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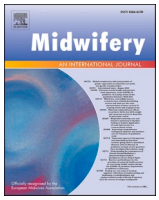

Paradoxes in the cultural doula concept for migrant women: Implications for gender-inclusive care versus migrant-friendly maternity care☆

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ABSTRACT

Objective: Swedish healthcare policies promote gender equality, shared parenting and cultural diversity. In response to the risk of adverse outcomes for migrant women, cultural doulas were introduced as support for migrant women during pregnancy and/or labour. The aim is to investigate potential tensions in the cultural doula concept in relation to policies of gender equality and diversity.

Design: An interview study was designed to analyse perceptions of the cultural doula concept among healthcare providers in Swedish sexual and reproductive healthcare. Through the framework of Bacchi's approach 'What Is the Problem Represented to Be?' and Hochschild's concept of 'global care chains', we analyzed whether the introduction of the cultural doula concept is in line with the policies of gender equality and culturally sensitive care by exploring paradoxes, unintended consequences and what was not reflected upon.

Setting and participants: Semi-structured interviews ($n = 18$) with midwives and obstetricians at hospitals in two Swedish counties during 2022.

Measurements and findings: The interviews were analyzed through thematic analysis. Cultural doulas were perceived as multi-tasking resources for facilitating integration and providing healthcare information and psychosocial support. Respondents did not identify doula support as a cultural practice in migrants' origin countries. Despite awareness of cultural differences in gender norms, many respondents stated that doula support included male partners.

Key conclusions: The cultural doula concept includes paradoxes in relation to gender equality and diversity. Rather than empowering migrant women, the cultural doula concept is related to gendered patterns of low-educated, underpaid care work. Labour support interventions including migrant women's social network and intensified partner involvement would be more in line with Swedish policies of gender equality, shared parenting and cultural sensitivity when needed. However, doulas may be an imperfect solution for women lacking partners or social networks, for example, newly arrived migrant women, if no support is to be found within the perinatal care system.

Implications for practice: Midwives and obstetricians need reflexivity about what the problem is represented to be when it comes to gender equality and cultural sensitivity in their collaboration with cultural doulas, boundaries between roles, how they handle confidentiality, and why cultural doulas are needed in relation to migrant women's integration.

Introduction

Sweden is recognized for having one of the world's strongest universalist and gender-equal welfare systems (Blomqvist and Palme, 2020). The image of Sweden as modern and gender-equal, often referred to as 'Swedish exceptionalism' (Martinsson et al., 2016), has regularly been reproduced through the Inglehart-Welzel cultural map (World Values Survey, 2020), confirming that Swedes express some of the world's most egalitarian and liberal values. This is also reflected in Swedish policies, which is permeated by the gender mainstreaming

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approach (SKR 2016/17:10; The Swedish Secretariat for Gender Research, 2020). Gender mainstreaming is the ambition to incorporate gender perspectives into regulatory measures, spending programs and policies (EIGE, 2019), including policies regarding maternal and reproductive health. For example, Swedish midwives are expected to promote equality between women and men (The Swedish Association of Midwives, 2021).

Sweden has a diverse population with an estimated 20% foreign-born residents (SCB, 2022). Since the 1990s, many migrants have immigrated from countries where support for egalitarian values is lower than in Sweden (Kostenko et al., 2016; World Values Survey, 2020; SCB, 2022). Sweden has embraced multiculturalism as a political idea and integration policy (Prop, 1997/98:16), which holds that cultural diversity should be publicly recognized and that minority groups should be protected from discrimination (Borevi, 2014; Wickström, 2015). Accordingly, the Swedish healthcare system promotes and protects diversity through a cultural relativist approach to transcultural care (Arousell, 2019; Handbook for Healthcare, 2022). A cultural sensitive approach to healthcare includes being curious and respective of different customs, habits and traditions, which in turn might impact healthcare seeking behaviour (Arousell and Carlbom, 2016). However, Kleinman and Benson (2006) raise the concern that the concept of 'cultural competence' stems from the equating of culture with language and ethnicity. Cultural competence thus becomes a toolkit, or "a series of do's and don'ts" for clinicians on how to treat individuals with a given ethnic background, which contrasts the anthropological understanding of culture, as something dynamic contingent upon multiple factors (Kleinman and Benson, 2006). In this study, we use the term cultural sensitivity to refer to the ways in which healthcare providers (HCP) take into account and respect habits, traditions and values that migrants bring from their countries of origin, and in its most extreme form respect the culture of origin regardless of whether it conflicts with the norms of the host country.

Sweden has one of the lowest perinatal and maternal mortality rates in the world, with the maternal mortality risk at 4/100,000 births in 2017 (WHO, 2019). Yet, migrant women from low-income countries are identified as risk groups for maternal and perinatal mortality and morbidity (National Board of Health and Welfare, 2016). Refugees from sub-Saharan Africa (SSA) have the highest maternal and perinatal mortality and morbidity, both in Sweden (Essén et al., 2000; Esscher et al., 2013; Wahlberg et al., 2013) and internationally (Small et al., 2008). Socioeconomic background factors, such as low-education levels and single-household and a higher burden of diseases such as eclampsia, tuberculosis and heart diseases, increase their vulnerability for adverse obstetric outcome (National Board of Health and Welfare, 2016). Perinatal and maternal audit studies have shown an increased risk of sub-standard care resulting in an increased risk for too late emergency c-section, higher risk for vaginal breach deliveries, severe post maturity, intrauterine growth restriction, low Apgar and lower chance for neonatal intensive care (Essén et al., 2002; Esscher et al., 2014). Hence, HCPs should be aware of the risks as parents from SSA are among the most common migrant groups giving birth in Sweden (SCB, 2022).

As a response to the risk of adverse outcomes for migrant women, cultural doulas, sometimes referred to as 'community-based doulas' (Schytt et al., 2020), have been initiated across Sweden. The term used for these doulas differ between counties, either 'cultural doula' or 'doula and cultural interpreter' (Doula & Kulturtolk, n.d.; Region Uppsala, 2018). The introduction of cultural doulas in Sweden stems from local engagement by activists, and the NGO called 'Födelsehuset Doula & Kulturtolk' received governmental funding in 2008 for introducing doula support for migrant women (Tidigt Föräldrastöd, 2022). Several Swedish counties have since then implemented the cultural doula concept. A cultural doula is defined as a non-relative support person without any healthcare degree, who herself has a migratory background and should be proficient in the birthing woman's native language. Cultural doulas are intended to provide 'culturally competent care' and act as a support person for birthing women, in addition to facilitating communication in a clinical setting (Region Uppsala, 2018; Doula & Kulturtolk, 2022). Integration promotion is one of the aims of cultural doula support (Region Uppsala, 2018). Cultural doulas undertake a minimal training of 48 to 64 h (local variations) that includes information about a huge variety of issues, such as anatomy, physiology, sexually transmitted infections, female genital cutting, pain relief, normal and complicated birth, the Swedish patient law, breastfeeding, in addition to strategies for providing continuous labour support (Region Uppsala, 2018; Schytt et al., 2020). The cultural doula is not a legitimized healthcare profession, and lacks labour regulation and supervision.

Continuous labour support has proven efficient in terms of improving some birth outcomes such as a decreasing the probability of having an instrumental vaginal birth (Bohren et al., 2017), in addition to improving the overall birth experience in non-migrant context (Lunda et al., 2018; Bohren et al., 2019). However, studies on the effects of cultural doulas do not show any significant results in terms of improving obstetric outcomes relevant for the well-known adverse outcomes among SSA women and their offspring (Byrskog et al., 2020; Schytt et al., 2022).

Swedish HCPs in reproductive healthcare meeting migrant patients in their daily work have to balance promoting gender equality and maintaining respect for cultural diversity, which might give rise to tensions (Arousell et al., 2017). Encouraging and fostering gender equality is part of the midwife's job (Arousell, 2019), but according to the International code of ethics for midwives, under which the Swedish midwifery complies, the job also includes the culturally relativistic ambition to "provide care for women and childbearing families with respect for cultural diversity" (ICM, 2014). This reflects a wider paradox within Swedish policy, in which respect for cultural diversity collides with the ambition of gender mainstreaming (Arousell, 2019). Hence, in this study, we investigate tensions in the cultural doula concept in relation to gender equality and diversity. We explore the following research questions:

1. In what way is the cultural doula concept in line with the policies of gender equality and culturally sensitive care?
2. What is the role of the cultural doulas according to HCPs, and what is left unproblematic?
3. Are there any unintended consequences of the concept of cultural doulas?

Methods

Design and conceptual framework

This is a qualitative study using semi-structured interviews. An interview guide was constructed based on previous research and clinical experience (see Supplementary material). It encompassed four broad issues relevant to the research questions: background and definition of the problem, labour support in Sweden, interprofessional dynamics, and evaluation.

We use Bacchi's (2016) WPR approach (What's the Problem Represented to be?) to investigate tensions in the cultural doula concept in relation to gender equality and diversity. We analyse how respondents reflect upon problems, what is left unproblematic in the doula concept, and effects or implications of doula support (cf. Bacchi, 2016). Our discussion is inspired by Hochschild's concepts of 'global care chain' and 'emotional labour' as a conceptual framework. Hochschild uses the term 'global care chain' to draw attention to the complex networks shaping the supply and demand for healthcare professions. Women from the global labour market are recruited to care professions to address resource shortages in the healthcare system (Ehrenreich and Hochschild, 2004). Inequalities are embedded in global care chains due to the low value placed on care work, and women usually do most of the paid

or unpaid care work, which sometimes is offered abroad due to marketization and globalization of care (Hochschild, 2014). Hochschild (2003) conceptualizes care work as 'emotional labour', which she defines as professions requiring the management of one's own emotions through emotional work one undertakes for others' wellbeing (Hochschild, 2003, p. 20).

Setting

This study explores the cultural doula concept in two counties in Sweden. In both counties, migrant women are offered doula support through maternity clinics. However, in county A, the cultural doula provides support before and after labour, whereas in county B, doulas also offer labour support. Although doulas' countries of origin are not specified in either county, the available languages are. County A has a primary focus on providing cultural doulas in Arabic, Tigrinya, Somali, and Dari (Region Uppsala, 2018), which are included in county B, with the addition of, for example, Persian, Mongolian, Russian, Spanish, Turkish, Ukrainian, and Urdu (Doula & Kulturtolk, n.d.).

Participants

18 respondents, 3 obstetricians and 15 midwives, were sampled based on having experiences of working with cultural doulas, either in a clinical, organizational or administrative role.

Data collection

We adopted a purposeful sampling strategy, combined with a snowball strategy.

Interviews were conducted both online and face-to-face from January through April 2022. Interviews lasted between approximately 30 to 90 min. All interviews were audio-recorded with permission, and respondents were given the choice to decide if the interview should be on-site or online.

Data analysis

We undertook a thematic analysis, inspired by Braun and Clarke (2006) six-step framework, which allows for rich description and flexible analysis of qualitative data. Initially, AB and MÅ transcribed all data verbatim. Thereafter, we coded the material using both latent and manifest codes, and identified arising themes and patterns in the data relevant to our research questions. Data were discussed and analyzed by all members of the group (AB, BE, LE, MÅ). Thus, intercoder reliability was ensured by frequent methodological and analytical discussions with the other group members, in addition to reading each other's coded material (Campbell et al., 2013). When translating the quotes from Swedish, we stylized them in order to facilitate for the reader.

Ethical considerations

The study obtained ethical approval by the Ethics Committee Board (registration number 20-01043). Written and verbal information was provided to all participants prior to their participation, stating their right to withdraw from the study at any time. Informed consent was obtained verbally by all respondents. All respondents were provided pseudonyms.

Findings

Culturally sensitive care – being curious and showing respect

The concepts of culture and culturally sensitive or competent care were described in various ways. Many respondents were not familiar with the concept of culturally sensitive care, but provided a spontaneous interpretation. Cultural sensitivity and cultural competence were defined as showing respect and consideration for other people's attitudes, traditions and ways of being in relation to their cultural background. However, when probed about the meaning of culture, and more specifically about the role of culture in the 'cultural doula' concept, several respondents mentioned that 'culture' was tied to different expectations of healthcare in general, and experiences of maternal healthcare in particular:

Yes, culture is a huge concept, but from our perspective it's mainly about childbirth, the birthing culture in their home countries. Since you carry with you so many preconceived notions about childbirth from growing up […] (Eva).

One of our respondents explained that culture entailed three different cultures: the Swedish culture, the culture of the women's origin countries and the birthing culture:

Well, culture in this context is both about the culture that the woman and the family come from, ehh, and the one they are in now, and the birthing culture […] So I would like to say that it's three different kinds of cultures that will meet (Maria).

Another respondent perceived culture in terms of information: "Well I have more translated it to knowledge about society […] Swedish culture, yes to receive information about our Swedish culture" (Johanna). Hence, cultural doulas were perceived to facilitate the uptake of information about Swedish maternity healthcare systems. A few respondents also equated culture with language in relation to the concept: "[…] the fact that they come from the same country or… speak the same language" (Sanna). In sum, culture in the doula concept was understood as the birth culture, and culturally sensitive care implied showing respect, knowledge, and interest for women's different cultural expressions.

Experiences of men's participation during childbirth

In relation to gender equality, our respondents discussed men's involvement in childbirth in various ways, which underscores the heterogeneity of their experiences of working with migrant families. While some described migrant partners being less active and engaged during birth, others emphasized that most partners do actively participate and provide support when their partners are in labour. Below Katarina, a midwife, provided her take on partner involvement:

We want to involve the partner as much as possible, and for the most part it works well. Because men of today are much more active. I can say that 10 years ago, male partners to women who came from … the Middle East, were much less active than today. […] So, I cannot say so clearly anymore that there are differences between different cultures there (Katarina).

Katarina pointed to changing patterns among the families she has met. Other respondents asserted that the fluctuating engagement in birth is not restricted to migrant families, but also occurs in Swedish families.

When discussing partner involvement, some HCPs highlighted the cultural ideals pertaining to childbirth in the families' origin countries, which subsequently might affect their expectations of birth companionship in Sweden. For example, Eva, a midwife, explained how different attitudes to childbirth could give rise to challenges in doula care:

[…] it is also challenging – the doulas sometimes say that. Because they say that families say "that in our culture men are not involved, that it is embarrassing and what women do and so" so… it is challenging sometimes (Eva).

Eva later stated that doulas play an important role in counteracting these gendered traditions and that she believed that doulas' and families' shared culture gives doulas an advantage in communicating the benefits of involving men in birth, which in turn might facilitate the uptake of the "Swedish" expectations on gender equality. While some of our respondents believed that doulas included partners during maternity care and childbirth, others underscored that this ambition was not

consistent with the families' local traditions. Thus, they claimed that many women prefer to give birth in the presence of other known women from their extended family: "[…] in relation to migrant groups, many choose to not bring their partner, they bring a female friend or sibling, or the husbands sister or whoever it might be" (Julia). Moreover, a midwife explained that some partners prefer not to be present during birth. This implied that she took a more flexible approach to the ambition of shared parenting: "And there are incredible gains with it, but you cannot force someone who feels uncomfortable, then there will be setbacks" (Selma). On the contrary, one respondent expressed concerns that the partners might become excluded from the birth as a consequence of doula support. Another midwife stated:" […] But it's my feeling that they [doulas] often become like an extra mother, and then I often still think that the partner maybe ends up a bit more on the side than during a normal birth" (Stina). Similarly, a few respondents said that there are certain groups of women in which doula support is more common, for example if the woman's partner is poorly integrated into Swedish society, or cannot communicate properly in Swedish or English, or, as midwife Sigrid explains, when the partner simply is uninvolved in childbirth:

[…] I often don't meet the person who will be the father to the child, he's not involved in the pregnancy and as long as there is no baby outside the belly, […] I would say that it's often in that group, that you would like to have a cultural doula, that the mother says yes to a cultural doula (Sigrid).

However, since in one county, doulas meet pregnant women beyond the maternity clinic without the presence of midwives, several of our respondents lacked information about cooperation between doulas, women and their partners, described by midwife Lova as a glitch: "However, we don't meet the cultural doulas, so that's the glitch, in my opinion, kind of. We use their time and knowledge, but I have never met them personally" (Lova).

The doula role – multitasking and promoting integration

Many respondents talked about cultural doulas as extra support, which they described diversely as promoting integration as well as practical matters such as buying diapers. Eva, for example, mentioned that the doula could assist women with transportation, despite not being part of the doula role:

There are doulas that like… themselves give women rides here and there when they're vulnerable and exposed alone and don't have the means. It's not a part of the doula's role, but we know that there are some doulas that choose to do it on their free time. Because they feel committed and like they want to. But it's not a part of their job tasks, either to transport the women to the delivery ward or to other appointments (Eva).

Similarly, midwife Martina explained that doulas could help with practical matters for newly arrived migrant women:

We cooperate a lot even if we don't meet, I'm thinking primarily of a woman that I have now, who has been really helped by the doula. When I first met her, I felt "wow, I'm going to have to put in so much time on this woman", she had so many questions about everything. But then she accepted the contact with the cultural doula, and she has received so much help with practical matters such as starting up a bank account, the Swedish Social Insurance Agency, applying for parental allowance, ID-card also. […] (Martina).

Helena, a midwife, confirmed the benefits of doula support in relation to The Swedish Social Insurance Agency: "And I've seen that the doulas have been a tremendous resource. Amongst other things, in relation to The Social insurance Agency, several of them [the migrant women] mention it" (Helena). Elin explained that integration is one of the goals of the project:

[...] the goal is integration of the women into society. It's not just to give them a safer birth, but it's one of the things, but primarily it's to integrate them in society and to give them a better life. That's what's been most important. And to identify them during pregnancy is easier than just going out in society. Because women are more receptive during their pregnancy (Elin).

A prominent way in which the HCPs perceived the doula concept to promote integration was by encouraging women and their doulas to visit the open preschool, a social resource for parents with young children under the age of five. This was emphasized as particularly relevant as it would expose the women to other social support measures:

Our goal in this, except that the women get a safer pregnancy, is that they locate the open preschool. The open preschool has a lot of education regarding relationships and children and those kinds of things. And the open preschool also arranges thematic workshops with both the maternity central, maternity care, and the social services, which the doulas have been involved in […] (Elin).

When discussing the doula concept, some HCPs described a strained working situation. A lack of time and staff, in addition to a heavy workload were presented as factors. Some respondents stated that the doulas mitigated these problems:

My impression is, and this is why I think this project is so very good, that the women have a need for extra support. And not just with language, but they need more information, explanation than what Swedish speaking women need, or other women who can make themselves understood in English. So I really think they managed to pinpoint a large problem, or rather, maybe it wouldn't have been such a big problem if we weren't so understaffed as we are, and we could provide the time and so on, but that's not the reality today […] (Stina).

Obstetrician Julia found that doulas were an improvement, because of "[…] an ethical and moral stress as staff to feel that you can't perform your work tasks because you feel that you can't get that contact, you feel you can't create the sense of safety that she [the woman] needs" (Julia). Respondents also shared problems associated with the usage of authorized interpreters. The right to a professional interpreter in contact with authorities is regulated by Swedish law (SFS 2017/900; Torkpoor et al., 2022). Nonetheless, logistical problems, such as not having an interpreter available throughout labour, or individual problems, such as the interpreter being male, or lacking medical vocabulary, were presented as obstacles to satisfactory interpreter usage. When Eva discussed the risks with communication barriers, she highlighted the benefits of using doulas to facilitate communication, yet she underscored that doulas are not interpreters:

But we know that during the moments, where there's been an interpreter during labour, it's during a very limited time. So, it's something else than having someone on-site that has the possibility to help with the communication. However, it's very important to say that our doulas aren't language interpreters (Eva).

To manage these diverse tasks successfully, several of our respondents emphasized the importance of doulas being emphatic and compassionate (Katarina, Maria, Lina, Sanna), open-minded (Magda), humble (Selma), having a positive attitude (Johanna) in addition to having a strong desire to support and make a change for these women (Maria, Lova, Karin, Lina, Stina). One respondent also mentioned that they should be service-minded: "[…] you are compassionate and willing to help, and maybe even a bit like, service-minded maybe (Lina).

Some respondents mentioned that doulas themselves benefitted from the project by acquiring a job, which was seen by some as empowering and positive for integration: "[…] the cultural doulas have by getting a job, so it's women that are also supported in their own integration process, which implies empowerment […]" (Maria).

The cultural doula and confidentiality

Not all respondents had reflected upon the matter of confidentiality. While some knew that doulas sign a secrecy statement, others assumed that they do, or did not know exactly how doulas handled matters of confidentiality. Katarina mentioned a difficult demarcation for doulas in relation to confidentiality, as they access the information that women chose to share with them, but are left out of medical discussions guarded

by confidentiality. Similarly, Maria expressed concerns that some language groups were rather small and that women might be reluctant to use doulas out of fear for deficient confidentiality or information leakage.

Summary of results

Table 1 illustrates how the analysis questions based on Bacchi's WPR approach were used to explore themes in the interview data and paradoxes in the cultural doula concept.

Discussion

Drawing on Bacchi's (2016) WPR approach we analyzed respondents' reflections on problems in relation to gender equality and diversity, including paradoxes, implicit framings of the doula concept and what was not reflected upon. The major findings include several paradoxes in the cultural doula concept in relation to perceptions of gender equality, cultural diversity and the doula role. The first paradox is that respondents represented cultural doula support as 'culturally sensitive care', even though no one could link doula support during birth as a cultural practice in the migrants' countries of origin. HCPs' understanding of culturally sensitive care included showing respect and regard for other people's backgrounds and that culture in the doula concept was tied to the birth culture, in addition to different expectations and experiences related to healthcare.

The second paradox was found in relation to gender equality. Respondents were aware of different cultural norms pertaining to gender roles and birth. However, many still supported the cultural doula concept by being convinced that doulas made effort to include men. Hence, there is a gender paradox in the cultural doula concept by implementing an intervention involving a woman unfamiliar to the family instead of an intervention involving intensified gender-inclusive parental support, or including the extended family, for example, mothers or sisters participating in the birth – a practice well known in SSA. In several low-income countries in SSA, such as Somalia and Tanzania, women generally give birth in the presence of sisters, mothers, or other from their extended families (Wiklund et al., 2000) and giving birth is considered to fall within the female domain (Påfs et al., 2016). Doula support is primarily a western, middle-class service (Steel et al., 2015; McCabe, 2016; Bohren et al., 2017). Hence, supporting a strong social network for migrant women might be a more culturally sensitive approach than cultural doula interventions.

The third paradox concerns expectations on the cultural doula role and on what doulas may achieve. Respondents portrayed doulas as multitasking resources for facilitating integration and handling everyday practical matters. However, respondents did not present cultural doula support as a way to reduce the well-known medical risks, the substandard care or the high burden of illness (Essén, 2001; Esscher, 2014), but focused on integration as a means of addressing underlying factors. Unlike Hochschild's conceptualization of global care chains, cultural doulas are not migrating for work. However, the cultural doula concept is related to gendered patterns of global care work. In contrast to some respondents' argument of the cultural doula concept as empowering migrant women working as doulas, it is embedded in structures for low-educated and underpaid care work offered to migrant women (cf. Hochschild, 2014). Hence, cultural doulas are expected to carry out multiple tasks by seen as ambassadors for Swedish culture, bridge-builders between the homeland's culture and Swedish culture, and by enhancing health literacy among migrants by interpreting differences between birth cultures and between health systems. Our results demonstrate that HCPs did not reflect on the imbalance between high demands and expectations on cultural doulas and their working conditions, lack of education and low salary. The results are supported by a study describing multi-tasking cultural doulas in Sweden, handling challenges relating to unclear division of roles, insufficient education, lack of boundaries, insecure working conditions, and being underpaid, which negatively impacted the doulas' work satisfaction (Lindgren et al., 2022). Although HCPs and doulas are satisfied with their collaboration according to some studies (Akhavan and Lundgren, 2012; Ström et al., 2021), another study reported doulas interfering with medical decisions (Schytt et al., 2020). Some respondents in our sample described the cultural doula task as emotional labour (Hochschild, 2003) by emphasizing the doula's management of her emotions by being empathetic, compassionate, humble, personally invested, positive, and willing to make a difference. Some of these abilities are central to person-centered care, but in addition, doulas are expected to be personally and emotionally invested, which leads to a difficult demarcation between being too personal, for example by projecting their own experiences onto the women, and not giving private advice on medical matters. Few respondents reflected on the implications of this difficult demarcation, for example in relation to confidentiality and secrecy.

Hochschild suggests that involving men in childcare would solve inequalities embedded in global care chains:

> A final basic solution would be to involve fathers in caring for their children. If fathers shared the care of children, worldwide, care would spread laterally instead of being passed down a social class ladder (Hochschild, 2014, p. 261)

Swedish midwives have an outspoken ambition to promote gender equality between women and men in accordance with Hochschild's suggestion above (The Swedish Association of Midwives, 2021). Most of our respondents presented their work with cultural doulas as including men. However, some respondents indicated that doulas might substitute or exclude male partners, and others had low awareness to what extent doulas involved partners. Lack of transparency might partly explain this low awareness. In one of the analyzed counties, HCP lacked knowledge

Table 1
Themes in the interview data and paradoxes in the cultural doula concept based on Bacchi's 'What's the Problem Represented to be?' approach.

WPR questions	Gender-inclusive care	Culturally sensitive care	Paradox
What's the problem represented to be in maternity care for migrant women?	Migrant women from low-income countries, lacking partners or social networks	Migrant women from low-income countries, with different cultural traditions, communication problems and lacking integration	Tensions between gender-inclusive care and culturally sensitive care
How is cultural doula support assumed to fix the problem?	Several respondents stated that doula support is gender-inclusive and empowers women	Respondents stated that cultural doulas promote integration and provide healthcare information and psychosocial support	Doula support was represented as culturally sensitive care despite not identified as a cultural practice in migrants' origin countries
What is left unproblematic in the representation of the problem?	Rather than empowering migrant women, the cultural doula concept is related to gendered patterns of low-educated, underpaid care work, or emotional labour	Intensified gender-inclusive parental support, or including the extended family, would be a more culturally sensitive approach	Despite awareness of cultural differences in gender norms, many respondents stated that cultural doula support included male partners
What are the effects or implications of the cultural doula concept?	Imbalance between expectations of what cultural doulas can accomplish and their working conditions, lack of education, and low salary	Addressing underlying problems though integration rather than reducing medical risks, substandard care, or the high burden of illness among migrant women	Expectations of multi-tasking emotional labour, resulting in difficult demarcation between being personal versus not giving medical advice and managing confidentiality

of interactions between cultural doulas and families, because they never met doulas, since doulas met migrant women privately outside the maternity clinics.

This notwithstanding, our respondents perceived the doula concept as a satisfactory way to increase the sense of security for the women and improve communication, which reasons with other qualitative studies of HCPs' experiences of cultural doula support in Sweden (Akhavan and Lundgren, 2012; Schytt et al., 2021). Hence, our results suggest that cultural doulas might be helpful particularly for migrant women who lack a strong social network. However, these experiences have not been confirmed to impact adverse obstetric outcomes (Byrskog et al., 2020; Schytt et al., 2022), particularly among migrants from SSA (Essén et al., 2002; Esscher et al., 2014; Wahlberg et al., 2013). The utilization of competencies and social resources, including social services and child healthcare, was considered a strength of an extended postnatal home visiting program in the Swedish multicultural city district of Rinkeby-Kista, demonstrating positive experiences among both parents and staff (Marttila et al., 2017; Tiitinen Mekhail et al., 2019). Hence, instead of integrating a multi-tasking cultural doula in the chain of referral levels, we suggest intensified cooperation between HCPs and families to reach better birth support outcomes.

Clinical implications

The study can be used to increase reflection on unintended consequences of doula support for migrant women, and to better address the complexity of adverse obstetric outcomes among foreign-born women. The study underlines the importance to gain knowledge from randomized controlled trials before implementing diversity in caring programs. Solutions for the sake of diversity risk otherwise to generate unanticipated health consequences and reproduce further gender inequalities. The study reminds us not to shift responsibility for complex social and medical situations to cultural doulas without medical training. Further reflexivity is needed about when cultural sensitivity is helpful. For example, is it proper to impose foreign gender-inclusive policies on migrant women's maternity care, which might contrast with Sweden's gender-inclusive policies?

Strengths and limitations

A possible limitation was the differences in cultural doula practices between the two counties, since one county did involve the doulas in antenatal and postnatal care, but not during labour, while the other county involved doulas continuously before, during and after birth. A strength of the study was that we interviewed HCPs in different roles, collaborating with doulas in varying settings, who nevertheless gave similar answers. Our data constituted rich descriptions of HCPs' experiences of collaborating with cultural doulas. However, the respondents in an administrative role lacked experience of collaboration with cultural doulas in a clinical setting, despite frequent contact with the doulas. As an interdisciplinary project group including a senior obstetrician and sociologists, we managed to explore multiple aspects, bringing forth novel findings by situating the doula concept in a policy context.

CRediT authorship contribution statement

Birgitta Essén: Conceptualization, Formal analysis, Funding acquisition, Methodology, Resources, Supervision, Validation, Writing – review & editing. **Lise Eriksson:** Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Writing – review & editing.

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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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2023.103805.

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