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CLINICAL ARTICLE

Perceptions about labor companionship at public teaching hospitals in three Arab countries

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ABSTRACT

Objective: To explore the perspectives of women, female relatives, and healthcare providers on labor companionship. *Methods:* In a qualitative study, data were collected from women giving birth, female family members, and healthcare staff via semi-structured interviews in three large public teaching hospitals in Beirut (Lebanon), Damascus (Syria), and Mansoura (Egypt) between May and December 2012. Focus groups were conducted with midwives, nurses, and medical residents. Data were assessed by thematic analysis. *Results:* A total of 69 women, 57 female relatives, and 28 obstetricians were interviewed, and two focus groups discussions occurred. Women reported that being alone during labor raises feelings of fear and anxiety. They reported appreciating professional support, but found comfort in the psychological support offered by family members during labor. Midwives and nurses pointed to structural factors related to the organization of care and to the marginalization of their role as barriers to implementing best practices. Obstetricians referred to the absence of prenatal education classes, and social norms as factors impeding the organization of labor support initiatives. *Conclusion:* Implementing labor companionship can improve women's childbirth experiences and outcomes. Organizational structural barriers and non-supportive providers' attitudes need to be addressed to influence hospital practices.

1. Introduction

There is strong evidence showing that continuous support during labor effectively improves delivery outcomes: large trials have demonstrated that women who are supported throughout labor are less likely to have a cesarean or instrumental vaginal delivery or to need analgesia, and are more likely to be satisfied [1]. The benefits of this support are highest when it is offered by individuals who are not part of the professional team on labor and delivery wards [1].

Studies from different settings in Arab countries have reported similar beneficial childbirth outcomes. In the United Arab Emirates, Mosallam et al. [2] observed a decreased length of labor and reduced need for analgesia, labor augmentation, and neonatal intensive care in women who had a companion. In Jordan, women who had a female labor companion were less likely to require pain relief and reported an improved childbirth experience compared with those who did not have such a companion [3]. Additionally, simple inexpensive practices, including companionship in labor, improved quality of care and women's satisfaction in Egypt [4].

This evidence has not been acted on in some Arab countries, where hospital policies do not allow family members to be present during labor and delivery as companions, particularly in public hospitals. In addition, continuous one-to-one care by healthcare professionals is not offered owing to high workload, poor quality of care, or the fragmented organization of services [5]. However, these hospital practices do not align with Arab women's preferences. Women want a female family member to be present during labor: they have reported feeling lonely, experiencing fear, and sometimes being verbally abused by the staff [2,6,7]. Similar supportive attitudes toward the introduction of labor companionship in hospitals is reported by studies from African countries, highlighting the preference of women to have companions [8,9], even at the expense of rejecting delivery at a health facility [10].

The aim of the present study was to explore the perceptions of women, female relatives, and healthcare providers, and their acceptance of introducing labor companionship, in Beirut (Lebanon), Damascus (Syria), and Mansoura (Egypt).

2. Materials and methods

In a qualitative study, data from women giving birth, female family members, and healthcare providers were collected in the maternity departments of three large public teaching hospitals in Beirut, Damascus, and Mansoura between May 20 and December 12, 2012. The study proposal was approved by the institutional review boards at Damascus University, Mansoura University, and the American

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University of Beirut. The approval of hospital management was also obtained. Each participant provided informed consent before recruitment.

Selection of the study hospitals in Egypt, Lebanon, and Syria was based on a large size and the type of institution—teaching hospitals were chosen because they are influential in setting practice standards for other smaller and non-teaching public facilities in the respective countries. The three study hospitals identified all provide obstetric services for a low- to middle-income population, and deliver many neonates annually (16 000 in Mansoura, 1500 in Beirut, and 15 000 in Damascus). The hospitals in Mansoura and Damascus have separate, relatively small sections for paid (private) services; the hospital in Beirut is entirely public. The staff members responsible for providing labor care are nurses, midwives, medical and nursing interns, and residents (with slight variations between settings). The hospitals in Mansoura and Damascus do not support a labor companionship policy, in keeping with all public hospitals in these countries. The hospital in Beirut, similar to all other public and private hospitals in Lebanon, allows companionship during labor; however, it is not perceived as an institutionalized routine practice and is highly dependent on the subjective decision of individual healthcare providers.

A qualitative methodology was used to better understand and to gain an insider's view of the participants' experiences [11,12]. Semi-structured interviews and focus group discussions were used to collect data from the hospital's medical, nursing, and midwifery staff; women; and potential labor companions (female relatives). All interviews were conducted in Arabic.

A purposive sample of women attending prenatal clinics or on the postpartum ward of each hospital was obtained between May 20, 2012, and August 5, 2012. Recruitment was adjusted to ensure variability in age and parity. The sample attained in each site was guided by the data saturation principle. Female relatives were recruited either after delivery or in the waiting areas of the hospitals over the same 4 months. The female relatives who were recruited were not necessarily matched to the women recruited. The semi-structured interviews were conducted in a private space in the hospital.

A purposive sample of attending obstetricians, nurses, midwives, medical residents, and nursing interns was obtained in each hospital, ensuring variability in sex, age, and years of experience. A research assistant contacted each selected healthcare worker either by phone or on site to book an appointment for a semi-structured interview in their respective offices at the hospital or to invite them to a focus group discussion. Again, recruitment was guided by the data saturation principle. Two focus group discussions were conducted with midwives and nurses in Beirut; and two were conducted with postgraduate residents in Syria. The focus group discussions provided a way to assess the collective understanding of issues around labor companionship through observing the group interaction. Conducting focus group discussions in Egypt proved to be logistically difficult, so the research team there opted for personal interviews. Each focus group discussion included 6–10 participants.

Trained female research assistants collected data on the basis of three interview guides developed by the authors (Box 1). All interviews were audio-recorded and transcribed verbatim. Transcripts were read several times by the authors to identify and refine codes, and then coded into themes to allow the transfer of emerging common concepts and themes into matrices. The interview guide was followed for the coding process, while new emerging themes were added. Inductive thematic analysis was used to identify recurring themes and emerging patterns across different respondents, and to describe and analyze these themes further [13]. Preliminary findings were shared among the research team to enhance the credibility of the analysis and interpretation process.

3. Results

During the study period, data were collected from 24 women, 15 female family members, six obstetricians, and two focus groups with midwives in Beirut; from 30 women, 27 female family members, seven obstetricians, and two focus groups with medical residents in Damascus; and from 15 women, 15 female family members, and 15 obstetricians, nurses, and medical residents in Mansoura, Egypt.

The age of the women interviewed ranged from 18 to 38 years. Overall, 28 women in the sample were primiparous. The 57 female family members who were interviewed were the mothers (n = 32), sisters (n = 14), mothers-in-law (n = 7), and close friends (n = 4) of the women delivering at the hospitals.

Two main themes emerged from the analysis: fear as the dominant expectation and labor companionship as a perceived need (Box 2). In addition, responses to the questions elicited discussions about the choice of labor companion, forms of support, and perceived barriers for change in hospital policies, which were also used as themes (Box 2).

The discourse with potential companions—who were mainly the women's mothers and sisters—intersected with that of women when talking about fear during labor and delivery. Fear from complications that might arise during labor was a dominant concern: women perceived labor as an "unpredictable situation" that they go through, and their female relatives feared for their emotional well-being and the "suffering" of their daughters or sisters with labor pain.

It was very common for women interviewed in Lebanon and Syria to associate the process of labor and delivery with death. Because women do not receive information and guidance and so are not prepared for labor and delivery, many equated the "unknown" of this process with the "unknown" of death.

The interviews with women revealed that labor companionship is an important perceived need. Women expressed their need to feel safe among strangers, referring to the hospital staff. Women's preferences were given to female relatives as labor companions, especially to their mothers.

Women in Lebanon and Syria also talked about the involvement of husbands. Women's opinions about the extent of involvement of their husbands during labor and delivery varied from it being an essential part of a father's role to being culturally inappropriate. They sometimes referred to their own shyness and "weakness" in this situation to justify their preference for not wanting their husbands to witness labor and delivery. Others considered the presence of their husband as a right to

Box 1
Questions used in the interview guide for different groups of participants.

For women giving birth

- What are your childbirth expectations?
- What type of support would you need during labor?
- What are your previous experiences with receiving labor support?
- Who do you prefer as labor companion and why?
- What are your expectations from your labor companion?
- What do you think are the reasons for not allowing a labor companion in this hospital?

For female relatives

- What is your opinion about labor companionship?
- What experiences do you have with labor companionship?
- Who is the best labor companion and why?
- What is the role of the labor companion?
- What skills and information are needed by the labor companion?
- What do you think are the reasons for not allowing a labor companion in this hospital?

For healthcare providers

- What do you about labor companionship and its benefits?
- Why do you think this practice is not adopted in your setting?
- How this practice can be incorporated in your setting?