BIRTH COMPANIONSHIP AS PART OF RESPECTFUL MATERNAL CARE IN MOZAMBIQUE

Alcançar is a consortium comprising eight international and national organizations whose goal is to reduce maternal, newborn, and child mortality in Nampula and Zambézia provinces, Mozambique.
The consortium is led by FHI 360 and funded by the U.S. Agency for International Development (USAID) for 5 years (April 2019–November 2024). Alcançar aims to establish Nampula Province as a model for improving provision and increasing use of high-quality, patient-centered maternal, newborn, and child health services by delivering a package of technical support to all levels of Nampula's health system. The project strategy includes innovative, evidence-based, quality improvement approaches to sustain and enhance health service delivery. Alcançar includes FHI 360 (prime), Dimagi, Ehale, Institute for Healthcare Improvement (IHI), Viamo, Associação de Jovens de Nacala (AJN), HOPEM Network, and PRONTO International.

OVERVIEW

In Mozambique, promoting respectful maternity care (RMC) (see Box 1) has been a key priority for decreasing maternal and newborn mortality.[1,2] The rollout of the "Iniciativa Maternidade Modelo" (Model Maternity Initiative) had the dual purpose of improving quality of maternal and newborn care and integrating the tenants of RMC across the maternity care cascade.[2,3] While these efforts have been evaluated for their impact in improving common indicators (i.e., skilled birth attendance, breastfeeding rates), we have not yet seen a comprehensive evaluation of how these initiatives have affected a key component of RMC, birth companionship, in Mozambique.[2]

It is every woman's right to have a supportive companion such as a relative, partner, traditional birth attendant, or doula present during labor and childbirth.[4,5] These companions can provide a range of support including emotional and physical comfort, assistance with making medical decisions, and medical advocacy.[5,6] For mothers, having a supportive companion during birth can increase the likelihood of a spontaneous vaginal birth, reduce the duration of labor, decrease use of pain medication, and increase satisfaction with the birth experience.[5–7] Newborns also experience health benefits when their mothers have a birth companion, including reduced chance of low Apgar scores at 5 minutes after birth and an increased likelihood of being exclusively breastfed.[7]

Box 1. Key definitions

Respectful maternity care (RMC)
"encompass[es] basic human rights, including the rights to respect, dignity, confidentiality, information and informed consent, the right to the highest attainable standard of health, and freedom from discrimination and from all forms of ill-treatment. A woman's autonomy should be recognized and respected, as should her emotional well-being, choices and preferences—including the right to have a companion of choice during labor and childbirth."[3]

Birth companionship
The World Health Organization (WHO) defines a birth companion as any person "chosen by the woman to provide her with continuous support during labor and childbirth. This may be someone from the woman's family or social network, such as her spouse/partner, a female friend or relative, a community member (such as a female community leader, health worker or traditional birth attendant) or a doula (i.e., a woman who has specialty training in labor support but is not part of the healthcare facility's professional staff)."[4]

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OBJECTIVES

In this research brief, our objectives are to:

1. Take a mixed-methods approach to understanding birth companionship policies, statistics, and practices in Nampula Province, Mozambique, as reported by facilities, health care providers, parents of young children, and other stakeholders
2. Identify strategies to address gaps in current support for birth companionship in Mozambique

METHODS

We conducted a mixed-methods analysis of two sources of data from the Alcançar project: (1) a baseline survey of all facilities offering maternal, newborn, and child health (MNCH) services in Nampula Province, and (2) a gender equality and social inclusion (GESI) analysis of qualitative focus group discussion (FGD) and key informant interview (KII) data. We first analyzed the baseline survey data for a descriptive analysis of facility policies and attitudes toward birth companionship. We then analyzed the GESI qualitative data for instances of parents or health care providers discussing their experiences with birth companionship at facilities in Nampula. This mixed-methods analysis allowed us to triangulate multiple sources of data to better understand how well facility policy and intentions around birth companionship were realized in the community's labor and birth experiences.

Baseline assessment survey

The baseline assessment survey was administered between August and November 2019 to all 200 health facilities offering MNCH services in Nampula. The purpose of this survey was to understand MNCH service capacity and quality in Nampula by collecting data about facilities and providers. This brief presents data from the facility level about infrastructure and policies, the provider level about provider attitudes around birth companionship, and the individual client level by reviewing health facility registers to see if companions were recorded as present during labor.

Gender equality and social inclusion analysis

The GESI analysis aimed to examine gender and social inclusion dynamics, beliefs, norms, and practices within the health facilities and among community stakeholders where Alcançar operates. A total of 228 individuals participated in FGDs and KIIs across Nampula (Eráti, Nacala Porto, and Malema districts). FGDs were held with a variety of stakeholders, including adolescents, women who had given birth at Nampula facilities in the last two years, men with children under 2, traditional birth attendants (TBAs), nurses, and community health workers. KIIs were conducted with doctors, MNCH nurses, community leaders, provincial and district health services representatives, and leaders of community-based organizations. These data were analyzed using a rapid qualitative approach. We first summarized responses to KII and FGD questions, then aggregated and organized data in a matrix along six domains: (1) laws, policies, and regulations; (2) cultural norms and beliefs; (3) gender roles, responsibilities, and time used; (4) access to, and control over, assets and resources; (5) patterns of power and decision-making; and (6) dignity, safety, and wellness. To ensure accuracy of results, consultations were held with local health officials, community stakeholders, local partner organizations, and the United States Agency for International Development (USAID) team members presenting the preliminary findings.

RESULTS

Policies in place: Institutional support for birth companionship

The baseline survey data indicate that there was widespread uptake and acceptance of birth companionship in Nampula facilities. Out of 200 facilities (191 health centers and nine hospitals) offering MNCH services, there was high support for birth companionship, with policies

permitting women to have a female companion during admission (97% of facilities), labor (96% of facilities), and vaginal delivery (95% of facilities). This was corroborated by providers: 95% of providers surveyed (n=200) said that they permitted a companion in the delivery room. Disaggregated results by facility type are in Table 1. Facilities were more restrictive with allowing companions during a Cesarean delivery (8.5%) and postpartum (80%). No question was asked about male companions, but the GESI analysis revealed that women typically chose female family members or a female TBA to be their companion when giving birth. Additionally, the GESI analysis found that women often faced social pressure to bring a member of their partner's family, such as a sister- or mother-in-law, instead of their own family. While some men indicated they had wanted to be present during labor and were not permitted to be their partner's birth companion, others preferred to wait outside of facilities while their partners were giving birth. In these cases, a key role of the birth companion was sharing information with family members waiting outside of a facility.

Table 1. Facility and provider policies around birth companionship in Nampula Province, by facility type

Facility and Provider Policies	Hospitals n (%)	Health Centers n (%)
Total Facilities	9	191
Facility policy permits women to have female companions during:		
Admission	9 (100%)	185 (97%)
Labor	9 (100%)	183 (96%)
Vaginal Delivery	8 (89%)	181 (95%)
Cesarean Delivery	1 (11%)	16 (8%)
Postpartum	8 (89%)	152 (80%)
Total Providers	9	187
Provider permits the presence of a companion in the delivery room*		
	8 (89%)	177 (95%)

**Self-reported by provider who had attended the most births at each facility*

A health facility register review initially indicated positive results for birth companionship. In the six months preceding the survey, 93% of all mothers were recorded as having been accompanied during labor or delivery. Similar statistics were recorded in all districts of the province, except for Distrito de Nampula and Nacaroa, where approximately 70% and 83% of births were registered as accompanied, respectively. The presence of referral hospitals that treat more complicated pregnancies may be a contributing factor in the districts with lower accompaniment statistics: Only 54% of women were accompanied at hospitals. This could be due to the number of Cesarean deliveries seen by hospitals and restrictions on companionship during a Cesarean delivery.

> *"At the time of childbirth, my husband was supposed to accompany me… but the nurse did not call him in."*
>
> — Woman with child under 2, Nampula Province

Respectful maternity care: How much power do birth companions have?

Qualitative findings revealed complexities in the roles of birth companions in facility-based labor and childbirth. First, participants noted that having a companion made them feel safer and more protected during their labor and birth experiences. However, participants mentioned some instances in which birth companions were dismissed from the labor and delivery rooms after becoming nervous or upset. It is unclear if those births were recorded as having companions. Second, many participants, including nurses, described the ongoing disrespectful treatment of women giving birth in facilities. Despite the presence of birth companions who might advocate for their needs and preferences, women still experienced unfriendly care, verbal abuse, and being charged informal fees by providers. TBAs and grandmothers also described instances in which companions were not permitted to support women as they were moved from laboring

rooms to birthing rooms, resulting in some women giving birth alone, despite having a birth companion. TBAs and relatives accompanying women also are not permitted to provide traditional medicines that providers perceive as affecting the normal course of labor or maternal health outcomes. Overall, though birth companions may provide emotional and physical support during facility-based childbirth, these data suggest that birth companions may face challenges when trying to advocate for women's needs and preferences.

> *"[The woman in labor] chooses who accompanies her… but even if she chooses her partner, it is not possible because the health facility does not have the right conditions for him to be present."*
>
> — Nurse, Nampula Province

Balancing needs: Right to birth companionship conflicting with right to privacy

How should facilities balance a woman's right to have a birth companion with the right to privacy — two key components of RMC — while giving birth in settings where there is limited privacy during labor and delivery? More than half of facilities reported that, in the three months preceding the survey, patients had to share beds before or after childbirth, and only 58% of facilities had curtains or other means of providing laboring patients with privacy (Table 2). The qualitative GESI analysis revealed that privacy issues are one reason that gender plays a significant role in choice of birth companion. While some men preferred to wait outside facilities, others wanted to be more involved in their partner's pregnancies, especially in the case of obstetric emergencies. However, without sufficient infrastructure to assure privacy for all service users, facilities often only permitted female companions during labor and delivery, regardless of policy and women's preferences.

Table 2. Facility privacy infrastructure in Nampula Province, by facility type

Facility and Provider Policies	Hospitals n (%)	Health Centers n (%)
Total	9	191
Facility has curtain/ means of providing patients privacy	7 (78%)	109 (57%)
In the past 3 months, patients have shared beds before or after childbirth	6 (67%)	97 (51%)
In the past 3 months, patients have given birth on the floor, in the hall, or in the bathroom	2 (22%)	42 (22%)

STRENGTHS AND LIMITATIONS

There were significant data challenges that interfered with creating an accurate picture of birth companionship in Nampula. For example, three districts (Nacala-a-Velha, Lalaua, and Malema) registered more accompanied births than total number of facility births, suggesting reporting errors. There were also issues with how the data were recorded. Facility registers provide instructions for personnel to: "write an X if the woman had a companion with her during labor or delivery" [authors' translation], with no specific definition of "companion." These instructions do not specify the duration and nature of support provided by the companion. Though the World Health Organization (WHO) conceptualizes birth companionship as continuous support during labor and childbirth, births may have been recorded as "accompanied" even if companions were only present during admission or if a provider, not a companion, was present during delivery.[6] Overall, the lack of definitional clarity within facility registers reduces confidence in facility statistics and is a challenge in the assessment and monitoring of facility success in promoting birth companionship.

Additionally, while both the baseline assessment survey and GESI analysis included relevant

items, birth companionship was not the primary focus of either evaluation. For example, the GESI analysis only included qualitative data from three districts in Nampula. While these districts were selected to represent the geographic and economic diversity within the province, it is possible that experiences of birth companionship vary in the other districts included in the baseline survey. For the qualitative data, we identified the need for more specific questions on how long companions stayed during labor and if companions were present during delivery or postpartum.

However, our mixed methods analysis was a strength of this report. By triangulating qualitative and quantitative data, we had more information that we could use to contextualize and verify our findings, allowing us to obtain a comprehensive, multilevel picture of the promotion of birth companionship in Nampula.

DISCUSSION AND KEY TAKEAWAYS

Our analysis found that a high number of facilities in Nampula have adopted policies to permit the presence of birth companions during admittance, labor, and delivery. Female relatives and TBAs seem to be widely accepted as birth companions, and almost all interviewed providers reported that they allow women to have companions during labor and delivery. The levels of support for birth companionship we found appear higher than in many other low- and middle-income countries.[8] In Kigoma, Tanzania, Dynes et al. found that only 44.7% of their sample (n=935) reported having a labor companion, and only 12% reported having a birth companion.[9] A pilot of an intervention to increase birth companionship in this area raised these numbers to 77% and 68%, respectively, and increased quality of care and satisfaction with care for women at intervention sites.[10] Nampula's birth companionship appears notably high at 93%, which suggests the effectiveness of Mozambique's efforts to promote birth companionship. However, recent research has raised concerns about companion attrition as labor progresses.[8,11] A mixed-methods study in Rwanda found that while 98% of women arrived with a birth companion, only 47% had a companion during labor and only 11% had a companion during birth.[11] This additional context is needed to understand birth companionship in Mozambique.

Multiple studies in this and other regions have shown positive benefits of birth companionship but have also noted that, in many cases, issues with infrastructure and low quality care during childbirth limit the effectiveness of birth companions in supporting women during childbirth.[10,12,13] For example, in Kenya, a 2018 study of women delivering in a health facility (n=894) found that while 88% of women were accompanied to the health facility during childbirth, this did not translate to continuous support during labor (67%) or delivery (29%).[12] The study in Kenya had similar findings regarding privacy as a barrier to birth companionship: Only 29% of women were accompanied by a male partner, in part due to limited privacy infrastructure.[12] This is in line with our findings, which indicate that more efforts may be needed to ensure that women in Mozambique not only have birth companions, but also obtain the full range of benefits associated with birth companionship.

Key takeaways	
	Current data collection practices may affect our ability to estimate the actual percentage of accompanied births.
	Policies are in place to support birth companionship in Nampula, indicating institutional support — but serious issues with privacy infrastructure may restrict women's right to birth companions.
	Even when permitted a birth companion, women in Nampula still face barriers to accessing the full range of benefits birth companions can offer. Qualitative data revealed birth companions are dismissed or ignored, and that women still face disrespect and abuse during delivery.

CONCLUSION AND RECOMMENDATIONS

Our analysis identified three recommendations for improving the monitoring of birth companionship and increasing meaningful birth companionship in Nampula. First, there is a need for increased consistency in the monitoring of birth companionship in facility registers. With a broad definition of companionship provided for personnel completing facility registers, it is unclear whether the involvement of birth companions is being recorded accurately and consistently. To strengthen reporting, we recommend that district and national health offices provide more specific instructions in facility registers for personnel. These instructions could outline criteria related to the duration and type of support provided by the individuals who count as "companions," as well as clarifications that medical personnel are not considered companions. These instructions might help ensure the reliability of data completed by different personnel in different facilities as all these facilities work to promote RMC. Additionally, there is growing consensus that new indicators around birth companionship should be added to routine monitoring systems, including whether a woman arrived at a facility with a companion, whether the companion was present during labor, and whether the companion was present during birth.[8]

Second, monitoring may benefit from regular assessment of service user experiences of being (or not being) accompanied by birth companions during facility-based childbirth. Through exit interviews or qualitative assessments with service users, monitoring activities could gauge the types of support women receive from birth companions and thus gain a clearer understanding of women's satisfaction with maternity care services and health benefits from birth companionship. Moreover, this regular evaluation would help keep women's experiences and voices central to the monitoring and development of health services that serve them. This monitoring does not need to be limited to birth companionship — other aspects of RMC as outlined in the RMC charter such as freedom from disrespect and abuse would also benefit from increased monitoring.[4]

Finally, our analysis indicated that a lack of facility privacy infrastructure negatively affects facilities allowing women to have full choice of companion. With this dilemma, a right to privacy is often prioritized over a right to a companion. Therefore, improving quality infrastructure will be a key long-term strategy for improving quality of care and providing women with RMC through labor, delivery, and postpartum care. As public health efforts encourage more women to have facility-based deliveries, these infrastructure challenges must be proactively addressed so that quality of care can remain high.

Recommendations	
	Change our measurement of birth companionship. We should ask how long companions were present and if they were able to provide support during labor, delivery, and postpartum, and clarify reporting standards.
	Regular monitoring of facility-based childbirth should ask women about their experiences with birth companionship and other aspects of RMC.
	Facilities need long-term plans to address infrastructure issues that restrict women's rights to privacy and to having a companion of their choice (including male companions) when giving birth in facilities.

Alcançar project updates

The Alcançar project has taken several actions to address the issues identified in the baseline survey and GESI analysis, including:

Dialogue Sessions	Male Education	Advocacy
In community dialogue sessions, expecting couples are encouraged to jointly make decisions about important health information, including who should be a birth companion.	The project is educating men that they have a right to participate in births, antenatal appointments, and immunizations, something many of them did not know previously.	The project has been advocating for the Ministry of Health to coordinate with the Ministry of Public Works, Housing, and Water Resources to update construction guidelines for facilities to create more space, allowing women more privacy during birth.

For more information on the Alcançar project, you can read the baseline report or view our success stories.

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