Research article

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Enhancing Labour and Childbirth Companionship in Vietnam: A Qualitative Comparison of Public and Private Hospitals

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Abstract

Background/Objectives: Birth companionship is recognized as an essential component of respectful maternity care, contributing to improved maternal and neonatal outcomes. Despite its proven benefits, the practice remains less commonly practiced in Vietnam, particularly in public hospitals. This study aims to explore perceptions, barriers, and facilitators of birth companionship in both public and private hospital settings in Vietnam.

Methods: This qualitative study is part of the QUALI-DEC project, which focuses on optimizing the use of cesarean sections in various countries. We conducted an assessment of the hospital's preparedness and in-depth interviews at a public tertiary maternity hospital and a private obstetric hospital in Vietnam. Data were collected from 15 pregnant and postpartum women, 10 companions, and 5 healthcare providers. Thematic analysis was performed using NVivo software.

Results: The study revealed that birth companionship is rarely implemented, with only 1.4% of women in a public hospital and 4.9% in a private hospital receiving continuous companionship during childbirth. Although both women and companions expressed positive attitudes toward the practice, several barriers were identified, including hospital overcrowding, lack of facilities, infection control concerns, and financial limitations. Healthcare providers acknowledged the benefits of companionship but cited increased workload and lack of training as significant challenges.

Conclusions: To improve birth companionship in Vietnam, hospital policies must be adapted, ensuring that medical staff providers receive adequate training and that facilities accommodate companions. Educational initiatives, enhanced infrastructure, and integration of companionship into national maternity care guidelines are critical steps toward expanding this practice. A gradual approach, starting with pilot programs and engaging medical students as support personnel, could facilitate implementation in resource-limited settings.

Keywords: Birth companionship, childbirth support, maternal healthcare, public vs. private hospital, healthcare implementation.

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1. INTRODUCTION

Birth companionship provides pregnant women with informative, emotional, and practical support during childbirth. It contributes to improved maternal experiences and better clinical outcomes [26]. Its benefits have been well-documented across both high- and low-income countries, including enhanced quality of care, reduced mistreatment, shorter labor duration, and decreased reliance on medical pain relief interventions [14, 18, 24]. However, maternal support availability and implementation vary significantly depending on healthcare infrastructure, care organization, facility constraints, and cultural factors [27]. Despite increasing research on global barriers and facilitators, limited evidence exists on how public and private maternity services influence companionship practices [10].

While birth support is widely recognized as beneficial, its uptake is inconsistent across countries and populations. In Ghana, only 58% of pregnant women in 2011 preferred having a birth companion, whereas, in Nigeria, 80% desired emotional support from a family member during labor [5, 11]. These variations highlight the impact of cultural beliefs, healthcare policies, and systemic barriers on companionship practices. In Vietnam, where medicalized childbirth is prevalent, the role of birth companions remains unclear, necessitating further exploration of women's preferences and institutional policies [2].

Vietnam has made significant progress in reducing maternal and neonatal mortality over the past two decades, with maternal deaths decreasing from 68 per 100,000 live births in 2000 to 43 in 2017 [16]. Factors contributing to this decline include expanded health insurance coverage, improved healthcare infrastructure, and increased investment in maternity services [23]. Despite this, out-of-pocket costs remain high, and many women opt for delivery in overcrowded hospitals rather than community health centers, where maternity care is often underutilized [19]. This shift has raised concerns regarding the overuse of medical interventions such as episiotomy and cesarean section (CS), which reached a rate of 34.4% nationwide in 2021 [12, 23].

Despite its potential benefits, childbirth assistance is not included in Vietnam's national maternity care protocols, and available evidence suggests that only a small proportion of women in public hospitals have access to this practice [12]. The private healthcare sector, although still limited, offers better infrastructure and continuity of care but remains underutilized for childbirth services [20]. In 2014, only 3.9% of women gave birth in private hospitals, reflecting a strong preference for public maternity care, where more highly skilled clinicians are available [12, 20]. Nevertheless, studies indicate that urban women delivering in private hospitals are more than twice as likely to undergo a cesarean section compared to those in public facilities, further emphasizing the influence of institutional factors on birth experiences [17].

This study explores expectations, beliefs, and behaviors related to birth companionship, identifying key facilitators and barriers in both public and private hospital settings. We hypothesize that institutional challenges such as facility organization, healthcare worker awareness, and limited patient education

contribute to low companionship rates [10]. Additionally, we expect better conditions for delivery companionship in private hospitals, particularly in terms of infrastructure, privacy, and staff availability, given the overall trends in Vietnam's evolving maternity care landscape [20].

2. MATERIALS AND METHODS

2.1. Settings and Participants

We conducted in two hospitals in Vietnam: one tertiary public gynecology and obstetrics teaching hospital located in a major city and one secondary private gynecological and pediatric hospital in the same city's suburban area from May 2020 to August 2020. The selection of these hospitals allowed for a comparative analysis between the public and private healthcare sectors within a similar sociocultural and economic context. In the tertiary public gynecology and obstetrics teaching hospital, it includes a higher percentage of high-risk or complex cases and receives patients from both the city and surrounding areas. While the secondary private gynecological and pediatric hospital, patients are more likely to have routine or moderately complex gynecological and pediatric needs, and it serves a smaller, localized suburban population.

2.2. Procedures and measurements

This study was conducted by an interdisciplinary team consisting of social scientists and healthcare professionals with clinical backgrounds. The research follows the Standards for Reporting Qualitative Research (SRQR) [6]. This study is part of the QUALI-DEC multisite research project (2020–2025), which aims to develop and implement non-clinical interventions to reduce non-medically indicated cesarean sections (CS) [6].

This study employed a formative research approach consisting of two key components:

1) Hospital Readiness Assessment (2020, updated in 2021): This assessment evaluated policies, protocols, clinical practices, and organizational structures related to birth companionship.

2) Qualitative In-Depth Interviews (2020): Face-to-face interviews with pregnant and postpartum women, their companions, and healthcare providers to explore their experiences and perceptions of birth companionship.

2.3. Participant Selection and Recruitment

We used the readiness assessment as a framework to guide qualitative data collection. Before full implementation, the interview guidelines and procedures were tested in a pilot study.

Participants were selected based on medical records, with a focus on:

1) Nulliparous pregnant women at low obstetric risk of CS, defined as those with a single cephalic pregnancy, gestational age of at least 37 weeks, and no previous uterine scar [13].

2) Primiparous postpartum women who had undergone CS without medical indications were classified under Robson groups 1 to 4 [13].

Pregnant women were interviewed upon admission to the labor ward, while postpartum women were interviewed before hospital discharge. Companions were recruited independently during these periods, ensuring diverse perspectives. Healthcare providers were selected from delivery departments, outpatient obstetrics units, and hospital management offices.

2.4. Sample Size and Data Saturation

A total of 34 potential participants were approached, with four individuals declining participation due to fatigue or time constraints. Ultimately, 30 qualitative interviews were conducted, including 7 pregnant women, 8 postpartum women, 10 companions, and 5 healthcare providers.

2.5. Interview Process and Ethical Considerations

All interviews were conducted in Vietnamese by trained female researchers with experience in qualitative research. Before each interview, written informed consent was obtained from participants. Each session lasted between 45 and 90 minutes and was audio-recorded with permission. Participants were provided with a small amount of financial compensation for their time. Data collection continued until thematic saturation was reached, ensuring the depth and comprehensiveness of the findings.

2.6. Ethical approval

This study adhered to the ethical principles outlined in the Declaration of Helsinki (1964) and its subsequent amendments. Ethical approval was granted by the Ethics Committee of Pham Ngoc Thach Medical University (Approval No: 215/HĐĐĐ-TĐHYKPNT, dated Feb 25th, 2020), the French Research Institute for Sustainable Development, and the Ethics Committees of the participating hospitals in Vietnam (Approval No. 1270/HĐĐĐ-BVHV, dated May 5th, 2021).

2.7. Statistical analysis

The research team transcribed the audio recording in Vietnamese. A thematic analysis of transcripts was carried out. We refer to the technology readiness framework [18]. We hypothesize that the implementation of companionship can be analyzed similarly to the adoption of an innovation. It is a two-dimensional construct that depends on motivators and inhibitors in three main components: human relations, material conditions, and the environment. This framework informed the thematic coding of the transcribed qualitative interviews using NVivo software version 10. The research findings were discussed among 4 research team members following a semi-inductive method: quantitative data analysis used bivariate analysis and a Chi-square test with a significance level.

3. RESULTS

3.1. Participant Characteristics

The study included 15 women, eight from private and seven from public hospitals, covering both pregnant and postpartum women. Participants were aged 25 to 32 years. Among the 10 companions interviewed, six were from the public hospital, and four were from the private hospital. Companions included husbands, mothers, and sisters of the women. None of them had the opportunity to accompany the pregnant woman throughout the entire childbirth process. Five healthcare workers were interviewed, including one obstetrician, one midwife from each hospital, and one hospital manager from the private hospital. Most of them had over 10 years of professional experience in obstetric care.

3.2. Hospital Resources and Infrastructure

A significant barrier to implementing companionship was the hospitals' infrastructure, equipment, and workforce limitations (Table 1). The public hospital had a significantly higher patient volume, performing 41,730 deliveries in 2020, eight times more than the private hospital

(4,937 deliveries). In our survey, the cesarean section (CS) rate was also higher in the public hospital (52%) compared to the private hospital (48%). However, in reality, at other private hospitals, the cesarean section rate may actually exceed that of public hospitals.

Similarly, epidural analgesia was more commonly used in public hospitals (49% vs. 44%).

The public hospital had a higher workload, with each obstetrician managing 8.8 deliveries per day, compared to 4.5 in the private hospital. Midwives also experienced a higher workload in the public hospital (5.0 deliveries per shift vs. 2.7 in the private hospital). However, public hospitals are permitted to have midwives assist with normal deliveries, whereas private hospitals require doctors to perform even the simplest childbirth cases. (**Table 1**).

	Public hospital	**Private hospital**	**p**
Number of deliveries per year	41,730	4,937	-
CS rate (% of all deliveries)	52.1	47.8	**
Epidural analgesia (% of all vaginal childbirth)	49	44	**
Number of obstetricians	169	20	-
Deliveries per obstetrician per day	9	5	
Number of midwives in delivery service	107	29	-
Number of individual labor rooms	4	1	
Number of common delivery rooms	2	2	
Number of individual delivery rooms	4	1	
Number of deliveries per bed (common labor room)	1.5	1.1	-

Table 1. Comparison of Hospital Resources and Maternal Care Services (2020)

*Note: the number of healthcare workers per shift is the same for the day and the night. **: significant difference at 0.05 level. Source: Quali-Dec project in Vietnam, readiness assessment, 2021*

3.3. Availability and Restrictions on Companionship

The rules for companionship were more restrictive in public hospitals than private hospitals (**Table 2**). In public hospitals, companions could only enter the labor room for 10 minutes every 2–3 hours during visiting hours. In contrast, in private hospitals, companionship was allowed throughout the process unless there were specific restrictions, such as the COVID-19 crisis. Additionally, public hospitals only permitted companionship in individual labor rooms, while common labor and delivery rooms did not allow companions at all.

Table 2. Hospital Policies on Companionship (2020)

Hospital Area	**Public hospital**	**Private hospital**
Common labor room	Limited to visiting hours (10 min per 2-3 hours)	Allowed at all times
Common delivery room	Not allowed	Not allowed
Individual labor or delivery room	Allowed at any time	Allowed at any time
Restrictions during COVID-19	Yes	Limited visiting hours

Source: Quali-Dec project in Vietnam, readiness assessment, 2021

3.4. Cost of Childbirth and Companionship Services

The cost of vaginal delivery (VD) without companionship was more than double in private hospitals ($328 vs. $157 in public hospitals). The additional cost of companionship was 50% higher in public hospitals compared to only 20% higher in private hospitals. The total cost of vaginal delivery with companionship and epidural was 48% higher in private hospitals ($457 vs. $309 in public hospitals). Similarly, cesarean section (CS) costs were 53% higher in private hospitals ($335 vs. $219 in public hospitals). In this study, the private hospital was referred to as private hospitals with average quality of care. (**Table 3**).

Table 3. Cost of Childbirth and Companionship Services (2020) (in U.S. Dollars)

Service	Public hospital	Private hospital	Difference (from public to private)
Vaginal delivery (VD) alone	157	328	+109%
Companionship (whole process)	76	65	-15%
Companionship (active labor only)	38	Not available	-
Epidural anesthesia	76	65	-15%
VD + Epidural + Companionship	309	457	+48%
VD + Epidural + Companionship	219	335	+53%

Source: Quali-Dec project in Vietnam, readiness assessment, 2021

3.5. Perspectives on Companionship

Most women and companions had some prior knowledge about companionship, mainly through conversations with relatives, online sources, or hospital websites. Women viewed companionship as a valuable new practice and associated it with better mental support during labor:

"Having someone with me makes me feel reassured and less lonely during childbirth." – Postpartum woman, 25 years old, private hospital.

Husbands were generally supportive of companionship, expressing their willingness to accompany their wives during labor:

"If my wife has a normal delivery, I would like to be by her side to support her." - Husband, 27 years old, public hospital.

Healthcare workers also recognized the benefits of companionship, stating that it helped improve communication between families and medical staff:

"When companions are present, they better understand the mother's health and trust the medical team more." – Hospital manager, 40 years old, private hospital.

Women and healthcare workers believed that companionship reduced anxiety and labor pain, improving the overall birth experience. Additionally, companions were perceived as helping healthcare workers with non-medical tasks, such as massaging women during labor or providing emotional support.

"With her husband in the labor room, the pregnant woman is more relaxed, experiences less pain, and understands the process better." – Midwife, 43 years old, public hospital.

However, several obstacles to companionship were identified, including lack of knowledge, cultural barriers, and concerns about infection control. Some women feared that their husbands would feel uncomfortable or overwhelmed

witnessing childbirth, while others reported that their partners were reluctant to be present:

"My husband didn't dare to enter. He was scared to see me in pain." – Postpartum woman, 26 years old, private hospital.

Similarly, some husbands admitted they preferred not to witness the delivery:

"My wife wanted companionship, but I advised her to go alone because I was afraid to see her in pain." – Husband, 47 years old, public hospital.

Healthcare workers also raised concerns about companions interfering with medical procedures, noting that some relatives became overly anxious and pressured doctors to perform non-medically indicated CS. Infection control was another significant barrier, with staff expressing concerns about hygiene compliance among companions.

"I worry about hygiene—sometimes companions forget to change their clean shoes or handle medical equipment with bare hands." – Midwife, 41 years old, private hospital.

Despite these challenges, healthcare workers showed interest in expanding companionship programs, emphasizing the need for training and better infrastructure.

"We need more training so that we can guide companions properly and improve the quality of care." – Obstetrician, 40 years old, public hospital.

4. DISCUSSION

The findings of this study partially confirm our initial hypotheses. Despite high awareness and knowledge about companionship among women, its implementation remains low in both hospitals. The proportion of women benefiting from continuous companionship is higher in the private hospital (4.9%) than in the public hospital (1.4%). However, an additional 9.3% of women in the public hospital received companionship after the onset of active labor, a practice not available in the private hospital. These figures remain significantly lower than past estimates in Vietnam [25] and are far below the levels observed in Shanghai, China, where 87.7% of women receive companionship [21]. The low uptake of companionship is influenced by hospital investment policies, where financial returns take precedence over patient-centered care [3]. The higher proportion of planned CS in public hospitals (52%) compared to private hospitals (47%) is surprising. It may reflect the greater availability of skilled specialists in the public sector, reinforcing the broader trend toward biomedicalization in both sectors[7]. Additionally, a higher percentage of high-risk or complex cases that are typically referred to public facilities due to their tertiary care capabilities and specialized resources. In contrast, private hospitals tend to transfer more complicated pregnancies to public tertiary centers, thus lowering their overall CS rate in this specific comparison.

One of the main challenges in implementing companionship is the psychological barrier potential companions face. Many husbands and family members feel unprepared to witness labor pain, believing that pain management should be solely handled by medical professionals [4, 7]. The lack of prenatal education for women and companions contributes to this hesitation. In Vietnam, prenatal training is currently

limited, and strengthening it through educational booklets, mobile applications, and structured childbirth classes could help improve preparedness [15]. These programs should include basic knowledge of labor physiology, breathing techniques, and massage methods to support pregnant women. Furthermore, the formal integration of companionship into national reproductive healthcare guidelines—similar to Brazil's "Companion Law" enacted in 2005—would provide a regulatory framework for expanding this practice [8].

The motivators and barriers to companionship vary between tertiary public and private hospitals. Overcrowding in tertiary public hospitals—a common issue in low- and middle-income countries—poses a substantial challenge [9]. Although the workload per obstetrician is similar in both hospitals, midwives in public hospitals assist twice as many births as those in private hospitals, reducing patient-centered care time. Meanwhile, the private hospital exhibits greater flexibility in allowing companions to enter pre-labor rooms for extended periods, although both hospitals restrict access to shared delivery rooms. Ideally, companionship should be provided by a person of the woman's choice throughout labor and childbirth [26]. However, given space and privacy constraints in tertiary public hospitals, an interim solution could involve training medical students to act as doulas under supervision from obstetricians. This strategy has been successfully implemented in other countries as part of medical education programs [1].

Although the private sector offers a more midwife-centered model of care, its economic barriers limit its scalability. While companionship is perceived as beneficial, it is also seen as an added financial burden, reducing its feasibility as a sustainable hospital revenue source. Expanding health insurance coverage could address this challenge by subsidizing companionship services and making them accessible in public and private hospitals. The public and private healthcare sectors in Vietnam are deeply interconnected. The private sector, introduced in 1993 to address resource constraints, coexists with the public system at all levels of care. Many healthcare providers work in both industries simultaneously, and patients often seek care in both systems, depending on physician availability and hospital infrastructure [22]. This interconnectedness presents an opportunity for cross-sector collaboration, where policies developed in the private sector—such as improved infrastructure for companionship—could be adapted and scaled within the public healthcare system.

Hospital, provincial, and national leadership plays a critical role in successfully implementing companionship programs [22]. At the hospital level, introducing companionship requires additional training for healthcare workers to integrate support roles into routine obstetric care. A key implementation aspect is ensuring asepsis, as companions must comply with infection prevention measures to maintain hospital hygiene standards.

This study has both strengths and limitations. While it does not represent the entire public and private healthcare system, the diversity of participants provided valuable insights into the

primary challenges of companionship implementation in Vietnam. The findings are a foundation for future policy recommendations to help service providers and hospital managers expand companionship practices. Data collection occurred during COVID-19 waves, leading to temporary hospital restrictions that slowed the study's progress. Nevertheless, despite these challenges, we successfully met our research objectives and provided a comprehensive evaluation of companionship in Vietnam's evolving maternal healthcare landscape.

5. CONCLUSIONS

This study reveals that despite high awareness among women, birth companionship remains rare in Vietnam due to infrastructure limitations, restrictive policies, and economic constraints. Private hospitals offer better access to companionship than public hospitals, but financial barriers limit scalability. Expanding prenatal education, integrating companionship into national maternity guidelines, and training medical students as doulas could enhance implementation. Health insurance coverage and cross-sector collaboration between public and private hospitals may further support accessibility. Strong leadership and policy reforms are essential to make companionship a standard practice, improving childbirth experiences for all women.

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