

Article

More than health care: The implications of cultural diversity for health care practice in Norway

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Abstract

The Norwegian community health centres are one of the main providers of maternal and child health care services. They are often the primary, as well as a regular point of contact, for women during pregnancy and after childbirth. As such, they are a place where encounters between primary health care providers like public health nurses, midwives and immigrant women, are frequent.

Midwives and public health nurses play an important role as state employees in the distribution of universal health provisions at the local level. This is especially important in meeting the diverse needs of service users in a universal health care system. This study investigates the implications of cultural diversity for health care practice in a universal system. It employs a qualitative approach, using data from nine semi-structured interviews with midwives and public health nurses across three Norwegian municipalities. It analyses their experiences in working with immigrant women during pregnancy, and after childbirth, through thematic analysis. The findings illustrate the practitioners' different approaches to meeting with culturally diverse patients, the challenges they face in their work, and how they overcome them. The discussions address the practice of cross-cultural health care in the absence of national guidelines or formal training using street-level bureaucracy as an analytical concept. This article contributes to knowledge on the practice of cross-cultural health care at Norwegian community health centres in the absence of a culturally cognizant health policy. On a broader scale, this study illustrates the implications of diversity for policy and practice in a universal welfare state.

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Introduction

Norway has a universal health care system funded by progressive taxation. This health system is decentralized, with the central government maintaining a regulatory role in addition to managing the hospitals, while local governments are responsible for the implementation of national guidelines by the Directorate of Health and the distribution of primary care services (Norwegian Directorate of Health, 2017, 2018). This enables local governments to deliver universal health provisions in ways that best meet their populations' needs (Gjerstad, Johannessen, Nødland, Skeie, & Vedøy, 2016). This is tied to the long history of local autonomy and the decentralized state in Norway (Borge, 2010). Primary maternity and child health care in the municipalities are offered by both general practitioners, as well as midwives and public health nurses at community health centres known as 'Helsestasjon' in Norwegian. Midwives at these community health centres are generally responsible for antenatal checks and family planning services, while the public health nurses are responsible for monitoring the development of children from birth to five years of age (Norwegian Directorate of Health, 2020).

As a whole, diversity poses a challenge for universalism (Anttonen, Haikio, & Kolbeinn, 2012; Mehrara, 2020). Diversity requires unequal treatment for the equality of opportunity, and thus of the outcome, because 'to treat people equally is not always to treat them the same' (Zacka, 2017, p. 52). While teasing out the health equity debate is not the objective of this study, this article focuses on the effect of cultural diversity on the Norwegian maternal health system (hereafter: NMHS). In recent decades, Norway has experienced an influx of immigrants, resulting in a more ethnically and culturally diverse population. People with immigrant backgrounds make up over 18% of Norway's population (SSB, 2021). This population is scattered across the country, though the majority are concentrated in and around Norway's larger cities. For primary health care providers in these municipalities, this has meant more frequent encounters with immigrant service users who have diverse cultural backgrounds, and consequently health needs, practices and health care expectations.

The effect of immigration on the declining health of immigrants over time is presented across many studies as being associated with barriers, such as limited knowledge,

language, costs, location or cultural differences (Ng & Newbold, 2011; Nørredam & Krasnik, 2011; Norsk Sykepleierforbund, 2014). Immigrants are a diverse and heterogeneous population, with some better equipped to manage life in a new country than others. Nonetheless, immigrant women as a whole constitute a vulnerable group. Multiple studies show that immigrant women have poorer birth and other reproductive health outcomes, compared to non-immigrant women (Reeske & Razum, 2011; Urquia, Frank, Moineddin, & Glazier, 2010; Vik et al., 2019). However, the analysis of these effects from a sociocultural perspective remains limited, particularly with regard to the role of maternal health care providers who work with immigrant women in Norway. This perspective is important because it can offer insight into the barriers that health care providers face, and about how policy should systemically address these.

While Norwegian health policy recognizes socioeconomic and language barriers to accessing health care (Norwegian Directorate of Health, 2015), it overlooks other aspects such as immigrants' cultures or cultural diversity as a determinant of health (author, a, 2020; author, b, 2020). This may leave primary health care providers to handle challenges linked to cultural differences. This study investigates the cross-cultural experiences of midwives and public health nurses with immigrant patients, asking what the implications of cultural diversity for health care practice in a universal system are.

Community health centres (Helsestasjon)

The community health centres, known as *Helsestasjon* in Norwegian, are one of the main providers of primary maternal and child health care services in Norway (Gamst, 2012; author, 2022). As part of the universal health care system, they are free of charge and located across towns and cities, thereby making them an available and accessible health institution. The clinics also operate on a walk-in basis, and usually have open premises for those who need a private place to feed or change their babies while they are outside.

Midwives and public health nurses constitute the majority of the task force at these clinics, along with some doctors and physiotherapists. The structure and scope of health care for regular appointments is informed by the national health guidelines

(Nasjonal faglig retningslinje) for pregnancy care (Svangerskapsomsorgen) and childcare (Helsestasjons- og skolehelsetjenesten), as outlined by the Norwegian Directorate of Health (2017, 2018). Accordingly, midwives conduct nine antenatal consultations. After birth, the midwife and a nurse from the health clinic do a home visit to check on the mother and the baby. From this stage, the midwife offers post-natal checks and family planning consultations, while the public health nurse takes over the primary care responsibility for the baby's development. As per national guidelines, from birth up to five years of age, children get 14 health check appointments with their nurse, who will sometimes be accompanied by a doctor or a physiotherapist, to help assess their physical and psychosocial development and well-being (Norwegian Directorate of Health, 2020).

These community health centres provide maternal and some child health services, in parallel with care by family doctors (GPs) at the community level; however, the structure and scope of health care is different. The care offered at the health clinic is meant to be more holistic, meaning that during these appointments, which are typically longer than a doctor's appointment, care is generally less acutely medical, and covers other aspects and determinants of health related to the woman or the child (Helsenorge, 2021; Norwegian Directorate of Health, 2020). This structure differentiates the scope and quality of health care provided at these clinics, but also demands practitioners to be able and open to addressing topics outside, but related to their speciality in health care.

Conceptual framework

Culture is important in health care. It can have great implications for individuals' health and their perceptions of treatment (Petiprin, 2020). Immigrants coming from different countries and cultural backgrounds, bring with them experiences and knowledge from various health care settings and health practices. In this study, this is defined as 'cultural models' of health (D'Andrade, 1995). When immigrants meet a new cultural health model, such as that of the Norwegian health care system, they may find that it differs from their expectations. Cultural models are more or less clearly formulated ideas or explicit knowledge about the world that is common to members of a community, group, or culture, which have a decisive influence on how members understand and act in the world (Måseide, 1986). They have a crucial

impact on how people prioritize what they consider as acceptable behaviour and what is regarded as relevant knowledge. Cultural models are therefore essential for how people reason and act in relation to matters of health (Gjernes, 2004).

If practitioners fail to recognize the cultural needs of their patients, 'the patients will be less inclined to continue care, or may be forced to seek care elsewhere' (Ng & Newbold, 2011, p. 563). Cross-cultural health, however, can enhance the health outcomes and experiences of immigrant service users. For this, practitioners must have cultural sensitivity and awareness, or in other words have a cultural competence in providing health care to patients from different cultural backgrounds (Bauce, Kridli, & Fitzpatrick, 2018; Wikberg, 2020). Gustafson (2005) defines cultural competence as 'a quantifiable set of individual attitudes and communication and practice skills that enables the nurse to work effectively within the cultural context of individuals and families from diverse backgrounds' (p. 2). Nevertheless, being culturally competent and providing cross cultural care can be challenging for practitioners, who may have ambivalent requirements and consequent responses to cultural diversity (Gustafson, 2005).

Norwegian health policy does not recognize more implicit barriers, like culture, as a determinant of immigrants' health; consequently, national practice guidelines for midwives and nurses at the community health centres do not do so either (Mehrara & Young, 2020). As such, midwives and public health nurses play an important role in the distribution of universal services in Norway's decentralized health system (Mehrara, 2020; Mehrara & Young, 2020). Their role as the most local agents of the state, and as mediums between the state and its service users, makes them street-level bureaucrats (Zacka, 2017).

'Street-level bureaucrats acquire, over time, a deep knowledge of how the bureaucratic process works... this informal know-how is one of the most precious resources that street-level bureaucrats can distribute to their clients' (Zacka, 2007, p. 76). This is reliant on professional discretion. According to Zacka (2017), discretion 'ranges over questions of value...and the existence of such discretion makes it possible for street-level bureaucrats to inhabit their role in a variety of ways' (p. 66). How discretion is practiced in meeting *the needs of immigrant women with different*

cultural backgrounds may therefore be reliant on practitioners' tacit knowledge, normative judgement, and consequently, moral disposition.

Moral dispositions 'shape how bureaucrats perceive and frame the cases they encounter and what considerations they are inclined to prioritize when responding to them' (Zacka, 2017, p. 66). Moral dispositions are 'more enduring professional identities... revolving around a more explicit understanding of one's role and responsibilities... a "role conception", which is largely situation-independent' (Zacka, 2017, p. 87). Two of these models of role conception are indifference and caregiving. Indifference is the opposite to caregiving whereby care is given in a 'person -neutral' way (Zacka, 2007, p. 101). It is time-saving and does not lead to burnout in the same way as caregiving; nevertheless, it risks blindness toward cultural diversity, and can be problematic in terms of reproducing ethnocentric norms. However, cross-cultural health care requires practitioner' opposition to indifference, because different treatment in a universal system is the only plausible way of attaining equity.

The professional discretion of health care workers is an important dimension for consideration in the practice of cross-cultural health care. The concept of street-level bureaucracy in this study is therefore adopted as an instrument for the conceptualization of cross-cultural health care and its effects from both the policy and practice perspectives. Subsequently, this conceptual framework links the empirical findings of this study to broader policy and practice debates on the implications of cultural diversity for Norway's universal health system.

Methods

Data for this study was gathered through a series of interviews with primary maternal and child health care professionals in three Norwegian municipalities with a high immigrant population. Once the study was approved by the Norwegian Social Science Data Services (NSD-234675), neighbourhoods in these municipalities were strategically selected as sites for this study based on their high percentage of immigrant residents. Community health centres in these regions were contacted by calling and e-mailing their clinic chiefs. Once approval from the clinic chiefs was obtained, participants were recruited both by snowball sampling, and by purposive sampling at clinic lunchrooms or workshops.

Nine semi-structured interviews were selected, of which seven were individual and two in pairs, between May and December 2019. The nine participants included four practicing midwives and four practicing public health nurses, as well as a retired midwife. All the participants were female, reflecting the dominance of women in this sector. The participants had experience caring for women during their pregnancies, after birth, and their children from birth to five years of age. Eight of the participants were Scandinavian, and one was a naturalized Norwegian.

Prior to each interview, the participants signed a written consent form about the purpose of the project, the processing of data, confidentiality and their rights as volunteers, which was explained to them both verbally and in writing. The interviews lasted between one to two hours. The purpose of the interviews was to gain a better understanding of the experiences primary maternal and child health care providers had working with immigrant women. The interviews began with open-ended questions about their professional background and what their work involved. Then they were asked semi-structured questions about their experiences working with immigrants, the challenges they faced, and how they worked around them. This allowed them to reflect on their experiences, and to provide examples. Interviews were audio-recorded and later transcribed verbatim by the researcher. The transcripts were analysed on NVivo 12 software, following Braun and Clarke's (2006) model for thematic analysis. After familiarization with the data, broad categories on working with immigrants, trust and cultural practices were identified. The data was examined meticulously and then compared with literature in an abductive process, which led to the recognition of three themes: the importance of culture in health care, complexities in health care provision to immigrant women and addressing the challenges in working with immigrant women. This abductive process distilled and enriched the explanation of the empirical findings.

Findings

At the time of the data collection, seven of the interviewees had between 20 and 50 years of professional health care experience, and the other two between seven and 11 years of experience. As such, this was an experienced group of participants, most of whom had witnessed the changes in maternal and child health care, as well as an

increase in the immigrant population in Norway throughout their profession. There were no significant differences between the experiences of public health nurses and midwives in working with immigrant women. Yet, there were differences among the participants in how they conceptualized or approached their health care encounter with immigrant women, and in similarities in the types of challenges they faced in working with them. This section categorizes these experiences, starting with their conceptualizations of cultural differences in their health care encounters with immigrant women, the similarities of the complexities they experience in working with immigrant women, and how they addressed the needs of immigrant women in their practice.

Importance of culture in health care

All practitioners were aware of the challenges of cultural diversity associated with an immigrant background in their practice. However, their regard for culture as an aspect in their health care practice with immigrant women varied. While some prioritized its effects in health care provision, others prioritized issues other than the cultural background of the patients in their practice.

The practitioners who highlighted the integral importance of culture described it as key to enhancing the quality of care and improving the health outcomes of their immigrant patients, saying that acknowledging culture encouraged cooperation, dialogue and trust development. Linda, a midwife, explained that:

Communication is so very important because when a person feels understood, they relax. This is very important in developing a connection with a pregnant woman in a strange country [Norway], where she is worried about many things, has no network, no family or anything around her.

Josephine, a midwife, and Barbara, a nurse, both emphasized that recognizing, demonstrating interest, and discussing the cultural background of their immigrant patients in their meetings was important. Barbara explained:

It's very important to show interest in different cultural practices ... once you ask them, you really feel that the meeting becomes more of a dialogue, and they develop more trust in me. This is very important for our practice.

Communication and cooperation are important in the type of holistic and long-term care they provide at these health clinics, hence enabling the patients to become more active participants, which can have positive implications for their own and their

children's well-being. Josephine claimed that 'I do not always do that [ask her clients about culture]'. She explained that doing so, or becoming culturally sensitive, is: 'a matter of time, and consciousness. So, I have become more conscious and have started to be more like that [ask her patients about culture]'. Josephine points out the processual aspect of such work, especially when it is left to the professional discretion of the practitioners to incorporate culture in their meetings with immigrant patients.

Working with immigrant women from different cultures also raised the issue of cultural health models. Joan and Sharon, a midwife, and a nurse in another dyadic interview, described that immigrant women often had questions that were different from those of Norwegian patients:

Joan: We see that their questions are very often related to their culture. It's not the same questions as Norwegian groups.

Sharon: No, it's very different. In Norway they [Norwegians] have different knowledge... they are at a different level in a way! Because there are basic things that we assume everybody knows, but they don't know if they are not from Norway. Like cod liver oil [for vitamin D], for example. Everybody knows that in Norway, but it's not common for people from other countries'

Joan: And many think it's extremely cold here during winter, so they overdress their baby, or they just stay inside'.

Although some forms of knowledge may be assumed for the local population, they are not for immigrants. Identifying these in a culturally aware process of consultation can contribute to the better health outcomes of mothers and babies. Continuing the topic of culture and health models, Sharon said:

I know that it's very easy for us [practitioners] to think that 'oh, we have the knowledge. What we are doing is the right way to do it'. But I have to step beside myself and watch myself and think about the many ways there are to do things. Our way [Norwegian] is not the only right way. So, I try to ask my immigrant patients, 'how is it in your culture?'

Here, she additionally points out the discursive implications of cross-cultural practice by becoming more aware of alternative discourses on health care outside the dominant Western or Norwegian ones.

Finally, those who found culture and its impact important when working with immigrant women explained that discussing culture enabled them to develop a better understanding of their patients' backgrounds and needs. This allowed for identifying

cultural norms and practices adopted by their patients, and finding ways to recommend alternative practices when they found certain practices to be harmful. This acquired cultural knowledge, however generalized, could also be useful while working with other patients, and in helping colleagues who experienced challenges in working with immigrant patients. For example, through experience of working with immigrants, advising against the use of baby walkers and the use of certain foods like honey, or talking about alternatives to violence in disciplining children, were common topics practitioners addressed when working with immigrants. They learned through experience that these were common practices in many countries, but that they could be harmful to babies based on their professional training. In other cases, their acquired knowledge about different cultures resulted in promoting more understanding and tolerance of certain practices that would normatively be judged as harmful by the Norwegian-trained nurses and midwives. Linda, a midwife with many years of international midwifery experience, recalled a story illustrating this:

A colleague of mine that was working in the labour ward, called me one day, absolutely desperate, saying, 'I've experienced the most awful thing today! They gave the new-born baby butter! That's bad for the liver! Babies aren't to have butter!' I said, 'Relax! All Pakistani babies get butter because they believe that gets that stinky stool out! All of Pakistan survived'. Okay, it's not the healthiest of things, but this is a cultural aspect that they had no idea about. The whole labour ward got to know it's to be expected.

Linda helped her colleagues become aware of a common cultural practice which was not ordinary in the Norwegian care model, but that it was to be tolerated due to its harmlessness, and by doing so shared her knowledge in helping her colleagues become culturally aware.

Other participants treated culture as secondary to the common health needs of immigrant women and other service users. Ida, a nurse, explained that similarities in the needs of their patients were more important than the culture, unless it concerned a harmful cultural practice like female genital mutilation. She explained that:

At our clinic, there is no special focus on immigration because in the neighbourhood we service, there are other groups of women like the Norwegians who have low income, are not well educated, and they face similar problems. So, we try not to focus on immigration background, but on the similarity of needs and problems that we can address.

Another midwife, Maryam, supported the secondary nature of culture in her care provision to immigrant women, stating:

We're not there to police them for their cultural differences... because before I see culture, I see a human with certain needs. I think that needs are the same across all cultures... It doesn't matter where our patients come from. Our top priority is to make sure they all have a good pregnancy.

She prioritized addressing the common biological and social needs of her immigrant patients without focusing too much on their cultural backgrounds when providing care. Like Ida, Maryam had an attitude of awareness and tolerance towards different cultural practices, saying, 'So many cultures have so many different practices, but many of them are not harmful. So, I just listen patiently and won't intervene unless I see a risk.' When it came to trust building, Maryam underscored the value of providing good care, arguing that time and the continuity of care were essential for developing a trusting relationship with the patient regardless of their cultural background. She said:

One good thing about practicing midwifery at this clinic is that you continue to see these women until they give birth. I never rush into asking them sensitive questions... for instance, as per the national guidelines for our first meeting, we have to talk about violence, abuse, drinking, smoking, what family they grew up in, etcetera. But I never rush into these questions because I believe we need to establish trust first. They need to understand and believe that I am not asking these questions for my own curiosity.

Maryam explained this process as a prerequisite for better health care provision irrespective of their immigrant background and culture. While the end goal of these practitioners may be the same - that is to provide good maternal health care - their approaches to treating the immigrant background and diverse culture of their service users as a variable in their practice was different.

Complexities in health care provision to immigrant women

The health care practitioners faced common challenges in working with immigrant patients, particularly concerning communication barriers and gaining their trust in the NMHS.

Despite immigrant women's entitlement to free interpreters in health appointments, communication issues were not eliminated. Most of the participants noted challenges with interpreters regarding their professionalism, their suitability for the context and their sensitivity to the appointments. Sandra, a midwife, recalled that once, the interpreter was a young girl with no experience about what they were going to talk about in the gynaecological appointment. Being in the examination room, she began

to cry when she heard the woman being examined experience pain. Similarly, Tamara (also a midwife) explained that when the interpreters were contacted by phone to assist in an appointment, they sometimes caused disturbances: 'They are cooking sometimes, flushing the toilet, their children are screaming... we don't understand what they're saying... sometimes they translate a very long time, and maybe they're telling their own story or their own opinion.' There were other such examples about challenges with interpreters, which often complicated the appointments instead of facilitating them. When interpreters were not used, practitioners felt that they had to spend more time to cover the same topics they would with patients fluent in Norwegian, linking the issue of language back to the need for longer appointments and time.

Another challenge some practitioners experienced in working with immigrant women was in gaining their trust in the NMHS. The NMHS was described as a different model of care and a different system of maternity care for some of the immigrant women, which they did not fully understand or readily trust. Consequently, these practitioners felt that sometimes the responsibility of caring for immigrant patients extended beyond their appointments at the clinic. Josephine explained the consequences of immigrant women coming from different health care systems:

It's a very different [health] system in Norway which they are not familiar with. They don't know where to go or what to do. It's very different from their home. Or they don't trust our competence [as midwives] or our methods at the clinic. They want to go to the hospital to get scans... So, that is a challenge, to convince them that they can trust us.

Developing trust was often described as a complicated and time-consuming process with immigrant women who were new to the NMHS. The health care providers felt that it was their responsibility to work on trust building to ensure these immigrant women and their children better health outcomes.

Addressing challenges in working with immigrant women

The complexities practitioners in this study experienced in working with immigrant women were presented at two levels. One was at the individual level, where the practitioners personally dealt with the consequences of their immigrant patients requiring different or additional care. The other was at the clinic level, where such

challenges were targeted collectively through grassroots initiatives developed by the practitioners.

Personal level

The need for extra time, by way of longer or additional appointments with immigrant women, was a common theme in the experiences of health care providers. Sandra, a midwife, explained that 'for a Norwegian woman, 30 minutes might be enough [for an appointment], but for a foreigner, we always need an hour each time... because we know they need so much more extra outside the pregnancy'. This can be due to several factors ranging from having interpreters for translation, to acquainting the woman with the Norwegian health and welfare system, to answering questions about differing health care and lifestyle practices. The care provided at the health centre is more than medical care, which is enabled by the structure of the meetings encouraging dialogue and knowledge building between the patient and practitioner. During these sessions, knowledge is shared, and when working with immigrant women, this may help them understand the system.

Sometimes this extra time spent with immigrant patients left the clinic boundaries because the practitioners felt a sense of responsibility for those who had no one else to go to for information or help regarding the NMHS or general life in Norway. This altruism can be classified as empathetic work that goes beyond the job description. For example, Sandra explained:

The women might be concerned about something totally different than their pregnancy. I really don't want to be their advocate ... because that's not what I'm educated in, but I sometimes see that it's important that someone helps them because they don't have the knowledge... they don't know where to go... and they're not treated fairly, so they don't get their rights.

Similarly, Maryam explained that when working with immigrant women, she felt responsible for helping them with issues outside of her role as a midwife, stating:

Someone needs to be there for them and guide them, you know? And it's not forever, they need guidance now... there are a lot of issues they face as new immigrants here. I try to encourage the women to find work, and enter the system, become self-sufficient. I know this because as an immigrant, I've lived through it.

Whilst Maryam did not prioritize culture in health care provision, she acknowledged challenges associated to being a new immigrant in Norway and how that could affect these women's health and life. She extended her care beyond her duty because she

felt that by guiding them through the Norwegian welfare system and way of life, she was helping them integrate into this new society better, and thus helping them attain better health and life outcomes in the long run. In other words, as a primary health care professional, Maryam did not limit her role to midwifery but also functioned as a cultural bridge builder for some immigrant women to help them fare better in Norway.

Clinic level

Another response to these challenges of working with immigrant women occurred at the clinic level. One clinic started a grassroots initiative offering pre- and post-natal workshops for immigrant women. TEGRA, the name of the programme, which is short for integration, serves to collectively address the common needs of immigrant women in Norway (Mehrara & Young, 2020). Seeing the success of the TEGRA programme, Barbara's clinic, which is in another immigrant-dense community, adopted it as an initiative as well.

When I heard about it [TEGRA], which was back in 2014 ... me and another midwife travelled to [another city] to join one of their workshops, and we observed and then we thought that this is something for [our] municipality too, because we have so many mothers who are pregnant with different origins or backgrounds... so that is when we started it.

Barbara described the programme as efficient, time-saving and cheaper in the long run, saying:

We saw that immigrant women needed many extra consultations. They had the standard programme, but they needed more, and we used a lot of time talking to them again and again. I also believe that my colleagues and I did things a little differently from one another, like some would say one thing, and I would maybe say another thing. So, we wanted to collect all this knowledge and experience in one place.

Furthermore, in response to a prominent need, Barbara's clinic amended the implementation of national practice guidelines by allocating extra time for immigrant women's appointments with midwives and public health nurses. Barbara explained that this was targeted towards 'those immigrants who are new to the country, especially if it's their first child in Norway... so we have the option in our consultations and use it when there is need for it'.

Therefore, at both levels, the practitioners recognized the need for extra resources, such as time in working with immigrant women through their professional experiences, and addressed it. Maryam stated that an 'increased immigrant

population goes hand in hand with experience in working with immigrants and recognizing their diverse needs'. The practitioners' experiences were thus fundamental, not only for individual-level initiatives, but also clinic-level ones in addressing the challenges of working with immigrant women. Consequently, they would be critical for change at the national level.

Discussions

The findings present the experiences of midwives and public health nurses working with immigrant women, and is by extension a representation of the effects of cultural diversity on the NMHS. In their health care interactions with immigrant women, some prioritized addressing culture as a prerequisite for establishing trust, while others treated culture as secondary to the common needs of women. The conceptualization of culture as an important factor in health care practice depended on subjective experiences and knowledge of working with immigrant women. Working with immigrant women posed similar challenges for midwives and nurses alike, the consequences of which they described as a compromise to the quality of care they were able to provide, as well as being time-consuming. Most of the practitioners felt a sense of responsibility extending beyond their profession for making sure that their patients got some support and direction from them. These findings lead to the discussion of 'doing more than health care' when working with immigrant women, and the implications of professional discretion.

More than health care

The experiences of the participants reflected that they were doing more than health care. Establishing trust with women coming from different countries and backgrounds was one of their priorities because it was fundamental to having a good health care experience and ensuring good health outcomes for the mother and her child. Næss (2019) supports that 'a lack of trust has been identified as a prevalent barrier to immigrants and ethnic minorities' health care utilization' (p. 297). Developing trust was often a time-consuming process, not only because of communication barriers, but also because the women came from different cultural health models, whereby their expectations of maternity care differed from what they encountered in Norway. As conceptualized earlier, cultural models of health refer to both the different health care settings and health care practices shaped by cultural practices, norms and

knowledge. While some of the participants recognized the distrust of immigrant women as linked to their encounter with an entirely different model of health care and norms, others attributed this to a lack of knowledge about the Norwegian maternity care system. As such, some participants emphasized the importance of inquiring about their immigrant patients' cultures during their consultations, to acknowledge their cultural models of health, encourage dialogue and promote trust in the NMHS. Other participants did not prioritize culture as such, and instead focused on addressing the common needs of immigrant women, and encouraging their trust through continued care.

Culture is arguably an important aspect of health care and communication with a culturally diverse population. Næss (2019) highlights cultural bridge builders' importance in gaining Somali immigrants' trust in the Norwegian health system. Other studies show that 'culture and ethnicity can influence significantly how people communicate their health care needs' (Shrestha-Ranjit, Payne, Koziol-McLain, Crezee, & Manias, 2020, p. 1698), which is supported by Ladha, Zubairi, Hunter, Audcent and Johnstone (2018), who discuss the impact of culture on health care interaction with immigrant service users. Ng and Newbold (2011) found that 'often, differences in cultural expectations or knowledge of different cultural groups resulted in less than optimal consultations' (p. 566), one of the reasons being that immigrant women 'may feel that they are not receiving appropriate care when their cultural needs are not being met' (p. 566). Lastly, Mehrara et al. (2022) presented that some immigrant women found Norway's approach to maternity care to be less medicalized in comparison to that of their home countries, which consequently hindered their trust in it. This speaks directly to the encountered differences between cultural health models that extend beyond a concern for immigrants' knowledge or language barriers. It points to the issue of trust and acceptance. Acknowledging and addressing cultural differences is therefore fundamental in addressing differences between cultural models of health.

The challenge in Norway is that health policy and maternal health care guidelines are not systematically cognizant of the challenges of cultural diversity (Mehrara & Young, 2020). Thus, the practice of cross-cultural health care has become a *laissez-faire* practice, whereby the midwives and nurses decide at the individual level, and based

on their experience, knowledge, and goals, how to best provide care for immigrant women. While this degree of local and professional autonomy in a universal health system is required to target services to individuals, it can pose challenges, as exemplified in this article.

On the one hand, this approach risks the essentialization or the overlooking of culture and its nuanced implications for health-care provision and reception, based on the care provider's subjective position, knowledge, and experiences. Practitioners may treat culture with a lack of awareness and through generalizations. This risks the representation of tolerant behaviour towards different cultures in an ethnocentric or prejudiced manner. Gustafson (2005, p.12) argues that:

In a white, female dominated profession, demonstrations of tolerance, sensitivity, understanding, and empathy can stand in for being fair and being fairly represented. Those of us in positions of power have the luxury of expressing tolerance and sensitivity for nondominant beliefs and practices.

This may have the opposite effect on the health care utilization and outcome of immigrant women than health care professionals intend.

On the other hand, this approach may require that midwives and public health nurses working in community health centres do more than health care. While this may to some degree be expected given their roles as primary care providers at the health centre, most of the interviewees explained that working with immigrant women was often demanding and different from working with non-immigrants due to their distinct needs and circumstances. Doing more than health care was demonstrated by practitioners taking more time within or beyond clinic boundaries to help immigrant women with what would often be 'assumed knowledge' for Norwegian women, such as coping with the climate, the welfare, health care and child protection systems. Other times, the practitioners found themselves in difficult ethical situations where they had become the contact person, or a part of an immigrant woman's support network in Norway as experts of its systems. They did more than health care because they believed that by helping these women, they were contributing to the long-term well-being and better integration of these women and their children in Norway. The implications of these two issues are elaborated using Zacka's (2017) concept of street-level bureaucracy.

Street-level bureaucracy

The professional discretion of practitioners in this study enabled them to target health services and bridge ambiguous universal health policy goals when certain needs of immigrants were not recognized. Those who extended their professional discretion beyond that of their role description during appointments, or of the clinic boundaries in caring for their immigrant patients, can be classified as caregivers, following Zacka's (2007) model of role conception as discussed in the conceptual framework. Many of the participants in this study felt responsible, as faces of an institution, for helping those who had no one else to turn to in informal matters. Embodying the caregiving disposition, to them, 'Clients are no longer "cases" or "numbers", but individuals who are treated with the compassion and attention they deserve' (Zacka, 2007, p. 105). While some of them were aware of overstepping ethical boundaries in their professions, being a caregiver has broader consequences. For the individual practitioner, it can lead to emotional burnout, whereas for the health system this approach does not universalize because 'caregivers simply do not have the resources necessary to offer the same level of dedication and service to everyone' (Zacka, 2007, p. 106). This is also supported by findings from Debesay, Harsløf, Rechel and Vike (2014) on the emotional burnout of nurses working with immigrant patients in Norway. Another issue is that the lack of impartiality by caregivers may expose some service users to an arbitrary use of power, indifference or essentialization of their needs based on their immigrant backgrounds as well. Can more specific guidelines for cross-cultural health care limit the use of discretion and encourage equity? This is a question for future research.

Street-level bureaucracy at the organizational level was presented in the form of grassroots initiatives in an effort to tackle challenges with cultural diversity more systematically. By synergizing their knowledge and experience in addressing the needs of immigrant women at the clinic level, practitioners aimed to reach a normatively categorized vulnerable group of immigrant women. This approach, too, has the potential to replicate stereotypes about cultural practices as analysed by Mehrara & Young (2020). Hence, despite its good intentions, like the individual practices of street-level bureaucracy, this approach is not void of consequences for cross-cultural health care provision. However, this institutional approach does fill a void in policy guidelines about caring for immigrant women, and despite its

shortcomings, it has been successful. In this light, this approach may on a national level lead to inequity from an inequality of opportunity for immigrant women in municipalities that have adopted this approach and those that have not.

Conclusions

The decentralization of the Norwegian health care system has been necessary for the functioning of the universal health system, as it gives local governments and actors discretion in delivering national health services. Although Zacka (2007) writes in an American context about institutions, the clause ‘...institutional principles will have to co-exist with a significant margin of frontline discretion’ (p. 53) accurately describes the functioning of the Norwegian welfare state as a decentralized institution. In this way, local actors such as health care providers are faces of the institution, and are responsible for addressing challenges that may arise in their work, such as those linked to increasing cultural diversity and the normativity of universal health provisions.

While professional discretion and local autonomy are cornerstones in Norway’s universal health care approach, working with culturally diverse patients poses certain challenges to the system. These challenges have not been addressed by Norwegian health policy, and are dealt with at the local level by health care practitioners. The focus of this study was on the response and experiences of midwives and public health nurses in working with immigrant women at community health centres, asking what the implications of cultural diversity for health care practice are in a universal system. The findings presented that working with immigrant women had some challenges, the response to which were varied among the participants and the clinics they worked at; thus, the practice of cross-cultural care was at the discretion of practitioners. Health care providers, as street-level bureaucrats, have to improvise cross-cultural health care, relying on their experience, knowledge, professional discretion and moral dispositions.

In summary, this study offers insight into the implications of cultural diversity for both health care practice and the health care system. It suggests that midwives and public health nurses act as mediators and translators of policy for their patients’ diverse needs. Although this is critical for the functioning of the universal health care system,

enabling blanket provisions to be targeted, this approach cannot be a compensation for an oversight of cultural diversity in health care policy. The current approach, as exemplified in this article, poses challenges for both the professionals and for the clinics. Cross-cultural health care is improvised locally based on local knowledge and experience, thereby raising the question of how suitable this approach to diversity is in a universal system. To conclude, this article contributes to knowledge on the implications of diversity for Norway's universal health system, and underscores the significance of primary health care providers' experiences in policy change and the need for a multicultural health policy.

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