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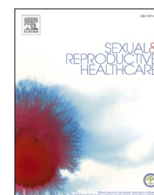

Multicultural doula care from the perspectives of immigrant women in Norway: A qualitative study

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ABSTRACT

Objectives: The aim of the study was to illuminate immigrant women's experiences of multicultural doula care as part of the 'Vulnerable, pregnant and new in Norway – Safe during childbirth with a multicultural doula' project.
Methods: The qualitative design was based on Braun & Clarke's thematic analysis. Semi-structured interviews were held, assisted by an interpreter, with seven immigrant women from three different countries.
Results: The overarching theme illuminated a significant caring relationship between the immigrant women and their multicultural doula. The relationship was important for the women's positive childbirth experience. Furthermore, four themes emerged as follows: feeling alone and scared; needing to be looked after; not knowing the language; and giving birth in a new and unfamiliar culture. The results revealed that the women felt safeguarded by the multicultural doula. They felt cared for and understood when the doulas acted as guides, knowing the culture and language, in collaboration with the midwife in maternal care.
Conclusions: Multicultural doulas can contribute to optimizing the quality of care provided to immigrant women during pregnancy and childbirth, with focus on an equal quality of care for all women. The findings can raise awareness of cultural competence in midwifery practice. More research is needed to develop new models that incorporate multicultural doulas into healthcare policies.

Introduction

Women's experience of migration to and settlement in a new country reveals hardship for the women, and an increased need for support during pregnancy, birth and postpartum [1]. Awareness of these challenges is necessary to maintain patient safety and patient rights [1]. Of a total of 56,060 new-borns in Norway in 2021, 14,394 had a mother with an immigrant background, which amounts to 25.6 % of the number of births in Norway in that year [2]. A probabilistic forecast of the immigrant population of Norway indicates strong growth over the next four decades with a median value in 2060 of 44 % higher than in 2022 [3]. Immigrant women do not always receive optimum care during pregnancy and childbirth, due to language barriers, while there is limited knowledge of intercultural care among midwives and other healthcare personnel [4,5]. The need to improve care for immigrant women is highlighted in Norway [6]. A caregiver such as a doula can contribute to a positive childbirth experience [7]. A doula is a caregiver who provides continuous physical, emotional and informative support to the pregnant woman during pregnancy, childbirth, and the post-partum period [8].

Background

An immigrant in Norway is defined by the Central Statistical Office (SSB) [3] as a legally residing person who was born overseas and has two foreign-born parents and four foreign-born grandparents. A refugee or an asylum seeker is not considered an immigrant until their application is granted [3]. However, in this study they will be classed as an immigrant. In Norway, countries in the Middle East and Sub-Saharan Africa, such as Somalia, Syria, and Eritrea are among the ten most frequently represented countries as the mother's country of birth. Somalia and Syria are also among those with the highest risk of perinatal death of newborns [10].

There are public health concerns related to health issues for immigrants, as their maternal outcomes are poorer than for Norwegian-born women. Immigrant women from countries with a lower Human Development Index have an increased risk of complications and interventions

Abbreviation: MCD, multicultural doula.

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such as emergency caesareans, postpartum haemorrhages, episiotomies, and instrumental births [9]. There is a lack of models for maternity care adapted to the needs of immigrant women [11–13]. This also accords with the women's own perspectives [12]. Immigrant women in Norway struggle to navigate the health system, experience language barriers and psychosocial challenges, and have unmet needs and encounter conflicting recommendations [6]. They expect the same care as non-immigrants, but the women's expectations are less often met [14]. Norway is known for its high quality healthcare, which may contribute to higher expectations and a lower threshold for criticism [15]. Even so, immigrant women are not generally confident that they will receive the best care [16], especially when the interventions in the new culture crashes with their previous experiences [12]. Immigrant women are however generally satisfied with the quality of the healthcare system itself [17], but have negative experiences regarding attitudes, care and communication with healthcare personnel [5,17,18]. Bains et al. [6] describes negative cultural hospitality by healthcare providers when it comes to immigrant women's wishes for various cultural rituals. Immigrant women who are pregnant are in a vulnerable situation, and health services must be improved to meet their needs and continuity of care [12,18], including the cultural competence of healthcare personnel [19]. The challenges for the healthcare system concern dealing with the barriers immigrants face, by improving communication, increasing women's understanding of the care offered and reducing discrimination [4,14].

Immigrant women with less education and resources may not have social networks available and have concerns about the different health care system [16]. Challenges to expressing needs and wishes will affect communication [16]. This can be balanced by a doula who is advocating for the woman [21], especially when health professionals cannot provide continuous support [22].The MCD can create bridges of cultural understanding – as well as linguistic understanding – through the translation of conversations between the immigrant women and the health professionals [23]. Akhavan and Edge's [22] study uses the concept of a community-based doula (CBD). A recent randomized controlled trial by Schytt et al. [24] concluded that CBD support for migrant women made no difference to their intrapartum care experiences or their emotional wellbeing. Notwithstanding, they still recommend doula support for immigrant women as it can improve communication between health professionals and the women [24].

Considering the limited research of the concept of MCD/CBD, several studies encourage new research [24,25]. In view of the lack of care models and the implementation of a new multicultural doula care initiative, it is important to gain knowledge from the immigrant women's own perspectives, which so far have been little studied.

Theoretical perspective

The theoretical perspective of the study is based on Wikberg's [26] theory of intercultural caring. According to the theory, childbearing and migration create a double vulnerability for the woman. The intercultural caring theory guided us to focus on the perspectives of the immigrant women themselves and was used to deepen the discussion of the findings [26]. The theory consists of the caring relationship between the woman and the midwife. Intercultural caring has four dimensions: universal, cultural, contextual, and unique caring. Universal caring is non-dependent on time and space. Cultural caring considers the cultural background, and the acculturation and the safety of each mother, while contextual caring considers the specific cultural features of each unique childbearing woman. In unique caring, the mother expects and hopes for effective communication, respect for the family, and caring for her needs, so that trust can be built between the woman and the midwife. Intercultural caring may reduce misunderstandings and conflicts and promote health and life.

Aim

The purpose of the study was to illuminate immigrant women's experiences of multicultural doula care during pregnancy and childbirth.

Methods

Research design

A qualitative thematic analysis research design was chosen to study participants' subjective experiences and perspectives [26].

Context

This study is based on the project 'Vulnerable, pregnant and new in Norway – Safe during childbirth with a multicultural doula' that began in 2017 at Oslo University Hospital and is now run by the Norwegian Women's Sanitary Association in several Norwegian hospitals [20]. The projects' main purpose is to strengthen and facilitate equal maternity care for immigrant women through a multicultural doula (MCD) [20]. The project invites immigrant women to their doula course through their website and word by mouth. A MCD is a doula with experience of two cultures and who shares the country of origin, language, culture and traditions of the immigrant women [20]. The pregnant immigrant women are assigned to a doula based on these criteria by the project management. The MCD must have experience of giving birth in a Norwegian hospital and have the competence to be a guide into the Norwegian health system [20]. The MCD must have completed a 56-hour training course that covered different topics related to becoming and being a doula, childbirth, communication issues, and cultural perspectives. The MCDs had met regularly for reflection and supervision [20].

Data collection

An interpreter was necessary, due to the participants' limited knowledge of Norwegian or English. Careful selection of interpreters took place, to avoid linguistic and cultural problems in connection with translation, and to ensure trust between the interpreter and the participant [27]. The interpreters were all women, spoke the same language and shared country of origin with the participant. The interviews were held by the first author at the health centre, with the interpreter participating by phone, to ensure confidentiality. The interviews took place in connection with a planned check-up, six weeks after childbirth. This was considered an ideal time and facilitated participation. An interview guide was created as a support tool and manuscript that structured the interview process [27]. Inspired by earlier research and theory, there were four topics in the interview guide: The relationship, follow-up, care and caring, and development of the offer. Here are two examples of questions: Why did you want to be cared for by the doula? How did the combination of multicultural doula and midwife work? Discretion and tact determined how much follow-up each question received [27]. The semi-structured interviews were audio recorded and had an average duration of one hour in a peaceful atmosphere. The interview guide was sent to each interpreter ahead of time, so that they could prepare for the topic and language used, for quality assurance [28].

Participants

Newly arrived immigrant women (<5 years) who had voluntarily participated in the Norwegian project offering MCD in pregnancy and childbirth [20] were eligible for the study. Three women were excluded from the study due to lack of access to a doula (one premature labour, one precipitous labour and one case, where the doula did not answer the woman's phone call during the night). The seven participants represented three different nationalities: five of them were Arabic speakers

from Syria; one was from Somalia, who spoke Somali; and one was from Ethiopia, speaking Amharic. Most of them had a brief period of residence in Norway of around one to two years, but one woman had lived there for five years. Some had come to Norway as refugees and others in the context of family reunification. They were aged between 22 and 49 and each had between one and four children. In their home country, they had been housewives, students, or workers. Most of the participants received the offer one to two months before their due date, but one received the offer when three months pregnant and another at the start of labour itself. There was variation in how many encounters they had altogether, but all except one met the doula physically before giving birth and had the opportunity to call when needed.

The recruitment was conducted in dialogue with the project manager and contact person for the project at the hospital in question. The immigrant women had been matched with the doula based on three aspects, which were common language, country, and culture. This assignment had been done by the contact person at the hospital in question for the project [20] before this study started. For the women to have enough time for reflection and preparation, it was desirable for them to already be included during pregnancy. The information and consent form had been translated by carefully selected agencies and was presented to the woman by her midwife or public health nurse [29].

Data analysis

The audio recordings were subsequently transcribed into a text of 21,025 words. Thematic analysis was prepared in line with Braun and Clarke's [26] six recurring phases. The analysis was done by the first author and discussed and validated together with the second author. The process began with getting to know the data material via the data collection and transcription. Then, all codes of meaning to illuminate the aim were highlighted from the data set, regardless of repetition. The codes were listed for a better overview. At this point it became easier to sort the various codes into candidates for themes, conducted using mind maps for visual presentation. Repeated reading of the data material was undertaken by both authors to look for codes that might have been overlooked [26], and also to look for new connections and development of themes. A thematic map was finally produced by both authors, to ensure an interesting, cohesive, logical and concise presentation [26].

Ethical considerations

Research ethics applications were approved by the Regional Committee for Medical and Healthcare Research Ethics (REK, ref. 249089), with assessment by the Norwegian Centre for Research Data (NSD, ref. 487942) and the healthcare organisation involved (e-protocol, no. 2362-2362). Informed consent was obtained from the participants, who were assured that their participation was voluntary. Participants were informed of the protection of confidentiality and their right to withdraw from the study at any time. Private data that might identify the participant is not disclosed [27]. The ethical principle of beneficence guided us to be aware of the risk of harming a participant by not protecting the anonymity of this small group that might risk recognition, and the characteristics were therefore only briefly summarised [27]. We did not involve the MCDs in the recruitment process due to ethical reasons, to not interfere in the doula care. The women were invited to the study with the help of the contact person for the project. Data processing was in accordance with the ethical approvals.

Results

The results of the study reveal that multicultural doula caring was experienced as a significant relationship for immigrant women in pregnancy and childbirth, and contributed reassurance, caring, and understanding, through working together with midwives as a dependable guide. Based on the results, a Table 1 was developed to illustrate the findings as one overall theme and four main themes.

Table 1
Overview of themes.

Overall theme:
The significant relationship with the multicultural doula was important for the immigrant women's birth experience
Four themes:
Feeling alone and scared - safeguarded by the multicultural doula
Needing to be looked after - cared for by the multicultural doula
Not understanding the language -understanding with the multicultural doula
Giving birth in a new and unfamiliar culture - the multicultural doula as a guide with the midwife

Feeling alone and scared – safeguarded by the multicultural doula

Feeling alone, scared, and anxious about unfamiliar pregnancy and childbirth in a new country was described by the participants and created a need for community with other women who could understand them. The women described vulnerability factors such as having a refugee background, a brief period of residence in Norway, difficult circumstances in life, an unfamiliar healthcare system, loss of children in their home countries and being pregnant without their network.

> 'Throughout my pregnancy I thought about childbirth. How would this turn out here in Norway? Because everything was new and different from our home country. Culture, language, everything. New system for me. I was scared, so scared' (Participant 2).

During the interviews, several of the women repeated that they were lonely. Some were completely alone with no husband, family, or others by their side. This created great uncertainty and worry about childbirth and the future. The women looked for the reassurance from the doula that they experienced as from the first encounter.

Needing to be looked after – cared for by the multicultural doula

Being cared for by the MCD reflected the participants' need to be looked after. They recalled physical and psychological support, availability, presence, empathy, and a feeling of being cared for. The women expected to be able to get support from the MCD along the way. Physical help, the way the doula spoke, and accessibility, were emphasised. All participants felt that the doula contributed something positive, and when they were asked how they thought it would have been for them without the doula, most said it would have been more challenging.

The doulas were close to the women, and the participating women described a relationship characterised by love, and that the MCD's work seemed to come from the heart. Several participants also mentioned that female support was important, regardless of whether it was from a mother, sister, or another woman. According to a participant, being of the same gender created a common and greater understanding of her needs.

> '…the doula was present, and it seemed like mum was present. She took care of me, showed love, and we need love. And it makes it easier to cope with the pain when you feel safe' (Participant 3).

Not knowing the language – understanding with the multicultural doula

The doula was described as a safe mediator for the women throughout pregnancy and birth, creating a mutual understanding in a country where they did not know the language. The role was described as greater and richer in content when compared to a telephone interpreter, even if the interpreting function of the MCD was recognised. The doula answered questions when it came to preparations in pregnancy,

concerns and expected help at the hospital. During labour, the doula helped by conveying breathing techniques and used hand and body signalling during the pushing stage. Hand and body signalling were described as a way the midwife could maintain contact with the woman in the pushing stage instead of using many words. The doula translated what the meaning was behind the necessary hand and body gestures, for example how she should breathe and then push, and other instructions to ease communication. The language barrier with the midwife was described as problematic for the women and contributed to concern. Several of the participants explained that since the doula came from the same tradition and language as the woman, it was easier to communicate with each other. Another participant described the mutual understanding as follows:

> 'I hope that there will be an offer for all women who do not have anyone here; to get a doula from the same culture. Language is very, very important; if we speak the same language, it is much easier to communicate and understand what we feel and manage to explain our feelings in the same way and be understood' (Participant 4).

Giving birth in a new and unfamiliar culture – the multicultural doula as a guide with the midwife

With a new culture and an unfamiliar healthcare system, the women's experiences show that there is a need for predictability. The women described how they were embraced and met with care, recognition and respect by the midwives and doula, despite having to adapt to cultural differences. Even though the women did not understand what the midwives said, they were satisfied with the care from the midwives during childbirth. They felt that the midwives were genuinely happy to help them, treated them well, supported and guided them, and provided information along the way. When it came to the midwives' cultural understanding, participants felt respected and considered. Regardless of this, language was also a major common denominator when it came to concerns among the participants:

> 'I do not know the language. I was also a bit worried if I am in pain, how will I convey that I am in pain? Will they realise and understand that I am in pain?' (Participant 4).

All participants expressed a need for a doula, due to the language barrier and lack of family members, and that a doula could contribute cultural understanding. The wish for a doula concerned the continuous presence and support. Yet it was still not the doula alone who provided comprehensive care and attention. Several of the participants said that the midwife, their husbands, and the doula each had their own functioning role. They noted that the doula and midwife worked as a team, and that the midwife had the knowledge, while the doula was by the woman's side as an aid and support. MCD was described as a relief and help for the partner. The doula was there all the time, so that the husband could have breaks when he needed to. Only one participant experienced that the doula was mostly an interpreter. The women preferred the doula to be there before childbirth, and especially in the last month of pregnancy, when the need increased. It turned out that the participants showed gratitude for the MCD.

Discussion

This qualitative study of multicultural doula care in pregnancy and childbirth – a project involving several Norwegian municipalities [20] – reveals immigrant women's experience of a significant relationship with their doula. The multicultural doula had knowledge of Norwegian childbirth practice, culture, and language as well as knowledge of the immigrant women's country of origin, language, and cultural tradition. The women felt that the doula contributed a sense of safety, caring and understanding in collaboration with the midwife, which corresponds to, and thereby supports Wikberg's theory of intercultural caring [5].

Feeling alone and scared – safeguarded by the multicultural doula

The women in this study missed family members and worried about giving birth alone. The MCD helps to fill this void by alleviating loneliness. Loneliness and limited social networks are one of the main barriers to optimal health and well-being in pregnancy and childbirth [6]. Family is often represented as the most valuable resource in an unfamiliar situation for immigrant women; a protective factor, as well as an important moral and practical support [12]. The women in this study did not perceive the MCD as taking the partner's place even when the partner was present at birth. The participants also found the MCD to be a relief and help to the partner. This accords with Akhavan and Lundgren's Swedish study [30], in which midwives perceived partners to be more present when a MCD was involved.

Needing to be looked after – cared for by the multicultural doula

A positive birth experience is reflected in emotional support and care [31] and the significance of continuous support in childbirth has been established in several previous studies [7,22,23]. A doula can provide relief by being present and developing trust through continuity [21], to which this study can relate. The women in this study felt that the warmth of the care provided by the doulas was sincere. It must be mentioned that it is difficult to expect this connection from the multicultural doulas, but this connection seemed to come naturally, due to their mutual understanding. Parallels can be drawn to the study by Bondas and Wikberg [32] that highlights motives such as personal gain and joy from helping women. In line with Wikberg and Bondas' [21] doula caring model, based on doula perspectives, the MCD in this study is described as a developer of trust and continuous support.

Not knowing the language – understanding with the help of the multicultural doula

Immigrant women generally may have a feeling of mistrust and suspicion towards authorities [19] and doubt whether they are receiving the best care [16]. In this study, the women had faith in the healthcare system, but were uncertain whether they would be understood. This corresponds to the study by Bains et al. [17]. The participants described a mutual understanding with the MCDs as they shared the women's language, culture, and gender. This seems to have contributed to creating a safe environment for the women in an unsafe situation with a new language and healthcare system.

Midwives and immigrant women have a common desire to understand each other's worlds, but this becomes difficult when language barriers lead to limited communication, insufficient information, and little opportunity to present needs and wishes [12]. This challenges Wikberg's [5] dimension of unique caring, when communication does not work and women's needs are not met. The WHO [31] points out that information in the woman's language and the cultural competence of healthcare personnel are important for the best possible communication and birth experience. The findings in this study show that immigrant women had good experiences concerning language translation and cultural understanding with the help of the MCDs.

The midwives in antenatal care, together with the MCDs, contributed to preparations and care ahead of the birth. These preparations enabled the women to participate in their childbirth experience by getting answers to their questions and concerns, with the MCD as a messenger [21] who enabled informed choices [21]. Women from lower-income countries are less likely to express personal choices and to make decisions [31]. It is important to mention that immigrant women may come from cultures where co-determination is not necessarily practised in the same way as in Norway. Mehrara et al. [16] show that the expectations and requirements of immigrant women vary on the basis of culture, social class, network, knowledge and personal experiences, and that their ability to communicate their healthcare needs will be affected by these

circumstances. The MCD can help the women to communicate their needs and wishes, as this study shows.

Giving birth in a new and unfamiliar culture – the multicultural doula as a guide with the midwife

The women perceived the midwives and doulas as a team that provided guidance and collaboration for a safe and positive childbirth experience. Wikberg [5] considers birth in a new country to be an important intercultural consideration when providing maternal care. The absence of the doula, even during short breaks, was experienced as stressful for the women in this study and confirms how significant the continuous presence of the MCD was for them, echoing research from doulas' perspectives [21]. Research shows that midwives themselves appreciated the MCD as a facilitator, improving communication to augment cultural care and quality of care, as midwives often have to attend to several women at the same time [30]. The participants in this study felt that the midwife had professional knowledge of mother and child but felt a need for the involvement of both the doula and the midwife, each with their own function. Lucas and Wright [33] have nevertheless shown how midwives had conflicting attitudes towards doulas, and that there could be a tense dynamic with misunderstandings and overstepping. This study reveals the opposite, namely a caring collaboration. Notwithstanding, it must be mentioned that Lucas and Wright's study [33] did not take the MCD as its starting point, and this may explain the differences. It may be that when the MCD is present, there is a focus on cultural sensitivity that can help to avoid possible tensions between midwives and immigrant women [5]. Intercultural caring [5] can contribute to increased cultural awareness and self-reflection in midwifery care. Immigrant women themselves describe having an MCD as a human right that ensures dignity [22], which is consistent with both this study and Wikberg's [5] dimension of universal caring. The results of the study show that with the help of a MCD, it is easier for the women to gain an understanding of the new culture and, at the same time, have their own cultural needs translated for the midwife. The women found that the midwives had an awareness and a respectful attitude towards their culture. This is in line with Wikberg's [5] intercultural caring theory.

By including cultural competence and intercultural caring, Wikberg [5] believes that well-being will be enriched. There are, however, various circumstances in society that can affect the care provided [5]. The principle of universal equality underpins Norwegian social and health care policy – and cultural awareness and responsiveness are necessary extensions to this universal principle for successful service provision to specific groups [13]. The healthcare system should recognise that the provision of MCD services is not only a human right, but also a decisive factor to ensure the safety and quality of patient care [22].

The immigrant women in Mehrara et al.'s study [16] wished for continuity in midwifery care and hoped that it would be possible to establish a relationship before giving birth. Similarities are shown in the present study, as some of the women would have preferred the MCD to be introduced in early antenatal care. Our findings show that the MCD also eases the concerns of the women during pregnancy, and it would therefore be an advantage to introduce the MCD at an early stage. This echoes Akhavan and Lundgren [30], who researched the midwives' perspective. Early introduction would contribute predictability and create a more needs-oriented approach whereby the women themselves could express what they needed help with.

Strengths and limitations

A commitment to develop equal access to health services is shared by the first author, with a background as a midwife, and the second author, with a background as a public health nurse in maternal care, as well as experience in qualitative, midwifery and doula research. The authors had a continuous reflective dialogue that was fruitful for the quality of the research process.

A challenge in connection with recruitment was that there were few possible participants, and an ongoing Covid-19 pandemic. Without these limitations, it would have been beneficial to have more participants, to optimise the strength of the information. There was variety in the characteristics of the participants, who came from three different countries. Women from countries other than Syria, Ethiopia and Somalia may experience the MCD in a different way. There was still a consensus among all the women, regardless of their country of origin.

The Covid-19 restrictions meant that we had to sit one metre apart, but a calm and pleasant atmosphere was created in the room, and the interpreter was available on the phone. Attention was paid to not directing the conversation towards one's own preconceptions as a midwife, while also responding and listening carefully and balancing between flexibility and management. It cannot be ruled out that the women avoided mentioning anything that put the MCD offer in a negative light since the interviewer was a midwife. Despite this, it was still considered an advantage that the interviewer was a midwife. This may have contributed to increased trust in the interview process where the participants became more relaxed, given the interviewer's greater knowledge and understanding about what birth and pregnancy entails.

Interviewing across languages and cultures is challenging, and assurance that the data obtained is completely accurate is unattainable [28]. When an outsider can influence the answers, different linguistic messages can be misinterpreted [28]. Nevertheless, the similarities in the answers of the various participants enhance the intersubjective reliability. Moreover, a professional interpreting agency was used, so that the interpreter was qualified to ensure quality [27]. The interpreter's role was assessed in advance, and to the extent that compliance with this was possible, cultural acceptance, linguistic competence and support as an assistant who did not take over the interviewer's role were preferred. This risk could be reduced by using a professional interpreting agency [27]. Berman and Tyyskä [29] state that an interpreter is an active producer of knowledge, and their skills and CV should be assessed. Contact was set up with the interpreter before the interview, whereby it was clarified that this was a research project, and that careful translation was importance, to achieve the best possible interpreting quality. One limitation to consider is that the information was first translated by the interpreter and then transcribed by the first author. The linguistic analysis was not the essential aspect of the study, but rather the content and the meaning, which Berman and Tyyskä [29] justify by saying that language is not neutral anyway. The interpreters also commented that sometimes the questions had to be repeated and reworded for the women to understand the questions. The participants learned that the interpreter did not receive any of the women's personal details and that the interpreter came from another city, which corresponds to the procedure recommended by Merry et al. [28].

Conclusions

Multicultural doula care may create a significant caring relationship from the woman's perspective that has an impact on the childbirth experience and can strengthen trust and adaptation processes for women who are giving birth in a new country. Based on the immigrant women's positive experience of the MCD care offered in this study, principles of universal equality can be more easily met. The usefulness perspective of the study is assessed to be high in relation to the disadvantages it entails. Researchers are recommended to explore a follow-up perspective from different perspectives for the development of health policy and services in the maternal and family care of the immigrant family.

Declaration of Competing Interest

The authors declare that they have no known competing financial

interests or personal relationships that could have appeared to influence the work reported in this paper.

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Ethical approval and informed consent

Ethics applications and informed consent were approved by the regional committee for medical and healthcare research ethics (REK, ref. 249089), and assessment by the Norwegian Center for Research Data (NSD, ref. 487942) and the involved health care organization (e-protocol, no. 2362-2362).

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Authors’ contribution

Both authors contributed to the design of the study. The first author was responsible for the recruitment, data collection, the preliminary data analysis, interpretation and drafting of the manuscript. The second author read the transcribed data, reviewed the analysis critically, and participated in the writing process. Both authors approved the final version of the manuscript.

References

[1] Robertson EK. “To be taken seriously”: women’s reflections on how migration and resettlement experiences influence their healthcare needs during childbearing in Sweden. Sex Reprod Healthc 2015;6(2):59–65.
[2] Statistikkbanken: 12481: Samlet fruktbarhetstall og antall levendefødte for innvandrerkvinner, etter morens landbakgrunn 2011-2021: Statistisk sentralbyrå; 2021 [cited 2022 26.10.22]. Available from: https://www.ssb.no/statbank/table/12481/.
[3] Keilman N. A probabilistic forecast of the immigrant population of Norway Statistics Norway, Research Department (SSB): University of Oslo; 2023 [updated January 202Available from: https://www.ssb.no/en/befolkning/befolkningsframskrivinger/artikler/a-probabilistic-forecast-of-the-immigrant-population-of-norway/_/attachment/inline/a81d8e55-6486-4086-8e91-7e9dad204176:9d51113a606286e18ae348db4198303f6d86782c/DP996_web.pdf.
[4] Sellevold VL, Hamre LL, Bondas TE. A meta-ethnography of language challenges in midwifery care. Eur J Midwifery 2022;6:41.
[5] Wikberg AM. A theory on intercultural caring in maternity care. Scand J Caring Sci 2021;35(2):442–56.
[6] Bains S, Skråning S, Sundby J, Vangen S, Sørbye IK, Lindskog BV. Challenges and barriers to optimal maternity care for recently migrated women - a mixed-method study in Norway. BMC Pregnancy Childbirth 2021;21(1).
[7] Bohren MA, Berger BO, Munthe-Kaas H, Tuncalp O. Perceptions and experiences of labour companionship: a qualitative evidence synthesis. Cochrane Database Syst Rev 2019;3(7):CD012449.
[8] Klaus MH, Kennell JH. The doula: an essential ingredient of childbirth revisited. Acta Paediadrica 1997;86:1034–6.
[9] Helsedirektoratet. Endring i fødepopulasjon og konsekvenser for bemanning og finansieringssystem. IS-2895 Oslo: 2020 [Available from: https://www.helsedirektoratet.no/rapporter/endring-i-fodepopulasjon-og-konsekvenser-for-bemanning-og-finansieringssystem/Rapport%20om%20f%C3%B8depopulasjonen.pdf/_/attachment/inline/3435df20-ea13-4d9f-99ed-f711d6ffbe f0:51f3f1f4a94cd0893d94f09f3c7663d150ae61b0/Rapport%20om%20f%C3%B8depopulasjonen.pdf.
[10] Guðmundsdóttir EÝ, Gottfreðsdóttir H, Hálfdánsdóttir B, Nieuwenhuijze M, Gissler M, Einarsdóttir K. Challenges in migrant women’s maternity care in a high-income country: a population-based cohort study of maternal and perinatal outcomes. Acta Obstet Gynecol Scand 2021;100(9):1665–77.
[11] Viken B, Lyberg A, Severinsson E. Maternal health coping strategies of migrant women in Norway. Nurs Res Pract 2015;2015:1–11.
[12] Origlia Ikhilor P, Hasenberg G, Kurth E, Asefaw F, Pehlke-Milde J, Cignacco E. Communication barriers in maternity care of allophone migrants: Experiences of women, healthcare professionals, and intercultural interpreters. J Adv Nurs 2019;75(10):2200–10.
[13] Mehrara L, Young S. Health equity and universal provision in Norway: a case study. Nordic J Soc Res 2020;11(1):39–65.
[14] Small R, Roth C, Raval M, Shafiei T, Korfker D, Heaman M, et al. Immigrant and non-immigrant women’s experiences of maternity care: a systematic and comparative review of studies in five countries. BMC Pregnancy Childbirth 2014;14(1):152.
[15] Bains S, Skråning S, Sundby J, Vangen S, Sørbye IK, Lindskog BV. Challenges and barriers to optimal maternity care for recently migrated women - a mixed-method study in Norway. BMC Pregnancy Childbirth 2021;21(1):686.
[16] Mehrara L, Gjernes TK, Young S. Immigrant women’s experiences with Norwegian maternal health services: implications for policy and practice. Int J Qual Stud Health Well Being 2022;17(1).
[17] Bains S, Sundby J, Lindskog BV, Vangen S, Diep LM, Owe KM, et al. Satisfaction with maternity care among recent migrants: an interview questionnaire-based study. BMJ Open 2021;11(7):e048077.
[18] Balaam MC, Akerjordet K, Lyberg A, Kaiser B, Schoening E, Fredriksen AM, et al. A qualitative review of migrant women’s perceptions of their needs and experiences related to pregnancy and childbirth. J Adv Nurs 2013;69(9):1919–30.
[19] Leppala S, Lamminpaa R, Gissler M, Vehvilainen-Julkunen K. Humanitarian migrant women’s experiences of maternity care in Nordic countries: A systematic integrative review of qualitative research. Midwifery 2020;80:102572.
[20] Flerkulturell doula: Oslo University Hospital; 2020 [cited 2022 26.10.22]. Available from: https://oslo-universitetssykehus.no/likeverd-og-mangfold/flerkulturell-doula.
[21] Wikberg AM, Bondas TE. Lay voluntary doula caring for the childbearing woman and her partner. Int J Hum Caring 2021;25(1):60–73.
[22] Akhavan S, Edge D. Foreign-born women’s experiences of Community-Based Doulas in Sweden–a qualitative study. Health Care Women Int 2012;33(9):833–48.
[23] Haugaard A, Tvedte SL, Severinsen MS, Henriksen L. Norwegian multicultural doulas’ experiences of supporting newly-arrived migrant women during pregnancy and childbirth: a qualitative study. Sex Reprod Healthc 2020;26:100540.
[24] Schytt E, Wahlberg A, Eltayb A, Tsekhmestruk N, Small R, Lindgren H. Community-based bilingual doula support during labour and birth to improve migrant women’s intrapartum care experiences and emotional well-being–Findings from a randomised controlled trial in Stockholm, Sweden [NCT03461640]. PLoS One 2022;17(11):e0277533.
[25] Byrskog U, Small R, Schytt E. Community-based bilingual doulas for migrant women in labour and birth - findings from a Swedish register-based cohort study. BMC Pregnancy Childbirth 2020;20(1):721.
[26] Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol 2006;3(2):77–101.
[27] Kvale S, Brinkmann S. Interview[s] - learning the craft of qualitative research interviewing. 3rd ed. Oslo: Gyldendal Academic; 2015.
[28] Merry L, Clausen C, Gagnon AJ, Carnevale F, Jeannotte J, Saucier J-F, et al. Improving qualitative interviews with newly arrived migrant women. Qual Health Res 2011;21(7):976–86.
[29] Berman RC, Tyyskä V. A critical reflection on the use of translators/interpreters in a qualitative cross-language research project. Int J Qual Methods 2011;10(2):178–90.
[30] Akhavan S, Lundgren I. Midwives’ experiences of doula support for immigrant women in Sweden–a qualitative study. Midwifery 2012;28(1):80–5.
[31] WHO recommendations: intrapartum care for a positive childbirth experience: WHO; 2018 [updated 07.02.18; cited 2022 26.10.22]. Available from: https://www.who.int/publications/i/item/9789241550215.
[32] Bondas TE, Wikberg AM. Becoming a voluntary doula: personal and caring motives. Int J Childbirth 2018;2:101–14.
[33] Lucas L, Wright E. Attitudes of physicians, midwives, and nurses about doulas: a scoping review. MCN Am J Matern Child Nurs 2019;44(1):33–9.