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## Midwives' experiences of doula support for immigrant women in Sweden—A qualitative study

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## ABSTRACT

**Objective:** to describe and analyse midwives' experiences of doula support for immigrant women in Sweden.

**Design:** qualitative study, analysed using content analysis. Data were collected via interviews.

**Setting:** interviews were conducted at the midwives' workplaces. One midwife was interviewed at a cafe.

**Participants:** ten midwives, who participated voluntarily and worked in maternity health care in western Sweden.

**Findings:** the interview data generated three main categories. (1) 'A doula is a facilitator for the midwife' has two subcategories, 'In relation to the midwife' and 'In comparison with an interpreter', (2) 'Confident women giving support,' has two subcategories, 'Personal characteristics and attitudes' and 'Good support,' (3) 'Doulas cover shortcomings' has two subcategories, 'In relation to maternity care' and 'In relation to ethnicity'.

**Key conclusion and implications for practice:** The findings of this study show that midwives experience that doulas are a facilitator for them. Doulas provide support by enhancing the degree of peace and security and improving communication with the women in childbirth. Doulas provide increased opportunities for transcultural care. They may increase childbearing women's confidence and satisfaction, help meet the diverse needs of childbearing women and improve care quality.

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### Introduction

Globalisation, war, poverty and political conflicts have all caused more people to migrate and settle in a country other than that of their origin. Sweden is one of the European countries that grants residence permits to immigrants and refugees and one of the European countries that has gradually changed from a largely ethnically homogeneous society into a multi-ethnic society. Today, roughly 20 per cent of the population is non-native, i.e. they were either born outside of Sweden or have at least one parent who was born outside of Sweden (Swedish National Statistics Bureau, 2005).

There are structural inequalities in health care, which means that immigrant women do not receive the same level of care as native-born Swedish women (Robertsson, 2003). Immigrant women, primarily from Somalia and Ethiopia are at a much higher risk of losing their children during pregnancy or in childbirth, compared with native Swedish women. African women also give birth to more children with low birthweight. Despite the increased risk of complications, these women do not receive the same level of care and treatment as Swedish

born women (Essén, 2009). Poor communication and cultural differences may lead to misunderstandings, lack of confidence and insecurity, especially for female refugees during pregnancy and childbirth (McLeish, 2002).

One important factor for a positive birth experience for women is support. Continuous support is associated with shorter labours, a decreased need for the use of analgesics, oxytocin, forceps, Caesarean sections and higher levels of satisfaction with the birth experience (Simkin and O'Hara, 2002; Hodnett et al., 2007). Continuous support has the greatest benefits when the support begins early in labour and when the provider is not an employee (Hodnett et al., 2007). One example of a non-employee supporting a woman during childbirth is the doula (a Greek word meaning 'woman caregiver of another woman'). According to Koumouitzes-Douvia and Carr (2006) the term doula has now expanded to include physical, emotional, informational and advocacy support to women during the pre-, peri- and postnatal periods. The effect of a supportive doula has been measured in several international scientific studies and shows good results (Sosa et al., 1980; Hofmeyr et al., 1991; Scott et al., 1999; Pascali-Bonaro and Kroeger, 2004; Lantz et al., 2005; Hodnett et al., 2007; Deitrick and Draves, 2008). Questions have been raised about the different nature of support by nurses or midwives and doulas (Gilliland, 2002; Ballen and Fulcher, 2006; Lundgren, 2010), and unclear roles between doulas and midwives are an existing problem (Ballen and Fulcher, 2006). A study

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from Sweden shows that a midwife's supporting role is unclear for women when a doula is present during the birth (Lundgren, 2010).

According to some studies, doula support has better outcomes for vulnerable women such as single mothers (Kennell et al., 1991; Abramson et al., 2000; Pascali-Bonaro and Kroeger, 2004). An American study (Shelp, 2004) shows that providing doula support for Somali women resulted in a decrease in the use of pain killers and the number of Caesarean sections performed. Doulas acted as cultural bridges between mothers and midwives.

In Sweden, doulas are rare and they are not included in the public health-care system (Lundgren, 2010). One qualitative study shows that women experience the doula as 'the missing piece' (Berg and Terstad, 2006). A doula project for immigrant women was conducted in the western part of Sweden for the purpose of ensuring more equitable and secure maternity care for all women. The project was funded by the Swedish National Public Health Committee in Västra Götaland. Within this project, foreign-born women (mainly non-European immigrants) who were interested in this project, had given birth, had their own child/children, could speak Swedish and could attend a birth at any time were systematically trained by midwives to become doulas and support their peers before, during and after childbirth. Immigrant women were trained to become doulas to serve their communities of origin. There was therefore a pool of doulas available to 'match' foreign-born childbearing women of the same culture (Breedlove, 2005).

In summary, immigrant women are at greater risk for complications and inequalities during childbirth. Continuous support from doulas is beneficial to women in general and vulnerable women in particular. There are few studies that include midwives' experiences of doula support when the woman is an immigrant, and none from a Swedish context. Thus the aim of this study is to describe and analyse midwives' experiences of doula support for immigrant women.

## Method

A qualitative study was conducted in order to describe and analyse midwives' experiences of doula support in Sweden. According to Morse and Field (1996), the qualitative method is used when only little is known about the phenomenon under study. This approach is also particularly useful when describing a phenomenon from the 'native's point of view' (Vidich and Lyman, 2000). We used semi-structured interviews, which mean that the researcher prepared a number of questions in advance. The interviewer could then ask spontaneous questions and change the order of the set questions along the interview. Semi-structured interviews allow the interviewees to recount their experiences with as little guidance as possible from the interviewer (Morse and Field, 1996). The results were analysed using a qualitative content analysis method. This is a dynamic form of analysis of verbal and visual data that is oriented toward summarizing the informational contents of that data (Altheide, 1987; Morgan, 1993). When using content analysis, the aim is to build a model to describe the phenomenon in a conceptual form. Inductive analysis processes are represented as three main phases: preparation, organisation and reporting. The concepts are derived from the data in inductive content analysis (Elo and Kyngäs, 2008). Because of its focus on human communication, content analysis offers practical applicability, promise and relevance for research involving the practice and education of nurses and other helping professionals (Downe-Wamboldt, 1992).

### Participants

Ten midwives working in obstetric units at different hospitals or at Maternity Health Care Centers (MHCC) in the Västra Götaland region and have had been in contact with doulas were interviewed.

The mean age was 48.7; respondents ranged between 35 and 58 years old. Five had worked in the profession for more than 20 years, while the others had between two and eighteen years' experience. Most met many childbearing women with immigrant background often or almost always.

### Data collection

A list of 25 midwives who were working in obstetric units in different hospitals or at MHCCs in the Västra Götaland region and had been in contact with doulas was sent to the first author (SA) by The Birth House Association. The people on the list were reviewed in the sequence in which they were received. The midwives or the superintendent of their units were informed about the study by telephone or via e-mail and appointments were made with those who were interested in being interviewed. Some of the midwives did not want to be interviewed, some were on maternity or sick leave, and some did not reply to our e-mails or telephone calls (a total of 15). Interviews took between 40 and 60 minutes. All interviews were tape-recorded. Interviews were conducted at the interviewees' workplaces. One midwife was interviewed at a cafe. The interviews were conducted between January and September 2009.

The research questions were as follows: What does doula support mean to midwives when the woman giving birth is an immigrant? What is it like to work with a doula? What is it like to work with immigrant childbearing women? Is there a need for culturally skilled staff (such as doulas) in Swedish maternity health care? What do you think of the maternity health care?

The basic requirements of this study were that oral and written information would be provided to participants and that written consent was obtained from them. The interviews were voluntary and informants were able to terminate the interview without justification. The process by which the midwives' names were accessed will be kept confidential and participants will remain anonymous. The study was conducted in accordance with guidelines for the ethical evaluation of medical research on humans (Medical Research Council's Board on Research Ethics, 2003).

### Data analysis

The purpose of data analysis is to organise structure and interpret the collected data (Polit and Tatano Beck, 2006). A qualitative content analysis method has been used to analyse the interviews. Content analysis involves identifying, coding and categorising the primary patterns that emerge from the collected data (Krippendorff, 1980; Patton, 1990). In the first phase, transcripts were read through repeatedly to obtain a composite perspective. In the second phase, sentences or phrases that contain information that was relevant to the questions were selected. The third phase was a systematic analysis of interview responses. Each interview was read several times and codes that were relevant to the study's purpose were identified. Claims were cut out and sorted according to the different themes that had been chosen. The multiple codes were sorted into subcategories. These were then merged into main categories after a thorough, comparative analysis (Holme and Solvang, 1991; Graneheim and Lundman, 2004).

### Findings

The interview data generated three main categories and six subcategories. The first category, 'A doula is a facilitator for the midwife' has two subcategories, 'In relation to the midwife' and 'In comparison with an interpreter.' The second category 'Confident women giving support' has two subcategories, 'Personal characteristics and attitudes'

and 'Good support.' The third category 'Doulas cover shortcomings' has two subcategories, 'In relation to maternity care' and 'In relation to ethnicity.'

#### *A doula is a facilitator for the midwife*

The doula is experienced as a facilitator for the midwife in the course of their work. The doula also serves as an interpreter.

#### *In relation to the midwife*

Midwives state that the doula is a facilitator for them. The doula is in the room all the time and is a facilitator as the midwives often have to care for more than one woman at the same time. Midwives do not view doulas as competitors, but rather as assets. One midwife stated '*The doula does not take over, [there is] absolutely no competition. The doula is just a great help to me.*'

One of the doula's roles is to be able to co-operate and collaborate. A midwife explained that '*everything was moving on very well, we could work together, the woman felt safe*' and a colleague of hers said '*I was very pleased, there was an interaction in the room, we became a team ... We supported the mother together.*' Another midwife felt that she and the doula '*interacted with each other, had realistic goals, and bridged the cultures. We learned that there are different approaches to childbirth and learned from each other.*' In general, the midwives were satisfied with the doulas that they collaborated with, as the doulas had knowledge of the childbirth process. One midwife, however, as reported that the doula who accompanied her in the delivery room took a lot of space and stated that she was not satisfied with the degree of cooperation. '*She [the doula] wanted to take over and could not collaborate with me.*'

When the doula is present as a facilitator, the midwife may feel left out. One midwife said that sometimes when the mother and the doula were speaking their common language, she herself felt excluded. She added '*... but my doula was very good. She balanced, she could be both an interpreter and a doula.*'

In addition, the doula may also let the midwife relinquish the support role to them. During these circumstances the midwife gave medical and instrumental care and the doula gave emotional and psychological care and support. A midwife explained, '*Some midwives are clinically-oriented and use themselves as instruments. Supporting the mother requires a huge amount of energy ... it is easier to watch the contractions and the process on the screen ... only entering and leaving the room as is necessary. Midwives can stand back and let the doula do the support job.*'

Further, the midwives experienced that it could be difficult for them to support women when they did not speak the same language. In that case, the doula is helpful in relation to the midwives. One midwife said '*I need a doula, it is difficult to work with women who cannot speak the language, have been traumatized, isolated and are unaccustomed to the system. Doulas can help to prevent the women from becoming depressed after the birth ... women feel cared for. We have taken in many immigrants in Sweden, the doulas are worth every penny. A good start for the new life in Sweden.*' The fact that the doula shares a language and culture with the woman giving birth is vital to understanding her needs and providing support. A midwife said '*A doula has cultural competence, which means that she understands the woman's perception of life-based experiences, her customs and practices, which may be relevant to the woman giving birth.*'

#### *In comparison with an interpreter*

The doula is a facilitator, in contrast with an interpreter. All interviewed midwives except one stated that there are differences between a doula and an interpreter. A doula encourages, assists and

supports women when they give birth. One midwife said '*We may use an interpreter only via telephone and for a short while, but a doula is here in the delivery room all the time.*' A doula assists the midwife and explains cultural differences. A doula is interested, is a trained cultural interpreter, adding some of her own thoughts throughout the process. One midwife said '*an interpreter is like a translation machine, it is not her role to assist and support the women.*' Another important difference between the interpreter and the doula is that '*there is interaction, affinity between doula and mother as they have met before.*' Another midwife explains: '*Interpreters just translate, it's not their role to support and help and they have no knowledge or interest in childbirth.*'

#### *Confident women giving support*

Doulas are viewed as confident women who give women in childbirth good support. The doulas' personal characteristics, attitudes and continuity are of particular importance.

#### *Personal characteristics and attitudes*

According to the midwives it is important that the doula is confident, has not had traumatic experiences of childbirth and is able to co-operate. They are viewed as confident women who are not tense or nervous, they know that their job is to support the mother. One midwife explains: '*doulas are pliable, interested and engaged, aware of the situation, can take a break and rest, they are not there for their own sake but for the sake of the woman in labour.*' A midwife stated '*a doula is there to give advice, but does not make decisions or take over.*' According to one midwife, the doula was '*totally aware of the birthing process.*' Another midwife, describing her view of the role played by a doula, stated that '*it places demands on me as a midwife: what do I have to offer the woman in front of me?*'

One midwife believed that doulas should not be self-assertive, and makes clear that her doula was not. '*My doula was calm, committed, a warm human being. She had a certain amount of medical knowledge and translated what I said.*' She added '*[for the mother] to have someone with her who she trusts and can communicate with, someone with knowledge of childbirth, is incredibly important and makes her feel safe.*'

Of the 10 people interviewed, there was one midwife who was not satisfied with her doula. The midwife's experience was that the doula was like an interpreter who was not engaged in the woman in labour. She said '*the doula herself was heavily pregnant and had another job, she was really tired. A doula should be bright and encouraging. She was more like an interpreter. A doula should be strong, she should not talk about herself and should be able to stand back.*' She believed that there are other sectors of the health-care system that need support and investment, that maternity health care does not need changes and support.

#### *Good support*

According to the midwives, doula support is incredibly valuable for the women. The women in labour were satisfied with the doula support because '*a doula clarifies things, provides information on childbirth and supports the mother.*' One midwife stated '*The doula is there during the whole birth process and provides physical and emotional support. She even supports the father who can in turn provide support to the mother.*' The doula is an '*aide to the mother, a fellow, a defense lawyer and a professional and friend who is on the woman's side and provides personal support.*' The doula communicates, conveys peace and has the woman in her focus. She is responsive and positive. '*The doula sees the woman in childbirth and uplifts her. She knows the language, acts as a bridge, translates and explains and provides security.*' The doula brings joy even when it

hurts. A doula creates a sense of community. *'The doula's presence means that the women in delivery feel safe and confident'*.

Another midwife explained that doula support calms the mother and makes her feel safe, which in turn helps the mother to relax and thus be less likely to need pharmacological pain relief or opt for Caesarean sections. There is less risk of a traumatic childbirth. *'The doula's presence and support help the mother to relax, help me to understand the mother's signals; the baby in the stomach feels good, which makes it easier for us all and we get positive and good results. It takes time to reach a scared mother, to get her confidence.'*

A midwife said *'Doulas can be good for their [the mothers'] self-confidence, provide confirmation and support in their own language; the husbands may not know much about childbirth, may not understand.'* She added, *'The doula's role is to help women to express themselves'*

Sometimes fathers cannot or will not be included in the childbirth process. Doula support then becomes even more important. According to the midwives, fathers have reacted positively to the doula's presence. One midwife explained that there may be a risk that the father is *'somewhat excluded'* but another midwife said *'the father did not end up outside, he was present, the doula did not take his place, the three were like a family (mom, dad, doula)'*. Another midwife said *'The father may also need support, it's his childbirth too.'*

The midwives agreed that it was important that doulas met the mother before the birth. Most of the interviewed midwives said that the doulas they worked with had met the mothers before and so they knew each other, which created security for the mother. *'It is not easy to support a woman giving birth... doulas should meet them before delivery work'*.

#### *Doulas cover shortcomings*

According to the midwives, there are shortcomings in maternity health care and community-based doulas can play a role in countering deficiencies. Furthermore, the doulas cover shortcomings in relation to cultural competence.

#### *In relation to maternity care*

Some of the interviewed midwives were critical of the childbirth system in Sweden. A main complaint was about continuity of care which is lacking in Sweden. The midwives gave examples from maternity care in other countries. *For example, midwives in Denmark work in teams. A midwife meets the mother before the birth and is also with her during labor; it is a good model that we don't have in Sweden. When the mother recognizes the midwife, she feels safe. Our system does not fit with this model.* Midwives also described maternity care as being medically oriented, which may lead to a lack of interest in supporting aspects of care, and midwives wanting to be like clinicians. *Midwives are mini-doctors and clinically-oriented and thus not so good at giving support'*.

Economy is another control factor that results in failures. *'We cannot [afford to] have an interpreter at all times during childbirth, only during the most necessary hours'*.

Midwives are stressed due to high demands and time constraints. They have to care for several women at the same time. *'Midwives can have several women in labour, she will run between them, we cannot keep up with everyone and we cannot be in the room all the time. We have to deal with stress, inadequacy and lack of staff, especially in the summer'*.

One midwife felt that doulas were needed not because of deficiencies, but to safeguard the quality of maternity care: *'we need to raise the quality ... the doula's presence and support facilitate the delivery process ... to have a doula is to enhance the quality'*. Most of the interviewed midwives work almost daily with

immigrant women. One stated that the *'need for doulas is much greater than is generally known'*. One midwife stated *'doulas are absolutely needed'*. Another midwife said *'antenatal clinics have struggled to get groups together for immigrant parent education, they do not come...doulas can help to activate our parent education [drives]'*.

However, another midwife stated that *'there are no gaps in the delivery and maternity care system, the doula is unnecessary and it is enough to have an interpreter at the birth'*. She believed that there are many deficiencies in Swedish health care and the priority to overcome deficiencies should focus *'on other sections of health care, such as geriatrics'*.

#### *In relation to ethnicity*

The theme of childbearing immigrant women and ethnicity appeared throughout all interviews. The midwives explained that an immigrant who visits a maternity care unit *'takes up more time... language and interpretation take time ... there are nuances in language that can make communication more difficult'*.

Lack of cultural competence in a multi-ethnic society is another deficiency, according to the midwives. *'We lack cultural competence, nowadays women from other countries and with different cultures are coming to Sweden ... sometimes when we don't understand them ... misunderstandings can arise'*.

A midwife who worked in an ethnically segregated area said *'immigrant women are more troubled by social, psychological problems as a result of war, trauma, unemployment ... ill-health'*. The midwives do not have *'resources, such as cooperation with social workers and the social services... we need larger premises and we need to have social workers, counsellors and doulas in place'*.

Doulas can be a step to prevent segregation of the newly arrived women. *'It is phenomenal, to be able to establish a bridge between the newcomers and those who have been here longer [doulas]'*.

Cultural competence was a theme that arose in several interviews. All of the midwives stated that they had not attended courses on ethnicity/cultural competence. A midwife explained: *'you cannot train for 80 different cultures ... there are cultural differences even between Swedes ... I can have much more in common with a highly educated Iranian woman than with a native Swede.'* She argues that there are cultural differences that are important but *'what is important is to accept, respect and to be open and responsive'*. Another midwife said *'I want to understand, just because I'm sitting here in Sweden does not mean that my way is best ... we need to facilitate communication and we need cultural competence. Doulas can play a big role here'*.

A midwife added that doulas can help midwives understand cultural differences regarding birth. *'I will not say any way is wrong (such as swaddling the baby rather than hugging it skin to skin, or giving honey or water to the baby) ... I think it's interesting to see and learn from different cultures ... women from one country would like to intervene regarding gynecological positions, have an injection and get drops, then they can relax and give birth ... we have to understand this and to be able to give birth in different positions and we try to ... I do not want to generalize, what I want to say is that no way is wrong'*.

Most of the interviewed midwives agreed that they needed more knowledge about working with women from different cultures. They also agreed that they had not had any courses or even lectures on this theme. A midwife explained: *'we should have lectures on ethnicity and health and on cultural competence, I missed this in our training; the course takes 1.5 years and is very intensive. Perhaps they could extend the years of education or we could obtain those skills through work'*. Many felt that they have acquired cultural competence through training and by working with immigrant

women. 'Midwives are a group who themselves are motivated, we learn through experience and interest' ... 'we're self-taught'.

## Discussion

The results of this study show that midwives experienced the presence of a doula as a facilitator in their work with immigrant women. Furthermore, the results show that doulas overcome shortcomings in relation to maternity care. A doula relieves the pressure on the midwife by giving support and by being in the delivery room throughout the childbirth. She also relieves pressure on the midwife by bridging communication gaps. Midwives stated that continuity of contact, that is, meeting the mother before, during and after the birth, is a crucial part of the doula support system. This has been verified in another study that midwives are incapable of giving continuity of presence, i.e. assurance that the women will not be left alone during the birth, and continuity, i.e. meeting the women before and after birth. The study also shows that the supporting role of the midwife is unclear for women when a doula is present (Lundgren, 2010). The question that arises is whether the maternity health-care system should use doulas or midwives or both to provide ongoing support to mothers. As discussed by Olafsdottir it is of concern to midwifery if trained support persons, such as doulas, take over the supporting role. Then the midwife may no longer be at the side of the woman and is merely left to supervise the instrumental care (Olafsdottir, 2006). In addition, if midwives are not able to give the women continuity and be constantly present for them, they tend to leave the women even if they have time for them. As stated by Walsh et al. (2007), a collegial approach valuing the contribution by midwives and lay supporters in providing continuity of support can be beneficial for women.

There was also dissatisfaction with doula support, as expressed by one midwife. In this case, the doula in question was not a facilitator for the midwife and lacked the personal characteristics and attitudes necessary to support the women in labour. Being open-minded and creative, as well as being able to learn from the past and accept help are vital skills for becoming a doula (Behnke and Hans, 2002). According to Berg and Terstad (2006) and Hodnett (1996), emotional support, i.e. continuous presence, reassurance, encouragement and praise is central to doula support. These findings show the important role of the doula and the influence of personal characteristics and attitudes. One question is how to protect women from doulas who are not fulfilling their obligations, when the work is not an established profession, with prescribed rules and ethical guidelines? A point for consideration is that women may be negatively exposed to other women from the same culture if the doulas they meet lack suitable personal characteristics and attitudes. If so, without support from the midwife, doula support may lead to negative outcomes for the woman.

According to our study, doula support could cover shortcomings in maternity care. The Swedish health-care law which was passed more than 20 years ago enshrined the right of all citizens to equal treatment under equal conditions. Empirical studies have documented significant and widespread ethnic disparities in health care in many countries that host immigrants and refugees or have ethnic minorities (Etchason et al., 2001; Fiscella et al., 2002; Smedley et al., 2002; Swedish National Board of Health and Welfare, 2008). Immigrants and non-natives do not seek care when they need to, are dissatisfied with the treatments they receive and rely less on public health care than the total population (Diala et al., 2002; Swedish National Statistics Bureau, 2006; Swedish National Board of Health and Welfare, 2008; Xu and Broders, 2008). Our study suggests that doula support is one way of countering the dissatisfaction, expanding the comfort of childbearing immigrant women and increasing levels of satisfaction and trust in the Swedish health-care system. As one midwife puts it, doula support

'increases health care quality,' it enables and facilitates achieving the objective of the Swedish health-care policy. An American study (Koumoutzes-Douvia and Carr, 2006) also suggests that doula support can increase patient satisfaction as an important theme in health care. Earlier research shows that women with lower incomes, lower levels of education, fewer preparations for childbirth or a lack of social support may particularly benefit from the use of doulas (Gordon et al., 1999). Understanding why this population may benefit more than other women requires evaluating possible ways in which doulas may affect outcomes. For example, the presence of a doula in the delivery room may decrease feelings of loneliness of the woman in labour and reduce the woman's anxiety (Kennell et al., 1991). However, it is important to further study the provision of doula support to vulnerable women, such as isolated pregnant immigrant women. If the doula lacks good attributes then an exposed group of women may even become more exposed.

Doulas may help to create a transcultural climate of care which in turn may contribute to achieving the objective of the health-care policy. Transcultural care may result in fewer communication problems due to language and cultural differences (Salt, 2007). The employment of bilingual and bicultural staff, especially in obstetric services, is recommended for creating transcultural care (Caley, 1998). It is necessary to raise the health-care system's awareness of delivering culturally and linguistically appropriate services. The health-care system should recognise that the delivery of these services is not only a patient's right but also a determinant for safety and the quality of patient care. Cultural bridges can be established through the deployment of culturally competent staff from different ethnic backgrounds. Cultural competence can be achieved by: cultural knowledge, cultural sensitivity and collaboration with the community to be served (Flaskerud, 2007). The interviewed midwives expressed the importance of transculturally competent staff during childbirth and maternity care. According to the researchers, cultural prejudices, stereotyping and negative attitudes may occur when midwives meet immigrant patients (Caley, 1998; Straus et al., 2009). One way to combat prejudice and stereotyping is to use doulas, bilingual and bicultural health-care staff. Shelp (2004) and Dundek (2006) noted that midwives who have worked with doulas more than three times have an entirely different attitude towards cultural differences and ethnic minority women. Results from this study show that doulas can help midwives in meeting different cultures and developing cultural competence. As one midwife says, 'I want to understand their [immigrant women] way of giving birth, just because I'm sitting here in Sweden does not mean that my way is best ... we need to facilitate communication and we need cultural competence. Doulas can play a huge role here'.

The results of this study are in agreement with another previous study (Kai et al., 2007) which shows that although interviewed midwives demonstrated an awareness and understanding of ethnic diversity, they were anxious and uncertain about being culturally inappropriate, causing affront or appearing discriminatory. Previous research (Kai et al., 2007) emphasises requirements for self-reflection on one's own cultural identity as an individual and health professional and toward placing a greater focus on the patient as an individual.

One limitation of the study is that qualitative studies are contextual, i.e. they must be related to the context in this study, namely midwives working in a city in Sweden (Graneheim and Lundman, 2004). However, the fact that the findings are contextual does not mean that they have no meaning in other contexts, but must then be interpretive in relation to the new context. Another limitation is that some midwives were on maternity or sick leave, or did not respond to our e-mails or telephone calls. These may have held different perceptions and had different experiences. The study's strength is the opportunity to deeply explore the

experiences of the midwives. Furthermore, this is the first study to be conducted in Sweden on midwives' experiences of doula support for immigrant women. It casts new light on the subject in relation to Sweden and other European countries which also face large-scale immigration.

Future research is necessary to study in which ethnic groups and for which specific groups of immigrant women doula support is needed. Further quantitative studies are necessary to measure the impact of doula support before wide-scale implementation, and qualitative studies in order to understand the role of the doula in different contexts.

## Conclusions and implications for practice

Ethnic diversity is increasing in Sweden as in many other European countries. In order to provide equal levels of maternal health care for all citizens, existing inadequacies must be addressed. The findings of this study show that midwives experience doulas as facilitators, both in the course of their work and in contrast with an interpreter. Doulas provide support by enhancing security and improving the level of communication with the woman in childbirth. Doulas increase the range of transcultural care. The presence of a doula may increase childbearing women's confidence and levels of satisfaction, improve catering to the diverse needs of the childbearing women and improve the quality of care. The question for future research is whether maternity health care should use doulas to provide ongoing support, or to develop policies to address identified inadequacies. Another issue for further research could be to measure the effect of doulas on birth outcomes through quantitative studies.

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