Thamini Uhai

WHAT DOES IT TAKE TO SCALE AND SUSTAIN BIRTH COMPANIONSHIP IN TANZANIA?

Respectful Maternity Care Innovation Case Study Produced by Thamini Uhai

IMPLEMENTATION SCIENCE COLLABORATIVE

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USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

ACRONYMS

AMDD	Averting Maternal Death and Disability Program
ANC	Antenatal care
CHW	Community health worker
DBC	Desired birth companion
EmONC	Emergency obstetric and newborn care
MOH	Ministry of Health
NACTE	National Council for Technical Education
OBC	On-call birth companion
RMC	Respectful maternity care
WHO	World Health Organization

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ABSTRACT

Birth companionship refers to the psychosocial and practical support provided to a woman during childbirth. It may be provided by a partner, family member, friend, doula or healthcare professional. Continuous emotional and psychosocial support during labor and delivery contributes to positive maternal and child health outcomes, including reported positive birth experiences. We introduced birth companionship to learn feasibility and acceptability in public health facilities in Kigoma, Tanzania. This case study describes the process and lessons learned from four years of implementation of a birth companionship project designed to identify facilitators and barriers for potential scalability and sustainability. Results indicated that over 80% of delivering women had a birth companion during childbirth and the majority (96-99%) were satisfied and would recommend it to a relative (82-97%). The providers also appreciated the presence of birth companions. Findings of this study suggest birth companionship is a feasible and acceptable practice if: (1) diverse stakeholders are involved; (2) maternity wards are renovated for privacy; (3) effective advocacy for institutionalization is in place; and (3) birth companionship is included in pre-service and in-service training modules.

INTRODUCTION

Continuous emotional and psychosocial support during labor and delivery contributes to positive maternal and child health outcomes, including reported positive birth experiences. Women who are supported by a companion of choice may have shorter labor durations, fewer invasive procedures, report higher levels of satisfaction, and their newborns may score higher on the Apgar scale. The benefits of birth companionship have been further promoted by the inclusion of "emotional support" as a core component in the World Health Organization (WHO) framework for quality of maternal and newborn health care

- Birth companionship of choice is one of the key attributes of respectful maternity care.
- Birth companionship has been associated with better maternal and newborn outcomes.
- The benefits of birth companionship and the advantages of choosing birth companions early can be promoted during antenatal care (ANC) clinics.
- Women and providers appreciate the support that birth companions provide.
- Maternity ward infrastructure improvement for visual and auditory privacy is key for successful implementation.
- Stakeholder engagement is needed for smooth and successful implementation.

Thamini Uhai is a local non-governmental organization that has been supporting government efforts to reduce maternal and perinatal mortality in the Kigoma, Morogoro, Pwani, and Katavi regions since 2008. The organization supports coverage of high impact maternal and newborn care interventions such as emergency obstetric care and respectful maternity care (RMC). In 2016, a birth companionship intervention was introduced into a comprehensive Maternal and Reproductive Health Program, which included availability and accessibility to quality Emergency Obstetric and Newborn Care (EmONC) services among others. Thamini Uhai implemented a pilot project that aimed to learn if birth companionship would be feasible and acceptable in public health facilities and if it would improve both the clinical and experiential outcomes of women by promoting women-centered RMC. Birth companionship is already recognized and recommended as a key intervention for RMC by Tanzania's Ministry of Health (MOH), through the National Guideline (2019). However, there is little documentation on adoption, scale and sustainability of birth companionship interventions. Thamini Uhai is in a unique position because of its experience with introducing birth companions in Tanzania, has already informed national level policy, and was subsequently used to sustain the intervention in Kigoma and expand companionship to Katavi region.

OBJECTIVES

This case study examines four years of implementing a birth companionship intervention in Kigoma, Tanzania. The goal is to document the process and lessons learned related to scalability and sustainability and identify implications for other low-resource settings.

Specifically, we aimed to:

1. Describe birth companionship utilization trends among project facilities;
2. Establish facilitators for scaling and sustaining birth companionship in health public facilities;
3. Establish barriers for scaling and sustaining birth companionship in public health facilities;
4. Make recommendations for countrywide adaptation and scale-up.

INTERVENTION

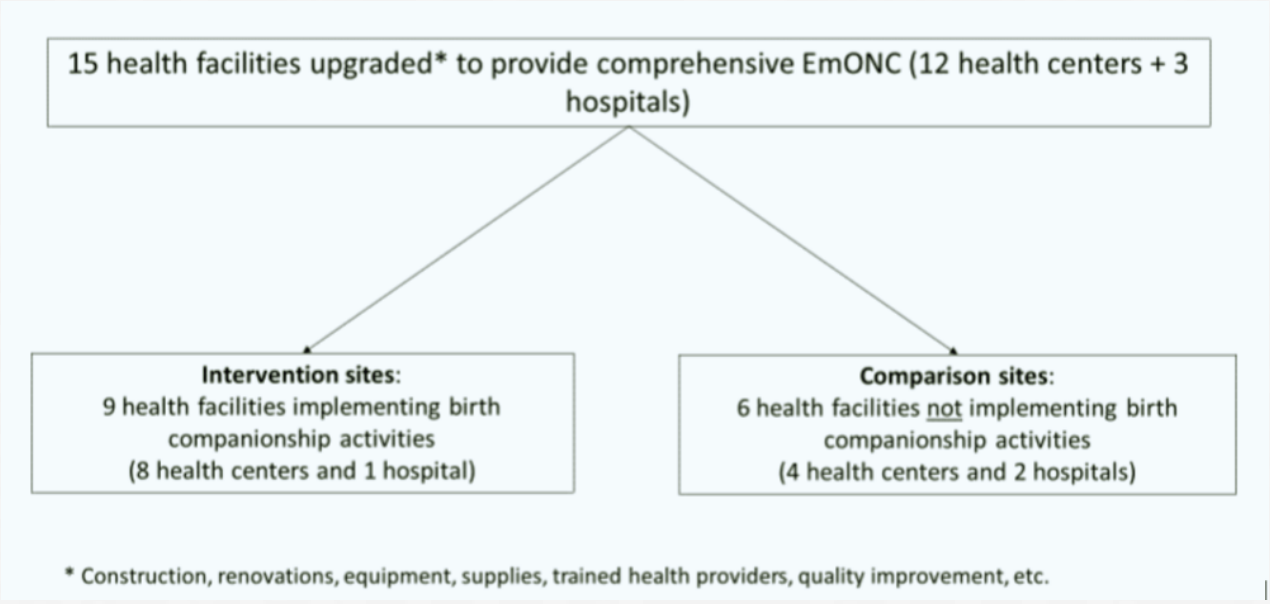
Birth companionship refers to the psychosocial and practical support provided to a woman during childbirth. It may be provided by a partner, family member, friend, doula or healthcare professional. Companions provide women with informational, practical, and emotional support and can serve as advocates for women. Birth companionship is strongly recommended by women in improving women-centered childbirth experience. In addition to making it possible for women to have a companion of her choice, the project was designed to make maternity services more respectful and client-centered

Kigoma, a mostly rural region in the Western Zone, has an estimated 92,000 births per year with maternal, reproductive, and neonatal health indicators that have lagged behind other regions in Tanzania. While partner efforts across the region contributed to increasing facility deliveries from 48% in 2011 to 55% in 2015, many women continued to deliver outside of health facilities. Barriers found were traditional and family influences, distance to facility, cost, and a lack of supportive attendance and comforting care at facilities.

The birth companionship pilot was co-designed and implemented between July 2016 and December 2018. Intervention and comparison sites were 15 health facilities (hospitals and health centers) that had been upgraded and supported by partners to provide comprehensive EmONC. Birth companionship was implemented at nine intervention sites, including one urban district hospital and eight health centers which were selected based on facility layout and space that would allow portioning of delivery rooms. The remaining project facilities, including two hospitals and four health centers, were designated as comparison sites (Figure 1).

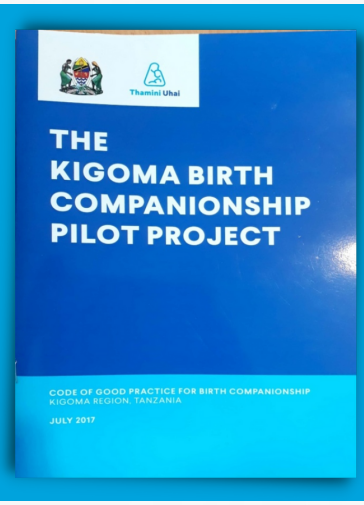
Implementation partners were Thamini Uhai (lead), Vital Strategies, Kigoma Health Management team, the Averting Maternal Death and Disability Program (AMDD, Columbia University), US CDC (Division of Reproductive Health). The Thamini Uhai team was composed of full-time staff and consultants who were mainly obstetricians/gynecologists, public health specialists, and nurse-midwives who supported healthcare providers (medical doctors, clinical officers, and nurse-midwives) at intervention facilities, and conducted several orientation meetings and trainings for healthcare mangers, providers and communities.

Figure 1: Birth companionship intervention and comparison sites in Pilot Phase



IMPLEMENTATION DESIGN, METHODS, AND EXPERIENCE

Partners conducted formative research before the pilot to gain a deep understanding of the perceptions and norms around childbirth and birth companionship and to identify potential barriers to and facilitators for implementation. A participatory approach was used to co-design the project implementation approach and to ensure that the introduction of birth companionship responded to the needs and concerns of women and health providers. Lessons from the formative research were shared in a workshop with a group of diverse stakeholders (i.e., community members, health providers, local government officials). This workshop led to the development of a guiding document (Code of Good Practice) that defined the rights, roles, responsibilities, and limitations of key players, including birth companions. Women delivering at intervention sites were given the choice of having a birth companion with them during childbirth. Two types of birth companions were available: a) “desired birth companions” (DBC) selected by women during pregnancy and brought from their home or village to the facility; and (b) “on-call birth companions” (OBC) selected by communities and based at intervention facilities. OBCs were an option for women who did not bring a companion to facilities at the time of labor and for women who preferred a companion who was a non-family member/friend

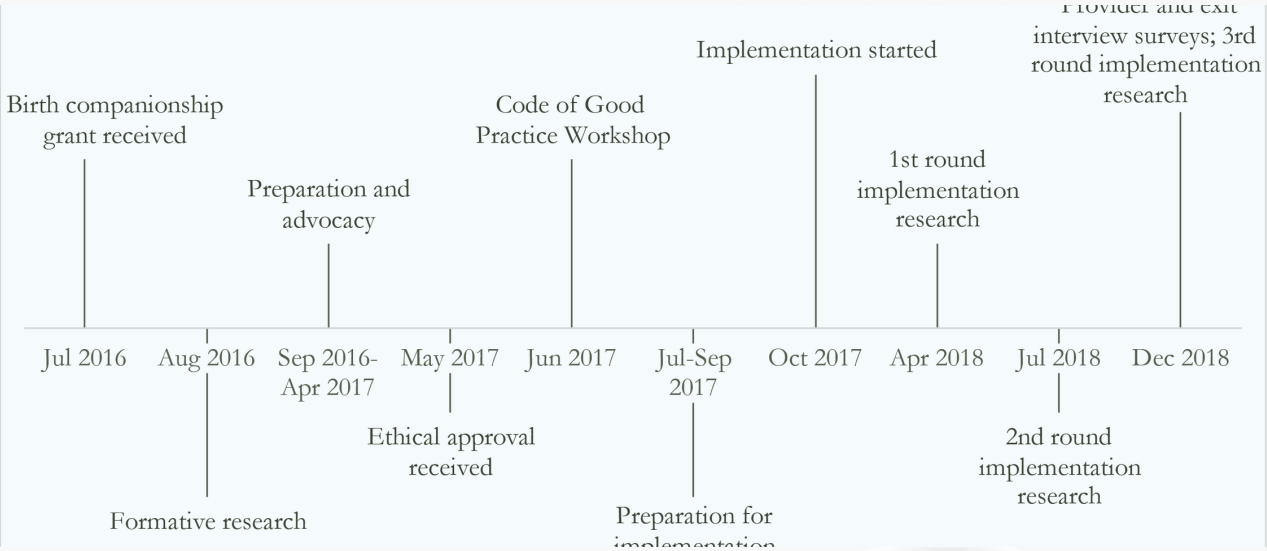


The Code of Good Practice is a local guiding document created in a multi-stakeholder workshop conducted in Kigoma in June 2017. The purpose was to define the roles of various players in ensuring successful introduction of the "new intervention". It further described the types, roles, responsibilities, and limitations of birth companions as they support women during childbirth.

Existing labor/delivery rooms were renovated and divided into individual rooms with full partitions. Infection concerns were addressed through the addition of hand-washing stations and uniforms for OBCs. To ensure providers and government officials understood the benefits of companionship and supported the pilot, the Thamini Uhai team conducted several orientation and advocacy meetings with them. Midway through implementation, a U.S.-based certified doula and childbirth educator facilitated refresher trainings on nonmedical comfort measures for OBCs and maternity ward and Reproductive and Child Health clinic in-charges.

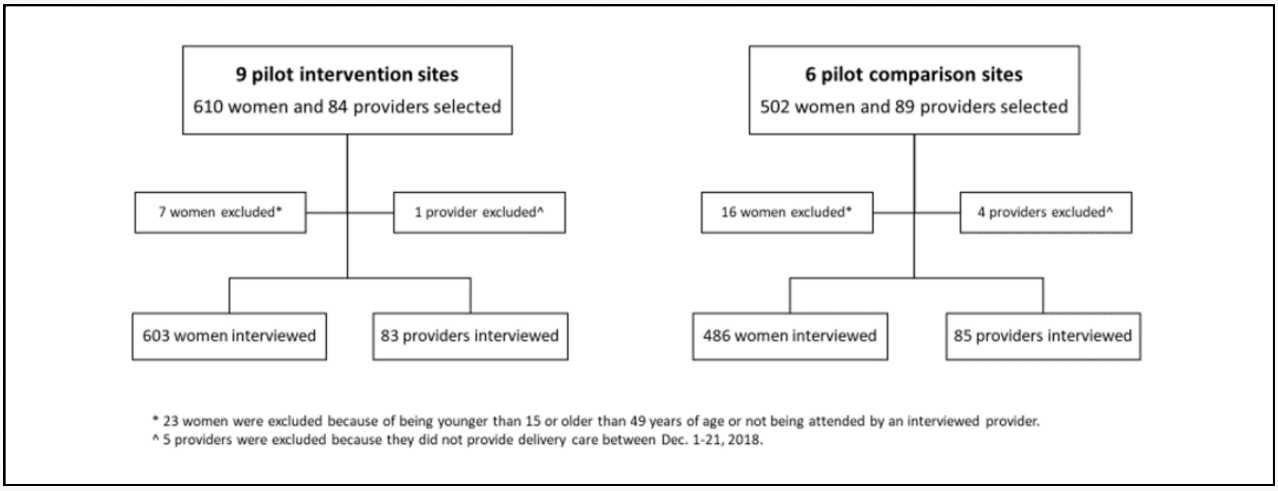
Pregnant women in intervention sites were informed during ANC visits and in community meetings that they could choose to have a DBC of their choice or have an OBC assigned to them. DBCs received two orientation sessions and a badge that allowed them entrance into the maternity ward; OBCs received two days of training and monthly supportive supervision. Key milestones during implementation of the pilot are summarized in Figure 2.

Figure 2: Key milestones during implementation of pilot phase



We used five data sources to monitor and evaluate the pilot activities: (a) routine pilot monitoring data (quantitative); (b) implementation research focus group discussions and interviews (qualitative); (c) women's exit interviews (quantitative); (d) provider interviews (quantitative); and (e) external pregnancy outcome data collected annually (quantitative). Distribution of client and provider interviews is presented in Figure 3.

Figure 3: Distribution of client and provider interviews



Phase II and III

In May 2019, the project was further scaled up to the nearby region of Katavi. Phase III of project implementation started in May 2021 in Katavi and Kigoma and covered 23 facilities, up from initial nine in the pilot. Informed by pilot implementation research findings and motivated to ensure sustainability, some adjustments were made to the project design in the second and third phase to reduce operating costs. These changes discontinued project funding and support to OBCs and continued promoting the use of DBCs from communities. Figure 4 details the causal pathway from activities to intended impacts and Table 1 differentiates key approaches in the pilot and second phase.

Figure 4: Pilot and phase II causal pathway

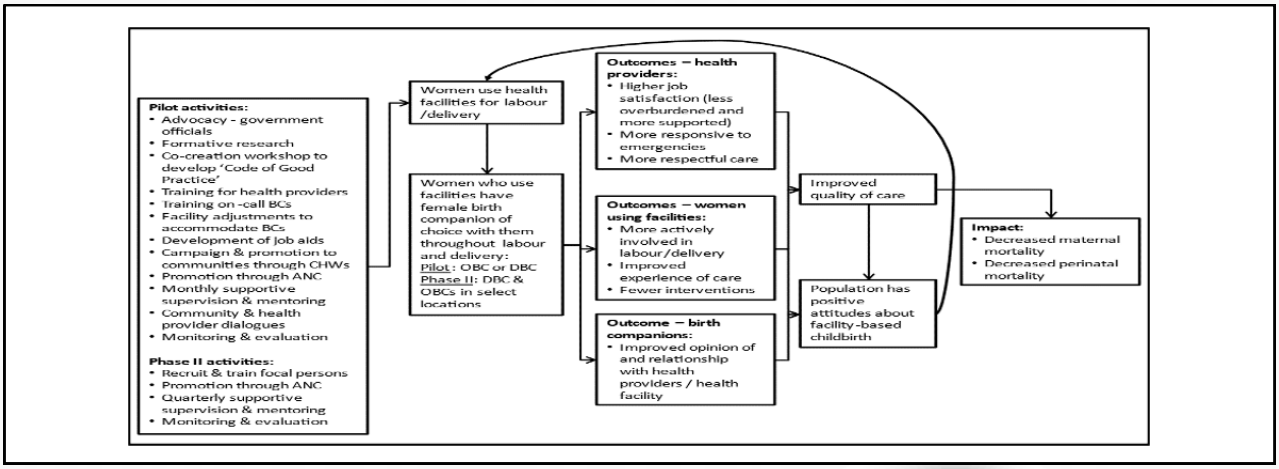


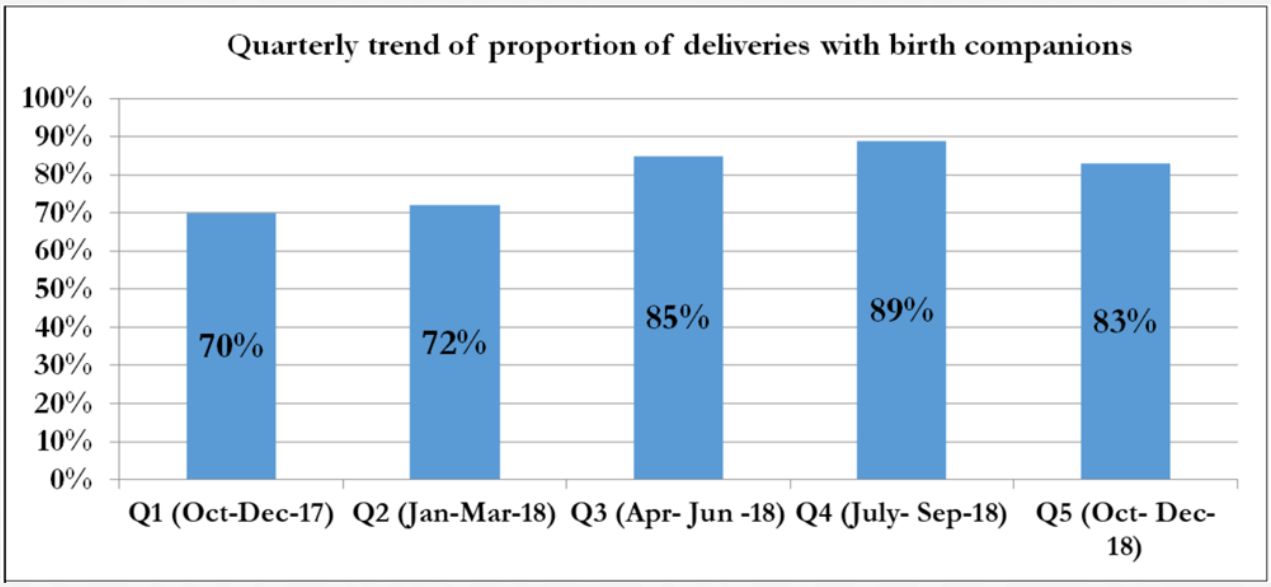
Table 1: Comparison between the pilot and phase II

Parameter	Pilot	Phase II
How pregnant women receive information about birth companionship	• Community Health Workers (CHWs) • Health providers during antenatal care (ANC)	• Health providers during ANC
Types of birth companions	• DBCs • OBCs	• DBCs • OBCs in 4/9 facilities
Birth companionship coordination at facilities	OBCs oversee day-to-day birth companionship activities	One to two nurse-midwives working in each intervention facility were selected, trained, and identified as birth companionship focal persons to oversee implementation at facility level including orientation of birth companions.
Roles of OBCs compared and focal persons	3 OBCs in each health center and 6 OBCs in the hospital. They were selected by and from the community, and their roles were to: • Serve as birth companions; • Oversee day-to-day birth companionship implementation at the facility level; • Orient desired birth companions at the time of labor, delivery and postpartum; • Orient DBCs on comfort measures ; • Record data on birth companions' utilization. They received a monthly stipend, mobile phones with closed user group connection, monthly airtime recharge, uniform, and on-call/night shift allowance.	1 focal person per health center and 2 focal persons in the hospital. They did not serve as birth companions and are health providers employed by the facility. Their roles were to: • Manage birth companionship implementation at the facility level as well as ensure DBC orientation; • Ensure quality of implementation; • Orient DBCs at the time of labor, delivery and postpartum and train DBCs on comfort measures; • Oversee birth companion-related data collection. They received monthly stipend/honoraria allowance and airtime (airtime amount was the same as OBCs in the pilot but the allowance was less).
Types of support provided to women during labor, delivery and postpartum	OBCs and DBCs provided emotional support (comfort, encouragement, allaying fears, giving hope, etc.), information (advice, translation, etc.), and practical/instrumental support (massage, help women into bed, hold hands, etc.)	DBCs provided the same types of support as DBCs in the pilot but there was more focus on providing comfort measures using locally-produced comfort measure tools.
Types of support provided to providers	OBCs and DBCs alerted providers when women needed help/were ready to push, kept women calm, prepared the delivery bed, cleaned beds after delivery, acted as a link between providers and relatives, etc.	DBCs provided the same support in phase II as in the pilot.
Facility-level coordination of birth companionship activities	• Labor ward in-charge • OBCs (routine data collection, report writing, liaise with Thamini Uhai)	• Labor ward in-charge • Focal persons (routine data collection, report writing, liaise with Thamini Uhai, orientation of other staff on the project)
Thamini Uhai oversight of birth companionship activities in facilities	Monthly supportive supervision visits.	Quarterly supportive supervision visits (content mostly the same but emphasized training on comfort measures).

KEY FINDINGS

Over 80% of women delivering at pilot health facilities had a birth companion during childbirth. Most women (96-99%) interviewed were very satisfied with having a birth companion and would recommend one to their relatives as it improved their childbirth experience (82-97%). The providers also appreciated the presence of birth companions, who helped alleviate their workload. Birth companions could follow up on some services for the women in labor and alert them about any changes to a woman's status. Overall, birth companionship continued in all facilities in phase II.

Figure 2; Quarterly birth companionship utilization trends



FACILITATORS and BARRIERS to IMPLEMENTING BIRTH COMPANIONSHIP

A panel of experts who developed this case study, reflecting on the implementation experience and achievements, identified key facilitators and barriers to inform other stakeholders who wish to scale or sustain birth companionship.

A. Facilitators for scaling up and sustaining birth companionship

I. Design

- *Co-creation with a diverse set of stakeholders:* Involving health providers, community members and government officials in the design phase and in developing the Code of Good Practice generated buy-in for the process and the concept of birth companionship.

- *Integrating birth companionship with EmONC program:* Birth companionship should not be implemented as stand-alone intervention but integrated within other access and quality improvement initiatives such as EmONC to yield better results.

- *Maternity ward renovations:* Women genuinely appreciated the maternity ward renovations that provided both visual and auditory privacy to women and their companions during labor and delivery.

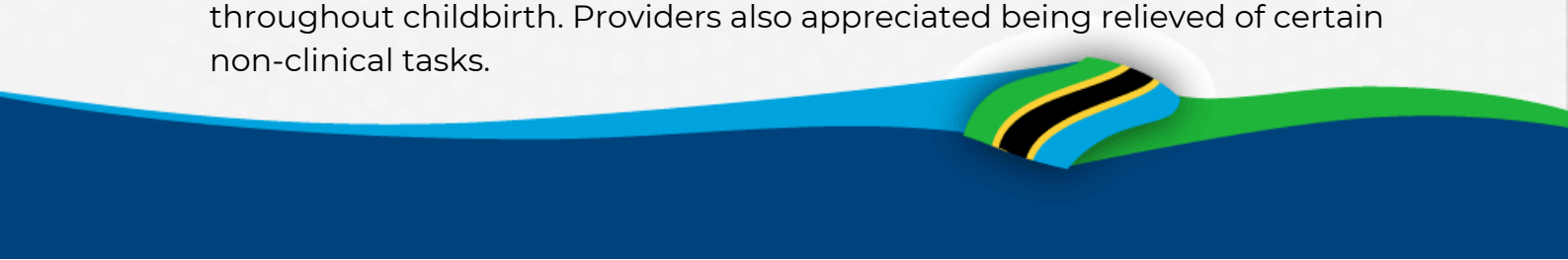
II. Implementation

- *Initial use of OBCs to speed up roll-out:* The initial use of OBCs allowed for an almost immediate introduction to the idea; this may have sped-up the understanding of a birth companion's role and the type of support they provide.

- *Regular and consistent feedback from implementation research:* Adjustments such as refining approaches and frequency of community messaging, providing DBCs with uniforms and badges for easy identification, and creating a rapid orientation for DBCs upon arrival at the facility are a few examples of solutions to challenges identified through the implementation research.

- *Consistent and trusted implementation support and monitoring:* The project team played an important and consistent role in implementation support to the introduction and evolution of the birth companionship intervention.

- *Women and providers appreciated being supported:* Both women and providers shared their appreciation for the support that birth companions provided. Women appreciated having a trusted family member with them throughout childbirth. Providers also appreciated being relieved of certain non-clinical tasks.



- *Focus on using comfort measures:* Training on comfort measures for healthcare providers and birth companions enhanced the types of support that could be provided to women during childbirth.

B. Barriers/limitations for scaling and sustaining

- *Financial/budgetary need for implementation:* Implementation of birth companionship requires renovating maternity wards for visual and audio privacy. This minor infrastructure upgrade requires financial resources which may not be readily available due to many competing priorities in government budgets.

- *Critical human resources for health shortages:* Most facilities in Tanzania are severely understaffed. Therefore, a companion may be seen as someone who can help healthcare providers perform other tasks (e.g., cleaning, mopping), thereby interfering with their primary role to be close to laboring women at all times.

RECOMMENDATIONS

The following recommendations can guide the government and other stakeholders in Tanzania and beyond looking to institutionalize birth companionship. The recommendations are grouped into three phases: design, implementation, and sustainability.

A. Design

1. *Dedicate adequate time and effort to the formative phase:* It is important to conduct formative research to understand the contextualized information on current birth experience, concerns about birth companionship, and any positive factors that women and providers feel could help improve their birth experience.
2. *Conduct diverse stakeholder planning meetings:* Co-creation is hard and takes time, but this is inevitable. Coming up with methods for sharing feedback from the formative research, addressing issues raised, and jointly adapting the model so that it works for the community lead to successful interventions.

B. Implementation

1. **Engage communities in a meaningful way:** Implementation partners should sensitize, mobilize, and raise awareness in communities about the birth companion program, working closely with and engaging communities through meetings and song and dance festivals.
2. **Ensure companionship is integrated into ongoing supportive supervision:** Providing implementation support through regular and routine supportive supervision with action-oriented feedback is critical.
3. **Ensure privacy and confidentiality because it really matters to women:** Including renovations (aluminum partitioning) in budgets would be ideal and may be included in future Tanzania MOH plans. Creative measures for structural improvement for privacy using curtains, screens, and adjusting the physical placement of beds can be done in the short term.
4. **Use ANC clinics as informational opportunities:** The benefits of birth companionship and the advantages of choosing birth companions early can be promoted during ANC clinics.

C. Sustainability

1. **Incorporate companionship into routine monitoring and evaluation systems:** Simple adjustments can be made to routine data collection systems so that birth companionship utilization can be easily monitored. Incorporating this into existing monitoring systems will be important for sustainability.
2. **Develop pre-service training to institutionalize companionship:** It will be important for all future health providers in Tanzania to receive training on the practice of birth companionship and its role on advancing RMC as part of their pre-service education degree/certification. This will mean working with key stakeholders including the responsible Directorate of Human Resource Development at the MOH, Tanzanian training institutions (i.e., medical universities and colleges as well as the National Council for Technical Education [NACTE]), and professional associations.
3. **Allocate adequate funding in budgets to support implementation:** The success of implementing birth companionship will rely on adequate funding to cover the minimum costs for advocacy, developing and conducting training for providers and regional and district teams, building of partitions, incentives for facility-based birth companion focal persons, and purchasing basic supplies and equipment.

Conclusions

Birth companionship intervention is feasible and acceptable in low-resource settings. Successful scale should invest in engagement of key stakeholders, including communities, as well as maternity ward renovations for privacy for audio and visual privacy. This intervention, when properly designed and implemented, leads to a better healthcare experience and higher satisfaction among clients and healthcare providers.

APPENDIX A- CONCEPT NOTE FOR EXPANDING THE EFFORT

Introduction

Background

The evidence has become increasingly clear that continuous emotional and psychosocial support during labor and delivery significantly contributes to positive maternal and child health outcomes, including reported positive birth experiences (Bohren et al., 2017; Diamond-Smith et al., 2016; Kabakian-Khasholian, El-Nemer, &Bashour, 2015; Hodnett et al., 2012; Kungwimba, Maluwa, & Chirwa, 2013; Banda et al., 2010; Morhason-Bello et al., 2009). Women who are supported by a companion of choice may have shorter labor durations, fewer invasive procedures, and report higher levels of satisfaction and their newborns may score higher on the Apgar scale (Bohren et al., 2017; Hodnett et al., 2012). This has been further promoted by the inclusion of emotional support as a core component in the WHO's framework for the quality of maternal and newborn health care (WHO, 2016).

In 2016, Thamini Uhai, a Tanzanian non-governmental organization working in the Kigoma region of Tanzania was awarded a grant to introduce birth companions, people who provide emotional and psychosocial support to women in labor in the public health sector. Thamini Uhai investigated if the introduction of a birth companion into often under-staffed, overworked public health facilities was feasible and acceptable and if it would improve both the clinical and experiential outcomes of the women delivering in the facilities. One central question was if the model would promote women-centered, respectful care. Thamini Uhai, collaborating with Columbia University's AMDD Program, conducted formative research to understand what a companionship model would look like in rural Tanzania, and how to co-design an intervention with community, facilities, government officials, and other stakeholder groups. During the project period, more than 80% of women delivering in pilot facilities had a birth companion by their side throughout childbirth. Positive childbirth experience was reported as indicated by higher proportions of women who gave birth at pilot sites reported being "very satisfied" with the care they received ($p<0.001$), and that the staff were "very kind" ($p<0.001$) and "very encouraging" ($p<0.001$).

The implementation was well sustained in the original pilot sites (N=9); during scale-up phase with over 62% women delivered with a birth companion in Kigoma region; there was high acceptance in the scale facilities (N=4) in Katavi region, in which 91% of women delivering had a birth companion.

Rationale

Despite significant progress in improving access to provision of routine and emergency obstetric care in Tanzania, there are a limited number of documented evidence-based interventions that improve experience of care. Birth companionship as part of RMC was introduced with high level of acceptability and satisfaction among key stakeholders and women reported improved experience of care during childbirth in the Kigoma and Katavi regions of Tanzania. There is overwhelming national policy support for birth companionship and champions are emerging at national, regional, facility and community levels; suggesting an opportunity to accelerate birth companionship institutionalization efforts so that it becomes a standard routine practice across maternity wards countrywide. Thamini Uhai proposes to further strengthen the evidence base and provide specific and actionable recommendations for institutionalization of the birth companionship practice —including informing aspects such as planning, resource allocation, budgeting, and construction of improved maternity ward infrastructure for privacy and confidentiality during childbirth. Furthermore, efforts to institutionalize the practice will be done through evidence-informed advocacy of birth companionship as a practical intervention for RMC in pre-service and in-service training

Project GOAL

Institutionalization of a birth companionship model using desired birth companions so that it becomes a standard routine practice across maternity wards countrywide.

Objectives

In order to reach the stated goal, the following objectives will be implemented over 3 years:

- Refine birth companion implementation model based on lessons learned from introduction and scale-up of birth companionship in Kigoma and Katavi.
- Design an advocacy strategy and conduct advocacy campaign to influence planning, resource allocation, budgeting, and construction of improved maternity ward infrastructure for privacy and confidentiality to support birth companionship practice.
- Scaling-up birth companionship model using desired birth companions to two other strategic regions (Geita and Tabora).
- Evaluate and disseminate implementation lessons to stakeholders at the sub-national, national and global levels.

METHODOLOGY

Project focus:

Advocating for sustainable institutionalization of a comprehensive evidence-based birth companionship model, study and disseminate.

Design:

Implementation research project on the scale-up of birth companionship in 20 public health facilities in Geita and Tabora regions and conducting high-level resource advocacy for institutionalization of birth companionship in Tanzania.

Target population:

Primary target population are parliamentarians; government technocrats at national, regional, and council levels; faculty members and tutors; and NACTE with the beneficiary target population identified as pregnant women, their families, and communities.

Proposed project activities

Use evidence to refine birth companion implementation model to build consensus for government and partners to own the model:

- Conduct desk review and secondary analysis of implementation reports.
- Convene relevant multi-stakeholders' workshop to review and validate the model.
- Produce and package a revised birth companionship model for institutionalization.

To support scale-up of the birth companionship model:

- Conduct advocacy campaign to influence planning, resource allocation, budgeting and construction of improved maternity ward infrastructure for privacy and confidentiality to support birth companionship practice. Advocacy will be led by Thamini Uhai but final implementation will be led by the government and maternal and child health partners.
- Design/develop advocacy plan/strategy (including methodology, messages and materials) and disseminate through mainstream (radio, TV) and social media platforms.
- Hosting advocacy meetings with parliamentarians through existing parliamentary forums (social service committee, parliamentarian group for safe motherhood).

- Conduct one-on-one meetings with high level technocrats from President's Office, Regional Administration and Local Government Tanzania, MOH (Reproductive and Child Health Services, Department of Policy and Planning) to influence planning and budgeting for infrastructure designs and renovations in support of the birth companion model.
- Make presentations at national technical health forums such as Regional and District Medical Officer meetings to share facts that can be useful to influence budgetary consideration on birth companionship.
- Hosting dedicated discussions at national level scientific forums such as Tanzania Health Summit and Reproductive Maternal, Newborn, Child, and Adolescent Health Scientific Conference.
- Present experience and lessons learned at technical working group meetings for a wide range of stakeholders to mobilize resources for further scale-up.
- Make presentations to the select regional and council health management teams to promote desired birth companionship model.
- Scaling-up birth companionship model using desired birth companions to two other strategic regions (Geita and Tabora).
- Conduct inception meeting in new implementation regions to sensitize about the intervention, seeking implementation support.
- Conduct rapid assessment and selection of implementation facilities within new region(s).
- Developing capacity at council and regional level to provide implementation support.
- Implement birth companionship model using desired birth companions including minor renovations of 20 intervention facilities in Geita and Tabora.
- Evaluate the birth companionship model and disseminate results at sub-national, national and global stakeholder' audience.
- Using qualitative and quantitative methods, evaluate desired birth companion project outcomes (e.g., birth companion utilization rates, quality of care, satisfaction with childbirth services) and overall acceptability of birth companionship at the beginning and end of the project (from the perspective of women, companions, health providers and government officials).
- Monitor and track progress of birth companion model institutionalization efforts.
- Package results in various formats for different audiences (e.g., project briefs, video testimonies, peer-reviewed articles, etc.).
- Share findings at conferences, technical meetings, professional associations, etc.