of seven Independent Regional Committees with authority to either approve or disapprove Medical Research Studies conducted within Norway, or by Norwegian Institutions, in accordance with the Act on Medical and Health Research (2008).

Please do not hesitate to contact the Regional Committee for Medical and Health Research Ethics Section South East D (REK Sør-Øst D) if further information is required, as we are happy to be of assistance.

Yours faithfully,

Finn Wisløff  
Chair of the Regional Committee for Medical  
& Health Research Ethics of South East Norway,  
Section D

Ingrid Donåsen  
Higher Executive Officer

# Appendix B: NSD receipt



Ane Haaland  
Institutt for helse og samfunn Universitetet i Oslo  
Postboks 1130 Blindern  
0318 OSLO

Vår dato: 10.11.2016

Vår ref: 50384 / 3 / AGH

Deres dato:

Deres ref:

## TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 04.10.2016. Meldingen gjelder prosjektet:

50384	<i>Communication between physiotherapist and non-Norwegian speaking women following an Obstetric Anal Sphincter Injury</i>
Behandlingsansvarlig	Universitetet i Oslo, ved institusjonens øverste leder
Daglig ansvarlig	Ane Haaland
Student	Iselin Overskeid Vinje

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, <http://www.nsd.uib.no/personvern/meldeplikt/skjema.html>. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://pvo.nsd.no/prosjekt>.

Personvernombudet vil ved prosjektets avslutning, 31.05.2017, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

Agnete Hessevik

Kontaktperson: Agnete Hessevik tlf: 55 58 27 97

*Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.*

# Appendix C: Informed Consent



UiO : University of Oslo

## Request for participation in a research project – interviews

### “COMMUNICATION BETWEEN HEALTH WORKERS AND NON-NORWEGIAN SPEAKING WOMEN FOLLOWING AN OBSTETRIC ANAL SPHINCTER INJURY”

This is a request for you to participate in a research project that aspires to increase the understanding on the communication between health workers and non-Norwegian speaking women following an Obstetric Anal Sphincter Injury.

This study is being conducted by Iselin Overskeid Vinje, a master student in International Community Health with the University of Oslo. You have been selected for the study on the background of your diagnosis of obstetric anal sphincter injury and your fluency in the Norwegian language. If you wish, final results of the study will be provided to you upon completion.

#### What does the study entail?

In this research, you will be invited to participate in one or more interviews conducted by the researcher and assisted by an interpreter. Approximately 15 participants will participate in the research. Interviews will be conducted at a location of your choice and last between one and two hours. Topics covered will be obstetric anal sphincter injury and the communication you experienced when at the maternity ward or clinic with the physical therapist and interpreter. With your permission, the interviews may be audio recorded. If you permit, details concerning your name, age, marital status, number of children, ethnicity, country of origin, time residing in Norway and fluency in the Norwegian language will be collected and subsequently stored in a locked location. In addition, the researcher may request to view any notes from physiotherapists stored in your electronic medical journal with the hospital. This will only be done with your permission, and is requested to be able to see what treatment you have received at the hospital.

#### Possible disadvantages and advantages

A disadvantage of participating in this research is that we may discuss potentially painful or private moments. This may result in discomfort, emotional upset or the recollection of events that you find is difficult. It is difficult to predict how different people react to discussing these topics.

Advantages of the study are that discussing your experiences may feel meaningful. You may feel satisfied in contributing to increasing the knowledge and understanding of how communication is experienced by non-Norwegian speakers, and as to how communication in health consultations can be improved.

### **Voluntary participation and withdrawal from the research**

Participation in the project is voluntary. If you wish to participate, please sign the consent form attached on the last page. By signing this informed consent form, you agree to your contact information including name and telephone number being shared with the researcher. The researcher will not know your name or contact information until you sign. You will after signing this form be contacted by the researcher, or be able to contact her.

You can withdraw your consent to participate in the study at any point in time, without providing a reason for doing so. Participating in or withdrawing from the study will not have consequences for your treatment in any way. If you choose to withdraw from the project, you can request that all information and details collected about you are removed from the study data, as long as material is not already published.

If you later wish to withdraw from the study or have any other questions, please contact the researcher: Iselin Overskeid Vinje, phone: [REDACTED], e-mail [REDACTED], or her supervisors: Ane Haaland, e-mail: [REDACTED], or Viva Combs Thorsen, e-mail: [REDACTED]

### **What will happen to information about you?**

Information about you is only to be used in accordance with the purpose of the study as described above. All data will be processed without name or any other directly recognizable information. A code number will link your data through a list of names, and only the researcher will have access to the list of names and be able to identify you.

You have the right to read the information that is stored about you, and a right to correct any mistakes in the information registered.

The main researcher has responsibility to ascertain that information about you is stored and handled correctly. The project is a master thesis and will be completed by May 10th. Data will be stored up to 5 years after the project's end date for possible publication. After the five-year period, recordings and transcripts will be destroyed.

## Data protection

The study has been notified to the Data Protection Official for Research, NSD – Norwegian Centre for Research Data.

## Consent for participation in the study

**I am willing to participate in the study:**

-----  
Place and date

-----  
Participants signature

-----  
Participants signature in bold letters

I consent to give the researcher access to my medical journal as described in the text above:

Yes:

No:

I confirm that I have given information about this study.

-----  
Place and date

-----  
Signature

-----  
Role in project



# Appendix D: Interview guide

## Interview guide for non-Norwegian speaking women with obstetric anal sphincter injury

*Introduction and small chat, bonding and creating trust. Introduce myself.*

*Ask permission to record. Explain why recording is helpful for me.*

*“The purpose of this talk is for me to learn more about you and your experiences of being a patient in the maternity ward in a Norwegian hospital, and to discuss your life after being discharged. Since I unfortunately don’t speak your language (learn a few phrases), we will talk with the help of \*insert interpreter’s name\*. She will translate directly everything that both you and I say today, to make it easier to talk together. (Everything we talk about is confidential.)”*

*“Can you tell me a little about what made you want to participate in this interview?”*

*“Before we start, do you have any questions?”*

- Firstly, I was wondering if you could tell me a little bit about yourself and your daily life?
  - Do you have a big or small family?
    - Children? Age?
  - How long have you and your family been in Norway?
  - Can you describe how your everyday life was like before giving birth to \*insert baby’s name\*?
- How did you experience your/this pregnancy (in relation to the others)?
  - What kind of contact did you have with the health services during your pregnancy?
    - Can you tell me more about \*experience/opinion etc.\*?
- Can you describe your experience at the hospital when giving birth to your son/daughter?
  - What do you remember best from your time at the maternity ward?
  - How did you feel when being there?

*An important part of this conversation is for me to learn more about your thoughts around being sutured because of a tear/rupture that occurred in your muscles while giving birth and your experiences concerning this at the maternity ward.*

- I am wondering, when I say the word “rupture” or “tear”, what do you think of?
  - How did you first feel about this tear that occurred?
  - .. has your feelings towards this tear changed?
    - What made your feelings towards the rupture change?

- What kind of help did you receive at the maternity ward?
  - Can you tell me more about what kind of help and advice you received at the maternity ward in regards to this tear?
  - From whom did you receive this advice?
    - Who was present when you received this information/advice the first time?
    - Was the information given orally or written or both?
    - (In what language was the information given?)
  
- Do you remember talking to a person about doing exercises (talking to a physiotherapist) while there?
  - Can you tell me about this visit with the physiotherapist?
  - Have you had any previous experience of talking to a physiotherapist?
  - Have you had any previous experiences with doing exercises like these?
  - Did you feel that your questions and comments were addressed during this meeting with the physiotherapist?
    - How so?
  - Is there anything you would like to have happened differently during this meeting?
    - How do you think this could be addressed?
  - What did you first think when you were advised to do these exercises?
  
- How have you followed up on this advice?
  - Has there been any challenges in following up on these exercises?
    - What have been barriers to doing the exercises?
  - What helps you do them?
  
- How would you describe your health (preferably find a way to ask in relation to rupture) at the moment?
  - What do you think has helped you improve your health?
  - What do you think will be important to you in order to get well?
  
- Apart from today, can you remember having spoken to a health worker through another person in your language like we are doing now with \*insert interpreter's name\*?
  
- Before we close of, are there any topics we have talked about today that you feel you didn't get to fully express your thoughts and feelings on?

*Sum up, close off interview and have a chat before leaving. Answer any final questions. Thank her.*

# Appendix E: Facebook invitation

Dear all international mothers,

My name is Iselin Overskeid Vinje and I am a student in the master program “International Community Health” with the University of Oslo. For my master thesis, I would like to come in contact with women who speak little or no Norwegian, and who have sustained a third or fourth degree perineal rupture during childbirth.

I wish to interview you about your experiences in the maternity ward and in the postnatal period, and about your experiences regarding communication and language in the health services. If you have received physiotherapy, I would also like to hear your experiences with this. Your experiences will be important to the research and will be the focus of the project. The goal of the research is for the health services to learn more about how to communicate better with patients who are not fluent in Norwegian.

Before agreeing to participate, you will receive more information and you will sign an informed consent form. Participation in the project is voluntary, and all information will be anonymized and treated confidentially. The project is approved by the Norwegian Centre for Research Data. If you speak a language other than English, it is possible to get the help of a professional interpreter.

If you are interested in participating or if you just want to know more about the project, please don't hesitate to contact me. You can reach me by phone: [REDACTED] or email: [REDACTED], or just send me a message here on Facebook.

I would love to hear from you!

Best regards,

Iselin Overskeid Vinje

# Appendix F: NSD confirmation of delay

 **Belinda Helle** <belinda.helle@nsd.no>  
Til: Iselin Overskeid Vinje

Hei,

Takk for tilbakemelding. Vi har registrert at ny dato for prosjektslutt til 10.05.18. Ved ytterligere forlengelser ber vi om at du sender inn en [endringsmelding](#) til [personvernombudet@nsd.no](mailto:personvernombudet@nsd.no).

Vi vil ta kontakt med ny prosjektslutt.

Vennlig hilsen,

Iselin Overskeid Vinje skrev den 08.11.2017 09:27:

> [Vis opprinnelig melding](#)

--

Belinda Gloppen Helle  
Rådgiver | Adviser  
Seksjon for personverntjenester | Data Protection Services  
Tlf: (+47) 55 58 28 74

NSD – Norsk senter for forskningsdata AS | NSD – Norwegian Centre for Research Data  
Harald Hårfagres gate 29, NO-5007 Bergen  
Tlf: (+47) 55 58 21 17  
[postmottak@nsd.no](mailto:postmottak@nsd.no) [www.nsd.no](http://www.nsd.no)