

Medical and Administrative Barriers to the Implementation and Sustenance of a Labor Companionship Program: A Cross-sectional Study in a Teaching Hospital in Sri Lanka

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ABSTRACT

Aim: The aim of the study was to describe how medical and administrative barriers in implementing a labor companionship program were overcome and to identify similar barriers adversely affecting the sustenance of the program.

Materials and methods: Medical and administrative barriers encountered when implementing a labor companionship program at the Academic Unit (AU) of Teaching Hospital, Mahamodara, Galle (THMG), in 2012 and how these barriers were overcome are described. From March to April 2016, a cross-sectional study was carried out using an interviewer-facilitated self-administered questionnaire, on specialist obstetricians and gynecologists, house officers, staff nurses, and midwives of AU of THMG, to identify possible reasons for the failure to sustain the labor companionship program. Data regarding demographic characteristics, knowledge and attitudes regarding women having a labor companion (LC), and counseling pregnant women to have an LC were collected.

Results: Four out of five specialists, all 13 house officers, 23 out of 30 staff nurses, and 12 out of 16 midwives participated in the study. All the specialists and nurses, 85% of house officers, and 58% of midwives were aware that the presence of an LC was beneficial for women in labor. However, only 24% of doctors and 17% of staff nurses and midwives had counseled pregnant women routinely regarding an LC and only 53% of doctors and 20% of nurses and midwives had counseled more than 10 pregnant women regarding LC, during the week immediately preceding the data collection.

Conclusion: Medical and administrative barriers are encountered when establishing a labor companionship program, but they can be overcome. Midwives must be educated regarding the beneficial effects of an LC. Doctors and nurses must be motivated to increase counseling of women and their partners regarding the beneficial effects of an LC in order to sustain a labor companionship program.

Keywords: Administrative barriers, Implementation, Labor companion, Labor companionship program, Medical barriers, Positive childbirth experience, Quality of care during labor, Sustenance.

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INTRODUCTION

Historically, women have usually been supported by other women during labor and childbirth, in their own homes. However, when women were being hospitalized for labor and childbirth, providing such continuous support to them became increasingly difficult, especially in hospitals with low human resources. Nevertheless, the fact that having a labor companion giving continuous support during labor and childbirth has beneficial effects on the outcomes of labor, and that women who have an LC have a positive childbirth experience, have been well known for several decades. Therefore, for every pregnant woman in labor, the presence of an LC of the pregnant woman's choice is currently strongly recommended and in fact is considered as a vital component in the World Health Organization (WHO) vision for quality of care for pregnant women and newborns.¹⁻⁵

The partner of the woman in labor has been the accepted LC, for several decades, in well-resourced, high-income countries. In low- or middle-income countries with limited resources too, labor companionship programs have been successfully implemented recently.⁶⁻¹³ In Sri Lanka, because state sector hospitals have only labor wards with about 10 beds, separated from each other by retractable curtains, and separate labor rooms are not available for individual women, the LC is always a female.¹⁴⁻¹⁶ However, it

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is essential to provide appropriate physical space that respects women's and their companion's privacy.

The implementation and sustenance of any new healthcare practice require the continuous professional development, commitment, and dedication of not only the healthcare professionals but also the hospital administrative staff to change institutional policies of healthcare facilities, when needed. In a recent review which collated and described the factors which affected the implementation of a labor companionship program,

allocation of resources, organization of care, and facility-related constraints were identified as implementation barriers. Further, it was also recommended that the implementation research in the future should document the factors that affected implementation and how they were addressed.¹⁷

Although a labor companionship program had been introduced in a Teaching Hospital in Colombo, three years earlier,¹⁵ up to 2012, such a program had not been implemented in the Teaching Hospital Mahamodara, Galle, which was the premier tertiary care hospital for women and the only teaching hospital for the southern province of Sri Lanka. Approximately 750–1,000 pregnant women attended the five antenatal clinics conducted by the AU of the THMG per week and there were approximately 550–600 deliveries per month, in the unit.

MATERIALS AND METHODS

All arrangements had been made to commence the functioning of a new labor ward at the Academic Unit (AU) of the Teaching Hospital Mahamodara, Galle, on July 30, 2012. During several weeks prior to this date, the second author had extensively counseled all the medical, nursing, and midwifery staff of the AU of the THMG about the benefits of women in labor having LCs and the need to implement a labor companionship program in the new labor ward. As it would be the first occasion that LCs would be entering a labor ward of the THMG, the second author, with the assistance of the nursing sister in charge of the unit and the other nursing and midwifery staff, had prepared all the requirements for the LCs, and all arrangements had been made to implement the labor companionship program when functioning of the new labor ward was commenced. Two women, who were awaiting induction of labor had arranged for their mothers, both nursing sisters at the THMG, to be their LCs, and both these LCs had been adequately counseled as to their role as LCs. However, the commencement of the labor companionship program that morning had to be abandoned because one specialist obstetrician and gynecologist in the unit had strongly objected to LCs entering the labor ward, and stated that the Director of THMG was also against LCs entering the labor ward, and that approval should be sought from the Ministry of Health, Sri Lanka.

Later, in the afternoon, the second author had reminded all the specialists in obstetrics and gynecology in the unit about the beneficial effects of a labor companionship program and also enlightened them that the “National Strategic Plan on Maternal and Newborn Health (2012–2016)” of the Ministry of Health Sri Lanka, not only recommended the presence of a female LC, but had also set a target of achieving at least 40% all women in labor to have an LC by 2016.¹⁴ Thereafter, a consensus was reached that the labor companionship program should be commenced as soon as possible. It was decided that each pregnant woman attending the antenatal clinic should be provided with a detailed information sheet which included the following: a clear explanation about the benefits of having an LC; the role and the expected conduct of the LC; advice for each pregnant woman to arrange for a female LC of her choice; and a disclaimer for liability if an unexpected, accidental injury was suffered by the LC, while being in the labor ward.

The labor companionship program was commenced a few days later, and by the end of 2012, approximately 13% of women in labor had LCs. However, instead of this proportion of women in labor having an LC progressively increasing as expected, it drastically reduced thereafter. During the three months from January to March

2015, the labor companionship rate in the unit was 0, 0.8, and 0.5%, respectively, (Goonewardene, unpublished data).

Perceptions of pregnant women and their partners could affect the successful sustenance of a labor companionship program. Although many women admitted to the AU of the THMG and their partners had knowledge about the program prior to admission to hospital, very few women had arranged for an LC due to varying reasons (Dilruwan et al., unpublished data). The aim of the current study in 2016 was to determine the knowledge and attitudes of healthcare providers regarding the presence of an LC and to identify any medical or administrative barriers for the failure to sustain the labor companionship program that was commenced in 2012.

A cross-sectional, interviewer facilitated, questionnaire-based study was carried out on the medical, nursing, and midwifery staff of the AU of the THMG, Sri Lanka, during the months March and April 2016. The three authors of the study were excluded. The data collected in this questionnaire included: basic characteristics such as age and years of experience; whether the presence of an LC in the labor ward interfered with their ability to efficiently carry out their duties in the labor ward; opinions on the implementation of a labor companionship program in the unit; knowledge about effects of labor companionship; whether they would recommend LCs to their relatives and friends; whether the female staff members would be happy to have an LC in the future; whether the male staff members would be happy for their wives to have a female LC when their wives were in labor; opinion as to who would be an ideal LC; the frequency and the number of pregnant women, presenting for antenatal care, that they had counseled regarding the labor companionship program. Ethical approval for the study was obtained from the Ethical Review Committee of the Faculty of Medicine, University of Ruhuna. Administrative approval was obtained from the Director of THMG in 2016.

RESULTS

Data were collected from four out of five specialist obstetricians and gynecologists, all 13 house officers, 23 out of 30 staff nurses, and 12 out of 16 midwives. Due to logistic reasons, it was not possible to obtain data from seven nurses and four midwives. One specialist obstetrician and gynecologist declined to participate in the study. Therefore, the total study sample was 52, representing 81% of the maternity care team (excluding the authors).

The distribution of age and the years of experience of each category of staff are shown in Table 1. While all the specialists

Table 1: Age and experience of healthcare workers (N = 52)

	Range	Mean (SD)	Median (IQR)
Age			
Specialists (n = 4)	41–51	46 (5.2)	41 (41–50)
Senior house officers (n = 5)	28–46	38 (6.7)	40 (32–43)
Intern house officers (n = 8)	27–29	27 (0.8)	27 (27–28)
Nurses (n = 23)	26–48	38 (7.3)	39 (35–44)
Midwives (n = 12)	31–45	39 (6.3)	40 (34–45)
Experience			
Specialists (n = 4)	12–25	17 (6.2)	18 (12–23)
Senior house officers (n = 5)	1–16	05 (6.2)	02 (1–16)
Intern house officers (n = 8)	0.5–1	0.5 (0.2)	0.5 (0.5–1)
Nurses (n = 23)	1–15	10 (6.7)	09 (1–12)

SD, standard deviation; IQR, interquartile range

and nurses and 11 out of the 13 house officers were aware of the beneficial effects of an LC to the mother, three out of the 12 midwives considered the presence of an LC to be harmful to the mother. While one specialist obstetrician and gynecologist, and approximately half the house officers, nurses and midwives had no idea about the beneficial effects of an LC to the fetus, six out of the 23 nurses and four out of the 12 midwives considered the presence of an LC to be harmful to the fetus (Table 2). While two of the specialist obstetricians and gynecologists considered the presence of an LC as being helpful for their routine duties in providing care to women in labor, the majority of house officers, nurses, and midwives considered the presence of an LC to adversely affect their ability to carry out their routine duties (Table 3). Using the median age of the nurses (39 years) as the cutoff point, there was a statistically nonsignificant increased odds of a nurse considering that the LC had adverse effects on her ability to carry out her duties if she were more than 39 years of age [odds ratio (OR) 2.4, 95% confidence interval 0.4–16.2, $p = 0.621$]. No such trend was observed with an increased age of any of the other healthcare workers or with the increased experience of any healthcare worker.

Table 2: Knowledge and perceptions of healthcare workers regarding the effects of labor companionship (N = 52)

Outcomes of labor companionship	Specialists (n = 4)	House officers (n = 13)	Nurses (n = 23)	Midwives (n = 12)
Maternal effects				
Good for the mother	4	11	23	7
No idea	—	1	—	2
No significant impact	—	1	—	—
Harmful to the mother	—	—	—	3
Fetal effects				
Good for the baby	3	5	11	7
No idea	1	7	6	1
No significant impact	—	1	—	—
Harmful to the baby	—	—	6	4

Table 3: Effects of the presence of a labor companion on healthcare workers' routine duties (N = 52)

	Helpful	No effects	Mild adverse effects	Severe adverse effects	Effects depend on LC
Specialists (n = 4)	2	2	—	—	—
Senior house officers (n = 5)	2	2	3	—	—
Intern house officers (n = 8)	2	2	1	1	2
Nurses (n = 23)	5	1	17	—	—
Midwives (n = 12)	5	5	1	—	1

LC, labor companion

Counseling regarding the labor companionship program was carried out for individual women by the specialist obstetricians and gynecologists and house officers while the nurses and midwives counseled groups of women. Only one out of the four specialist obstetricians and gynecologists and three out of the 13 house officers and less than 20% of nurses and midwives had routinely counseled the pregnant women about the labor companionship program. Only two out of the four specialist obstetricians and gynecologists, seven out of the 13 house officers, four out of the 23 nurses, and three out of the 12 midwives had counseled more than 10 pregnant women about the labor companionship program during the previous week (Table 4).

One house officer, one nurse, and six midwives stated that they would not recommend the presence of an LC for a friend or relative. All the specialist obstetricians and gynecologists and 12 of the 13 house officers preferred to have an LC during labor for themselves or their wives. One female house officer, seven nurses, and five midwives did not wish to have an LC if they were in labor. Two specialist obstetricians and gynecologists, six house officers, eight nurses, and six midwives considered the pregnant woman's mother to be the best LC while two specialist obstetricians and gynecologists, five house officers, eight nurses, and one midwife considered the woman's partner as the best LC.

DISCUSSION

Although there were medical and administrative barriers to the implementation of the labor companionship program in 2012, they were overcome by reminding the specialist obstetricians and gynecologists in the unit not only about the benefits of a labor companionship program but also about the fact that the implementation of such programs was considered to be a national priority. Further, as the new Director of THMG in 2016 approved the current study, administrative barriers most probably would not have had an adverse effect on the sustenance of the program. However, the specialist obstetrician and gynecologist who objected to the commencement of the program in 2012 declined to participate in the study in 2016.

Table 4: Healthcare workers' patterns of counseling regarding labor companionship (N = 52)

Counseling	Specialists (n = 4)	House officers (n = 13)	Nurses (n = 23)	Midwives (n = 12)
Frequency				
Routinely (100%)	1	3	4	2
Frequently (60–100%)	—	3	6	2
Sometimes (30–60%)	3	2	5	1
Occasionally (<30%)	—	2	6	6
None	—	3	2	1
Number of antenatal women counseled per week				
None	—	5	5	8
Less than 10	2	1	14	1
10 or more	2	7	4	3



It is important to note that although a very high proportion of the doctors and nurses and more than half the midwives were aware of the beneficial effects of a woman having an LC, the proportion of pregnant women counseled regarding the labor companionship program was very low. Further, the fact that three out of the 12 midwives considered the presence of an LC to be harmful to the mother and four of them considered the presence of an LC to be harmful to the fetus is of great concern. This is linked to the fact that the majority of them considered that the presence of an LC would interfere with their ability to monitor the mother and her fetus properly. The majority of house officers and nurses also being of the opinion that the presence of an LC would interfere with their ability to carry out their routine duties emphasizes the importance of understanding the concerns and attitudes of healthcare professionals, educating them on the benefits of a labor companionship program and allaying their undue fears of such a program, if a labor companionship program is to be successfully implemented and sustained.

In an online survey regarding labor companionship carried out in Sri Lanka in 2017, only 68 (48.5%) of specialist obstetricians and gynecologists responded, and 40 of them did not allow a female LC in their units. Inadequate space was the main reason reported for not allowing an LC while a “heavy work load” was the second frequent reason reported. It was also reported that nursing and midwifery staff opposed it in 17 units while the directors of 10 hospitals had also not approved it. In the labor ward of the AU of the THMG, however, there was adequate space in between the beds to keep chairs for the LC, and the retractable curtains provided privacy to the women in labor and their LCs. Although the AU of THMG had a very heavy workload, two out of the four specialist obstetricians and gynecologists who participated in the study considered the presence of an LC to be helpful in carrying out their duties. However, the majority of house officers, nurses, and midwives were of the opinion that the presence of an LC would interfere with the proper conduct of their duties. In the current study, although it was not a statistically significant association, probably due to the small sample size, there was a possibility of increasing age of the nurses being associated with negative attitudes regarding LCs. However, no such trend was observed with increased age of any of the other healthcare workers or with increased experience of any healthcare worker.

Although there are reports of healthcare personnel in centers with shortages of nurses and midwives considering the presence of an LC to be helpful in managing the women in labor, there are healthcare providers in both high-income and mid- or low-income countries having negative attitudes toward LCs, especially with regard to risk of cross-infection; crowding of the labor ward; reduced collaboration of women and their LCs with the healthcare team; and interference with clinical decision-making.¹⁷ These findings reemphasize the need to educate and counsel all healthcare personnel regarding the benefits of an LC to a woman in labor and also to allay their undue fears of possible adverse effects of a labor companionship program.

Strengths and Limitations

The main limitation of this study is that it is a single-unit study with a small sample size, but it included 81% of the maternity care team. Further, in spite of the doctors and nurses having good knowledge about its beneficial effects, the reasons for the low rates of counseling of pregnant women presenting for antenatal care regarding the labor companionship program were unfortunately

not explored. The main strength of the study is that it clearly describes the presence of medical and administrative barriers in the implementation and sustenance of a labor companionship program, and that these barriers could be due to the lack of knowledge and inappropriate attitudes regarding evidence-based clinical practice guidelines as well as national policies, and not due to constraints due to the lack of facilities or infrastructure. Although this a single-unit study, these findings would be of relevance to other centers, regions, or countries as well.

CONCLUSION

For a labor companionship program to be successfully implemented and sustained, hospital administrators need to be educated about its benefits to the woman in labor as well as her fetus; encouraged to adopt new evidence-based national policies; and encouraged to provide the necessary infrastructure. Further, all healthcare personnel need to engage in continuous professional development and update themselves with new evidence-based, global, regional, and local clinical practice guidelines on the value of labor companionship. National colleges, societies, and associations of obstetricians and gynecologists should conduct in-service workshops and training programs and obtain feedback about the implementation and sustenance of labor companionship programs.

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