

BIRTH COMPANIONSHIP IN INTRAPARTUM CARE: A SYSTEMATIC REVIEW

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Abstract: *Background: Birth companionship — the presence of a chosen support person during labour and delivery — is increasingly recognised as a cornerstone of respectful maternity care (RMC). Despite WHO recommendations advocating continuous labour support for all women, implementation remains inconsistent, particularly in low- and middle-income countries (LMICs). This systematic review synthesises current evidence on the role, impact, and challenges of birth companionship in intrapartum care.*

Objectives: To systematically review evidence on (1) the benefits of birth companionship on maternal and neonatal outcomes, (2) the practice of respectful maternity care and associated barriers, (3) factors influencing maternal satisfaction with intrapartum care, and (4) innovative models of companionship in resource-constrained settings.

Review Methodology: A systematic search was conducted using PubMed, Google Scholar, CINAHL, and MEDLINE databases. Six peer-reviewed studies published between 2021 and 2025 were included following PRISMA guidelines. Studies encompassed qualitative phenomenological designs, cross-sectional surveys, prospective comparative observational studies, population-based cohort studies, and narrative reviews from India, Ethiopia, Italy, Zimbabwe, and Eastern India.

Key Findings: Birth companionship was consistently associated with higher rates of spontaneous vaginal birth (89.3% vs. 76%), reduced need for oxytocin augmentation (13.3% vs. 30.7%), higher Apgar scores, earlier breastfeeding initiation, and significantly greater maternal satisfaction. In resource-limited settings, physical presence may be replaced by psychological presence through mobile communication. Barriers to RMC include lack of privacy, staff shortages, inadequate policy implementation, and infrastructure limitations. Maternal satisfaction was significantly influenced by ANC attendance, planned pregnancy status, and labour duration.

Conclusion: Birth companionship is a low-cost, evidence-based intervention with measurable benefits for maternal and neonatal outcomes. Policy reform, infrastructure investment, and sensitisation of healthcare workers are urgently needed to ensure universal implementation of birth companionship as part of comprehensive RMC.

Categories: Obstetrics & Gynaecology; Maternal Health; Respectful Maternity Care; Intrapartum Care

Keywords: Birth companionship; Labour support; Intrapartum care; Respectful maternity care; Maternal satisfaction; Neonatal outcomes; PRISMA; Psychological presence

INTRODUCTION

Childbirth is among the most significant events in a woman's life. The World Health Organization (WHO) recommends that all labouring women receive continuous support from a companion of their choice. This support encompasses emotional reassurance, physical comfort, information sharing, and advocacy — collectively forming the foundation of respectful maternity care (RMC). Despite robust global evidence, birth companionship remains inconsistently practised, especially in low- and middle-income countries where infrastructure constraints, restrictive hospital policies, staff shortages, and privacy concerns create formidable barriers.

In India, the Ministry of Health and Family Welfare formally endorsed birth companionship in public health facilities, and the Laqshya Scheme — a labour room quality improvement initiative — aims to expand this practice to over 2,235 facilities. Nevertheless, birth companions are present in fewer than half of deliveries in Indian hospitals, reflecting the persistent gap between policy intent and clinical reality.

The physiological rationale for companionship is well-established. Labour pain activates hypothalamic and limbic pathways, triggering stress and anxiety that can impair uterine contractility and prolong labour. Continuous support by a trusted companion — providing endorphin-mediated stress reduction, emotional stabilisation, and informed advocacy — counters these adverse effects. The resulting improvements in labour progress, mode of delivery, and maternal satisfaction have been confirmed by multiple randomised controlled trials and systematic reviews.

A critical gap exists in low-resource settings where physical presence is impossible due to spatial and infrastructural constraints. Emerging evidence from Zimbabwe introduces the concept of 'psychological presence' — the woman's perception of being supported, even in the absence of physical proximity — achieved through telephone and video communication. This review synthesises evidence from six studies spanning five countries to provide a comprehensive understanding of birth companionship across varied resource settings.

REVIEW METHODOLOGY

Search Strategy

A systematic literature search was conducted in accordance with PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. Electronic databases searched included PubMed/MEDLINE, Google Scholar, CINAHL, and EMBASE. The search was conducted for studies published between 2018 and 2025.

MeSH terms and keywords used: 'birth companion', 'labour support', 'intrapartum care', 'respectful maternity care', 'maternal satisfaction', 'birth companionship', 'psychological presence', 'doula', 'continuous labour support', 'quality of intrapartum care', 'low-resource setting', and 'midwifery care'.

Inclusion Criteria

- Peer-reviewed studies published in English (2018–2025)
- Studies addressing birth companionship, RMC, or maternal satisfaction with intrapartum care
- Studies involving women during labour, delivery, or immediate postpartum period
- Original research articles: RCTs, observational studies, cohort studies, qualitative studies
- Studies from both high- and low-/middle-income countries

Exclusion Criteria

- Editorials, letters, opinion pieces, and conference abstracts
- Studies focused exclusively on antepartum or postpartum care without intrapartum data
- Studies with incomplete methodology or unavailable full text
- Duplicate publications from the same dataset

PRISMA Flow

Initial database search: 248 records identified. After deduplication: 198 records screened. Following title and abstract screening: 42 full-text articles assessed for eligibility. After application of inclusion/exclusion criteria: 6 studies met final eligibility and were included in qualitative synthesis. Reasons for exclusion (n=36): did not address birth companionship or intrapartum care directly (n=14), duplicate populations (n=7), conference abstracts or grey literature (n=9), full text unavailable (n=6).

Quality Assessment

Methodological quality was assessed using the Newcastle-Ottawa Scale (NOS) for observational studies and the Consolidated Criteria for Reporting Qualitative Research (COREQ) for qualitative studies. Studies scoring 6 or above on NOS were classified as high quality. All six included studies met this threshold.

KEY FINDINGS

1. Impact of Birth Companionship on Maternal and Neonatal Outcomes

Dubey et al. (2023) conducted a prospective comparative observational study at a government tertiary care centre in New Delhi among 150 primigravida women (75 with birth companion; 75 standard care). Birth companions were female relatives chosen by the woman; a 20-minute orientation on supportive techniques was provided at admission.

Women supported by a birth companion had significantly higher rates of spontaneous vaginal birth (89.3% vs. 76%; $p=0.03$), lower need for oxytocin augmentation (13.3% vs. 30.7%; $p=0.01$), higher five-minute Apgar scores (8.15 vs. 7.79; $p=0.02$), earlier breastfeeding initiation within one hour (93.3% vs. 73.3%; $p<0.01$), and significantly greater overall maternal satisfaction (80% vs. 58.7%; $p<0.01$). While the first stage of labour was approximately 70 minutes shorter in the companion group, this did not reach statistical significance ($p=0.06$). Companion profiles revealed a mean age of 44.67 years; 64% were illiterate, underscoring that formal education is not a prerequisite for effective support. Mothers-in-law (30.7%), mothers (24%), and sisters-in-law

(21.3%) were the most frequently chosen companions.

halu and Devi (2023) reviewed nine evidence-based studies and corroborated these benefits. Birth companions were found to reduce anxiety and fear, provide physical comfort through massage and positioning, serve as advocates communicating maternal preferences to healthcare providers, facilitate informed decision-making, and promote early breastfeeding and mother-newborn bonding. Hindering factors identified included restrictive hospital policies, cost of professional doula services, lack of awareness, cultural and language barriers, and unsupportive healthcare providers.

2. Respectful Maternity Care (RMC) and Barriers: Eastern India

Yadav et al. (2022) conducted a descriptive cross-sectional study at AIIMS Bhubaneswar, Odisha (n=246 postpartum women; 10 healthcare workers). Most women (61.38%) reported good RMC. Excellent ratings were given for physical environment (99.20%) and resource availability. However, non-confidential care was reported by 94.30% of women, non-consented care by 62.26%, and abandonment or denial of care by 23.77%. Physical abuse was reported by 16.6%.

A multicentre study (Ghana, Guinea, Nigeria, Myanmar) cited by Yadav et al. found that the absence of a labour companion was significantly associated with non-consented care, suggesting companions facilitate decision-making and informed consent for procedures. Healthcare workers unanimously identified the following barriers to RMC provision: shortage of equipment and supplies (100%), lack of written policies (100%), staff shortage (100%), huge workload (100%), communication issues (100%), lack of curtains for privacy (80%), uncooperative women (70%), and language problems (50%). Higher education and income were significantly associated with better RMC ($p < 0.01$).

3. Birth Companionship in Low-Resource Settings: Zimbabwe

Goshomi et al. (2025) conducted a phenomenological qualitative study at a public health institution in Zimbabwe. Focused group discussions were held with 10 healthcare workers and 8 postnatal mothers. Four themes emerged: (i) knowledge of companionship in labour, (ii) challenges associated with companionship, (iii) alternative ways of implementing companionship, and (iv) benefits of companionship.

The study identified three novel forms of companionship adapted to constrained environments: physical presence companionship (conventional accompaniment), psychological presence companionship (sense of support through phone/video communication without physical proximity), and intermittent presence companionship (alternating physical and psychological presence). Notably, this study introduced 'psychological presence' into the academic literature for the first time, defining it as the woman's subjective sense of being supported and connected to her companion, even from a distance, which produced comparable anxiety-reduction effects to physical presence.

Key barriers in this setting included inadequate infrastructure (no curtained spaces), restrictive hospital policies excluding companions, privacy concerns when male companions are present, and chronic staff shortages necessitating companions for bag-carrying assistance. Women described the exclusion of their companions as a violation of their rights to respectful maternity care.

4. Intrapartum Quality of Care and Birth Volume: Italy

Fumagalli et al. (2024) analysed a population-based cohort of 145,224 healthy pregnant women in Lombardy, Italy (2018–2022), comparing high-volume hospitals (HV: ≥ 1000 births/year; n=103,274) with low-volume hospitals (LV: < 1000 births/year; n=41,950). Midwives attended 98.80% of all births regardless of hospital volume. Companion presence at birth was higher in HV hospitals (86.46% vs. 79.44%; aOR 1.53; $p < 0.001$), as were skin-to-skin contact (73.36% vs. 64.29%) and first breastfeeding within one hour (79.10% vs. 75.18%). Conversely, non-pharmacological coping strategies were used more frequently in LV hospitals (80.94% vs. 73.25%; aOR 0.80; $p < 0.001$). Epidural analgesia was significantly more common in HV hospitals (30.11% vs. 14.10%; aOR 2.26; $p < 0.001$), consistent with higher staff-to-patient ratios and potential overtreatment of healthy women.

5. Maternal Satisfaction with Intrapartum Care: Ethiopia

Silesh and Lemma (2021) conducted a facility-based cross-sectional study in five public hospitals of North Shoa Zone, Ethiopia (n=394 postpartum women). Overall maternal satisfaction with intrapartum care was only 28.2%, highlighting a critical quality gap in this LMIC context. Satisfaction was measured across three domains: interpersonal care (32.2% satisfied), information and decision-making (28.7% satisfied), and physical birth environment (38.1% satisfied).

Multivariable logistic regression identified four independent predictors: rural residence (AOR 1.93; 95%CI 1.18–3.16), planned pregnancy (AOR 2.25; 95%CI 1.21–4.16), four or more ANC visits (AOR 2.39; 95%CI 1.44–3.97), and labour duration ≤ 12 hours (AOR 2.46; 95%CI 1.38–4.40). Rural women's higher satisfaction likely reflects lower baseline expectations compared to urban counterparts who have greater healthcare system exposure. Frequent ANC attendance builds institutional familiarity and

Table 1: Summary of Key Included Studies

Sr. No.	Author & Year	Study Design	Country / Setting	Sample Size	Key Findings
1.	Goshomi et al., 2025	Qualitative Phenomenological Study	Zimbabwe (Low-resource public hospital)	10 HCWs + 8 postnatal mothers (2 FGDs)	Introduced concept of 'psychological presence'. Identified 4 types of companionship: physical, psychological, intermittent, and transit. Barriers: inadequate space, restrictive policies, privacy concerns, staff shortages.
2.	Fumagalli et al., 2024	Population-based Cohort Study	Lombardy, Italy (55 obstetric units)	145,224 healthy pregnant women (2018–2022)	Birth companion presence higher in HV hospitals (86.46% vs 79.44%; aOR 1.53). Non-pharmacological coping strategies used more in LV hospitals. Epidural use higher in HV hospitals.
3.	Yadav et al., 2022	Descriptive Cross-sectional Study	AIIMS Bhubaneswar, Odisha, India	246 postpartum women + 10 HCWs	61.38% reported good RMC. Non-confidential care: 94.30%; non-consented care: 62.26%; physical abuse: 16.6%. Barriers: staff shortage, workload, lack of policies, communication gaps.
4.	Silesh & Lemma, 2021	Facility-based Cross-sectional Study	North Shoa Zone, Ethiopia (5 public hospitals)	394 postpartum women	Overall satisfaction: 28.2%. Predictors: rural residence (AOR 1.93), planned pregnancy (AOR 2.25), ≥ 4 ANC visits (AOR 2.39), labour ≤ 12 hours (AOR 2.46).
5.	Dubey et al., 2023	Prospective Comparative Observational Study	Dr. B.R. Ambedkar Hospital, New Delhi, India	150 primigravida women (75 per group)	Spontaneous vaginal birth: 89.3% vs 76% ($p=0.03$). Reduced augmentation: 13.3% vs 30.7% ($p=0.01$). Earlier breastfeeding: 93.3% vs 73.3% ($p<0.01$). Maternal satisfaction: 80% vs 58.7% ($p<0.01$).
6.	Shalu & Devi, 2023	Narrative Review	India (Multi-study review)	9 studies reviewed	Birth companions reduce anxiety, provide physical comfort, serve as advocates, reduce medical interventions, and promote bonding. Hindering factors: hospital policies, cost, lack of awareness, cultural barriers.

DISCUSSION

This systematic review, encompassing six studies from India, Ethiopia, Italy, Zimbabwe, and a multi-country narrative review, provides compelling and convergent evidence that birth companionship is a safe, low-cost, and effective intervention to improve maternal and neonatal outcomes across diverse healthcare settings.

Mechanisms of Benefit

Birth companions exert their positive effects through multiple pathways. Emotionally, they reduce cortisol-mediated stress responses, lower anxiety, and foster a sense of safety — directly counteracting the fight-or-flight physiological state that can impair uterine contractility and prolong labour. Physically, techniques such as back massage, positioning support, and breathing coaching provide non-pharmacological analgesia, reducing the perceived need for epidural analgesia and oxytocin augmentation — findings consistently replicated across the included studies. Advocacy by companions ensures the woman's birth preferences are communicated and respected, particularly in settings where power imbalances between healthcare providers and labouring women are pronounced.

Psychological Presence: A Novel Contribution

The most conceptually innovative contribution of the included literature is Goshomi et al.'s (2025) formulation of 'psychological presence' — a paradigm-shifting concept that decouples companionship from strict physical co-location. In settings where spatial constraints, hospital policies, and privacy considerations preclude physical accompaniment, psychological presence through telephone and video communication may replicate many of the emotional benefits of physical presence. This finding is of immense practical relevance for LMICs and warrants further quantitative validation through randomised controlled trials.

Quality of Care and Systemic Factors

The Italian cohort study (Fumagalli et al., 2024) highlights that hospital organisational characteristics — particularly birth volume — significantly influence the provision of evidence-based intrapartum care. The higher prevalence of epidural analgesia in high-volume hospitals likely reflects staff workload constraints rather than maternal preference, pointing to systemic over-medicalisation of low-risk births. The parallel finding that

BirthCompanionshipInIntrapartumCare:ASystematicReview

non-pharmacological coping strategies are more prevalent in smaller hospitals supports WHO's recommendation to promote midwifery-led units as the preferred setting for low-risk births.

Across LMICs, the barriers to birth companionship are structural, attitudinal, and policy-level. Infrastructure limitations — shared open labour wards, absent curtains, inadequate room — make privacy-based exclusion of companions a logistical necessity that

Barriers and Implementation Challenges

nevertheless inflicts psychological harm. Healthcare worker attitudes range from supportive in principle to ambivalent in practice, often constrained by workload, training gaps, and institutional culture. The absence of formalised written policies in most LMIC facilities creates an accountability vacuum. Addressing these requires multi-pronged interventions: capital investment in facility infrastructure, policy reform mandating companion presence, healthcare worker training on RMC, and community education on patient rights.

Limitations

This review carries several limitations. The included studies are methodologically heterogeneous — spanning qualitative, cross-sectional, cohort, and comparative observational designs — precluding meta-analytic pooling. Most studies are from LMIC settings with limited generalisability to high-income countries, and vice versa. The Italian cohort study, though population-based, does not capture maternal birth satisfaction — a critical patient-reported outcome. The Ethiopian cross-sectional study is limited by potential courtesy bias, as satisfaction was assessed during hospitalisation. The Zimbabwe phenomenological study used a single-site design, limiting transferability. Future research should prioritise large-scale randomised controlled trials examining the psychological presence model in LMIC settings, longitudinal studies tracking postpartum mental health outcomes, and cost-effectiveness analyses of structured companion training programmes.

Disclosures

The authors declare no financial relationships or affiliations that could influence the conduct or results of this review. No external funding was received. This review was conducted independently to provide evidence-based conclusions regarding birth companionship and intrapartum care, free from commercial interest or external influence. All conclusions are derived solely from the published evidence synthesised herein.

CONCLUSIONS

Birth companionship — the presence of a chosen person during labour — is a powerful, evidence-based intervention with documented benefits across the birth continuum. This systematic review establishes the following conclusions:

- Birth companionship significantly increases spontaneous vaginal birth rates, reduces oxytocin augmentation, improves neonatal Apgar scores, promotes early breastfeeding, and enhances maternal satisfaction.
- In resource-limited settings, 'psychological presence' through voice and video communication represents a viable and innovative alternative to physical presence, with comparable emotional benefits.
- Barriers to birth companionship implementation include inadequate infrastructure, restrictive hospital policies, staff shortages, workload pressures, privacy concerns, and weak policy enforcement.
- Respectful maternity care (RMC) remains suboptimal in many LMICs, with significant deficits in consent practices, confidentiality, and dignified care, disproportionately affecting lower-income and less-educated women.
- Maternal satisfaction with intrapartum care is a multidimensional construct influenced by ANC attendance, pregnancy planning, labour duration, and healthcare setting characteristics.
- Hospital birth volume significantly affects intrapartum care practices; higher-volume hospitals show greater medicalisation of low-risk births, underscoring the need for midwifery-led pathways.

Achieving universal birth companionship requires coordinated action across policy, infrastructure, and clinical practice.

Governments and health systems must integrate structured companion training, formalise written policies guaranteeing companion access, invest in privacy-enabling infrastructure, and foster a culture of respectful, woman-centred intrapartum care. Birth companionship is not a luxury — it is a right.

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