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Acceptability and experience of supportive companionship during childbirth in Malawi

G Banda,[a] G Kafulafula,[b] E Nyirenda,[a] F Taulo,[c] L Kalilani[d]

[a] Department of Obstetrics and Gynaecology, Queen Elizabeth Central Hospital [b] Department of Obstetrics and Gynaecology, College of Medicine, University of Malawi [c] Department of Obstetrics and Gynaecology, Centre for Reproductive Health, College of Medicine, University of Malawi [d] Centre for Reproductive Health and Research Support Centre, College of Medicine, University of Malawi, Blantyre, Malawi
Correspondence: Dr G Banda, Department of Obstetrics and Gynaecology, Queen Elizabeth Central Hospital, P.O. Box 95, Blantyre, Malawi. Email wit1gwbanda@yahoo.co.uk

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Objective To study the acceptability and experience of supportive companionship during childbirth by mothers, health professionals and supportive companions.

Design Cross-sectional surveys before and after introducing supportive companionship.

Setting Maternity facilities in Blantyre City, Malawi.

Population Mothers who had normal deliveries before discharge from hospital, health professionals in health facilities and women from the community, who had given birth before and had interest in providing or had provided support to fellow women during childbirth.

Methods Combined qualitative and quantitative methods.

Main outcome measure Perceptions on labour companionship among participants.

Results The majority of supported women (99.5%), companions (96.6%) and health professionals (96%) found the intervention beneficial, mainly for psychological and physical support to the labouring woman and for providing assistance to healthcare providers. Some companions (39.3%) unwillingly accompanied the women they were supporting and 3.5% of companions mentioned that their presence in the labour ward was an opportunity for them to learn how to conduct deliveries.

Conclusion Supportive companionship for women during childbirth is highly acceptable among mothers and health professionals, and the community in Malawi, but should be governed by clear guidelines to avoid potential harm to labouring women. Women require information regarding the need for a supportive companion and their expected role before they present at a health facility in labour. Such notification will provide an opportunity for the pregnant woman to identify someone of their choice who is ready and capable of safely taking up the role of a companion.

Keywords Acceptability, companionship, experience, labour, supportive.

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Introduction

Continuous support for a labouring woman by a lay person or a professional is a well-evaluated intervention. Large randomised controlled trials have been carried out all over the world and these have shown positive pregnancy outcomes for mother and baby.[1–4] The supported woman is more likely to give birth without using analgesia, less likely to have a caesarean delivery or instrumental vaginal birth and less likely to report dissatisfaction with her childbirth experience.[1,2,4,5] The baby benefits from the mother's positive attitude towards her childbirth experience. This fosters mother-to-child bonding and results in successful breastfeeding and successful child-rearing practices. This support is most effective when the caregiver is not an employee of the hospital and when it starts early in labour.[1,2,4–7]

In spite of the overwhelming evidence of benefit when a labouring woman receives continuous support from a lay person, implementation of the intervention sometimes meets resistance, particularly from healthcare providers working in maternity units.[5,8] This resistance is present even in environments where staffing levels are low or where epidural analgesia is not available—that is, situations where companions would be of benefit or comfort to a labouring woman. Other than fears of introducing infection and other harm, cultural factors have also been the source of this resistance even among the potential beneficiaries.[5,8]

In Malawi, there is a severe shortage of staff in health facilities, including labour wards, which means that labouring women have little contact with the midwife.[9] There is little information in the literature on the type of support these women receive during labour and on the impact of companionship during labour on delivery outcomes in Malawi. Although studies have shown the advantages of providing companionship to women during labour, there is still a need to assess the introduction of such services to take into account the effect of cultural beliefs and the infrastructure available at health facilities in Malawi. Two studies were conducted. The first aimed to assess the acceptability of supportive companionship to labouring women, to healthcare providers providing midwifery and obstetric care, and to potential supportive companions from the community. The second study examined acceptability and feasibility after introducing the service.

Methods

The two studies were conducted in Blantyre City, in the southern region of Malawi. Each participant was interviewed using a semi-structured questionnaire with closed and open-ended questions that were pretested for validity and reliability. The questionnaires were administered in English to health professionals and in Chichewa, a local language, to other participants. Consent was obtained from all study participants before enrolment into the study and privacy and confidentiality were maintained by using codes to identify the study participants and by conducting the interviews in a private room.

The first study was conducted between 26 June and 23 July 2006. Midwives, mothers who had recently delivered normally before discharge from the postnatal ward and potential supportive companions were recruited. The midwives were those working in health facilities providing maternity services in Blantyre City, including a tertiary facility; six public, primary-care health centres, which are non-fee-paying facilities; and two private hospitals, both of which are fee-paying facilities. All the midwives who were on duty during the duration of the study and who were willing to participate in the study were recruited. The mothers were recruited from the tertiary hospital and from one health centre, which was randomly selected from the other five health centres. Mothers delivering in private hospitals were too few in number so this group was not included in the study. Every third mother admitted to the postnatal ward was recruited until the required sample size was obtained. The estimated monthly normal deliveries in the health facilities in Blantyre City based on the number of deliveries in the last quarter of the year 2005 was 1703. Assuming 50% as the expected proportion of mothers who wanted a supportive companion during labour, a 95% confidence level and 7% margin of error, the minimum sample size required was 176 using Statcalc in Epi-info version 3.3.2 (Centers for Disease Control and Prevention, Atlanta, GA, USA). The potential supportive companions were a convenient sample of women residing within Blantyre City who met the criteria for potential supportive companions, that is, they had given birth before, were willing to support a fellow woman during labour and responded to an advertisement aired on the national radio during the first study. All those eligible were included in the study. The potential companions were interviewed at a health facility closest to them or at their place of work. Information collected during the interviews included demographic characteristics of participants, perceptions on the advantages and disadvantages of providing companionship during labour, and the expectations of the roles to be played by the companions.

Before the start of the first study, women were not allowed to have a companion in the labour ward during labour. Relatives or companions were only allowed to escort the women to the door of the labour ward and to visit the women in the postnatal ward after delivery. Soon after obtaining the results of the first study, women were allowed to have a companion of their choice in the labour ward by their bedside throughout labour.

The second study was conducted from 21 December 2007 to 11 January 2008 at the tertiary hospital after the introduction of these services to assess the acceptability and feasibility of having companions during labour. This study recruited women who had received supportive companionship during labour (referred to as supported women). The estimated number of deliveries per 3 weeks in the labour ward based on the number of deliveries in the first quarter of the year 2007 was 900. Assuming that all these women had supportive companions and 80%[8] of these women found it beneficial, and accepting a 5% margin of error and a 95% confidence level, the sample size was estimated to be 193 using Statcalc in Epi-info version 3.3.2. The study also recruited nurse midwives and clinicians (referred to as health professionals) working in the labour ward who had attended to a woman in labour in the presence of her supportive companion. Lastly, individuals (referred to as companions) who had actually provided supportive companionship to the supported women in labour during the time of the study were recruited. Information collected during this study included the demographic characteristics, assessment of the advantages, disadvantages and acceptability of providing companionship to labouring women, the role the companions played during labour, the type of companions the women preferred, and the perceptions of the women, health professionals and companions on the whole process.

Ethical approval

Both studies were approved by the College of Medicine Research Ethics Committee.

Data analysis

Quantitative data on the demographic characteristics of the participants was entered, cleaned and analysed using EPI-INFO Version 3.3.2. Categorical data were described using frequencies and percentages and continuous data were described using medians and ranges. Qualitative data were manually coded and content analysis for common themes was performed.

Results

A total of 220 mothers (18 refusals), 60 midwives (two refusals) and 325 potential companions were recruited during the first study. In the second study, 192 supported women (18 refusals), 148 companions (two refusals) and 25 health professionals (one refusal) were recruited. The socio-demographic characteristics of these participants are illustrated in Table 1. Only 48.0% of health professionals in the second study were married compared with 86.7% of midwives in the first study. The health professionals also comprised largely a younger population with median age 28 years (24–55 years) as opposed to the midwives with a median age 37 years (26–57 years).

Women's perceptions of companionship in labour

Before introducing the service

Before labour companions were introduced into the labour ward, mothers (83.6%) wanted companions so that they could provide company (41%), help the midwife (40%), provide verbal reassurance (40%) and give emotional security (39%). Some mothers also said that the companion would monitor the progress of labour and conduct deliveries (8%) as illustrated by one (06-M-102) mother who said, '*…sometimes we are left to give birth on our own so the companion would examine me and tell me what to do when it is the right time for me to give birth and help me give birth without complications…*'. The mothers also said that a labouring woman needed to be protected from verbal abuse from midwives and that her baby needed protection in case it was born in the absence of the midwife (5%). One mother said, '*The midwife who attended to me kept shouting at me and everyone in the labour ward…I think a companion could have stopped her…*' (06-M-98). The mothers also expected that a companion would provide physical support (4.1%).

However, 16.4% of the mothers recruited had reservations against companionship in labour. These mothers said that companions would lack expertise in the care of women in labour (40%). They indicated that labouring women were entitled to get all the care they needed from health professionals (27%) and that a companion's presence would add to the embarrassment of having to undress in front of many people because of the limited privacy in the labour ward setting (17%). The mothers mentioned that companionship does not fit into Malawian culture (5%) as illustrated by one mother (06-M-89) who said '*…this is not part of Malawian culture…*' and that '*…labouring women would become lazy in the presence of a relative as a companion*'. Another respondent (06-M-45) mentioned that companions would be rough and make the labouring woman's experience worse instead of making it more satisfying and another respondent feared witchcraft. Other reasons that were cited for not supporting companionship in labour include: the companion would disturb the nurses (06-M-132) and the companion would feel sorry (06-M-37).

After introducing the service

In the second study, the women who received companionship during labour expressed satisfaction with their companion for providing reassurance (50.5%), meeting their physical needs (49%), being a sure source of information (21.9%), providing security (20.9%), pain relief (2.6%) and company (19.3%). One (07-SW-143) woman said, '*My companion would hold me if I needed to walk*'. Another (07-SW-156) said, '*My companion was listening to my fears*'. Yet another (07-SW-87) said, '*My companion was telling me what to do at different times*'. The women also mentioned that the companions helped by calling the health professionals when needed, enforcing messages provided by the healthcare providers and passing on items to the healthcare providers during delivery (5%). The supported women felt that they received very good care because the companion was around (2.6%) and said they were happy with the fact that someone witnessed all that they went through (2.6%), '*The midwife took very good care of me. I don't think this could have happened if I did not have someone there with me…*' (07-SW-55).

The only supported woman (07-SW-66) who was not happy to have a companion said, '*My mother-in-law was uncomfortable in my presence and so was I. There was nothing she was doing. In actual fact, her presence was a burden.*'

Type of companion preferred

Before introducing the service

The majority (70.9%) of the mothers in the first study who wanted a supportive companion during labour preferred someone they knew but the remainder said that they would be happy with anyone who offered companionship. The preferred companions were mother, sister, grandmother, aunt, mother-in-law, friend, male partner, anyone and midwife in order of frequency. Only 11.4% of the mothers wanted their male partner as a companion.

Table 1. Socio-demographic characteristics of participants in the acceptability and experience of supportive companionship during childbirth in Malawi study (these are represented in the table as frequencies)

Variable	Mothers (2006 study)	Supported women (2007 study)	Potential companions (2006 study)	Companions (2007 study)	Midwives (2006 study)	Healthcare workers (2007 study)
	(*n* = 220)	(*n* = 192)	(*n* = 325)	(*n* = 148)	(*n* = 60)	(*n* = 25)
Health facility						
Tertiary institution	90.0	100	N/A	N/A	N/A	100
Primary-care health centre	9.1	N/A	N/A	N/A	N/A	N/A
Age (years)						
≤23	52.3	59.9	7.1	5.4	0.0	0.0
24–33	37.2	36.5	54.2	25.7	33.3	76.0
34–43	10.5	3.6	21.8	29.7	41.7	12.0
44–53	0.0	0.0	12.3	25.7	20.0	8.0
54–63	0.0	0.0	4.6	8.8	5.0	4.0
≥64	0.0	0.0	0.0	4.7	0.0	0.0
Marital status						
Married	90.4	88.5	83.4	75.0	86.7	48.0
Never married	8.2	6.8	1.8	2.7	5.0	40.0
Divorced/separated	1.4	2.1	7.4	6.1	1.7	0.0
Widowed	0.0	0.5	7.4	16.2	6.6	8.0
Cohabiting	0.0	2.1	0.0	0.0	0.0	0.0
Education						
Primary	55.9	45.8	24.9	54.0	N/A	N/A
Secondary	35.9	44.8	66.2	18.9	N/A	N/A
Tertiary	0.0	6.8	7.4	4.1	100	100
None	8.2	2.6	1.5	23.0	N/A	N/A
Employment						
Unemployed	87.2	75.5	50.2	58.8	N/A	N/A
Self-employed	6.4	13.0	35.1	29.1	N/A	N/A
Formally employed	5.4	11.5	14.8	12.1	100	100
Religion						
Christian	79.5	88.5	90.8	85.1	100	96.0
Muslim	11.4	11.5	3.4	14.2	0.0	4.0
Other religion	7.3	0.0	5.8	0.7	0.0	0.0
None	0.5	0.0	0.0	0.0	0.0	0.0
Parity						
Nulliparous	0.0	0.0	0.0	0.7	N/A	N/A
Primiparous	39.5	53.6	12.6	3.3	N/A	N/A
Multiparous	60.5	46.4	87.4	96.0	N/A	N/A
Profession						
Midwife	N/A	N/A	N/A	N/A	100	52.0
Clinician	N/A	N/A	N/A	N/A	N/A	48.0
Cadre						
Enrolled nurse midwife	N/A	N/A	N/A	N/A	90.0	40.0
Registered nurse midwife	N/A	N/A	N/A	N/A	10.0	12.0
Intern	N/A	N/A	N/A	N/A	N/A	40.0
Registrar	N/A	N/A	N/A	N/A	N/A	4.0
Consultant	N/A	N/A	N/A	N/A	N/A	4.0
Institution						
Public	N/A	N/A	N/A	N/A	76.7	100
Private	N/A	N/A	N/A	N/A	23.3	N/A

N/A in the table stands for not applicable.

After introducing the service

After the introduction of labour companions at the tertiary health facility, the majority (74.5%) of the 192 supported women were notified for the first time that they were allowed to have a companion during labour after they had already arrived at the hospital. The women who knew in advance before getting to the hospital that they were allowed to have a companion obtained this information from friends (10.9% of supported women), the antenatal clinic (11.5%) and radio (3.6%). Out of all the supported women recruited, 77 (40%) indicated that they would have preferred to have a companion different from the one they had, even though all but one supported woman had someone they knew for a companion. The companions included the woman's mother, sister, mother-in-law, sister-in-law, friend, grandmother, aunt, neighbour, male partner, niece, daughter, 'mkazi mzawo' (another woman married to the same man as her) and a woman from her religious congregation. The one supported woman who had a companion she had never met before took someone she had just met outside the labour ward as a companion. The preferences that the 77 supported women had were within this pool of companions. Only two (2.6%) of the 77 wanted a doctor as a supportive companion and only one (1.3%) wanted her male partner. Both women who had their male partner as a companion, would have preferred to have another companion, mother or sister. Despite this, 99.5% of the supported women were happy to have had a companion and wanted companionship for labouring women to continue.

Health professionals' perceptions of companionship during labour

Before introducing the service

In the first study, 78.3% of the midwives said that it was important for a labouring woman to have a supportive companion and 75.5% wanted the women they were serving at their health facilities to benefit from this. The midwives said a companion would provide pain relief (35%), give assistance to labour ward staff (8.3%), explain the progress of labour to the women (33%), and provide reassurance (33%) and company (18.3%) to the labouring women. Some midwives (5%) also said that companions would help the midwives to verbally discipline 'uncooperative' labouring women and that if the women's male partners were labour companions there would be an increase in uptake of contraceptive methods (5%). One midwife (06-MW-12) said that the companion would look for transport in case there was need for referral to another facility and another (06-MW-34) said that the labouring woman needs to be supported because she is a patient. More details on the cited advantages are provided in Table 2.

However, 21.7% of the midwives did not favour labour companionship. Some (23%) of these midwives pointed out that only health professionals had the expertise to care for labouring women. Another 23% mentioned that the presence of a companion would make the labouring woman stubborn and less likely to follow the midwife's instructions resulting in stillbirths. To illustrate this, one midwife (06-MW-20) said, '*Companions won't help. They will only make women more stubborn and increase the numbers of stillbirths*!' Other opinions were that the companions would gossip about the labouring women (23%) and that the Malawian culture does not encourage 'spectators' for the childbirth experience, which would be the case if husbands were companions (23%). The midwives also feared increased litigation (5%) as illustrated by one midwife (06-MW-45), who said, '*…a lot of bad things are already said about midwives and we are taken to court for things that are practically impossible to rectify with no one to back us up…with the shortage of staff and materials, it is not possible to provide standard care and I'm sure no midwife will be spared!*'.

After introducing the service

After companions were introduced into the labour ward, most (96%) of the health professionals found the intervention beneficial and wanted it to continue. The health professionals said that the labouring women had company (58%), reassurance (50%) and that the women's needs were met (45.8%). The health professionals also said that the companion was of some assistance to them (41.7%). One health professional (07-HP-23 said, '*She reminded me when it was time for me to re-examine the woman…*' and another health professional (07-HP-09) said the companion: '*… helped by holding the woman in lithotomy position…*' and yet another (07-HP-11) said '*Problems were identified earlier…For instance when intravenous fluids stop running and when there is bleeding*.' The health professionals further said the supported women had pain relief in form of back rub (25%), were provided with information (20.8%), physical support (20.8%) and that the companions reinforced discipline among the labouring women (16.7%). One health professional (07-HP-10) said, '*I have noted that some companions are encouraging the women to follow the instructions I give them…Some women can't just follow instructions*!' The health professionals also indicated that it was good to have the companions because if there was a complication they would understand what had happened because they were present during the labour (07-HP-15).

The only health professional who saw no benefit of supportive companionship said, '*…the presence of the companion made the woman more uncooperative and confused her. She caused much more confusions. She just couldn't follow my instructions anymore*!'

Table 2. Acceptability and experience of supportive companionship during childbirth in Malawi (these are represented in the table as frequencies)

Variable	Mothers (2006 study)	Supported women (2007 study)	Potential companions (2006 study)	Companions (2007 study)	Midwives (2006 study)	Healthcare workers (2007 study)
	(*n* = 220)	(*n* = 192)	(*n* = 325)	(*n* = 148)	(*n* = 60)	(*n* = 25)
Supportive companionship beneficial	83.6	99.5	100	96.6	78.3	96
Noted benefits of supportive companionship						
	(*n* = 184)	(*n* = 191)	(*n* = 325)	(*n* = 143)	(*n* = 47)	(*n* = 24)
Provide company to mother	41.0	19.3	0.0	0.0	18.3	58.0
Verbal reassurance	40.0	50.5	36.7	16.8	33.0	50.0
Help staff	40.0	5.0	20.0	22.5	8.3	41.7
Provide emotional security to mother	39.0	20.9	0.0	0.0	0.0	0.0
Monitor progress of labour and conduct deliveries	8.0	0.0	28.0	0.0	0.0	0.0
Protect mother from verbal abuse	5.0	0.0	15.0	0.0	0.0	0.0
Discipline 'uncooperative' mothers	0.0	0.0	20.0	0.0	5.0	0.0
Increase uptake of family planning methods	0.0	0.0	0.0	0.0	5.0	0.0
Protect baby	5.0	0.0	0.0	0.0	0.0	0.0
Mother gets very good care	0.0	2.6	0.0	4.2	0.0	0.0
Witness to all that is done to mother	0.0	2.6	0.0	14.7	0.0	0.0
Physical support	4.1	49.0	0.0	30.3	0.0	20.8
Meet woman's needs	0.0	0.0	0.0	0.0	0.0	45.8
Pain relief	0.0	2.6	20.0	0.0	35.0	25.0
Source of information	0.0	21.9	0.0	5.8	33.0	20.8
Reinforce midwives' advice	0.0	5.0	0.0	5.8	0.0	16.7
Companion to look for transport	0.0	0.0	0.0	0.0	1.7	0.0
Mother needs care as any other patient	0.0	0.0	0.0	0.0	1.7	0.0
Opportunity to learn how to conduct deliveries	0.0	0.0	0.0	3.5	0.0	0.0
Reservations against supportive companionship						
	(*n* = 36)	(*n* = 1)	(*n* = 0)	(*n* = 5)	(*n* = 13)	(*n* = 1)
Lack expertise	40.0	0.0	0.0	0.0	23.0	0.0
Entitled to care by health professionals	27.0	0.0	0.0	0.0	0.0	0.0
Limited privacy	17.0	0.0	0.0	0.0	0.0	0.0
Embarrassment	0.0	0.0	0.0	0.0	0.0	0.0
Not part of culture	5.0	0.0	0.0	0.0	23.0	0.0
Abuse mothers	2.6	0.0	0.0	0.0	0.0	0.0
Disturb midwives	2.6	0.0	0.0	0.0	0.0	0.0
Mothers stubborn	0.0	0.0	0.0	0.0	23.0	100
Companions would gossip about the mothers	0.0	0.0	0.0	0.0	23	0.0
Increased litigation	0.0	0.0	0.0	0.0	5.0	0.0
Companion has no role	0.0	100	0.0	80.0	0.0	0.0
Fearful experience for companions	2.6	0.0	0.0	20.0	0.0	0.0

Companions' perceptions of companionship in labour

Before introducing the service

The potential companions thought that they would provide reassurance to the labouring woman (36.7%), provide assistance to the midwives (20%), provide pain relief by rubbing the back (20%), and that they would monitor the progress of labour and conduct deliveries (28%). One of the potential companions (06-PC-243) said, '*…there are few midwives and women usually deliver alone…I can help the labouring woman give birth when she is ready and prevent some of the deaths and stillbirths that result from inadequate care…*'. Another said that reporting problems to the midwives would lessen the midwives' work and at the same time ensure that deviations from normal labour are noticed and corrected early, before harm to the mother or baby ensues (06-PC-49). The potential companions also said that the midwives needed a hand in handling 'uncooperative' labouring women (20%). The potential companions further said that they would protect labouring women from physical and verbal abuse from the midwives (15%), and protect

the baby from theft (06-PC-85) and harm in case it was born while the midwife was away (06-PC-77).

After introducing the service

Most of the supportive companions found their experience beneficial (96.6%) and 93.2% said the intervention should continue. These companions said that they were able to provide physical support (30.3%) (holding the woman when she was walking or turning on the bed or during bearing down, providing water, food, urine pot), to listen to the women's worries and relay them to the health workers and at the same time go to call for help when it was required at a time when the health worker was attending to someone else (22.5%). The companions also said that they reassured the women they were supporting (16.8%) and that they were witnesses to what health professionals do in the labour ward (14.7%). One companion (07-SC-133) said, '*I'm glad I have witnessed the good work that midwives and doctors are doing…They are very caring and I do not know where the rumours that they are rude and kill newborns come from…*' Some companions (4.2%) said that the women they were supporting received very good care, as illustrated by what one (07-SC-109) companion said, '*My presence was of great benefit because my sister-in-law received a lot of attention and all the care she needed…*'

The companions mentioned that they provided information (5.8%), reinforced the nurses' and doctors' advice (5.8%) and that their presence in the labour ward gave them an opportunity to learn how to attend to a delivery (3.5%). One companion (07-SC-64) rejoiced saying, '*I have learnt a lot! Next time I come with a woman and a midwife is not around, I would be able to assist her…if I found a woman in labour at home I will now be of great help*!'

There were only five companions who did not think it was good that they were companions for a woman in labour. Four of these said companions had no role to play in the labour ward and one companion felt afraid because they had not seen a woman during childbirth before (07-SC-140).

The reasons for accepting the role of a supportive companion were diverse. Most companions said that they desired to help the woman in labour with the realisation that this woman needed their help (36.5%). Some companions said that they did it as a gesture of love for the woman in labour, either because the woman in labour deserves that gesture or because they just liked to show love to those who needed it (12.8%). Some companions said that they did not really have a choice, either because there was no other person in their family to take up that role (24.3%) or because the health professional attending to the woman asked them in (15%). One companion (07-SC-101) said, '*The midwife told me to go with her (the supported woman) and did not say I could choose not to…*' The other companions said that they needed to help the nurse discipline the woman they accompanied (6.1%), to bear witness to all that happened to the woman they were supporting (4.7%), and that it was their responsibility to be there for the woman they were supporting (3.5%). One companion (07-SC-28) said, '*I know how stubborn my daughter is. So when I was given the chance, I went in to help the midwife discipline her*.'

Discussion

One-to-one supportive companionship for women during labour has been shown to be effective in other studies.[1] Our two studies explore the acceptability of this intervention and the perceptions surrounding companionship. Groups of people that could influence labour companionship and the uptake of maternity services were included in the study.

Supportive companionship was highly acceptable among most participants, both before and after its implementation. This finding has been noted in other facilities with experience in labour companionship.[1] Mothers are found to be accepting of companions when aware of the benefits and after they have experienced their presence. Healthcare professionals have also been seen to overcome their worries and concerns regarding provision of such support after they experience it themselves.[1,5] We found that 96% of health professionals were accepting of supportive companionship after its implementation, compared with 75.5% before its implementation. This difference in level of acceptance, however, cannot be attributed to the experience with labour companionship that the former group had because these two groups were different in composition and number.

It is encouraging that supported women, companions and health professionals in this study, as in previous studies,[8,11] perceive the supportive companion as a person who provides information and physical and psychological support to the labouring woman. Novel findings from our studies are that some perceptions among the companions have the potential for negative consequences. First, some companions saw their presence in the labour ward as an opportunity to learn how to assist at deliveries and expressed eagerness to do so should opportunities arise. This is a threat to the provision of skilled attendance at delivery, even in the context of delivery at a health facility. Such companions may subsequently start assisting at deliveries while health professionals attend to other women. There is a need to have guidelines on what is expected of companions to ensure that there is a clear demarcation between the duties of companions and health professionals. Companions are not trained in managing labour, so such guidelines could prevent compromises in the care of

women in labour. Without clinical practice guidelines on companionship for women during childbirth, there is no yardstick for assessing the boundaries that the companions and health professionals need to observe.[12] There is also a need to equip companions with the knowledge and skills required of them before their presence in the labour ward.

Second, some companions unwillingly accompanied the labouring women and 40% of the supported women would have preferred to have a companion different from the one they had. Unwilling companions are less likely to play the role expected of a labour companion and a woman supported by a companion not of her choice may not benefit from the companionship. However, 75% of the supported women did not know that they could have a companion during labour until they arrived at the hospital. Most of the supported women therefore had little opportunity to select an alternative person to be their companion so they ended up with companions they would not have chosen. The crucial role of prior communication to the woman regarding the need for a companion and proper explanation of the expected role of the companion cannot be overemphasised. Equipping pregnant women and their potential companions with knowledge on supportive companionship would ensure that only those who are ready to and are capable of meeting the criteria are offered the opportunity to be companions. In Malawi, the antenatal care clinic would be the best source of such information for these women, knowing that 93% of pregnant women in Malawi attend antenatal care services at least once.[10]

Some of the potential companions reported that their presence would prevent poor treatment of women by midwives and some supported women felt that they received very good care because of the presence of their companion. However, we noted that after implementation of the intervention, none of the companions or the supported women reported abuse by midwives. It is possible that the concerns about midwives mistreating pregnant women were based on rumours in communities. Alternatively, midwives may change their behaviour in the presence of companions, in which case the intervention would indeed benefit women during delivery. Before implementing the intervention, some of the potential companions and health professionals also indicated that the companions would discipline 'uncooperative mothers', which was another area of concern. However, none of the mothers that had companions during labour reported that they were harshly treated by their companions.

Our study had several limitations. First, during the second study we recruited different women and companions from those who were recruited in the first study. Therefore we could not measure the actual change in the perception in the original study group. Second, the two studies recruited a predominantly urban population, which may have perceptions different from those in the rural areas. Third, we only included women who had normal deliveries. These women might have had different experiences from women who presented with pregnancy complications or underwent a caesarean section. We therefore recommend conducting further studies to assess whether women with pregnancy complications would have similar perceptions of labour companionship.

Conclusions

Supportive companionship for women during childbirth is highly acceptable among mothers, health professionals and community members in Malawi. Women require information regarding the need for a supportive companion and their expected role before they present to a health facility in labour. Such notification will provide an opportunity for the pregnant woman to identify someone of their choice who is ready and capable of taking up the role of a companion. There is a need for clear guidelines to govern the practice of companions and health professionals in the context of labour companionship to avoid potential harm to the labouring woman. Labour companionship by lay persons may help clear the bad image that community members have of health professionals while at the same time having the potential to protect labouring women from abuse by health professionals.

Disclosure of interests

There are no conflicts of interests to disclose.

Contribution to authorship

GB made substantial contributions to the conception, design, acquisition, analysis and interpretation of data for both studies; and writing up the manuscript. LK-P made substantial contributions to interpretation of data for both studies and writing up of the manuscript. EN made substantial contributions to the conception, design, acquisition of data for the 2007 study; and writing up the manuscript. FT made substantial contributions to the conception, design of the 2007 study; and writing up the manuscript. GK made substantial contributions to the conception, design, and interpretation of data for the 2006 study; and writing up the manuscript.

Details of ethics approval

The study was approved by the College of Medicine Ethics Committee (COMREC); 24 May 2006, reference number P.05/06/434

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