

RESEARCH

Open Access



The association between labor companionship and obstetric violence during childbirth in health facilities in five facilities in the occupied Palestinian territory

Yasmeen Wahdan^{1*} and Niveen M. E. Abu-Rmeileh¹

Abstract

Background Studies show that the presence of companionship during childbirth leads to positive outcomes for women. This study investigates the protective effect of having a labor companion on obstetric violence in the health facilities of the Occupied Palestinian Territory.

Methods A secondary analysis of a cross-sectional study of women who gave birth in five health centers in the occupied Palestinian territory up to 8 weeks following childbirth was performed. The presence of a labor companion was examined in relation to socioeconomic variables and physical abuse, verbal abuse or stigma or discrimination, failure to achieve professional standards, vaginal examinations, and pain relief.

Results According to the findings, the total number of women with a labor partner or a birth companion present at any stage during the labor process was 92% in the West Bank, and 77.4% in the Gaza Strip. According to the timing of support, 23.5% of women had a labor companion present during labor, childbirth, and after childbirth whilst in the hospital. Women who did not have labor companions were more likely than women who did to report at least one sort of mistreatment, such as unconsented procedures. Women with a labor companion were less likely to report abuse (16%) compared to women without labor companion. In terms of informed permission for procedures, 75% of women who did not have a labor companion had unconsented episiotomy.

Conclusion Labor companionship assists women by providing them with companions who are less likely to be mistreated during labor. Efforts should be made to best implement the presence of labor companions, including the duration of the labor companionship and women's preferences.

Keywords Labor, Companion, Mistreatment, Childbirth, Palestine

Introduction

Maternal health is defined as women's health during pregnancy, childbirth, and the postnatal period [1–3]. Each phase is an important event in the childbirth experience and should give women and their newborns to reach their recovery for health and well-being [3]. In global efforts to reduce maternal and newborn mortality and morbidity, the quality of care provided during childbirth in hospitals has been identified as a

*Correspondence:

Yasmeen Wahdan
yasminwahdan95@gmail.com

¹ Institute of Community and Public Health, Birzeit University, West Bank
Occupied Palestinian Territory, Birzeit, Palestine



necessary factor. Global efforts to promote maternal health to advance the quality of care delivered to pregnant women [1]. Women's experience of care is a crucial aspect of the quality of treatment, as defined by the World Health Organization (WHO) as ensuring that all women are treated with respect, have excellent communication with health personnel, and have access to support that meets their conditions and needs [1–5].

The care experiences of women have a direct effect on their mental well-being. Consequently, cross-sectional research revealed that more than one-third of women were subjected to at least one form of mistreatment [2, 4]. Fifty percent of women in hospitals across four countries reported not having a labor companion [1]. Companionship during childbirth is defined as the continuous presence of a support person during labour and birth [4]. Therefore, having a labor companion throughout birthing care is an excellent way to improve pregnant women's experiences by giving necessary care and support [2, 5]. Labor companionship improves the outcome of the woman and baby during childbirth [1, 6]. A Cochrane intervention review reported the significance of the presence of help for women during childbirth. Women with support were less likely to have a Caesarean section, less likely to report negative feelings about their childbirth care experience, labor was shorter, and there was a reduction in unpleasant birth experiences [7, 8]. This companion can be the woman's spouse, husband, friend, healthcare professional, or family member [9, 10]. According to the absence of a labor companion, women who did not have a labor partner were more likely to experience physical abuse, feel abandoned, and have poor communication [10].

Many countries do not yet have rules for labor companionship, and many healthcare facilities do not permit women to have a companion. So there are significant differences in hospital guidelines regarding labor companionship [1–3]. Private hospitals have adopted the presence of labor partners, although government hospitals have often disallowed this practice. This approach contrasts with women's demand for companionship or partners during labor and childbirth [4–6].

Despite labor companion importance, the presence of labor companions varies widely globally in different settings [8]. For example, 47.3% of women in Ghana have a labor companion [2]. 81% in Brazil [4], 55% in Iran [11], 12.7% of women in Guinea, and 23% of women in Myanmar had a labor companion [2]. According to a multi-country survey, the most common person acting as labor companions were family members (mother/ mother in law) [3]. And 73% of Syrian women preferred to have their mothers with them during childbirth [8].

Also, if the women receiving care from the midwife, this support will reduce unplanned caesarean sections and other medical interventions during labour as well as reduced maternal and neonatal morbidity [12].

In the occupied Palestinian territory, mistreatment during childbirth was 18.8%; this study assessed the quality of care during childbirth identified mistreatment. The presence of a companion or absence will substantially affect the women through the childbirth process. With such quality of care, we would investigate the association of having a labor companion [10].

Few studies document the association between Labor Companionship and the effect on obstetric violence during Childbirth in the region, particularly Palestine. This study investigates whether there is an association between a companion's presence and quality of care, and the quality of care will be measured through mistreatment.

Methods

This is a secondary data analysis based on a cross-sectional study done in the occupied Palestinian territory. A study started on 2/2019 until 2/2020 in five hospitals in West Bank and Gaza (three governmental hospitals, one private hospital, and one non-governmental hospital) [9]. In the preliminary investigation, five hospitals from the West Bank and Gaza Strip were chosen based on the inclusion criteria of (1) being a secondary or tertiary hospital and (2) having less than 200 births per month (3). Two hospitals were located in the heart of the West Bank, one public and the other private; two hospitals were located in the south, one public and the other private; and the final hospital was a public hospital in Gaza.

Data collection

Participants

Women were eligible to participate if they were at least 15 years old, had previously been admitted for childbirth, were willing to provide written consent to participate, were available for a follow-up interview up to 8 weeks post-partum, and lived within 15 km of the selected hospital [10].

Each study area had one data collector to trace the recruitment process. The data collectors were facility staff members from other departments that obtained appropriate training in safety measures and protection against COVID-19 compared to the research team [10]. For this study, they got clear instructions on the recruitment process and strategies, including the participants' wording, identification, eligibility lists, and reporting. The data collectors were trustworthy in accessing screening logs for hospital community surveys. Also, they documented to the participants that the interviews would

be via telephone or video call, and the women had the choice to select the best method for them [10].

The data interviewers had to analyze the community survey screening logs in the hospital and decide if each woman was suitable for inclusion based on the criteria. The survey screening log was done by trained research assistants who were part of the research team, had been given adequate training in surveying and were not healthcare providers. Oral consent was obtained from women at the hospital to contact them within two to six weeks post-partum. Due to the COVID-19 lockdown and protective measures, we conducted phone interviews with women to decrease fieldworker mobility, as it posed an increased risk to the team and the community [10]. The interviewers got a second oral consent from women after they agreed to participate in the study and later conducted the telephone interviews. The interviewers attempted to contact women up to five times over a two-week. Eligible women whom we could not reach were called up to five times before reporting the loss offollow-up. The interviewers used a pilot study to obtain consistent results and improve the validity of the answers [10].

Measurement tool

The development of the community survey tool has been described in previous studies [10]. Briefly, the questionnaire included different sections. The first one was related to sociodemographic data. The second was related to mistreatment typology (including physical and verbal abuse, stigma, or discrimination). The third section asked about the maternal outcome, babyoutcome, labor management practices, interventions, post-partum depression, and overall care satisfaction. An additional section related to assessing health service needs and provision during the COVID-19 pandemic was included. Finally, there were questions about the need and availability of health services, counseling services, and psychological services during the antenatal period and the need and availability of information about COVID-19, protective measures, and COVID-19 infection at the health facility during the childbirth process [10].

The primary independent variable in this study was the presence or absence of a labor companion at any time during care at the hospital, as reported by the women. (Total number of women with a labor partner or a birth-companion present at any stage during the labor process).

It was analyzed with dichotomous variables indicating the presence (yes/no) of any physical abuse (beating, slapping, kicking, pinching, or physically restraining women), nonverbal abuse (insulting, threatening, or blaming women), any stigma or discrimination (discrimination based on sociodemographic or medical characteristics), lack of informed consent during procedures

(the procedure was not explained or permission was not granted), and poor communication (concerns were not listened or responded to). We also included a new indicator variable indicating of physical abuse, verbal abuse, and stigma or discrimination [9]. Sociodemographic variables (age, education, marital status, number of pregnancies, number of previous births) and health outcome variables (physical abuse, verbal abuse, stigma or discrimination, failure to meet professional standards, vaginal examinations, and pain relief) were categorized as a proportion of the presence or absence of a labor companion.

Data analysis

The characteristics of the labor companion, including the timing of support and the identity of the labor companion, were investigated using a simple descriptive analysis. In addition, the connections between sociodemographic variables, obstetric characteristics, and abuse type by the presence or absence of a labor companion were assessed by descriptive crosstabulation. This was achieved using varied grouping and categorization as detailed below:

The mistreatment typology, physical or verbal abuse sub-items and stigma or discrimination sub-items were aggregated into dichotomous variables (yes or no replies) and combined into a single indicator for each item.

The association between a companion's presence and mistreatment was evaluated using a bivariate approach (physical abuse; verbal abuse; stigma or discrimination; non-consented vaginal examination; non-private vaginal examination; neglect; long wait times or delays; and poor communication). The data was later analyzed with SPSS software.

Result

The study involved 745 women, 475 from the West Bank and 270 from the Gaza Strip. Table 1 displays the characteristics of labor companionship by area (West Bank and The Gaza Strip). The presence of a labour companion at any point during care at the facility in oPt was as follow, 92.2 percent of women reported having a labor companion, compared to 96.7 percent in the Gaza Strip and 90 percent in the West Bank. In addition, 646 women reported the presence of a labor companion at any stage during the labor process. In the West Bank, 92% of women had a labor partner or birth companion present at any stage of labor, compared to 77.4% of women in the Gaza Strip. 23.5% of women had a labor companion present during labor, childbirth, and after childbirth in the hospital, ranging from 10% in Gaza to 35% in the West Bank, according to the time of support. Most labor companions were present during labor (75% in Gaza and 48.5% in the West Bank) and only after childbirth

Table 1 Characteristics of labor companionship by region

	Gaza N = 270 (%)	West bank N = 475 (%)	Total N = 745 (%)
Total number of women with a laborpartner or a birth-companion present at any stage during the labor process	209(77.4%)	437(92.0%)	646(86.7%)
Total number of women with a labor companion present at any point during care at the facility	261(96.7%)	431(90.7%)	692(92.2%)
Timing of support			
Labor only	0	4(0.9%)	4 (0.5%)
Childbirth only	0	2(0.5%)	2 (0.3%)
After childbirth only	24(8.9%)	52(10.9%)	76(10.2%)
During labor and childbirth only	7(3.3%)	8(1.8%)	15(2.0%)
During labor and after childbirth only	157(75.1%)	212(48.5%)	369(49.5%)
During childbirth and after childbirth only	0	4(0.9%)	4(0.5%)
During labor, childbirth, and after childbirth	21(10.0%)	154(35.2%)	175(23.5%)
Don't know	0	1(0.2%)	1(0.1%)
Labor companion			
Husband/male partner only	14(6.7%)	135(30.9%)	149(23.1%)
Family member only	206(98.2%)	405(92.7%)	611(94.6%)
Both (male partner and family member)	12(5.7%)	103(23.6%)	115(17.8%)
Friend only	1(0.5%)	7(1.6%)	8(1.2%)
Women trained to help	0	0	0
Traditional birth attendants	0	0	0
Others	0	0	0

(10.2%). The most prevalent labor companions were family members (94.6%), followed by husbands/male partners (23.1%), and then presence of 2 labor companion (male partners and family members) (17.1%).

Table 2 presents Sociodemographic information and obstetric characteristics of women by labor companion status. So, women who reported no presence of a labor companion were aged less than 29 years 74.5%, and 37.8% had some secondary education; 30.0% had one previous birth, while 29% this was their first pregnancy; 98% had delivered one baby in their most recent birth, and 71% had initiated breastfeeding within 24 h of birth.

Table 3 presents the prevalence of mistreatment typology by presence or absence of a labor companion. Women with a labor companion were significantly less likely to report any type of abuse (16%). More specifically, women with a labor companion were less exposed to physical abuse (2.5%) compared to (8.2%) of women without labor companion, and verbal abuse (14.7%) compared to (28.6%) of women with no labor companion.

Regarding informed consent for procedures, 75% of women without a labor companion received unconsented episiotomy. There was no significant difference in the prevalence of reported consent for vaginal examination-care, which was 64% without a labor companion episiotomies (75% without a labor companion and induction of labor (88% without a labor companion).

Regarding pain relief, there was a significant difference in terms of women who requested pain relief between women with a labor companion 53% compared to those without a labor companion 40%. Further, the percentage of women who denied pain relief during their time in the hospital was 27% for women without a labor companion.

According to communication, women with a labor companion were more likely to report that health staff not listened or respond to their concerns (70%) compared to women without a labor companion (45%). However, women with a companion had no significant difference in waiting a long time before being attended by health workers (32%) compared to women without a companion (30%). In terms of the absence of a staff member when the baby came out, there was no difference between women with a labor companion (10.5%) and women without a labor companion (9.6%).

Discussion

We presented the results of a community-based survey in the Occupied Palestinian Territory. We outlined the characteristics of labor companionship and investigated the relationship between labor companionship and abuse experiences. Women without labor partners were more likely to report mistreatment, and unconsented episiotomy than those with labor companions. Women with a labor partner were substantially less likely (16%) to

Table 2 Sociodemographic information and obstetric characteristics of women by labor companion status

	No labor companion present	Labor companion present	Total (N = 745)	p-value
Maternal age (years)				
≤ 19	14(14.3%)	78(12.1%)	92(12.4%)	0.367
20–24	29(29.6%)	150(23.2%)	179(24.1%)	
25–29	30(30.6%)	199(30.8%)	229(30.8%)	
30–34	13(13.3%)	135(20.9%)	148(19.9%)	
≥ 35	12(12.2%)	84(13.0%)	96(12.9%)	
Marital status				
Currently married	98(100%)	644(99.5%)	742(99.6%)	0.499
separated	0(0.0%)	3(0.5%)	3(0.4%)	
Education				
No education	1(1.0%)	0(0.0%)	1(0.1%)	0.005
Primary education	7(7.1%)	24(3.7%)	31(4.2%)	
Some secondary education	38(37.8%)	255(39.5%)	293(39.3%)	
Secondary education	15(15.3%)	72(11.1%)	87(11.7%)	
Tertiary education	38(37.8%)	291(45.0%)	328(44.1%)	
Vocational training	0(0.0%)	4(0.6%)	4(0.5%)	
Number of pregnancies (gravidity)				
1	28(28.6%)	149(23.1%)	178(23.9%)	0.488
2	16(16.3%)	143(22.1%)	159(21.4%)	
3	17(17.3%)	111(17.2%)	128(17.2%)	
4+	37(37.8%)	243(37.6%)	280(37.6%)	
Number of previous births (parity)				
1	31(30.6%)	169(26.3%)	200(27.0%)	0.733
2	21(21.4%)	146(22.7%)	167(22.5%)	
3	15(15.3%)	122(19.0%)	137(18.5%)	
4+	32(32.7%)	206(32.0%)	238(32.1%)	
Breastfeeding				
Currently breastfeeding†(yes)	97(99.0%)	596(92.1)	693(92.2%)	0.005
Currently breastfeeding†(no)	1(1.0%)	51(7.9%)	52(7.8%)	
Breastfeeding initiation†				
Within 1 h	70(71.4%)	401(64.6%)	471(65.5%)	0.234
Within 24 h	24(24.5%)	167(26.9%)	191(26.6%)	
Within 1 week or longer	4(4.1%)	53(8.5%)	57(7.9%)	
Number of babies at most recent birth				
One baby	96(98.0%)	625(96.7%)	721(96.9%)	0.397
Two babies	2(2.0%)	21(3.3%)	23(3.1%)	

report abuse. In general, women who had a companion to be present throughout labor and childbirth were less exposed to feelings of Neglect and ignore from health staff during childbirth. This was deemed a key aspect in boosting the quality of treatment during labor and childbirth [13, 14].

The findings showed that the most common labor companions were mothers and mothers in lows (family members), then the husband. This is related to cultural reasons, as the presence of a male companion is frowned

upon in many societies. As a result of the fearful form effect of the birthing scene on the sexual relationship. Or it was possibly owing to structural issues such as the presence of many women in the same room [1]. Labour companion is family or friends but the other type of support, such as trained women during childbirth (Doula (s), traditional birth attendants), was non-existent. But it is available in another context. We could not find it in the Palestinian context —moreover, the absence of this trend in Palestinian society. Because of Doula's support may

Table 3 Mistreatment among women with and without a labor companion present at any point during care

	No labor companion present	Labor companion present	Total	p-value
Any physical abuse, verbal abuse, or stigma, or discrimination	34(34.7%)	105(16.3%)	139(18.7%)	0.000
Any physical abuse	8(8.2%)	16(2.5%)	24 (3.2%)	0.008
Any verbal abuse	28(28.6%)	95 (14.7%)	124(16.6)	0.001
Any stigma or discrimination	0(0.0%)	5(0.8%)	5(0.7%)	0.494
Failure to meet professional standards				
Caesarean section (N= 745)	23(23.5%)	180(27.9%)	203(27.3%)	0.217
Unconsented Caesarean section (N= 203)	3(13.1%)	62(34.4%)	65(32.0%)	0.127
Episiotomy‡ (N= 251)	32(43.2%)	219(51.1%)	251(33.6%)	0.130
Unconsented episiotomy (N= 251)	24(75.0%)	152(69.4%)	176(70.1%)	0.001
Induction of labor (N= 700)	17(20.5)	123(20.0%)	140(20%)	0.521
Unconsented induction of labor (N= 140)	15(88.2)	102(82.9%)	117(83.5%)	0.177
Vaginal examination				
Woman had any vaginal examination	89(90.8%)	540(83.6%)	630(84.4%)	0.040
Unconsented vaginal examination	57(64.0%)	319(59.1%)	376(59.7%)	0.222
Pain relief				
Woman requested pain relief	39(39.8%)	345(53.3%)	384(51.5%)	0.008
Woman requested pain relief but did not receive pain relief	19 (48.7%)	168(48.6%)	187(48.6%)	0.002
Woman denied pain relief during time in hospital	26(27.4%)	86(13.4%)	112(15.2%)	0.001
Neglect and abandonment				
No staff member present when the baby came out ‡	7(9.6%)	48(10.5%)	55(10.4%)	0.506
Woman waited along time before attended by health workers	30(30.6%)	213(32.9%)	243(32.6%)	0.367
Woman felt ignored, neglected, or that her presence was a nuisance for health workers or staff	36(36.7%)	137(21.2%)	173(23.3%)	0.001
Communication				
Woman felt that health workers or staff not listened and responded to her concerns	44(45.4%)	444(70.0%)	488(66.7%)	0.000

be specifically applicable to perinatal immigrant women, especially those with limited resources, lack economic resources, and cannot access the best care and treatment [7, 14, 15].

Our finding reported the differences between Gaza and the West bank in having family members vs. having a husband, and this is due to cultural issues such as the bonding between the male–female relationship is strong. Our findings reported differences in having family members vs. having a husband between Gaza and the West Bank, and this is due to cultural issues (17–18) or hospital policies because the hospital in Gaza that collected the data was a governmental hospital where structured labor wards might not support companionship during childbirth [14].

Women who did not have a labor companion were more likely to have a bad birth experience [7, 16]. One of the most important advantages of the present companion is that it can lessen women's vulnerability to abuse [7, 17, 18]. This result is shown in the results, as 16.3% of women with a companion reported experiencing at least one sort of abuse, compared to 34.7% of women

without a companion. This finding is in line with previous research indicating that the absence of a labor companion increases the risk that a woman will experience mistreatment during childbirth and that the presence of a labor companion may protect against mistreatment and lead to a positive birth experience for women [1]. Also, based on the findings of the studies, the absence of a labor companion decreased the mothers' ability to express that they experience conflicts in various spheres of their daily lives and cannot discuss them with anyone. One of the main findings was that women with a labor companion were less exposed to unconsented vaginal examination, and unconsented episiotomy, which is consistent with evidence indicating that the presence of a labor companion decreased the possibility of unconsented treatments [10]. This finding is consistent with a review of women's perspectives conducted in high-income countries since labor companions can act as advocates who increase the communication of women's preferences to health workers [10].

In our study, the percentage of women who requested pain relief was higher among women with labor

companions. This result differs from the previous evidence, which indicates that the presence of a labor companion makes women request less pain relief [7, 10, 15]. However, the explanation can be that the presence of a labor companion increased her ability to ask for pain relief [19, 20]. Companions were supporters, which indicates they spoke up in support of the woman. Companions delivered helpful service, encouraging women to ask and discuss the health staff [16, 21].

Regarding communication, women with a labor companion reported feeling that health workers or staff listened and responded to their concerns. Also, the results indicated that they were less likely to feel ignored or neglected or that their presence was a nuisance to health workers or staff. This aligns with other studies that indicate that labor companions can be intermediaries who enhance the communication of women's preferences to clinical staff [1, 10, 11]. Also, companions can facilitate the communication process by helping women to feel in control of their concerns [2, 3, 12].

This study was conducted during the COVID-19 pandemic. A global study reported that the COVID-19 pandemic has negatively affected the provision of health care and women's right [22]. Fortunately, although the health system in the oPt was struggling with the pandemic, the presence of labor companions in the Palestinian context was high considering the provision of essential reproductive and maternal health services during the pandemic [23–26].

Conclusion

The presence of a labor companion was associated with a reduced risk of physical abuse, unconsented episiotomy, and less exposure to feeling ignored by medical professionals. Allowing women in occupied Palestinian territory to have a birthing companion of their choice can be a low-cost and effective method for reducing violence against women during labor and delivery. In the Palestinian context, efforts should be taken to adopt labour companionship across several elements and to guarantee that women's autonomy and choice are respected.

Strengths and limitations

This study documented relationship between the presence of labor companions and abuse during childbirth in Palestine especially during the COVID-19 pandemic when hospitals were required to prevent infections and maintain a suitable physical distance. However, the study analyzes secondary data and labour companion was secondary outcome and hence several factors of importance,

such as the duration of a companion's presence, were missing.

Acknowledgements

We would like to thank the administration and staff in the participating hospitals for supporting the data collection process. Also, we would like to thank the strong and patience women for participating in our study.

Author's contributions

YW conducted the data analysis and prepared the first draft of the manuscript. YW was involved in the main study supervised by NMEAR. YW and NMEAR wrote, revised and approved the main manuscript.

Funding

This study was funded by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), a cosponsored program executed by the World Health Organization (WHO).

Availability of data and materials

The datasets used or analyzed during the current study are available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate

This study methodology and protocol were approved by the WHO Ethical Review Committee, WHO Review Panel on Research Projects, the Institute of Community and Public Health at the Birzeit University Ethics Research Committee, and Ministry of Health. Informed consent was obtained from all participating women. Oral informed consent was obtained from women at the hospital to contact them within two to six weeks postpartum. The process to obtain oral informed consent from an illiterate participant was approved by the two committees which are: "Research Ethics Review Committee (WHO ERC)" and "Institute of Community and Public Health Ethics Review Committee."

Due to the Covid-19 lockdown and protective measures, we conducted phone interviews with women to reduce fieldworker mobility as it posed high risk for the team and the community. The interviewers obtained a second oral informed consent from women to conduct telephone interview after they agreed to participate in the study. Oral informed consent was approved by the WHO ethics Review Committee and ICPH Ethics Review Committee. The study was carried out in accordance with the relevant guidelines and regulations. The study did not include women less than 18 years old and hence informed consent was obtained from the legally authorized representative or the legal guardian was not required.

In our population, all women had at least 6 years of schooling (primary education). However, we have only one woman with no education. So for illiterate women, the researcher read all the information provided in the contact form and responded to all questions, and then oral informed consent was obtained from the said participant. The oral informed consent process is done between our researcher and participant by conversing to give information and obtain consent.

Consent for publication

Not applicable.

Competing interests

The authors declare they have no competing interests.

Received: 14 February 2023 Accepted: 25 June 2023

Published online: 05 August 2023

References

1. Were WM, MacLennan C, et al. Quality of care for pregnant women and newborns—the who vision. *BJOG Int J Obstet Gynaecol.* 2015;122:1045–9.
2. Bohren MA, Mehtash H, Fawole B, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. *Lancet.* 2019;394:1750–63.
3. Bohren MA, Vogel JP, Hunter EC, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med.* 2015;12:e1001847.
4. DA MATTA MACHADO FERNANDES, Luísa, et al. Brazilian women's use of evidence-based practices in childbirth after participating in the Senses of Birth intervention: a mixed-methods study. *Plos one,* 2021, 16.4: e0248740]
5. Khosla R, Zampas C, Vogel JP, et al. International human rights and the mistreatment of women during childbirth. *Health Hum Rights.* 2016;18:131–43.
6. Bohren MA, Hunter EC, Munthe-Kaas HM, et al. Facilitators and barriers to facility-based delivery in low- and middle-income countries: a qualitative evidence synthesis. *Reprod Health.* 2014;11:71.
7. Balde MD, Nasiri K, Mehtash H, et al. Labour companionship and women's experiences of mistreatment during childbirth: results from a multi-country community-based survey. *BMJ Glob Health.* 2020;5:1–10.
8. Bohren MA, Hofmeyr GJ, Sakala C, et al. Continuous support for women during childbirth. *Cochrane Database Syst Rev.* 2017;7:CD003766.
9. Organization WH. *Who recommendations: intrapartum care for a positive childbirth experience.* Geneva, Switzerland: World Health Organization; 2018.
10. Abu-Rmeileh ME. N, Wahdan, Y, Exploring women's experiences during childbirth in health facilities during COVID-19 pandemic in occupied palestinian territory: a cross-sectional community survey. *BMC Pregnancy Childbirth.* 2022;22(1):1–11.
11. Fathi Najafi T, Latifnejad Roudsari R, Ebrahimipour H. The best encouraging persons in labor: A content analysis of Iranian mothers' experiences of labor support. *PLoS ONE.* 2017;12(7):e0179702.
12. Mortensen B, Lieng M, Diep LM, Lukasse M, Atieh K, Fosse E. Improving Maternal and Neonatal Health by a Midwife-led Continuity Model of Care—An Observational Study in One Governmental Hospital in Palestine. *EclinicalMedicine.* 2019;1(10):84–91.
13. Shakibazadeh E, Namadian M, Bohren MA, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. *BJOG.* 2018;125:932–42.
14. Emelonye AU, Pitkäaho T, Aregbesola A, et al. Spouses' perspective of their participation and role in childbirth pain relief. *Ann Med Health Sci Res.* 2016;6:367–74.
15. Kozhimannil KB, Vogelsang CA, Hardeman RR, Prasad S. Disrupting the pathways of social determinants of health: doula support during pregnancy and childbirth. *J Am Board Fam Med.* 2016;29(3):308–17.
16. Bohren MA, Vogel JP, Fawole B, et al. Methodological development of tools to measure how women are treated during facility-based childbirth in four countries: labor observation and community survey. *BMC Med Res Methodol.* 2018;18:132.
17. Vogel JP, Bohren MA, Tunçalp Ö, et al. How women are treated during facility-based childbirth: development and validation of measurement tools in four countries - phase 1 formative research study protocol. *Reprod Health.* 2015;12:60.
18. Organization WH. *Reproductive, maternal, newborn, child, and adolescent health policy survey.* Geneva, Switzerland: World Health Organization; 2018.
19. Adeniran A, Adesina K, Aboyeji A, et al. Attitude and practice of birth attendants regarding the presence of male partner at delivery in Nigeria. *Ethiop J Health Sci.* 2017;27:107–14.
20. Khesheh R. Support in the first stage of labour from a female relative: the first step in improving the quality of maternity services. *Midwifery.* 2010;26(6):e21–4.
21. Craymah JP, Opong RK, Tuoyire DA. Male involvement in maternal health care at Anomabo, central region, Ghana. *Int J Reprod Med.* 2017;2017.
22. Asefa A, Semaan A, Delvaux T, et al. The impact of COVID-19 on the provision of respectful maternity care: findings from a global survey of health workers. *Women Birth.* 2021. <https://doi.org/10.1016/j.wombi.2021.09.003>.
23. United Nations Population Fund. Arab States Region COVID-19 Situation Report No. 8. Reporting Period: 1–30 September 2020.
24. Emelonye AU, Pitkäaho T, Aregbesola A, et al. Barriers to spousal contribution to childbirth pain relief in Nigeria. *Int Nurs Rev.* 2017;64:568–75.
25. Alexander A, Mustafa A, Emil SAV, et al. Social support during delivery in rural central Ghana: a mixed methods study of women's preferences for and against inclusion of a lay companion in the delivery room. *J Biosoc Sci.* 2014;46:669–85.
26. Kabakian-KH, Tamar, et al. Implementation of a labour companionship model in three public hospitals in Arab middle-income countries. *Acta Paediatrica.* 2018;107:35–43.

Publisher's Note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Ready to submit your research? Choose BMC and benefit from:

- fast, convenient online submission
- thorough peer review by experienced researchers in your field
- rapid publication on acceptance
- support for research data, including large and complex data types
- gold Open Access which fosters wider collaboration and increased citations
- maximum visibility for your research: over 100M website views per year

At BMC, research is always in progress.

Learn more biomedcentral.com/submissions

