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

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Abstract

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

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

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

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

Introduction

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

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

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

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

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

Methods

Design

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

Setting

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

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

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

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

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

Data analysis

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

Ethical considerations

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

Findings

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

Doulas lending migrant families and caregivers a hand

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

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

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

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

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

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

While the support during pregnancy was described as being focused on providing information, the support during labour and birth was more focused on hands-on support. CBDs talked about providing physical help to women by walking them around during the early stage of labour, doing massage and comfort touching or holding hands and they guided them on how to breathe during contractions to help them feel relaxed and secure.

A close relationship was perceived by the CBDs as helpful in their being able to provide women with all types of support, and as a result, they experienced that the women often paid more attention to them than to their partners:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Despite the rewards and positive feelings reported by CBDs in supporting migrant women they also expressed concerns regarding professional challenges they encountered. Underestimation and unfriendly behaviour from caregivers were some of the challenges they voiced.

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

Strengths and limitations of this study

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

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

Conclusion and recommendation

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

Declarations

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

Consent for publication Written and oral consent

Availability of data and material

Competing interests None to declare

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Authors' contributions

Authors' information

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