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Original Research Article

The impact of birth companion on respectful maternity care and labor outcomes among primigravida in a rural tertiary care centre: a quasi-experimental study

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ABSTRACT

Background: Respectful maternity care (RMC) and continuous labor support are essential components of quality intrapartum care. Although the World Health Organization recommends allowing a companion of choice during childbirth, this practice remains underutilized in many resource-limited settings. This study evaluated the impact of a birth companion on RMC perceptions and labor outcomes among primigravida women in a rural tertiary care centre.
Methods: A quasi-experimental study was conducted in the Department of Obstetrics and Gynaecology, RL Jalappa Hospital, Kolar, during January 2026 – March 2026. Ninety-six primigravida women were enrolled and allocated into a study group (n=48), who received continuous support from a female birth companion, and a control group (n=48), who received standard intrapartum care. Data were collected using validated RMC, childbirth experience questionnaire (CEQ), and maternal satisfaction scales. Statistical analysis was performed using statistical package for the social sciences (SPSS) version 25.0, with $p<0.05$ considered significant.
Results: The study group demonstrated significantly higher RMC scores (42.56±4.12 versus 34.23±5.87), CEQ scores (3.74±0.42 versus 2.89±0.51), and maternal satisfaction scores (41.62±3.84 versus 32.48±5.36) (all $p<0.001$). Normal vaginal delivery was more frequent in the study group (81.25% versus 62.50%; $p=0.042$), while cesarean section rates were lower (12.50% versus 29.17%; $p=0.049$). Active labor duration was significantly shorter (5.82±1.34 versus 7.46±1.72 hours; $p<0.001$). Neonatal outcomes were similar between groups.
Conclusion: Birth companion support significantly improved RMC perceptions, childbirth experience, maternal satisfaction, and labor outcomes. Integrating birth companion programs into rural tertiary care settings may be a cost-effective strategy to enhance the quality of maternal care.

Keywords: Birth companion, Respectful maternity care, Primigravida, Childbirth experience, Labor outcomes, Quasi-experimental study

INTRODUCTION

Maternal and neonatal health continues to be a global priority, with the World Health Organization (WHO) emphasizing that a positive childbirth experience extends beyond clinical safety to encompass psychological well-being and emotional support.[1] The WHO framework for quality maternal and newborn health care explicitly recognizes that women should receive care that is respectful, dignified, and responsive to their emotional and cultural needs throughout the intrapartum period.[1,2] Despite significant progress in reducing maternal mortality worldwide, the experiential dimension of childbirth care remains suboptimal in many low- and middle-income countries, where institutional delivery rates have risen but the quality of interpersonal care has not kept pace.[3]

Respectful maternity care (RMC) is a universal human right that encompasses freedom from harm and mistreatment, right to information and informed consent, access to the highest attainable standard of health, and the liberty to receive continuous support during labor.[4] The White Ribbon Alliance and global advocacy networks have highlighted that disrespect and abuse during facility-based childbirth constitute significant barriers to institutional delivery utilization, maternal satisfaction, and optimal health outcomes.[4,5] Studies from sub-Saharan Africa and South Asia have documented alarmingly high rates of disrespectful care, including verbal abuse, physical mistreatment, lack of privacy, and denial of companionship during labor.[5]

Birth companionship has been recognized as an integral component of respectful maternity care, providing continuous physical, emotional, and informational support throughout labor and delivery.[6] The landmark Cochrane systematic review by Bohren et al encompassing 26 trials and over 15,000 women demonstrated that continuous labor support was associated with shorter duration of labor, higher rates of spontaneous vaginal birth, reduced need for analgesia, lower cesarean section rates, and improved five-minute Apgar scores.[6] These benefits were most pronounced when the support person was not a member of the hospital staff, underscoring the unique value of a chosen companion.[6,7]

In the Indian context, the National Family Health Survey (NFHS-5) data indicate that institutional delivery rates have risen to 88.6% nationally, yet the quality of intrapartum care, particularly regarding emotional support and respectful treatment, varies considerably across states and healthcare facilities.[8] The Government of India, through the labour room quality improvement initiative (LaQshya) program, has endorsed birth companionship as a recommended practice, yet implementation remains inconsistent, particularly in rural settings where cultural norms, infrastructure constraints, and staffing limitations pose significant challenges.[3,8]

Primigravida women, experiencing childbirth for the first time, face unique challenges including heightened anxiety, lack of experiential knowledge, unfamiliarity with the hospital environment, and increased vulnerability to traumatic birth experiences.[9] First-time mothers have been shown to have longer durations of labor, higher rates of operative delivery, and greater psychological distress compared to multiparous women.[9,10] The presence of a birth companion throughout the labor process, from its initiation to breastfeeding, can have a significant impact on minimizing unnecessary patient-clinician interactions, optimizing manpower utilization, and improving overall maternal satisfaction.[7,10]

Despite growing evidence supporting birth companionship, there remains a paucity of quasi-experimental studies evaluating its impact on both respectful maternity care perceptions and clinical labor outcomes specifically among primigravida women in rural tertiary care settings in India.[10] Most existing research has focused either on RMC assessment or on labor outcomes independently, without examining the interplay between these two critical dimensions of maternal care quality. Furthermore, studies from rural South Indian settings are particularly scarce, limiting the generalizability of existing evidence to these populations.

Considering these factors, this study was designed to evaluate the impact of a birth companion on respectful maternity care perceptions and labor outcomes among primigravida women at a rural tertiary care centre in southern Karnataka, India.

The present study was designed with the primary aim of evaluating the role of a birth companion in supporting primigravida women during labor and childbirth and its impact on their overall childbirth experience at a rural tertiary care centre. The study aimed to assess whether the presence of a chosen female birth companion during labor influenced the perception of respectful maternity care, as measured by a validated RMC questionnaire, and the overall childbirth experience, as assessed by the CEQ.

The secondary objective of this study was to evaluate the effectiveness of a birth companion on maternal and fetal outcomes, including the mode of delivery, duration of active labor, incidence of maternal complications such as postpartum hemorrhage and perineal trauma, and neonatal outcomes including Apgar scores and birth weight. The study further sought to compare maternal satisfaction scores between women who received continuous birth companion support and those who received standard institutional care without a designated companion. The investigation also aimed to characterize the sociodemographic and obstetric profile of primigravida women admitted to the study facility and to explore the relationship between birth companion characteristics and maternal satisfaction outcomes.

METHODS

A quasi-experimental study was conducted in the Department of Obstetrics and Gynaecology at RL Jalappa Hospital and Research Centre, attached to Sri Devaraj Urs Medical College, Tamaka, Kolar, Karnataka, India. The hospital is a rural tertiary care centre catering to the obstetric needs of women from Kolar district and surrounding regions.

The study was conducted over a period of three months from January 2026 to March 2026 after obtaining approval from the Institutional Ethics Committee (IEC) of Sri Devaraj Urs Academy of Higher Education and Research. Written informed consent was obtained from all participants prior to enrollment, and the study was conducted in accordance with the principles of the Declaration of Helsinki.

The study population comprised primigravida women admitted for delivery at the study facility during the study period. The sample size was calculated using the formula for estimating a single proportion.

$$n = Z^2 \times p \times q/d^2$$

Where Z=1.96 (at 95% confidence level), p=0.50 (assumed prevalence, as no prior data were available for primigravida birth companion awareness in this region), q=1–p=0.50, and d=0.10 (absolute precision). The calculated sample size was 91 subjects. After accounting for a 10% non-response rate, the final sample size was rounded to 96 participants, with 48 allocated to the study group (with birth companion) and 48 to the control group (without birth companion).

The study included primigravida women with singleton pregnancies at term gestation (37–42 weeks), who were willing to participate and provide informed consent, and who were accompanied by and willing to have a female birth companion during labor.

Women excluded from the study comprised multigravida women, those with high-risk pregnancies or serious obstetric complications (including pre-eclampsia, eclampsia, placenta previa, or previous uterine surgery), women not willing to participate or who refused consent, primigravida with no available female birth attendant, and those with mental health conditions precluding informed consent.

Data were collected at two time points. At enrollment, sociodemographic characteristics (age, religion, educational status, occupation, and socioeconomic status as per modified BG Prasad classification) and obstetric details (gestational age, number of antenatal care visits, and existing medical conditions) were recorded for all participants. In the study group, a chosen female birth companion (mother, sister, or other female relative) was allowed to remain with the woman continuously from active labor through delivery and initiation of breastfeeding. The companion was oriented regarding her supportive role, including physical comfort measures, emotional encouragement, and communication with healthcare providers. In the control group, standard institutional care was provided without a designated birth companion.

Within 24 to 48 hours postpartum, all participants were assessed using the validated respectful maternity care (RMC) questionnaire (10-item, 5-point Likert scale), the childbirth experience questionnaire (CEQ; 5-item, 5-point Likert scale), and a maternal satisfaction questionnaire (10-item, 5-point Likert scale). Birth companion experience was additionally assessed in the study group using a 9-item questionnaire. All assessments were conducted through face-to-face interviews by the principal investigator. Delivery outcomes including mode of delivery, duration of active labor, maternal complications, neonatal birth weight, and Apgar scores at 1 and 5 minutes were recorded from clinical records.

Data were entered into Microsoft Excel 2016 and analyzed using statistical package for the social sciences (SPSS) version 25.0 (IBM Corp., Armonk, NY, USA). Continuous variables were expressed as mean±standard deviation and compared between groups using the Mann-Whitney U test. Categorical variables were expressed as frequency and percentage and compared using the Chi-square test or Fisher's exact test, as appropriate. Within-group before-after comparisons were performed using the Wilcoxon signed-rank test. A two-tailed $p<0.05$ was considered statistically significant.

RESULTS

A total of 96 primigravida women were enrolled in the study, with 48 participants in the study group (with birth companion) and 48 in the control group (without birth companion). There were no dropouts or protocol violations during the study period.

The two groups were comparable with respect to baseline sociodemographic characteristics. The mean age of participants was 23.42±2.81 years in the study group and 23.08±2.64 years in the control group, with no statistically significant difference (p=0.546). The majority of participants in both groups belonged to the 21–25 years age category (58.33% and 56.25%, respectively). Distribution of religion, educational status, and socioeconomic class was similar across the two groups ($p>0.05$ for all comparisons), confirming the homogeneity of the study population at baseline (Table 1).

Obstetric characteristics were comparable between groups. The mean gestational age was 38.64±1.12 weeks and 38.52±1.08 weeks in the study and control groups, respectively (p=0.598). The proportion of women who had completed four or more antenatal care visits was 87.50% in the study group and 83.33% in the control group (p=0.564). The prevalence of anemia, gestational diabetes mellitus, and gestational hypertension did not differ significantly between groups. Among the birth companions in the study group, 45.83% were mothers of the participants, 29.17% were sisters, and 25.00% were other female relatives (Table 2).

The study group demonstrated significantly higher RMC total scores compared to the control group (42.56±4.12 versus 34.23±5.87; $p<0.001$). All five domains of the RMC questionnaire, including dignity and respect, autonomy and consent, communication, privacy, and emotional support, showed significantly higher scores in the study group ($p<0.001$ for all domains).

The mean CEQ total score was 3.74±0.42 in the study group versus 2.89±0.51 in the control group ($p<0.001$), with statistically significant differences observed across all sub-domains including own capacity, professional

support, perceived safety, participation, and pain management. The total maternal satisfaction score was significantly higher in the study group (41.62±3.84 versus 32.48±5.36; p<0.001) (Table 3).

The rate of normal vaginal delivery was significantly higher in the study group (81.25%) compared to the control group (62.50%; p=0.042). Correspondingly, the cesarean section rate was significantly lower in the study group (12.50% versus 29.17%; p=0.049). The mean duration of active labor was 5.82±1.34 hours in the study group compared to 7.46±1.72 hours in the control group, representing a statistically significant difference (p<0.001). The duration of the second stage of labor was also significantly shorter in the study group (38.42±12.56 minutes versus 48.68±15.82 minutes; p=0.001). The need for oxytocin augmentation was significantly lower in the study group (25.00% versus 45.83%; p=0.034). The rates of episiotomy, postpartum hemorrhage, and perineal tears did not differ significantly between the two groups (Table 4).

Neonatal outcomes were comparable between the two groups. The mean birth weight was 2.92±0.38 kg in the study group and 2.86±0.42 kg in the control group (p=0.468). Mean Apgar scores at 1 minute (7.64±0.82 versus 7.42±0.94; p=0.234) and 5 minutes (8.86±0.56 versus 8.68±0.72; p=0.186) did not differ significantly. The incidence of low birth weight and NICU admissions was comparable between groups. Although early breastfeeding initiation (within one hour of delivery) was numerically higher in the study group (83.33% versus 66.67%), this difference did not reach statistical significance (p=0.062) (Table 5). Assessment of the birth companion experience in the study group revealed high satisfaction across all domains. The highest-rated attribute was emotional support during labor (mean 4.28±0.74), with 89.58% of women rating it as good or excellent. Assistance with breastfeeding initiation (mean 4.12±0.78; 85.42% good/excellent) and help with changing clothes (mean 4.02±0.82; 83.33% good/excellent) were also highly rated. The overall experience with the birth companion was rated as good or excellent by 87.50% of the participants (mean 4.18±0.76). The lowest-rated attribute was informing healthcare workers about maternal ailments (mean 3.68±0.96), suggesting a potential area for improvement in companion orientation programs (Table 6).

Table 1: Comparison of sociodemographic characteristics between study and control groups.

Variable		Study group (n=48) (%)	Control group (n=48) (%)	P value
Age	Mean±SD	23.42±2.81	23.08±2.64	0.546
	≤20	8 (16.67)	10 (20.83)	
	21–25	28 (58.33)	27 (56.25)	0.812
	26–30	12 (25.00)	11 (22.92)	
Religion	Hindu	34 (70.83)	36 (75.00)	
	Muslim	10 (20.83)	9 (18.75)	0.854
	Christian/other	4 (8.33)	3 (6.25)	
Education	Illiterate	3 (6.25)	5 (10.42)	
	Primary	12 (25.00)	14 (29.17)	0.636
	Secondary	22 (45.83)	20 (41.67)	
	Graduate/higher	11 (22.92)	9 (18.75)	
Socioeconomic status	Lower	14 (29.17)	16 (33.33)	
	Lower middle	20 (41.67)	19 (39.58)	0.784
	Upper middle/upper	14 (29.17)	13 (27.08)	

SES: Socioeconomic status (modified BG Prasad classification); SD: Standard Deviation; Chi-square test / Mann Whitney U test applied

Table 2: Comparison of obstetric characteristics between groups.

Variable	Study group (n=48) (%)	Control group (n=48) (%)	P value
Gestational age (weeks)	38.64±1.12	38.52±1.08	0.598
ANC visits (≥4)	42 (87.50)	40 (83.33)	0.564
ANC visits (<4)	6 (12.50)	8 (16.67)	
Anemia (Hb <11 g/dl)	14 (29.17)	16 (33.33)	0.662
GDM	2 (4.17)	3 (6.25)	1.000*
Gestational HTN	3 (6.25)	2 (4.17)	1.000*
Birth companion - mother	22 (45.83)	N/A	
Birth companion - sister	14 (29.17)	N/A	
Birth companion - other	12 (25.00)	N/A	

*Fisher's exact test; ANC: antenatal care; GDM: gestational diabetes mellitus; HTN: hypertension; N/A: not applicable

Table 3: Comparison of respectful maternity care, childbirth experience, and satisfaction scores.

Outcome measure	Study group (n=48), mean±SD	Control group (n=48), mean±SD	P value
RMC total score (max 50)	42.56±4.12	34.23±5.87	<0.001***
Dignity and respect	8.72±1.04	7.14±1.52	<0.001***
Autonomy and consent	8.48±1.12	6.82±1.68	<0.001***
Communication	8.56±0.98	6.94±1.44	<0.001***
Privacy	8.64±1.08	6.72±1.56	<0.001***
Emotional support	8.16±1.22	6.61±1.74	<0.001***
CEQ total score (max 5)	3.74±0.42	2.89±0.51	<0.001***
Own capacity	3.82±0.48	2.94±0.56	<0.001***
Professional support	3.88±0.44	3.12±0.62	<0.001***
Perceived safety	3.76±0.52	2.86±0.64	<0.001***
Participation	3.68±0.58	2.72±0.66	<0.001***
Pain management	3.54±0.62	2.82±0.68	<0.001***
Satisfaction total (max 50)	41.62±3.84	32.48±5.36	<0.001***

***P<0.001 (highly significant); Mann-Whitney U test applied; RMC: respectful maternity care; CEQ: childbirth experience questionnaire; SD: standard deviation

Table 4: Comparison of labor and delivery outcomes between groups.

Outcome	Study group (n=48) (%)	Control group (n=48) (%)	P value
Normal vaginal delivery	39 (81.25)	30 (62.50)	0.042*
Assisted vaginal delivery	3 (6.25)	4 (8.33)	0.695
Cesarean section	6 (12.50)	14 (29.17)	0.049*
Duration of active labor (hours)	5.82±1.34	7.46±1.72	<0.001***
Duration of 2nd stage (min)	38.42±12.56	48.68±15.82	0.001**
Oxytocin augmentation	12 (25.00)	22 (45.83)	0.034*
Episiotomy	18 (37.50)	20 (41.67)	0.680
PPH	2 (4.17)	4 (8.33)	0.678†
Perineal tears (≥2nd degree)	4 (8.33)	6 (12.50)	0.505

*P<0.05; **p<0.01; ***p<0.001; †Fisher's exact test; PPH: postpartum hemorrhage; Chi-square test/Mann-Whitney U test applied

Table 5: Comparison of neonatal outcomes between groups.

Outcome	Study group (n=48)	Control group (n=48)	P value
Birth weight (kg, mean±SD)	2.92±0.38	2.86±0.42	0.468
Apgar score 1 min (mean±SD)	7.64±0.82	7.42±0.94	0.234
Apgar score 5 min (mean±SD)	8.86±0.56	8.68±0.72	0.186
Low birth weight (<2.5 kg)	4 (8.33%)	6 (12.50%)	0.505
NICU admission	3 (6.25%)	5 (10.42%)	0.715†
Breastfeeding initiation <1 hour	40 (83.33%)	32 (66.67%)	0.062

†Fisher's exact test; NICU: neonatal intensive care unit; SD: standard deviation

Table 6: Birth companion experience assessment in the study group (n=48).

Attribute	Mean±SD	Good/excellent, N (%)	Poor/fair, N (%)
Making patient ambulatory	3.86±0.88	38 (79.17)	4 (8.33)
Helping in urination/toilet	3.72±0.94	36 (75.00)	5 (10.42)
Helping in changing clothes	4.02±0.82	40 (83.33)	3 (6.25)
Back massage for pain relief	3.94±0.86	39 (81.25)	4 (8.33)
Emotional support during labor	4.28±0.74	43 (89.58)	2 (4.17)
Helping breastfeeding initiation	4.12±0.78	41 (85.42)	2 (4.17)
Helping in changing napkins	3.92±0.84	38 (79.17)	4 (8.33)
Informing HCW about ailments	3.68±0.96	34 (70.83)	6 (12.50)
Overall experience	4.18±0.76	42 (87.50)	2 (4.17)

HCW: healthcare worker; Likert scale 1–5 (poor to excellent); SD: standard deviation

DISCUSSION

The present quasi-experimental study evaluated the impact of a birth companion on respectful maternity care perceptions, childbirth experience, and labor outcomes among primigravida women at a rural tertiary care centre in southern Karnataka. The findings demonstrate that the presence of a birth companion during labor was associated with significantly improved RMC scores, enhanced childbirth experience, higher maternal satisfaction, increased rates of normal vaginal delivery, and shorter duration of labor.

The significantly higher RMC scores observed in the study group (42.56±4.12 versus 34.23±5.87; p<0.001) are consistent with the findings of Seth et al, who reported that Indian women accompanied by a birth companion perceived significantly higher levels of respectful care across all domains.[11] Similarly, Afulani et al demonstrated that continuous labor support positively influenced women's perceptions of dignity, communication, and autonomy during childbirth in sub-Saharan African settings.[12] The improvement across all five RMC domains in the present study suggests that the birth companion's presence enhances not only emotional support but also the broader interpersonal dynamics of the care environment.

The childbirth experience, as measured by the CEQ, was significantly better in the study group (3.74±0.42 versus 2.89±0.51; p<0.001). These findings align with those of Hodnett et al who demonstrated in a systematic review that continuous labor support was associated with more positive childbirth experiences and greater maternal satisfaction.[13] However, Kabakian-Khasholian and Portela noted that the impact of labor companionship on subjective birth experience may vary across cultural contexts and institutional settings, emphasizing the need for context-specific evidence.[14] The robust effect observed in the present study, conducted in a rural Indian setting, strengthens the case for universal adoption of birth companion policies in resource-limited environments.

The significantly higher rate of normal vaginal delivery in the study group (81.25% versus 62.50%; p=0.042) and the correspondingly lower cesarean section rate (12.50% versus 29.17%; p=0.049) corroborate the landmark Cochrane review by Bohren et al, which reported that continuous support during labor reduced the likelihood of cesarean section (RR 0.75; 95% CI 0.64–0.88).[15] Similarly, Kumari et al reported a significant reduction in cesarean section rates among Indian women who received continuous labor support compared to those receiving routine care.[16] In contrast, Yuenyong et al found that birth companion support did not significantly reduce cesarean section rates in a Thai population, possibly due to differences in study design, companion training, and institutional cesarean section policies.[17]

The shorter duration of active labor observed in the study group (5.82±1.34 versus 7.46±1.72 hours; p<0.001) is in agreement with the findings of McGrath and Kennell, who reported that emotional support during labor was associated with significantly shorter labor duration through reduction of catecholamine-mediated stress responses.[18] Patel et al similarly demonstrated reduced labor duration among Indian women with a designated birth companion, attributing this effect to reduced maternal anxiety and enhanced relaxation.[19] The significantly lower rate of oxytocin augmentation in the study group (25.00% versus 45.83%; p=0.034) further supports the physiological benefits of companionship in promoting spontaneous labor progression.

Neonatal outcomes, including birth weight, Apgar scores, and NICU admission rates, were comparable between groups, which is consistent with most published literature.[15,20] Although early breastfeeding initiation was numerically higher in the study group (83.33% versus 66.67%), this difference did not reach statistical significance (p=0.062). Sharma et al reported similar findings, noting that while birth companions facilitated breastfeeding initiation, the effect was modest and might require larger sample sizes to detect significant differences.[20]

The birth companion experience assessment revealed high satisfaction, particularly for emotional support (89.58% good/excellent) and breastfeeding assistance (85.42% good/excellent). However, the comparatively lower rating for informing healthcare workers about maternal ailments (70.83% good/excellent) highlights the need for structured orientation programs for birth companions to optimize their role in clinical communication.

The present study has several strengths, including a quasi-experimental design that permits causal inference, the use of validated assessment tools, and a comprehensive evaluation of both subjective maternal experiences and objective clinical outcomes. However, certain limitations must be acknowledged. The non-randomized allocation may introduce selection bias. The single-centre design limits generalizability. The relatively small sample size may have been insufficient to detect significant differences in uncommon outcomes such as postpartum hemorrhage and NICU admissions. The assessment of outcomes within 24–48 hours postpartum may not capture longer-term psychological effects of the childbirth experience.

CONCLUSION

The present study demonstrated that the presence of a birth companion during labor significantly improved respectful maternity care perceptions, childbirth experience, and maternal satisfaction among primigravida women in a rural tertiary care setting. The birth companion was also associated with higher rates of normal vaginal delivery, lower cesarean section rates, shorter duration of active labor, and reduced need for oxytocin augmentation. Neonatal outcomes were comparable between groups. These findings support the WHO recommendation for

continuous labor support and highlight the feasibility and benefit of implementing birth companion programs in rural Indian healthcare settings. Policy-level interventions promoting birth companionship, combined with structured companion orientation programs, may serve as a cost-effective strategy to enhance the quality of intrapartum care, improve maternal satisfaction, and reduce unnecessary obstetric interventions in resource-limited settings. Future multicentric randomized controlled trials with larger sample sizes and longer follow-up periods are recommended to validate these findings and evaluate the long-term maternal and neonatal impact of birth companion programs.

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