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A qualitative study on community-based doulas' roles in providing culturally-responsive care to migrant women in Australia

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ABSTRACT

Background: There is limited exploration into how culturally-responsive care may be provided to migrant women through community-based doulas.
Aim: We aim to explore the roles of community-based doulas in providing culturally-responsive care to migrant women in Australian maternity settings, from the perspectives of maternity care providers and doulas.
Methods: We used an interpretive phenomenological qualitative approach with in-depth interviews with 30 maternity care providers and Birth for Humankind doulas, in Victoria, Australia. All interviews were conducted over video-call and inductive thematic analysis was performed using NVivo software.
Findings: Doulas were seen to support and enhance migrant women's maternity care experiences through numerous ways, strengthening cultural-responsive care provision. There were three domains which described the role of doulas in providing migrant women with culturally-responsive care: 1) enhanced care; 2) respectful care; and 3) supportive relationships with providers. The three domains included seven themes: 1) continuous individualised support; 2) social connectedness; 3) creating safe spaces; 4) cultural facilitator; 5) non-judgemental support; 6) enhancing communication and rapport with providers; and 7) making connections.
Discussion: Doulas appeared to counter negative factors that impact migrant women's maternity care experiences. Doulas with previous professional birth support qualifications and trauma-informed care training were equipped to create safe spaces and increase emotional safety for migrant women. Doulas may also have more responsibilities expected of them by providers when connecting migrant women with additional services in situations that may be missed through hospital care.
Conclusion: Birth for Humankind doulas in Victoria play an important role in providing culturally-responsive care to migrant women. Employment models may be the next steps in acknowledging their valuable contribution as a complementary service to maternity settings.

Statement of Significance

Problem

Migrant women have poorer maternity care experiences and outcomes than non-migrant women. There is limited research on how community-based doulas may provide culturally-responsive care to migrant women in Australia.

What is already known

Research has indicated that community-based doulas may provide culturally-responsive care to migrant women in high-income

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countries through shared language, cultural experiences, or by cultural facilitation in maternity settings.

What this paper adds

Our study provides insights from doulas and maternity care providers into how Australian community-based doulas may provide culturally-responsive care for migrant women. We developed a novel conceptual framework depicting doula roles in providing enhanced care, respectful care and through supportive relationships with providers.

1. Introduction

1.1. Community-based doulas and migrant maternal health in Australia

Women from migrant and refugee backgrounds represent a growing proportion of maternity care users in Australia. The proportion of women who were born in a non-English-speaking country and gave birth in Australia has steadily increased from 18% in 2007 to 27% in 2017 [1]. Migrant women have poorer maternal and newborn health outcomes compared to non-migrant women, including poorer psychological well-being [2,3], higher rates of low birth weight and stillbirth [4,5], and more negative childbirth experiences [6]. A recent qualitative evidence synthesis of migrant women's experiences of Australian maternity care highlighted barriers in communication and language; limited access to interpreters; discrimination; limited provider understandings of cultural practices; and tension between dominant Australian and other cultural healthcare practices that impact migrant women's maternity care experiences [7]. This review and a recent qualitative study identified factors enhancing migrant and refugee women's maternity care experiences including: midwifery continuity of care models [7,8]; trauma-informed care practice through building rapport, empowerment, and safety provision [7]; and culturally-responsive maternity care [7,8].

Culturally-responsive care is care that is respectful of an individual's cultural traditions, values and needs [9,10]. Culturally-responsive care is derived from the term 'cultural safety,' which was developed by First Nations Maori peoples in New Zealand as a response to health inequity [9,11]. Cultural safety is recognition of one's own culture and others' cultural differences and acceptance of others' and your own background and cultural differences [12]. A potential strategy to facilitate culturally-responsive care is support throughout pregnancy, childbirth, and postnatally from community-based doulas [13]. Community-based doulas are doulas who are trained in providing continuous emotional, physical, and social support throughout each stage of a woman's pregnancy, labour, birth and postnatal care experiences [14]. These doulas may share the cultural and/or racial backgrounds as the women they support, and/or provide their services to clients experiencing financial disadvantage [15,16]. Continuous support in labour and birth from a doula has a positive impact on duration in labour, risk of caesarean births and childbirth experiences [17]. A recent systematic review found that community-based doulas provided continuity of care and culturally-responsive and respectful care across the childbearing continuum for migrant women in high-income countries [14]. Despite these important benefits, there is limited research exploring Australian community-based doulas services or how culturally-responsive care may be provided.

1.2. Birth for Humankind

Birth for Humankind is the only Australian community-based volunteer doula program which has provided free doula support for underserved communities in Melbourne, Victoria since 2014 [18]. Each client receives support from a doula throughout their pregnancy, labour and birth and postnatal periods [18]. Extended postnatal care for up to 12 weeks is also available, as well as support through all pregnancy outcomes including third trimester abortions [18]. In the financial year of 2021–2022, 105 clients received doula labour and birth support [19]. To be eligible for doula support, clients must be experiencing financial disadvantage, with many also having no birth support person (81%), mental health challenges (56%), family violence or trauma (63%), homelessness (21%), and young age (19%) [20]. Newly arrived migrant and refugee women represented approximately 29% and 26% of Birth for Humankind clientele respectively in 2021–2022, with 56% of clients' primary language not being English and 32% of clients' requiring an interpreter [20]. Most clients are referred to the service from public maternity hospitals [20]. Birth for Humankind doulas are volunteers, and typically midwives, midwifery students, private practising doulas or student doulas from the Birth for Humankind Foundational Doula Training course [21]. In 2020, Birth for Humankind initiated a Doula Training Scholarship Program for bicultural people, aiming to recruit and train people from different cultural and linguistic backgrounds as doulas [22]. Bicultural doulas of the service includes people who have experience with one or more other cultures, which in this context is typically people from migrant or refugee backgrounds and Indigenous people.

Due to the emerging bicultural doula workforce, migrant and refugee clients are often matched with non-migrant doulas [18]. All volunteers receive Birth for Humankind doula induction training and learn about the expectations required of them, as governed by the service's Doula Code of Practice. Their training also includes trauma-informed care to understand how trauma can impact their client's lives, their requirements and engagement with services based on their histories [19].

1.3. Rationale for this study

While the benefits of doula support are well established [17], there is limited research on the role of community-based doulas in providing culturally-responsive care for migrant women in Australian maternity settings. Recent findings from a realist evaluation of the Birth for Humankind service reinforced that cultural matching may not be necessary to provide culturally-responsive care [23]. Rather, doulas who were deemed culturally safe by clients, were perceived as dedicated and reliable in establishing trust [23]. However, there is limited insights from providers themselves. Therefore, the aim of this study is to explore the roles of community-based doulas in providing culturally-responsive care to migrant women in Australian maternity settings, from the perspectives of doulas and maternity care providers.

2. Methods

2.1. Qualitative approach and paradigm

We conducted a qualitative interpretative phenomenological study using a social constructivist epistemology and interpretative phenomenological approach. These theoretical perspectives acknowledge that multiple realities exist, and this was useful in conceptualising the role of community-based doulas in culturally-responsive care [24,25]. This study is reported accordingly to Standards for Reporting Qualitative Research (SRQR) (Supplementary material 1) [26].

2.2. Study context and sites

There were two settings in Melbourne, Victoria, Australia involved in this study: Birth for Humankind and a tertiary maternity hospital which specialises in higher acuity of care. These settings were chosen given the diverse clientele accessing these services, including migrant women, with the hospital setting being the largest referrer to the doula service. The research team engaged in key stakeholder meetings with

representatives from Birth for Humankind and the hospital during study design, implementation, analysis, and dissemination.

2.3. Study participants, sampling and recruitment

We included four types of participants: Birth for Humankind doulas, hospital-based healthcare providers (midwives and doctors), social workers, and organisational managers. We aimed to recruit 30–40 participants using different recruitment strategies: in-person recruitment conducted at the maternity hospital; email recruitment sent by Birth for Humankind program managers and support officers; snowball sampling; and purposive sampling through email recruitment to relevant providers from management and casework positions. Interviews were conducted in English, and all participants consented to being audio-recorded. Interviews lasted 35 – 100 min in duration. Participants were offered a $40 gift card for their participation (one declined). Recruitment ended once data sufficiency [27] was reached and participant group recruitment exhausted.

2.4. Data collection and management

Semi-structured Zoom video-call interviews were conducted online by the lead researcher between June 2021 and July 2022 to comply with the COVID-19 pandemic enforced restrictions in Victoria, Australia. Interview guides were informed by the socioecological model of health to explore factors across individual, interpersonal, organisational and systemic levels [28]. The interview guides (Supplementary materials 2, 4, 3 and 5) were pre-tested with two midwives and a doula, and revisions were made and reviewed by the research team. Digital audio recordings and written data were stored within a password-protected cloud-storage.

2.5. Data analysis

After each interview, reflexive notes were recorded and transcribed. The interviewer transcribed all interviews with the assistance of Otter.ai transcription software [29]. Participants were offered the opportunity to member-check their interview transcripts and review the accuracy of their interview, provide clarification, edit or delete if necessary [30]. Nearly half of participants (n = 13) edited and the others did not. All participants were informed about their rights for participation and withdrawal from the study.

Thematic data analysis was used following a stepwise method prescribed by Braun and Clarke using a range of strategies to enhance rigor [31,32]. Data analysis approach occurred concurrently with data collection in which each participant group was interviewed separately to explore their realities and investigated themes were merged with other participant groups if required. The research team (MAB, CSEH, SA) and community-stakeholders (RED, KO) provided feedback during thematic analysis. Participants have been given pseudonyms and deidentified.

2.6. Ethical considerations

Approvals were received at the organisational and departmental levels, and ethics approvals were obtained from The University of Melbourne (Ethics ID Number: 2021–21783–18828–3) and from the Victorian maternity tertiary hospital (HREC/XXXXX/XXX-XX-XX). After expressing interest in participating, each participant received an electronic copy of the plain language statement and consent form and either returned an electronically signed copy of the consent form or provided verbal recorded consent before the interview.

3. Findings

Thirty people participated in interviews. Each had supported a migrant woman who had Birth for Humankind doula support in the past 24 months. Seven prospective participants were also contacted, but did not respond. The ethnic backgrounds of doula and provider participants were predominantly white Australian and due to the small sample size, other ethnicities will not be shared. Participant characteristics are shown on Table 1.

Table 1
Characteristics of participants.

	# of participants (n = 30)
Age	
20 – 29	11
30 – 39	11
40 – 49	3
50 – 65	5
Role/occupation	
Volunteer doula (bicultural)	1
Volunteer doula (non-bicultural)	9
Doula service manager	2
Registered midwife	11
Obstetrics and Gynaecology Registrar	2
Social worker	4
Maternity manager	1
Years of experience	
0 – 2	8
3 – 5	12
6 – 8	5
9 +	5

We mapped three domains depicting the role of community-based doulas in providing migrant women culturally-responsive care: 1) enhanced care; 2) respectful care; and 3) supportive relationships with providers (Fig. 1). The three domains included seven main themes: 1) continuous individualised support; 2) social connectedness; 3) creating safe spaces; 4) cultural facilitator; 5) non-judgemental support; 6) enhancing communication and rapport with providers; and 7) making connections. Fig. 1 depicts the intersecting nature of these main themes of culturally-responsive care which may also occur across other domains.

Domain 1: Enhanced care

Participants described migrant women often experienced complex intersecting identities and faced interpersonal challenges, such as differing cultural norms and difficulties navigating the Australian maternity system. Participants depicted migrant women's experiences of social isolation through their limited support networks, being newly arrived, cultural isolation, and being pregnant outside of marriage or a partnership was common. For example, one doula described:

> *(For) a lot of the migrant women, survival really is hard enough, and so they don't necessarily see birth as a rite of passage or a transformation that will help them step into motherhood. Doula 2*

Migrant women's experiences in navigating these complexities may be enhanced through community-based doulas providing continuous individualised, and known social support.

3.1. Continuous individualised support

Doulas provided continuous individualised support to women by ensuring their care would be 'person-centred,' (Doula manager 1). Participants expressed their physical presence and availability as examples of continuity of care which was highly valued by clients:

> *I find the women that I support … it's really just about not being alone and having continuity of care is the biggest thing I think for them….we're always there and they have access to us, pretty much 24 hours a day. Doula 5*

Continuity of care from doulas involved 'practical and emotional'

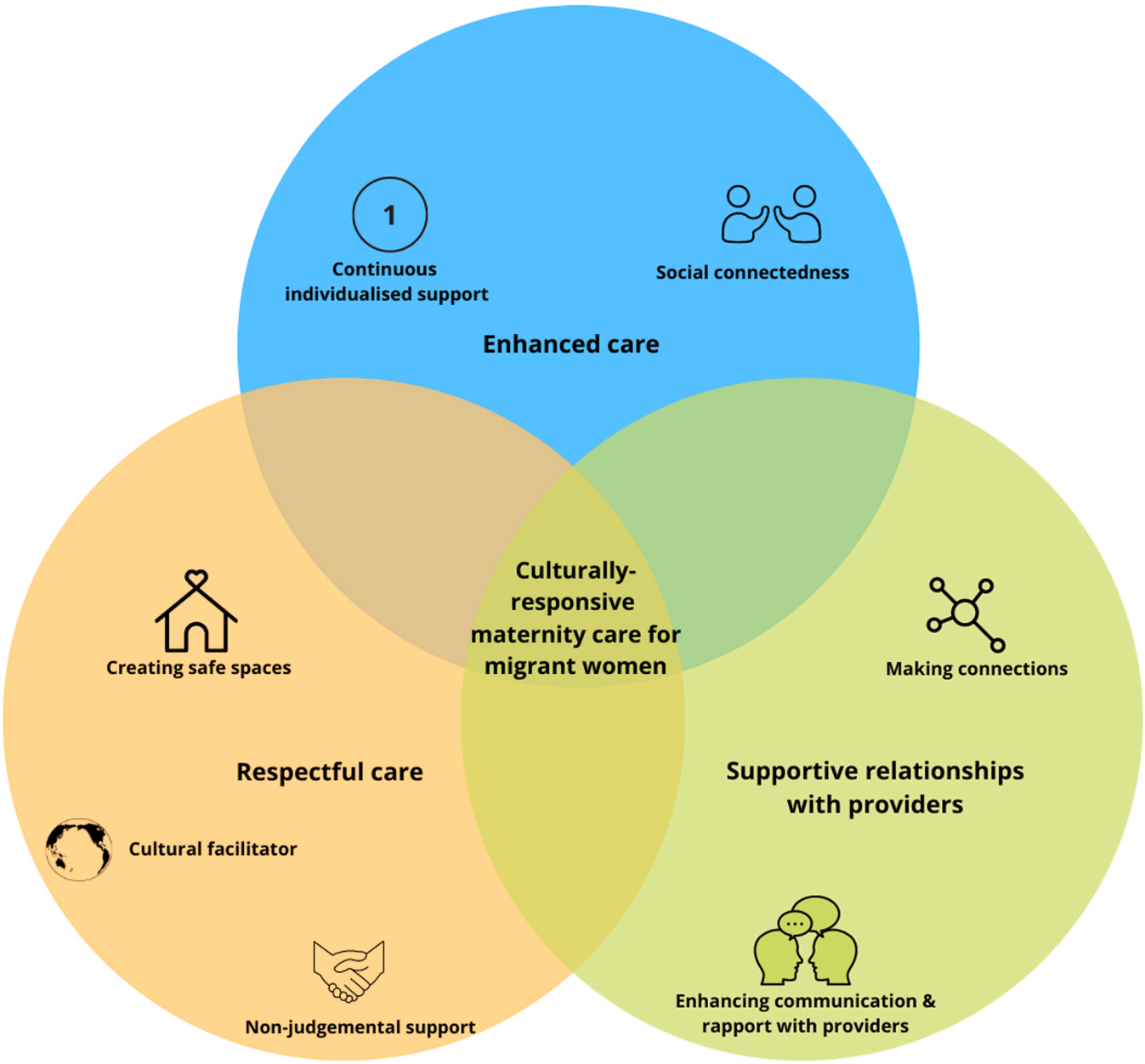

Fig. 1. Conceptual framework of how community-based doulas may provide culturally-responsive maternity care for migrant women.

(Midwife 2) and childbirth/perinatal educational support. Participants expressed without doulas, women received limited educational support due to time-constrained antenatal appointments or limited opportunities for cultural-specific education from hospitals. Doulas addressed these issues by providing 'more basic and more tailored' (Doula 2) educational support. The complex lives of some clients required an individualised approach to education. Participants described some clients as 'too overwhelmed with all other aspects that are going on in their life,' (Doula 10). These clients often had limited capacity to engage with education due to prioritisation of their own basic needs, such as insecure housing. Doulas demonstrated culturally-responsiveness through individualising educational support, in accordance with clients' needs.

3.2. Social connectedness

Doulas described themselves as the main support person for these women throughout their perinatal journey, as the women were often unpartnered and/or had limited other social networks. These personal doula-client relationships especially supported those women 'without any solid support around them' (Social worker 2) as women were able to 'meet someone and … build a relationship with them from really early on… to have that continued support,' (Social worker 2). This meant that doulas were able to enhance care through knowledge of their clients' needs and being more person-centred. In contrast, participants described limited opportunities for maternity services to provide continuity of care, partially due to hospital protocols, 'professional relationships (and) boundaries' (Midwife 5). The relationship between doulas and women often became stronger throughout labour and birth. As one doula demonstrated how her relationship changed when in labour and birth:

> *… in pregnancy it was a lot of effort to really communicate that I was there for her to support her… being with a woman through her labour and birth … completely creates that sense of trust and openness…I guess it really communicates to the woman that I'm really just there for her. Doula 6*

Doulas provided social support to these women who had limited social networks and this strengthened their social connectedness. The close relationships between woman and doula facilitated social connectedness and also a sense of belonging and confidence to engage with their community and other providers. The sense of trust and feelings of being heard by doulas enhanced newly arrived women or those with limited social networks own confidence in broadening these networks. As a doula described:

> *…it seems to really have a huge impact on their parenting and the way they interact with their community and their healthcare providers, they (can) ask questions … (have) positive associations with healthcare providers and support systems in this country. Doula 5*

Doulas established strong emotional connections and professional boundaries with clients which reinforced the challenges and responsibilities in ending the 'intensely intimate' (Doula 3) relationships particularly with women from 'refugee backgrounds…(because) the finishing has never been done,' (Doula 3).

Domain 2: Respectful care

Participants shared that many women who received doula support have experienced different forms of trauma such as family violence, trauma related to migration and displacement or sexual trauma. As a doula discussed:

> *I know a lot of women have had very difficult lives before moving overseas to Australia, or have had to make a very difficult decision and leave important family members and friends or lives overseas. Doula 8*

These complexities highlighted the need for a nuanced approach in ensuring migrant women experienced respectful care. Doulas in this study engaged in culturally-responsive strategies to provide respectful care by creating safe spaces, acting as cultural facilitators for providers and providing non-judgemental support.

3.3. Creating safe spaces

Most doulas described the importance of supporting women through pregnancy to ensure their emotional safety in labour and birth. The pre-existing relationship between doula and woman enhanced this level of safety and rapport between each other in which they find a 'space where it's quite powerful … (and) seeing the power trust can bring to the surface' (Doula 9) often leads to better birth experiences for women. This involved doulas planning a trauma-informed approach to manage potential triggering events as identified by women themselves. Many doulas expressed that labour and birth and particular interventions, such as vaginal examinations, often triggered the trauma responses. These interventions often required a trauma-informed care approach. An example is a woman's story of her mother's stillbirths she disclosed in early labour. Here the doula shared her reaction and actions to the trauma response:

> *…I was shocked that was coming out now…"Oh no wonder why you're full of fear and survivor's guilt"… (she) didn't want her baby to die… I repeated that there was a lot of doctors outside because she did often ask who's a doctor…and we just cried a lot about her mum… and repeating, "Yeah, that sucks. That's really sad and unfair."* Doula 9

Doulas also advocated to providers for their clients' preferences to manage trauma responses in labour and birth, where some providers themselves take a trauma-informed care approach. For example:

> *…because the doctor was talking to me, "What can we do here?" … I said, "Every shift a doctor's coming in here …'I need to know what's going on,' and they haven't built up rapport," … she came three times and sat on the side of the bed and chatted… And then the fourth time, she came back and had that conversation… she realised this young woman … was holding hands with her. she had built up the trust even in the one shift.* Doula 3

During labour and birth, doulas explained their role as 'holding the space' by providing a sense of emotional safety for women. 'Holding the space' meant being emotionally and physically present to support clients and ensure 'they're safe and they've got someone on their side' (Doula 1) advocating for their safe experience. As a doula expressed:

> *I think having that strong relationship in pregnancy is really what makes the labour and birth so special in the way that you don't necessarily have to do anything in particular or holding space and having that person there to share that glance with or share that look with you to be like, "Everything's okay. You're in control," works wonders. Doula 1*

The emotional security provided by the doulas may promote and enable positive birth experiences. Some providers perceived the role of the doula being external to hospital as integral in prioritising clients' needs rather than the hospital's in 'helping them feel safe and knowing that somebody's got their back' (Midwife 10) which 'creates confidence, empowerment and birth outcomes for the better because people relax," (Doula 4).

3.4. Cultural facilitator

Doulas valued learning about the women's cultures and traditions which supported their roles in being cultural facilitators. Doulas' respect and interest in learning about their client's culture demonstrated a cultural knowledge exchange. A doula shared positive feedback from one client:

> … even though I wasn't from her cultural background… I was still trying to really understand and ask those questions… "Why is that not accepted in your culture?"… she really appreciated being able to talk about all of that in a respectful space. *Doula 10*

Similarly, some providers observed bicultural doulas especially enhanced women's experiences in labour through shared culture or language as 'it's nice to speak your mother tongue," (Midwife 2). The majority of doulas in this study were not matched on language or cultural similarities which reflected the general experiences of many participants interacting with non-matched doulas. Doulas could still provide culturally-responsive care by supporting women's individual cultural needs and preferences in labour. This often involved pre-work and discussions during pregnancy. As one doula recounted:

> *… we have practiced how I'm going to massage her back … and the prayers that she's going to want so we had a really specific playlist and I had the (religious) icons that she wanted to see at certain times on laminated cardboard … and the two midwives that I had upon rotation were on board with me being an expert on that. Doula 9*

Despite not being culturally-matched, clients highly valued the role of the doula and felt doulas were 'genuinely there for them not to serve any other purpose, and that they're able to find some kind of common ground,' (Doula manager 1). Similarly, many providers found that doula support as beneficial in helping them to express, understand and implement women's cultural preferences or needs in labour and birth. This was particularly beneficial in providing culturally-responsive care when there were no pre-existing relationships established between women and provider. Some midwives found doulas as essential during circumstances when women had limited means to voice their preferences due to the process of labour or limited English by 'not speak(ing) for her, (but) speak(ing) on behalf of her,' (Midwife 9).

3.5. Non-judgemental support

Doulas' abilities to provide non-judgemental support for clients and for providers demonstrated respectful care. Most participants perceived doula's roles in non-judgemental support as supporting and advocating for what women want and 'not to be someone to be pushing a decision or trying to make a decision on behalf of the woman,' (Midwife 6).

Providers appreciated non-judgemental support, particularly those who had previous negative experiences with more 'obstructive' (Doctor 2) doulas and other birth support persons. Provider receptiveness to Birth for Humankind doulas' roles in non-judgmental support may be related to the service's Doula Code of Practice. Doulas were expected to work within the responsibilities and boundaries of the 'doula framework rather than through their past professions and experiences,' (Social worker 2). Likewise, although some doulas did not agree with their client's decisions, they continued to exercise non-judgemental care in their practice by respecting their choices. As a doula described:

I step back because it's her relationship with health providers. But my view is understanding 100% behind that woman supporting what she wants, so even if she's making decisions that I wouldn't make … the whole point of the exercise is to support her power, her decision-making, support her choice. Doula 4

As this reflection demonstrates, doulas understanding the importance in supporting their clients' decisions in facilitating informed consent and empowerment exhibited non-judgemental care.

Domain 3: Supportive relationships with providers

Most participants expressed communication and language barriers due to limited interpreter services as limiting providers' abilities to 'build rapport' (Midwife 9) with non-English speaking migrant women. Similarly, some providers reflected on the often inflexible approach to maternity care being detrimental to providing culturally-responsive care. As a midwife highlighted:

… in the normal standardised public midwifery care, it's may be a little bit inflexible towards the extra needs of people from migrant backgrounds. For example, often they have a language barrier requiring an interpreter and there's not necessarily more time enabled for communication which is really rough. Midwife 11

From our study, participants observed community-based doulas potentially addressed a number of barriers to culturally-responsive care in the maternity care system by strengthening migrant women's relationships with providers through: enhancing communication and rapport and making connections to other services.

3.6. Enhancing communication and rapport with providers

Doulas' pre-existing relationships with clients enabled them to share their client's communication needs with providers. Doulas enhanced communication for their clients, by advocating for in-person or phone interpreters, using Google Translate or providing language support as bicultural doulas. A doula manager explained the importance of this doula-client dynamic:

…if language is a barrier, then it's appropriate for you to advocate for an interpreter so that they can speak for themselves and to know where is that line where somebody has a level of English language competency… but then they get into a clinical situation and they don't really understand what's going on. And the doula is the only one who notices that because the doula …actually knows that person. Doula manager 2

Doulas acted like 'a bridge' (Midwife 2) enhancing communication between providers and clients in cases where interpreters were not used. Doulas explained information from providers to clients that was understandable particularly during labour and birth. The established doula-client relationship and doulas' ability to enhance communication when their client was unable to reinforced this dynamic. A midwife expressed relief from this relationship:

…if I can't speak their language, they can't speak mine. I feel a little bit panicked…whereas I feel the doula was that bridge … if the doula was calm and comfortable and not threatened by me, I felt the woman wasn't as threatened or scared… there was a few things I could ask the doula that she (migrant woman) didn't have to answer - she could just focus on her labour. Midwife 10

Doulas enhanced rapport between women and providers. The rapport established between doulas and women may contribute to women feeling confident and supported when engaging with providers. Similarly, providers developed rapport quickly with women who had a known doula particularly within emergency situations, as a midwife explains:

… we were in a situation where we had (to) expedite birth…the doula would essentially repeat what we'd said but say it in a way that she might understand … what was really helpful having the doula there who knew her to say, "No, it's okay to do what this midwife says, everything's going to be fine," and just more inclined to believe her than me. Midwife 8

3.7. Making connections

Doulas were the ongoing familiar presence for women through their maternity care experiences. This contrasted the different providers and multiple support services women engaged with at the hospital and within the community. Doulas had more of a comprehensive and holistic understanding of their clients lives which benefited the health care team. Their roles extended to also making connections between multiple services, as a doula described:

I'm a bit of glue … because our clients are so complex they'll have … all sorts of other workers involved… a lot of those services don't communicate with each other very well… because I'm the one who's only with the client and my only job is the client…I'm the one who can kind of connect the dots for everybody else who's not communicating properly. Doula 10

Doulas' roles in liaison and continuity complemented other providers who are 'not there for the birth' (Social worker 3) as it 'minimises (their) role' (Social worker 3) in integrating them with support and social networks. Doulas also recognised the limitations in their scope of practice and engaged in escalating care to social workers or to their managers for further follow-up if required. As a social worker describes reviewing disclosures from doulas:

And I think it's good for them to know…what they can or cannot hold, because then it really puts boundaries about them….they care for women in a really holistic, psychosocial way. They're getting disclosures from women and obviously (it's) a really tough place for people to tell them things. Social worker 1

Some doulas explained at the end of their professional relationship they felt personally responsible to ensure their clients continued to receive support once they ceased contact. Doulas managed this by making referrals connecting clients to support services in the community. For instance:

… you've developed a really close relationship with someone who's had a lot of experiences of abandonment …that's why we always try really hard to set them up with other services before we leave and make sure they're hooked up with a mother's group. Doula 5

These findings show how community-based doulas provide culturally-responsive care for migrant women through enhanced care, respectful care and supportive relationships with providers.

4. Discussion

Our findings illustrate community-based doulas' and providers' perspectives and experiences in how doulas provide culturally-responsive care for migrant women in Australian maternity settings. Participants described the often complex lives of migrant women who experienced interpersonal challenges to positive maternity care experiences. This included experiences of social isolation, trauma, limited

continuity of care, barriers to communication and rapport building with providers, which resonates with existing literature from Australia [7,8] and other high-income countries [33–36]. Our study shows that doulas can help migrant women navigate the perinatal period by providing culturally-responsive care.

Doulas enhanced migrant women's maternity care experiences by providing individualised emotional and physical support tailored to women's individual needs. This aligns with existing research highlighting migrant women's desires for individualised care in Australia [7] and in other high-income settings globally [15,16,37–43]. Doulas also described creating a sense of social support especially for women who had limited social networks, which likewise complemented findings from other studies [15,16,37–40,42,43]. Social connectedness resulting from doula support may increase migrant women's confidence in parenting and engaging with the community and other providers [23].

A recent review on community-based doula support for migrant women posited that respectful care was established between doulas and migrant women through cultural facilitation and non-judgemental support [15,16,37–45]. Our study reinforced these findings and illustrated how doulas also provided safe spaces for migrant women, overall demonstrating that clients valued respectful care more than cultural matching alone. These findings were further supported by recent studies on doula care, including a realist evaluation of the Birth for Humankind service, in which migrant women and women of colour highly valued doulas who were not matched by shared language or cultural similarities [23,46]. Rather, women of colour valued doulas who were trustworthy, respectful and open in supporting their cultural needs and preferences [23,46]. Interestingly, our study also shows that Birth for Humankind doulas fostered the creation of safe spaces and provided emotional safety for women who have experienced trauma. This may be due to Birth for Humankind's requirement for doula volunteers to have professional trained birth support experience, such as being a midwife, private practising doula or have completed Birth for Humankind's Foundational Doula Training course. This requirement of professional training is unique to Birth for Humankind - recent review of community-based doula services for migrant women in other high-income countries showed that most services do not have any pre-existing training requirements for doulas [14]. These findings may reflect the unique space Birth for Humankind serves in providing culturally-responsive care to under-served women, who have multiple intersecting identities and complex social experiences.

Doulas were seen to create supportive relationships with providers and migrant women by enhancing communication and rapport between the two. This strengthened the recent review findings by Khaw et. al., (2022) of doulas' complementary roles to the maternity care team [14]. Additionally, our study demonstrated the responsibilities some doulas held in making connections for women who were engaged in multiple social and health services throughout their perinatal period. These doulas' roles were perceived as supportive to hospital-based social worker roles, whereby they escalated and referred women to social work when disclosures were made to them and were beyond their scope of practice, such as family violence. This finding highlights the precarious and complex roles doulas may take on when acting as the primary support person for their client and when hospital screening processes may have missed opportunities for additional support.

4.1. Strengths and limitations

There were several limitations of this study. While Birth for Humankind supports all women and gender diverse birthing persons accessing their service, this research focuses on experiences supporting migrant women. We chose to focus on support for migrant women to minimise potential duplication of study findings based on recent evaluation on Birth for Humankind which explored client's and doulas' perspectives. However, migrant women are not a homogenous group, with a wide range in sociocultural and religious identities, language, migration experiences, histories of trauma, and visa statuses. Another limitation was related to pandemic in-person visitor restrictions of birth support from 2020 to 2021 in Victoria, Australia, which impacted the ability of Birth for Humankind doulas to support women birthing during this time. To address this limitation, we expanded eligibility criteria for participants to have supported or provided care for a migrant woman via Birth for Humankind include the last 24 months. Lastly, video call interviews had some connectivity issues which may have impacted how participants and researchers developed rapport.

One of the study's strengths is this being the first study exploring how community-based doulas may provide culturally-responsive care for migrant women through multiple participant perspectives. Another strength was that SMK worked casually as a midwife at the hospital site during the pandemic and was able to conduct in-person recruitment of prospective participants when working shifts at the hospital. SMK shared her doctoral research interests, background and working history as a midwife and researcher to participants before interviews and allowed for opportunities to member-check transcripts. This insider-outsider positionality helped SMK to develop rapport with participants which contribute to the rich experiences gathered. The findings of this study may appear to be overwhelmingly positive towards Australian community-based doulas likely due to the established relationship between the doula service and hospital. As this qualitative study is a part of a larger doctoral research study, the facilitators and barriers to the working relationships between Australian community-based doulas and maternity care providers will be shared in future publications.

4.2. Conclusion

Culturally-responsive care is essential for improving the maternity care experiences and outcomes of underserved communities, including migrant women, and community-based doula support is a potential solution. Birth for Humankind doulas maintained roles and responsibilities which were integral to providing culturally-responsive care for migrant women in maternity settings in Australia. Critical next steps for this area of work include how to integrate either employment models via community-based doula services or hospitals, or hospital-based doula employment models and demonstrate recognition of doulas for their valuable roles in providing culturally-responsive care to under-served women.

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Ethical statement

Ethics approvals were obtained from The University of Melbourne (Ethics ID Number: 2021–21783–18828–3) and from the Victorian maternity tertiary hospital (HREC/XXXXX/XXX-XX-XX).

CRediT authorship contribution statement

Sarah Min-Lee Khaw: Investigation, Methodology, Formal analysis, Conceptualization, Data curation, Writing - original draft, Writing - review & editing. **Caroline S.E. Homer:** Conceptualization, Formal analysis, Investigation, Methodology, Supervision, Writing - review & editing. **Ruth E. Dearnley:** Formal analysis, Writing - review & editing. **Kerryn O'Rourke:** Formal analysis, Writing – review & editing.

Shahinoor Akter: Investigation, Methodology, Supervision, Writing - review & editing. **Meghan A. Bohren:** Conceptualization, Formal analysis, Funding acquisition, Investigation, Methodology, Supervision, Writing - review & editing.

Declaration of Competing Interest

Ruth E. Dearnley is the Chief Executive Officer of Birth for Humankind (2018 to present). Kerryn O'Rourke was on the Board for Birth for Humankind and had resigned from this position before engaging in her doctoral evaluation research. Professor Caroline Homer, the Editor-in-Chief for Women and Birth, is a co-author on this paper. Professor Homer did not play any role in the peer review or final decision on this paper. Professor Linda Sweet, the Deputy Editor, managed the paper to remove conflict of interest.

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Reflexivity

The first author is a second-generation Chinese Malaysian migrant and Australian-born woman. Her background in midwifery and research experiences in public health as a PhD candidate have shaped her interests in exploring migrant women's maternal health and experiences. SMK shared her midwifery background and research interests with participants prior to the commencement of the interview. All authors endeavoured to practice reflexivity throughout the research process, acknowledging their own experiences in their respective fields: community- based doula programmes (KO and RED), midwifery (CSEH and SMK), and public health research (MAB, CSEH, SA and KO), may influence components of this research project.

Disclaimer

We would like to acknowledge that whilst our study refers to women not all biologically female sexed people identify as women. Similarly, whilst doulas of our study may support transgender, non-binary and gender diverse people, our research spoke to their experience working with people who identified as cisgender and as women from migrant and refugee backgrounds.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2023.04.003.

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