

Multi-Tasking Community-Based Bilingual Doulas are Bridging Gaps – Despite Standing on Fragile Ground. A Qualitative Study of Doulas’ Experiences in Sweden

Helena Lindgren (✉ helena.lindgren@ki.se)

Karolinska Institute

Amani Eltayb

Karolinska Institute

Anna Wahlberg

Karolinska Institute

Nataliia Tsekhmestruk

Karolinska Institute

Rhonda Small

La Trobe University

Erica Schytt

Landstinget Dalarna

Research Article

Keywords: Bilingual doula, migrant women, labour and birth, support, qualitative

Posted Date: July 6th, 2021

DOI: <https://doi.org/10.21203/rs.3.rs-542344/v1>

License: © ⓘ This work is licensed under a Creative Commons Attribution 4.0 International License.

[Read Full License](#)

1 Multi-tasking community-based bilingual doulas are bridging
2 gaps – despite standing on fragile ground. A qualitative study of
3 doulas’ experiences in Sweden.

4
5 Lindgren Helena¹, Eltayb Amani¹, Wahlberg Anna¹, Tsekhmestruk Natalia¹, Small Rhonda⁴,
6 Schytt Erica^{1,2,3}.

7

8 ¹Division of Reproductive Health, Department of Women’s and Children’s Health,
9 Karolinska Institutet, Tomtebodavägen 18a, 171 77 Stockholm, Sweden;

10 ²Centre for Clinical Research Dalarna – Uppsala University, Nissers väg 3, 791 82 Falun,
11 Sweden;

12 ³Faculty of Health and Social Sciences, Western Norway University of Applied Sciences,
13 Norway. Møllendalsveien 6, Postboks 7030, 5020 Bergen, Norway.;

14 ⁴Judith Lumley Centre, La Trobe University, Melbourne Victoria 3086, Australia *

15

16 **Corresponding author**

17 Helena Lindgren

18 Division of Reproductive Health, Department of Women’s and Children’s Health, Karolinska
19 Institutet, Tomtebodavägen 18a, 171 77 Stockholm, Sweden

20

21 **Conflict of interest:** None declared

22 **Ethical approval:** The study was approved by the Regional Ethical Review Board in
23 Stockholm (approval number: 2018/12 - 31/2).

24 **Funding sources:** Funding was partly provided by Stockholm County Council

25

26

27 Multi-tasking community-based bilingual doulas are bridging
28 gaps – despite standing on fragile ground. A qualitative study of
29 doulas’ experiences in Sweden

30 **Abstract**

31

32 **Background:** Community-based Bilingual Doulas (CBDs) are women from migrant
33 communities trained to support and comfort migrant women during labour and birth. The aim
34 of the study was to describe CBDs’ experiences of supporting migrant women during labour
35 and birth, working alongside caregivers, and to explore CBDs perceptions of their work
36 situation in a Swedish setting. As part of an ongoing randomised trial of CBD support in
37 Stockholm, Sweden, semi-structured individual interviews were conducted with nine of the 35
38 participating CBDs.

39 **Results:** The overarching theme which emerged was “*Multi-tasking bilingual doulas bridging*
40 *gaps – despite standing on fragile ground*”. To reach out a helping hand and receive
41 appreciation from the women when their needs were met, motivated the CBDs to continue
42 despite the constraints related to roles, working conditions and boundaries. The CBDs felt
43 proud of being acknowledged, although they did also feel a need for more supervision and
44 education.

45 **Conclusions:** The CBDs experienced their doula tasks as meaningful and emotionally
46 rewarding, which mostly outweighed the challenges of their work which they saw as insecure,
47 exhausting and underpaid. If CBDs are implemented on a larger scale, the scope of their role,
48 education, access to supervision and working conditions all need to be better addressed.

49

50 **Keywords:** Bilingual doula, migrant women, labour and birth, support, qualitative

51

52 **Introduction**

53

54 Community-based Bilingual Doulas (CBDs) have been introduced into maternity care settings
55 to respond to the challenges migrant and refugee women face in labour and birth, such as
56 communication difficulties and lack of familiarity with the maternity care system. The aim is
57 to increase migrant women's chances of receiving equitable care and having a positive birth
58 experience (Kozhimannil, Hardeman et al. 2016, Thomas, Ammann et al. 2017), increase the
59 probability of a normal labour and birth (Fortier and Godwin 2015) and improve their
60 pregnancy outcomes (Steel, Frawley et al. 2015, Bohren, Hofmeyr et al. 2017) . CBDs are lay
61 women from migrant communities, fluent in both the first language of the pregnant woman
62 and the language of the country where women are giving birth. They are trained to provide
63 continuous, empowering and woman-focused support that complements the role of midwives.
64 The CBD's language and cultural understanding facilitates communication between the
65 woman-partner-staff during labour and birth – though she does not replace an accredited
66 interpreter when required – and helps women and their partners in navigating an unfamiliar
67 maternity care system (Dundek 2006, Mottl-Santiago, Walker et al. 2008, Bohren, Hofmeyr et
68 al. 2017, McLeish and Redshaw 2019, Wint, Elias et al. 2019).

69

70 Studies have shown that migrant women have mainly valued CBD support (Akhavan and
71 Edge 2012, Darwin, Green et al. 2017, McLeish and Redshaw 2018), however, some
72 dissatisfaction with CBD support skills has also been reported (Akhavan and Edge 2012).
73 Midwives' and obstetricians' views on collaborating with doulas during labour and birth
74 include both positive and negative aspects (Akhavan and Lundgren 2012, Lucas and Wright
75 2019, Maher 2004), such as their continuous presence and skilled woman-centred physical
76 and emotional support (Akhavan and Lundgren 2012, Neel, Goldman et al. 2019), but also
77 potential interference with clinical decision-making (Neel, Goldman et al. 2019).

78

79 The main motivation to become a doula in multicultural settings, and to remain in the role,
80 seems to be a strong desire and commitment to support women from the doula's own cultural
81 community to achieve what they desire for birth and to have a positive birth experience
82 (Hunter 2012, Hardeman and Kozhimannil 2016, Spiby, McLeish et al. 2016). Doulas in
83 general seem to find their work rewarding on a personal, social and emotional level (Lantz,
84 Lisa et al. 2004, Eftekhary, Klein et al. 2010, Spiby, McLeish et al. 2016), however, some

85 concerns have been raised regarding their role (Eftekary, Klein et al. 2010, Amram, Klein et
86 al. 2014, Kang 2014, Spiby, McLeish et al. 2016, McLeish and Redshaw 2018, McLeish and
87 Redshaw 2019, Richards and Lanning 2019, Young 2019). Challenges are mostly on an
88 organisational level and include the doulas having to wait and not being allocated women to
89 support immediately after training, the stress of being ‘on call’, the difficulty of balancing
90 doula work with their own family and with other employment (Lantz, Lisa et al. 2004) and
91 dissatisfaction with the way the doula service was run (Spiby 2016), Doula services vary
92 greatly in terms of organisation and doula remuneration. Doula assignments may involve
93 private payment arrangements between a woman and the doula involved or doulas may be
94 employed by a doula service on hourly rates that are based on time spent on the assignment
95 (Darwin, Green et al. 2017). In many cases doula incomes are insufficient to provide a living
96 wage (Campbell, Lake et al. 2006, Eftekary, Klein et al. 2010).

97

98 A growing body of literature about CBDs’ own views on their assignments is emerging. As
99 their contribution to maternity care is further developed and potentially scaled up, it will be
100 important to develop their role, competence and working conditions. One model for doula
101 support to migrant women was developed in Gothenburg, Sweden and has now been in
102 operation for more than a decade. The same model has recently been implemented in
103 STOCKHOLM and is being evaluated by means of a randomised controlled trial (Schytt,
104 Wahlberg, Eltayb, Small, Tsekhmestruk, Lindgren 2020). The aim of the current study was to
105 describe the STOCKHOLM doulas’ own perspectives on supporting migrant women during
106 labour and birth, working alongside caregivers, and also to explore their experiences of
107 working conditions in this Swedish setting.

108

109 **Methods**

110

111 *Design*

112 A qualitative study was conducted to complement a randomised controlled trial (RCT) aiming
113 to evaluate the effectiveness of CBD support for improving intrapartum care experiences and
114 postnatal wellbeing of migrant women giving birth in Sweden (Schytt et al. 2020).

115

116 *Setting*

117 In Sweden, maternity care is free of charge and midwives are responsible for normal labour
118 and birth, with obstetricians taking over responsibility if complications occur (Stephansson *et*
119 *al.*, 2018). Doulas were not included in the public maternity care system during the study
120 period.

121
122 A CBD program was implemented in Stockholm, Sweden in 2016 by a local non-profit
123 organisation Mira ([www.doulakulturfolk.se/ Stockholm /](http://www.doulakulturfolk.se/Stockholm/)), replicating the model established
124 in Gothenburg in 2008 (Mammaforum/Födelsehuset). Funding was provided by Stockholm
125 County Council to cover the costs of the program, e.g. CBD organisation, training and doula
126 assignment remuneration, and evaluation funding was awarded to the Karolinska Institute.
127 The Mira organisation is managed by three midwives and up to now, 52 doulas have been
128 recruited and trained to provide doula services in Stockholm. CBD education is conducted by
129 a midwife over eight full days using the curriculum developed in Gothenburg, with theoretical
130 and practical training combined. The topics covered during the course include the following:
131 reproductive anatomy and physiology, information about normal birth and potential obstetric
132 interventions, strategies for providing effective continuous labour support, comfort measures
133 (breathing and relaxation techniques, providing massage, suggesting positions during labour
134 and birth), practical strategies for facilitating communication/interpreting to enhance
135 understanding between women and midwives and guidance about the CBD role and
136 boundaries. After the training, the CBD-to-be completes three assignments where they assist
137 women during labour and birth as practical training under the supervision of an authorised
138 doula (Table 1). Supervision and follow-up with CBDs is provided by the midwives from
139 Mira (Schytt *et al.* 2020).

140
141 During the study period, Mira recruited, employed, educated and trained thirty-five bilingual
142 doulas to support Arabic, Polish, Russian, Somali and Tigrinya-speaking trial participants
143 during pregnancy and labour. Two CBDs were assigned for each woman; one CBD to take
144 the main responsibility for the assignment and a reserve CBB to fill-in if the main CBD was
145 unable for any reason to attend the woman's labour and birth. CBDs were paid on an hourly
146 basis, receiving 130 SEK/hr (approx. 13 USD) and an extra 52 SEK/hr (approx. 5 USD) as
147 compensation for out of hours work, e.g. weekends and overnight hours. In addition, the main
148 CBD was paid 1000 SEK (approx. 100 USD) for each labour and birth and the reserve CBD

149 received 500 SEK. CBDs could undertake only two assignments per month to enable
 150 flexibility in timely provision of support to women in labour.

151

152 **Table 1 Community-based Bilingual Doula (CBD) tasks for each assignment**

Phase	Tasks
Third trimester	<ul style="list-style-type: none"> • Meet with the woman once or twice to connect and build trust • Provide the woman and her partner with information about what a doula can offer and her role • Agree on a plan on how to communicate and cooperate throughout labour and birth. • Be available in the 3 weeks before the due date and 2 weeks after
Labour and birth	<ul style="list-style-type: none"> • Assist the woman in her communication with the labour ward midwife about when to go to hospital • Meet up with the woman and her partner at the hospital when she is in active phase of labour (≥ 3 cm opened) • Be continuously present with the woman (up to 25 hours, the pre- and postnatal meetings included) • Provide continuous support (emotional, physical and information support) throughout labour and birth • Facilitate communication between the woman and her companion and her caregivers
After the birth	<ul style="list-style-type: none"> • Meet with the woman to follow up on any questions or concerns regarding the birth and postpartum period

153

154

155 *Participants*

156 Eleven CBDs working with Mira and involved in supporting women participating in the
 157 previously described RCT, were approached and agreed to participate in the study. Two were
 158 not interviewed due to personal constraints and limited time. The remaining nine participants
 159 were all female, ethnically diverse, bilingual or multilingual (Swedish, Arabic, Polish,
 160 Russian, Somali and Tigrinya), and all except one were mothers themselves. They ranged in
 161 age from early thirties to mid-fifties, two of them were studying to be an assistant nurse and
 162 all had lived in Sweden for more than 5 years.

163

164 *Data Collection*

165 Semi-structured interviews were conducted by AE and NT between January and June 2019.
 166 The interviews lasted between 30 and 90 minutes. All interviews were audio recorded with

167 permission, except for one where the participant preferred that the interviewer took notes
168 instead. The interviews took place in a room at the university premises or in a café depending
169 on participant preference. Interviews were held either in the participant's first language or in
170 Swedish, whichever was their preference. Audio recordings were transcribed verbatim and
171 translated into English.

172

173 In discussion with co-authors, HL and AE developed an interview guide with open-ended
174 questions prior to the first interview. The focus of the interviews was to enable the
175 participants' to describe their experiences of supporting migrant women during labour and
176 birth; and to explore their perceptions about doula work alongside caregivers and how they
177 perceived their working conditions. During the interviews, the order of the questions was
178 adapted to the situation and follow-up questions were asked. Data were collected until the
179 interviews reflected repeated perceptions and patterns, and topical saturation was considered
180 to have been reached (Lincoln and Guba, 1986).

181

182 *Data analysis*

183 Thematic analysis of data (Braun and Clarke, 2006) was used, allowing identification,
184 analysis, interpretation and reporting of patterns/themes across the entire data set. Applying
185 this approach enables a rich description of the phenomenon investigated and also to interpret
186 different aspects of it. A theme captures something crucial about the data according to the
187 overall research aim and signifies some level of patterned response or meaning in the data set.
188 Analysis was carried out by HL and AE, in discussion with co-authors, in five steps (Braun
189 and Clarke, 2006).

190

191 Ethical considerations

192 All methods were carried out in accordance with relevant guidelines and regulations. Written
193 and verbal information about the study was provided to all participants. Participants were
194 informed that their participation was voluntary and confidential, and that they could withdraw
195 from the study at any time. Written or verbal consent was given by all participants. The study
196 was approved by the Regional Ethical Review Board in Stockholm (approval number:
197 2018/12 - 31/2).

198

199 **Findings**

200

201 One overarching theme “*Multi-tasking bilingual doulas are bridging gaps – despite standing*
202 *on fragile ground*” and three subthemes were identified from the data (Figure 1). To reach out
203 a helping hand and be rewarded with appreciation from the women when their needs were
204 met, motivated the CBDs to continue despite the constraints they experienced. The CBDs felt
205 proud of their work, but they had some concerns regarding their working conditions, their role
206 and the education they had received.

207

208 *Doulas lending migrant families and caregivers a hand*

209 CBDs described their role as multi-tasking between simultaneous support for migrant families
210 and for caregivers during pregnancy, labour and birth, and postpartum. They described how
211 they met with the women, either alone or in the presence of their partners, once or twice
212 during late pregnancy to share with them needed information regarding health and childbirth,
213 and to prepare them mentally for the event of birth. During these meetings, CBDs prepared a
214 birth plan together with the women. The conversation between CBDs and women took place
215 not only during these meetings but also continued over the phone whenever was needed.
216 According to CBDs, good or bad chemistry between the woman and the CBD can be sensed
217 right from the first meeting:

218 *I meet the woman during her pregnancy once or twice, during the late months, when we*
219 *meet each other the first time... I often sense if the chemistry between us works or not.*
220 *In other words, if we like each other the trust will be built and she relies on me so the*
221 *communication will be soooooo great (D2).*

222 CBDs also mentioned examples where a sense of connection did not occur and women
223 contacted MIRA and asked to change the CBD directly after the first meeting.

224 *One lady, she didn't like me from day one ... I talked to her, she was playing with her*
225 *phone. The next visit she was putting on makeup and she said to me 'I'm listening, keep*
226 *talking', her friend was there and said 'stop it'. (D1)*

227 CBDs reported that, in most situations, they were asked by the migrant families to call the
228 hospital on their behalf when labour started, as women and their families found it difficult to
229 contact the hospital themselves because of language barriers. Some CBDs reported even
230 driving the women to the hospital using their own cars:

231 *It's 2 o'clock in the morning, no underground subway is available now, she [the*
232 *woman] cannot even walk properly to reach the bus station, what shall I do sister, he*
233 *screamed over the phone. I [the doula] answered, hold on, I will come and drive you to*
234 *hospital (D5).*

235 While the support during pregnancy was described as being focused on providing
236 information, the support during labour and birth was more focused on hands-on support.
237 CBDs talked about providing physical help to women by walking them around during the
238 early stage of labour, doing massage and comfort touching or holding hands and they guided
239 them on how to breathe during contractions to help them feel relaxed and secure.
240 A close relationship was perceived by the CBDs as helpful in their being able to provide
241 women with all types of support, and as a result, they experienced that the women often paid
242 more attention to them than to their partners:

243 *Women have full trust in the doulas, they trust us completely and always seek our*
244 *advice, we have an excellent relationship. They even have better communication with us*
245 *than with their own husbands... Women perceive us as rescuers or life buoys (D1).*

246 The CBDs also talked about providing women with emotional support via reassuring, calming
247 down, explaining the situation to them and how they could cope. CBDs acknowledged their
248 role in cultural navigation, in helping to communicate the women's wishes and customs to
249 caregivers and vice versa, helping women understand why care was provided in certain ways
250 they might be unfamiliar with.

251 *The doula is somebody who speaks the woman's language, will understand her, because*
252 *we have the same cultural background, we look on things similarly. And sometimes it is*
253 *difficult for her to understand why it is happening like this and not like in our country.*
254 *Like why they do not give me this or that. (D4)*

255 The CBDs thought that their linguistic and cultural understanding ensured the facilitation of
256 communication between the woman and the midwife. They mentioned that they regularly had
257 to explain to the woman what the midwife was saying in words the woman could understand,
258 and to help the woman to communicate her wishes to the midwife.

259 CBDs reflected on the cultural challenges linked to male partners attending labour. They
260 reported that in some cultures, men found it strange and difficult to handle the situation of
261 labour. Some CBDs spoke proudly about their unique cultural competence that mediated
262 partners' involvement, persuading them that their presence in the labour room was positive.
263 On the other hand, other CBDs also mentioned the desire expressed by some women not to
264 have their partners around during labour because of concerns related to their future sex life.

265 *Some woman asked me [the doula] in private not to let their partner into the delivery*
266 *room. Women believed that if their partners watched the delivery process they may be*
267 *put off and avoid them in bed later when recalling this image. Some had been avoided*
268 *in bed before, because the husband said: I can't touch you after what I have seen. But at*
269 *the same time the midwife often asks the partner to join in so how can we solve*
270 *this?(D6).*

271 The CBDs described a conflict between this concern and the well-established Swedish routine
272 of inviting and including partners in labour and birth.

273

274 *Rewards and positive feelings are motivating, in spite of financial, practical, organisational*
275 *and professional challenges*

276 CBDs talked about their assignments with pride and joy, and described their work as unique,
277 interesting and enjoyable, but fraught with challenges. They expressed different motives
278 behind continuing to work as a doula in spite of the difficulties they faced. In general, CBDs
279 nominated a helpful personality as a common feature shared by all CBDs. They found the
280 doula job rewarding, a “source of energy”. They described how their strong desire to help
281 others and make a difference in society was more important than the barriers or challenges
282 they faced while working as a doula. Being migrants themselves, to help their “own people”
283 was a strong motivation:

284 *From the very beginning I applied for the doula job as an extra job to increase my*
285 *income, but later on... I became more interested in the doula work as such because of*
286 *the energy I get when I help people who are in need... It's me, I enjoy helping others,*
287 *helping my people (D5).*

288

289 CBDs felt that while they aimed to provide a positive birth experience for women, through
290 supporting and empowering them and their families, they nevertheless faced several
291 significant barriers to providing this care. These barriers included financial, practical,
292 organisational and professional concerns and laid the foundation for their feelings of
293 insecurity and being exploited. They found the income generated through their doula
294 assignments poor and insufficient to get by on, even though some held other jobs
295 concurrently. They pointed to the relationship between low payment and the high turnover of
296 CBDs. The feeling of insecurity expressed by CBDs was mainly related to the issue of low
297 payment, however, some also identified other issues that led to a feeling of insecurity.

298 *Many doulas quit working within a short time. We do a very good job but get such low*
299 *pay on an hourly basis and especially without health insurance (D5).*

300 CBDs expressed resentment and felt exploited because there were a number of tasks within
301 the doula assignment that they often carried but never got any remuneration for. As an
302 example, they nominated the need to spend long periods of time supporting women over the
303 phone for free at any time of the day or even after midnight. CBDs claimed that their
304 employer didn't manage to restrict the assignment properly.

305 *Neither telephone costs nor time we had spent in supporting women over the phone*
306 *were covered by the organisation... women are afraid of labour, it's difficult for the*
307 *doula to limit their talk, they want to talk the whole time even if it's late at night, if you*
308 *end the call the woman will call you back again in five minutes...sometimes I might end*
309 *up talking many hours at night and should be going to the hospital supporting this*
310 *woman the next day...labour can take the whole day or longer (D9).*

311 Alongside the financial issues, CBDs also discussed practical challenges linked to doula
312 work. To be available and ready to attend a woman's labour and birth at any time of the day,
313 on any day of the week, regardless of whether it is a weekend or a public holiday, for a
314 continuous period of 5 weeks was considered problematic. In general, they found it difficult
315 to manage the demands of their doula work with their own family and other work life, and
316 they reflected on the stress of out-of-hours work, sleep deprivation and organising childcare
317 when attending labour:

318 *If I am working somewhere else and it is time to join her [the woman] during childbirth,*
319 *then I have to find a replacement at work. If I have a child home, I have to find a*
320 *babysitter, and of course I have to pay for it. I can't travel during these 5 weeks; in*
321 *other words, my life is kind of frozen until this woman delivers her baby (D5).*

322 From the CBDs' point of view, the organisational challenges were equally important and
323 more mentorship and follow-up was requested.

324

325 Despite the rewards and positive feelings reported by CBDs in supporting migrant women
326 they also expressed concerns regarding professional challenges they encountered.

327 Underestimation and unfriendly behaviour from caregivers were some of the challenges they
328 voiced.

329 *So I communicated the woman's wish not to be checked by a student again. The midwife*
330 *reacted negatively to this, but I did not want the woman to see this, so when the midwife*
331 *was going out and taking her gloves with a negative attitude, I just stood in front of her*

332 *[the woman], so she did not see it. And so, she left and thank God that she did leave*
333 *(D7).*

334 Even though CBDs were aware that their role is not a clinical one and they were cautious not
335 to give medical advice to women, they spoke of some situations where they felt lost and
336 where there was an unclear distinction, especially for women, between the CBD role and the
337 caregiver role. For example, some CBDs reported feeling uncertain when being asked by
338 women whose contractions had started about whether to go to hospital or not. These CBDs
339 reminded women of their non-clinical role and that the decision on attending hospital was
340 entirely made by the health personnel, saying that they always consulted midwives:

341 *I call the hospital for example if the woman mentions one of the signs of labour, such as*
342 *bleeding... or if her waters have broken, or regular contractions every five minutes.*
343 *So... I call the midwife to ask if the woman should go to hospital or not, the midwife is*
344 *the one who decides, not me. Midwives are often very cooperative (D6).*

345

346 *Conflicting views on the adequacy of doula education and on their role*

347 CBDs had conflicting views about whether the education they received was sufficient in
348 relation to the nature of their assignment. Some of them expressed satisfaction with both the
349 education they received: *Education was enough, most of the information was already known*
350 *for me (D1).* Others thought that the education was not enough. They believed that what they
351 had learnt was a good foundation but that it could have been longer and more in depth. For
352 example, some doulas indicated their need for more education on some topics such as the
353 latent phase of labour and breastfeeding:

354 *The courses we have had during the doula training were not enough at all, it*
355 *was just a base, it needs to be a lot more. It's important for a doula to know*
356 *more for example the latent phase. It varies between women; we do not know*
357 *that much it's difficult to decide sometimes. We also consult our organization*
358 *[Mira] (D8).*

359 Feelings of being accepted, involved, valuable, appreciated and trusted by women and their
360 families as well as by caregivers was also emphasised by the CBDs as a driving force in
361 continuing working, or even considering becoming a nurse and a midwife. The positive
362 atmosphere was experienced as encouraging and brought hope to a future in the field.
363 Sometimes they described feeling a part of the health care team when they attended hospital
364 with women.

365 *It feels like I am working there [at the labor ward]. They [the midwives] accept you to*
366 *their “team” and you do the things that they ask you. And in general, they are very*
367 *happy when we come. And when we go, they say to us that we have done a great job and*
368 *that we are great (D1).*

369 Some CBDs also described how information they shared with the woman and her family was
370 sometimes perceived as even more relevant than information from family or health care staff.
371 They also found themselves in situations where they had to interpret the symptoms and act as
372 a mediator between the woman and the midwife. Sometimes women were not precise in their
373 descriptions of their pain or other matters, and might therefore mislead both the CBDs and the
374 midwives. Accordingly, the responsibility if something went wrong, could be perceived as
375 resting on the CBD’s shoulders prior to women coming in to the hospital:

376 *She [the woman] called me saying that she has pain, I asked her is it severe? Is it each*
377 *5 min? She said, it is not severe and it comes every now and then, no not each 5*
378 *minutes. I asked do you have red blood? She said NO, I am here asking about signs of*
379 *labor. I called the midwife and reported what she told me, the midwife decided that she*
380 *should stay home. Then the husband texted me, she is still in pain, I asked her again all*
381 *previous questions, the answer was again no, I asked him to call back if anything*
382 *changes. I waited half an hour no news, I called, he answered, the baby is out...What? I*
383 *asked them to come to hospital to meet the midwife, they came and it was all fine, it*
384 *turns out that she delivered her previous baby the same way but she never informed me*
385 *(D2).*

386

387 **Discussion**

388 To our knowledge this is the first study in Sweden to describe the experiences of community-
389 based bilingual doula practice alongside caregivers and to explore their experiences of their
390 working conditions. The findings of this qualitative study provide a contemporary view of
391 CBDs’ experiences of their work in supporting migrant women during labour and birth in
392 Stockholm. Below our findings will be discussed both from the perspective of doula support
393 in general, and in the specific context of CBD support for migrant women.

394

395 In this study, CBDs described their work as rewarding and engaging, as a way to reach
396 out a helping hand to women and families from their own cultural context. In the literature we
397 have found similar findings in general studies of doula support and also in the few studies that

398 specifically describe CBDs. The doula role has previously been described as ‘holding the
399 space’ by creating and maintaining a close relationship before and throughout the birth
400 experience as a means to give the woman what she has articulated as her preferences for birth,
401 even within institutionalized settings (Hunter 2012). A common language and background can
402 be understood as a facilitator for the forming of this close relationship. The commitment from
403 the doula is also reflected in the extended support they provide beyond the actual assignment.
404 This is rewarding for the doula but can also cause conflicts when the doula’s private and
405 family life is affected. According to Wint and co-authors (2019), writing in the US context of
406 support to African-American women, doula often also provide new mothers with support and
407 resources beyond birth. This sometimes results in doula finding themselves in situations
408 where they see that the needs of the woman and her family are not met by the health service
409 system or society and the doula finds it difficult to limit her involvement because of this.
410 Despite the best intentions from the doula, attempting to help a client in every way is not
411 feasible (Kozhimannil et al. 2016). In contrast, fulfilling requests beyond the CBD assignment
412 was not raised as a major concern in our study. In line with other doula studies, we found that
413 CBD support was not only for the mothers, but also included women’s partners (A, 2006;
414 Koumouitzes-Douvia and Carr, 2006). A study of volunteer doula from England revealed
415 that 79% of doula saw friendship as part of their role and emotional connection as
416 instrumental in the success of their support (Spiby *et al.*, 2016). In this study the CBDs
417 reached almost the same conclusion, believing that developing a connection provided the
418 foundation for giving women all kinds of support. Another UK study showed that
419 disadvantaged women who received support from a volunteer doula during pregnancy, labour
420 and postpartum regarded their relationship more as a friendship than a relationship with a
421 professional and they described feelings of loss when the relationship ended (Darwin, Green
422 et al. 2017). A unique finding of our study was the importance of “good or bad chemistry”
423 between the woman and her doula which could be sensed right from the first meeting.

424

425 The CBDs had some conflicting views on their training and on their role. Being in the
426 doula role was sometimes seen as a stepping-stone for future education to professions in the
427 health care system, such as a nurse or a midwife. This finding differs from other studies,
428 where factors related to future employment were not raised or explored (Eftekhary, Klein et
429 al. 2010, Spiby, Green et al. 2015). Kang (2014) concludes that more integration of doula
430 services in healthcare settings and an expansion of culturally relevant community doula

431 programs are recommended to develop the profession and encourage doulas to stay in their
432 role. In the present study, doulas were employed and paid a stipulated amount. In the UK, a
433 doula is usually employed privately by the individual or doulas work on a volunteer basis
434 (Darwin, Green et al. 2017). The latter can be stressful, especially in dealing with on-going
435 requests for support from the mothers (Darwin, Green et al. 2017). Although recent doula
436 research has revealed the cost effectiveness of the doula model (Steel *et al.*, 2015;
437 Kozhimannil *et al.*, 2016), this study revealed some of the financial challenges that CBDs
438 faced. They discussed the poor wages and out of pocket costs, such as telephone card costs
439 and the time spent supporting women over the phone, and the lack of health insurance given
440 their limited, hours-based contracts. These were all sources of feeling exploited. In some
441 settings a low level of retention in doula organisations has been reported, due to low wage
442 levels, burnout or the opportunity the doula experience provides to move on to education or
443 other employment (Naiman-Sessions et al 2017). However, others do expect to continue to
444 provide doula care in five years' time (Lantz et al. 2005). Being a doula can be to some extent
445 like working in a grey zone between that of a volunteer and that of a professional. This may
446 help doulas in fact to be more effective mediators and brokers for pregnant immigrant women.
447 Given that doulas may be considered to be health-care outsiders, it might also be assumed that
448 they are more familiar and sensitive to the woman's needs and the experiences of care that she
449 receives. It has been shown that continuous support is beneficial for the birthing woman, and
450 this support can be effectively provided by a doula or someone who is familiar with, but not
451 part of the health system (Hodnett et al 2012). On the other hand, while there is evidence that
452 medically-focussed models of care may negatively impact the provision of 'with woman'
453 care, it can also be argued that midwives, when allowed to be with the woman continuously
454 during labour and birth, are the most suitable to support women fully in pregnancy, labour and
455 birth (Bradfield et al. 2018). Notwithstanding this proposition, the language and
456 communication assistance CBDs provide migrant women is not something that midwives are
457 usually able to offer.

458

459 A novel finding of this study is the conflicting views among the CBDs regarding their
460 education and training. Some felt it was adequate, while others wanted more training and
461 training that was more in-depth. The CBDs identified providing information and skills that
462 women needed for pregnancy, childbirth and child care as their main task during the antenatal
463 period, something also documented in prior studies (Gentry *et al.*, 2010). During labour and

464 birth, the CBDs mentioned providing physical, emotional, linguistic and cultural supports to
465 migrant women in line with the international literature (Steel *et al.*, 2015; McLeish and
466 Redshaw, 2019). Issues such as information about breastfeeding and physical and mental
467 well-being were *not* part of the training whereas the doulas considered that knowledge on
468 these subjects was needed. There is some evidence on the benefits of doula support for
469 women breastfeeding (Edwards et al 2013), however this was not the aim for the current
470 project. Consistent with data from midwives and obstetricians, doulas report a confusion
471 about the role as possibly challenging the role of the midwife (McLeish and Redshaw, 2018).
472 On the one hand they have a complementary role to the midwife and being a member of the
473 care team on the labour ward was described as encouraging. On the other hand they
474 sometimes lacked support from clinicians and felt they needed to defend the women's
475 informed choice and counterbalance disempowering treatment from staff, in this, as in
476 previous studies (McLeish and Redshaw 2019). They also expressed feelings of insecurity
477 because of unclear boundaries between their role and the caregivers' role which was voiced as
478 a challenge in their work.

479

480 In general, most CBDs experienced very collaborative relationships with caregivers,
481 where they felt themselves to be colleagues and were trusted by caregivers ("midwives often
482 appreciated my help and trust what I do") even though some CBDs reported not being valued
483 and experienced unfriendly treatment by caregivers. The positive communication between
484 CBDs and caregivers in this study confirmed previous findings of the views of Swedish
485 midwives feeling a positive and dynamic atmosphere when working with CBDs (Akhavan et
486 al 2012). An example of this collaboration is seen in the decision making about when the
487 woman was supposed to come to the hospital in labour being made in discussion between the
488 woman, the CBDs and the midwives.

489

490 Strengths and limitations of this study

491 The main strength of this study is its inclusion as part of a randomised trial of CBD support
492 for migrant women to enable the experience of CBDs to be articulated as an essential part of
493 the trial evaluation. Most of the interviews were carried out in the CBDs' own first language
494 which enabled the opportunity for detailed and rich expression of their views. The fact that
495 interviewers and interviewees shared similar cultural and linguistic backgrounds supported
496 the flow of the interviews and helped in creating rapport for the CBDs in openly sharing their
497 experiences. Complementary interviews with migrant women and their partners, if they were

498 present, and with midwives and obstetricians working in the labor wards, have also been
499 carried out to elicit their perceptions of supportive assistance.

500

501 Conclusion and recommendation

502 Generally, the CBDs described their doula assignments as unique and rewarding,
503 despite the financial, practical, organisational and professional challenges they faced. The
504 CBDs managed to provide continuous and meaningful linguistic and cultural and physical
505 support for migrant women during labour and birth. Based on our study findings however, it
506 is clear that the CBDs faced particular challenges which exposed them to additional stress in
507 performing their support role as doulas. For optimal operation and sustainability of CBD
508 programs, further consideration of the education and support provided to CBDs may be
509 needed. CBD workloads also need to be made more manageable and secure, and their
510 working conditions improved to achieve better remuneration and access to health insurance.

511

512

513 **Declarations**

514 *Ethics approval and consent to participate* Approval number: 2018/12 - 31/2

515 *Consent for publication* Written and oral consent

516 *Availability of data and material*

517 *Competing interests* None to declare

518 *Funding* Research reported in this manuscript was supported by a Grant from the Stockholm
519 County Council (Region Stockholm, RS).

520 *Authors' contributions*

521 *Authors' information*

522

523 References

524 Akhavan, S. and D. Edge (2012). "Foreign-born women's experiences of Community-Based Doulas in
525 Sweden--a qualitative study." *Health Care Women Int* **33**(9): 833-848.

526 Akhavan, S. and I. Lundgren (2012). "Midwives' experiences of doula support for immigrant women
527 in Sweden--a qualitative study." *Midwifery* **28**(1): 80-85.

528 Amram, N. L., M. C. Klein, H. Mok, P. Simkin, K. Lindstrom and J. Grant (2014). "How birth doulas help
529 clients adapt to changes in circumstances, clinical care, and client preferences during labor." *J Perinat*
530 *Educ* **23**(2): 96-103.

531 Bohren, M. A., G. J. Hofmeyr, C. Sakala, R. K. Fukuzawa and A. Cuthbert (2017). "Continuous support
532 for women during childbirth." *Cochrane Database Syst Rev* **7**: CD003766.

533 Bradfield Z, Duggan R, Hauck Y, Kelly M. (2018) Midwives being 'with woman': an integrative review.
534 *Women and Birth* **31**: 143-152

535 Campbell, D. A., M. F. Lake, M. Falk and J. R. Backstrand (2006). "A randomized control trial of
536 continuous support in labor by a lay doula." J Obstet Gynecol Neonatal Nurs **35**(4): 456-464.

537 Darwin, Z., J. Green, J. McLeish, H. Willmot and H. Spiby (2017). "Evaluation of trained volunteer
538 doula services for disadvantaged women in five areas in England: women's experiences." Health Soc
539 Care Community **25**(2): 466-477.

540 Dundek, L. H. (2006). "Establishment of a Somali doula program at a large metropolitan hospital." J
541 Perinat Neonatal Nurs **20**(2): 128-137.

542 Edwards RC, Thullen MJ, Korfmacher J, et al. (2013) Breastfeeding and complementary food:
543 randomized trial of community doula home visiting. Pediatrics. 132 Suppl 2:S160–S166

544 Eftekhary, S., M. C. Klein and S. Y. Xu (2010). "The life of a Canadian doula: successes, confusion, and
545 conflict." J Obstet Gynaecol Can **32**(7): 642-649.

546 Fortier, J. and M. Godwin (2015). "Doula support compared with standard care - Meta-analysis of the
547 effects on the rate of medical interventions during labour for low-risk women delivering at term."
548 Canadian Family Physician • Le Médecin de famille canadien **61**(June): e284-292.

549 Hardeman, R. R. and K. B. Kozhimannil (2016). "Motivations for Entering the Doula Profession:
550 Perspectives From Women of Color." J Midwifery Womens Health **61**(6): 773-780.

551 Hodnett ED, Gates S, Hofmeyr GJ, et al. . (2012) Continuous support for women during
552 childbirth. Cochrane Database Syst Rev. 10:CD003766.

553 Hunter, C. (2012). "Intimate space within institutionalized birth: women's experiences birthing with
554 doulas." Anthropol Med **19**(3): 315-326.

555 Kang, H. K. (2014). "Influence of culture and community perceptions on birth and perinatal care of
556 immigrant women: doulas' perspective." J Perinat Educ **23**(1): 25-32.

557 Kozhimannil, K. B., R. R. Hardeman, F. Alarid-Escudero, C. A. Vogelsang, C. Blauer-Peterson and E. A.
558 Howell (2016). "Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in
559 Preterm Birth and Cesarean Delivery." Birth **43**(1): 20-27.

560 Kozhimannil KB, Vogelsang CA, Hardeman RR, et al. . Disrupting the pathways of social determinants
561 of health: doula support during pregnancy and childbirth. J Am Board Fam Med. 2016;29:308–317

562 Lantz, P., K. Lisa and R. Watson (2004). "Doulas' views on the rewards and challenges of their work."
563 International Journal of Childbirth Education **19**(4): 31-34.

564 Lucas, L. and E. Wright (2019). "Attitudes of Physicians, Midwives, and Nurses About Doulas: A
565 Scoping Review." MCN Am J Matern Child Nurs **44**(1): 33-39.

566 McLeish, J. and M. Redshaw (2018). "A qualitative study of volunteer doulas working alongside
567 midwives at births in England: Mothers' and doulas' experiences." Midwifery **56**: 53-60.

568 McLeish, J. and M. Redshaw (2019). ""Being the best person that they can be and the best mum": a
569 qualitative study of community volunteer doula support for disadvantaged mothers before and after
570 birth in England." BMC Pregnancy Childbirth **19**(1): 21.

571 McLeish, J., H. Spiby, Z. Darwin, H. Willmot and J. Green (2016). "The process of implementing and
572 sustaining an intensive one-to-one support (doula) service for disadvantaged pregnant women."
573 Voluntary Sector Review **7**(2
574): 149-167.

575 Mottl-Santiago, J., C. Walker, J. Ewan, O. Vragovic, S. Winder and P. Stubblefield (2008). "A hospital-
576 based doula program and childbirth outcomes in an urban, multicultural setting." Matern Child
577 Health J **12**(3): 372-377.

578 Naiman-Sessions M, Henley MM, Roth LM. (2017) Bearing the burden of care: emotional burnout
579 among maternity support workers. Res Sociol Health Care 35:99–125

580 Neel, K., R. Goldman, D. Marte, G. Bello and M. B. Nothnagle (2019). "Hospital-based maternity care
581 practitioners' perceptions of doulas." Birth **46**(2): 355-361.

582 Richards, E. and R. K. Lanning (2019). "Volunteer doulas' experiences supporting cesarean births: A
583 qualitative analysis for preliminary program evaluation." Midwifery **77**: 117-122.

584 Schytt E, Wahlberg A, Eltayb A, Small R, Tsekhmestruk N, Lindgren H. Community-based doula
585 support for migrant women during labour and birth: study protocol for a randomised controlled trial
586 in STOCKHOLM, Sweden (NCT03461640). BMJ open 2020 10;2 e031290-

587 Spiby, H., J. McLeish, J. Green and Z. Darwin (2016). "'The greatest feeling you get, knowing you have
588 made a big difference': survey findings on the motivation and experiences of trained volunteer
589 doulas in England." BMC Pregnancy Childbirth **16**(1): 289.
590 Steel, A., J. Frawley, J. Adams and H. Diezel (2015). "Trained or professional doulas in the support and
591 care of pregnant and birthing women: a critical integrative review." Health Soc Care Community
592 **23**(3): 225-241.
593 Thomas, M. P., G. Ammann, E. Brazier, P. Noyes and A. Maybank (2017). "Doula Services Within a
594 Healthy Start Program: Increasing Access for an Underserved Population." Matern Child Health J
595 **21**(Suppl 1): 59-64.
596 Wint, K., T. I. Elias, G. Mendez, D. D. Mendez and T. L. Gary-Webb (2019). "Experiences of Community
597 Doulas Working with Low-Income, African American Mothers." Health Equity **3**(1): 109-116.
598 Young, C. (2019). "Professional ambivalence among care workers: The case of doula practice." Health
599 (London): 1363459319886115.
600
601
602

603
604
605
606
607
608
609
610

Figure 1. Community-based bilingual doulas' experiences of supporting migrant women during labour and birth, working alongside caregivers and their own working conditions

