O MUNDO DA SAÚDE

ARTICLE ORIGINAL

DOI: 10.15343/0104-7809.202650e18272025I
ISSN: 1980-3990

Inclusion of a companion in the operating room for cesarean delivery: a synthesis of evidence

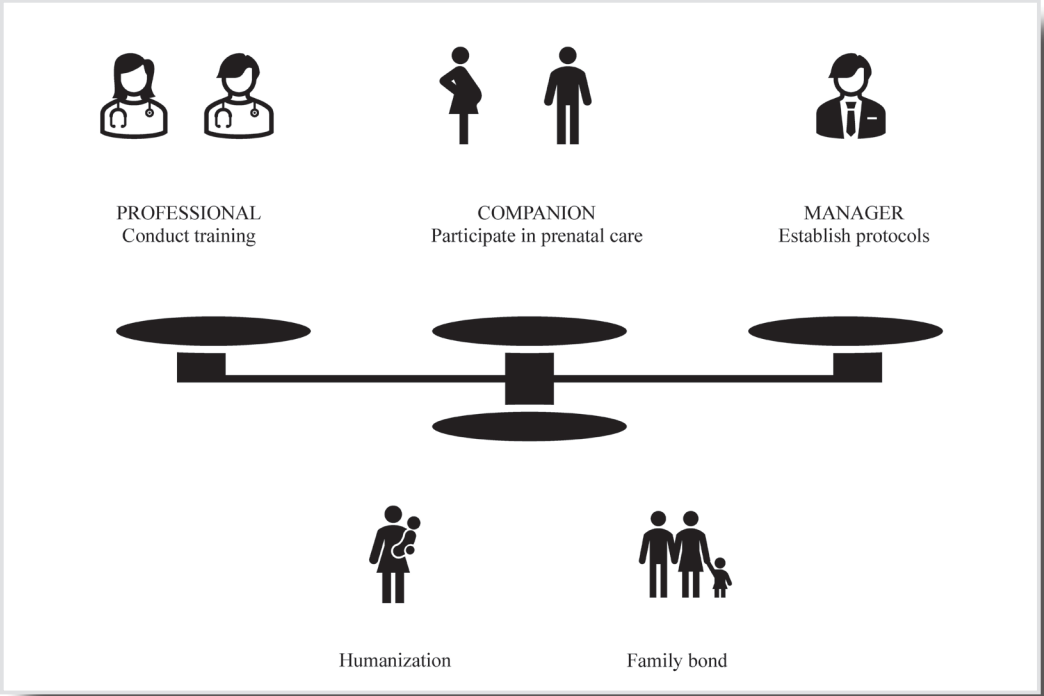
José Cosme dos Santos Camargo[1,2] **Maria Isabel do Nascimento**[3] **Valdecyr Herdy Alves**[4]

[1]Mestrado Profissional em Saúde Materno Infantil. Faculdade de Medicina, Universidade Federal Fluminense – UFF. Niterói/RJ, Brasil.
[2]Hospital Universitário Antônio Pedro (HUAP), Universidade Federal Fluminense – UFF. Niterói/RJ, Brasil.
[3]Departamento de Cirurgia Geral e Especializada, Faculdade de Medicina, Universidade Federal Fluminense – UFF. Niterói/RJ, Brasil.
[4]Escola de Enfermagem Aurora Afonso Costa, Universidade Federal Fluminense – UFF. Niterói/RJ, Brasil.
E-mail: jcscamargo@gmail.com

Highlights

- *The systematic review (PRISMA) retrieved 236 publications and included 21 of these.*
- *The companion should participate in educational activities during prenatal care.*
- *Companion support humanizes childbirth and increases maternal satisfaction.*
- *The presence of a companion encourages and comforts the parturient.*
- *Adoption of protocols and training of multidisciplinary teams are essential.*
- *The evidence reinforces the importance of Childbirth Humanization Policies.*

Graphical Abstract



Abstract

The companion of the pregnant woman is the person chosen by the woman to remain by her side throughout the entire childbirth process. The objective of this study was to synthesize the evidence addressing recommendations for companions present in the operating room during cesarean delivery. This is a systematic review that followed the guidelines established by the instrument "Preferred Reporting Items for Systematic Reviews and Meta-Analyses" (PRISMA) and sought to answer the question: "What is the current state of the art regarding recommendations for including companions of women in labor during cesarean section?". The review retrieved 236 publications and included 21 of them. The most prevalent profile of companions present during cesarean delivery was that of an adult individual, male, the baby's father, the woman's partner, and with completed secondary education. One of the main recommendations directed to companions was to attend educational activities offered during prenatal care, in order to acquire knowledge about the parturition process, including the use of non-pharmacological techniques for pain relief. The reviewed literature indicates that companions should participate in educational activities during prenatal care, an approach that improves maternal experience and contributes to the humanization of childbirth. The integration of companions in cesarean delivery requires the implementation of institutional protocols, training for healthcare professionals, and structural adaptations of health services.

Keywords: Companion. Cesarean Section. Guidance. Humanized Childbirth.

Associate Editor: Edison Barbieri
Mundo Saúde. 2026,50:e18272025
O Mundo da Saúde, São Paulo, SP, Brasil.
https://revistamundodasaude.emnuvens.com.br

Received: 04 october 2025.
Accepted: 23 march 2026.
Published: 23 april 2026.

INTRODUCTION

The companion of the parturient acts as a link between healthcare professionals and patients and has become an increasingly present figure in health services, working alongside professionals from different fields involved in the care process. These individuals help improve the reception of those who require psychological support and encouragement to face moments of fragility and insecurity that characterize the course of childbirth. They act as intermediaries in decision-making regarding therapeutic proposals and contribute to improving case outcomes. Therefore, the companion should be considered an "integral component of the therapeutic plan," according to clinical evidence guiding actions of the Ministry of Health[1].

The presence of a companion for the parturient is independent of the type of delivery (vaginal or cesarean) and is a right that contributes to maternal and child well-being and to the humanization of childbirth and birth care[2]. However, the inclusion of a companion in the operating room requires appropriate guidance and recommendations, in addition to compliance with institutional protocols[1].

It is expected that the presence of a companion contributes to reducing maternal anxiety, promotes family bonding, and enhances the humanization of surgical childbirth. However, there are barriers to the effective inclusion of companions in the surgical environment, represented not only by institutional challenges — such as the need for specific professional training, the use of protocols, and the provision of appropriate facilities to accommodate companions — but also by resistance from some professionals and managers[1].

The operating center is considered a hospital unit composed of several areas with different purposes. In recent guidelines, these areas have been defined as procedure rooms and operating rooms, including restricted and semi-restricted areas[3]. The operating room is a restricted environment for diagnostic and therapeutic procedures, involving anesthetic techniques in an aseptic setting. It is a space divided into functional zones for activities required during surgery. These include: the sterile zone, which surrounds the surgical table; the circulation zone, where professionals and companions move during the anesthetic-surgical procedure; and the anesthesia zone, where the anesthesia team performs tasks and procedures inherent to the specialty. This structure may pose risks to the multidisciplinary team, the patient, and the companion, as well as increasing the possibility of contamination due to the presence of individuals unfamiliar with such a restricted environment[4].

Considering the legal framework in force in Brazil, which guarantees the pregnant woman the right to be accompanied by a person of her free choice and trust during all stages of childbirth, this study turns to the scientific literature with the objective of synthesizing the evidence regarding recommendations and guidelines that support the participation of companions in the operating room during cesarean procedures.

METHODS

A systematic review with a narrative synthesis approach was conducted between February 2024 and February 2025, on the topic "companion of parturient present in the cesarean operating room," aiming to answer the question: "What is the state of the art regarding recommendations for including companions of parturients in the cesarean operating room?"

The development and presentation of the results of the systematic review followed the narrative synthesis model[5] and were structured according to the criteria established by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses instrument[6], encompassing: (I) independent reading of titles/abstracts; (II) duplicate checking; (III) analysis of agreement among researchers; (IV) full-text reading; (V) extraction of final data; (VI) narrative synthesis of results.

Information sources and descriptors

The review was conducted through consultation of the following bibliographic databases: (i) Scientific Electronic Library Online (SCIELO), (ii) Latin America and the Caribbean Literature on Health Sciences (LILACS), (iii) Medical Literature Analysis and Retrieval System Online (MEDLINE/PUBMED), and (iv) Web of Science. Manual searches were also performed on Google web pages.

Search strategies

To retrieve studies focusing on guidance for companions present in the operating room, the following English-language descriptors were used: 'companion', 'companionship', 'partner', 'caesarean section', 'cesarean section', 'cesarean operating', 'caesarean delivery', 'integration', 'implementation', 'orientation', 'recommendation'. In order to achieve the broadest possible coverage of publications, combinations of terms were adapted to each bibliographic database, as shown in Table 1.

Mundo Saúde. 2026,50:e18272025
DOI: 10.15343/0104-7809.202650e18272025I

Table 1 - Bibliographic databases and search strategy applied in the systematic review conducted between February 2024 and February 2025, Niterói, Rio de Janeiro, Brazil.

Bibliographic database	Descriptors and Boolean operators
SCIELO Brazil	*(companion OR companionship OR partner) AND (cesarean section OR caesarean section OR cesarean operating OR caesarean delivery)*
LILACS	*(companion* OR partner) AND (cesarean section OR caesarean section OR cesarean operating OR cesarean delivery)*
PUBMED/MEDLINE	*((((companion[Title/Abstract]) OR (companionship[Title/Abstract])) OR (partner[Title/Abstract])) AND (((cesarean section) OR (cesarean delivery)) OR (cesarean operating))) AND ((((integration) OR (implementation)) OR (recommendation)) OR (orientation))*
Web of Science	*((TS=(Companion OR Companionship OR Partner)) AND ALL=(caesarean section OR cesarean section OR caesarean delivery OR cesarean delivery OR caesarean operating OR cesarean operating)) AND ALL=(integration OR implementation OR orientation OR recommendation)*
Manual search	
Google	*companion AND cesarean section*

Sources: SCIELO Brazil; LILACS; PUBMED/MEDLINE; Web of Science; Google.

Eligibility criteria

The primary objective was to synthesize the guidance directed at companions of obstetric patients present in operating rooms. Studies addressing guidance directed to healthcare professionals, managers, and companions were included. Review studies were excluded because, in the authors' view, the detailing of the issue could be better captured through experiences reported in primary studies, in addition to the fact that reviews require specific methodologies. Studies written in languages other than English, Portuguese, and Spanish were also excluded.

Data extraction and variables of interest

Two researchers were responsible for study selection and data collection, according to the inclusion and exclusion criteria. A data extraction form was developed, considering the following study characteristics: (i) publication characteristics (author(s), year, country, journal, title); (ii) characteristics of the companion (partner, family member, healthcare professional, friend, doula, other); (iii) guidance provided to companions present in the surgical center/operating room; (iv) guidance provided to healthcare professionals/managers.

In cases of lack of consensus regarding study inclusion, the researchers reviewed the study, discussed the points of disagreement, and jointly decided on inclusion or exclusion. Cohen's Kappa coefficient was used to measure interobserver agreement, with interpretation based on the classification proposed by Landis & Koch (1977)[7], defined as: none/poor (≤ 0), slight (0.01–0.20), fair (0.21–0.40), moderate (0.41–0.60), substantial (0.61–0.80), and almost perfect/perfect (0.81–1.00).

Assessment of the quality of included studies

The methodological quality of the studies was assessed independently by two researchers using the instrument named "Mixed Methods Appraisal Tool" (MMAT)[8]. The MMAT was selected due to its suitability for evaluating virtually all types of study designs. The analytical criteria and final assessment were summarized according to the criteria established for each study design.

Ethical aspects

This study employed a review methodology based on the retrieval of publications available in bibliographic databases, conducted without direct or indirect involvement of human research participants and, therefore, exempt from formal evaluation by a Research Ethics Committee.

RESULTS

Operationalization of the review

This review retrieved 236 publications, identified in the following bibliographic databases: (i) Scientific Electronic Library Online (SCIELO) (n = 16), (ii) Latin America and the Caribbean Literature on Health Sciences (LILACS) (n = 69), (iii) Medical Literature Analysis and Retrieval System Online (MEDLINE/PUBMED) (n = 79), and (iv) Web of Science (n = 56). Manual searches of the first 10 pages of Google yielded 16 studies eligible for assessment.

After removal of duplicates (n = 52), 184 publications remained eligible for abstract screening and selection for full-text review.

After title and abstract screening, 127 publications did not meet the scope of the review and were excluded during the initial screening for the following reasons: outside the scope of the review (n = 116), literature reviews (n = 10), and publication not classified as an article (n = 1). Fifty-seven publications were eligible for full-text reading. At this stage, 36 studies were excluded for the following reasons: outside the scope (n = 33), literature review (n = 1), and publications that were not articles (n = 2).

The process of study selection and inclusion was evaluated through interobserver agreement, indicating a simple agreement of 91.10% and agreement measured by Cohen's Kappa coefficient of 52.23%, classified as moderate.

After completing the selection stages, 21 publications were included in the review (Figure 1).

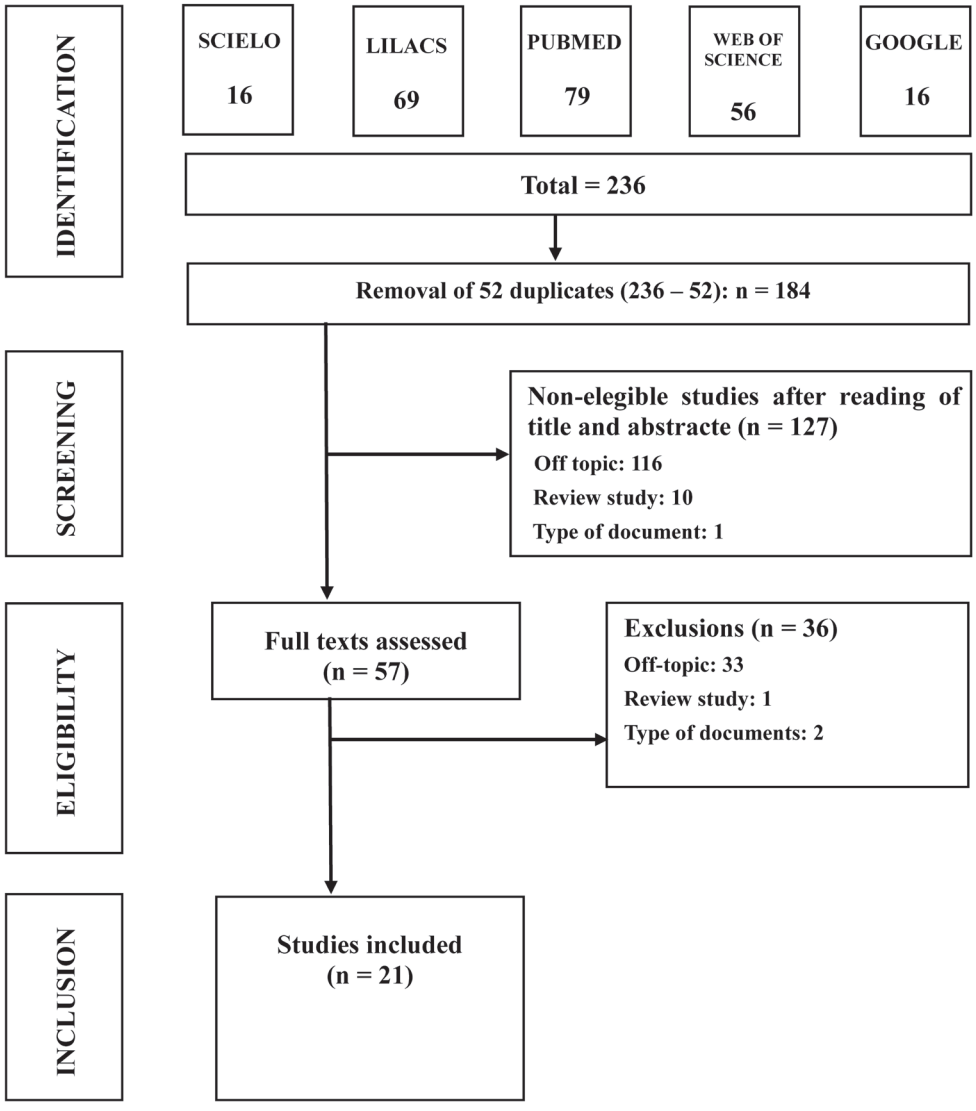


Figure 1 - Flowchart of the study selection process included in the review.

The characterization of the studies included in the review (n = 21) indicated that the majority (n = 12) were conducted in Brazil. One study was multicenter (Egypt, Lebanon, and Syria). Four studies adopted a comparative quantitative approach, while the remaining studies were conducted using descriptive quantitative (n = 5), qualitative (n = 11), and mixed-methods (n = 1) designs. Table 2 summarizes the characteristics of the studies included.

Table 2 - Characterization and thematic axes of the studies included in the systematic review conducted between February 2024 and February 2025, in Niterói, Brazil.

Study Qualification				Thematic Axes (recommendations)			
Author	**Year**	**Country**	**Type**	**Profile**	**Companion**	**Professional**	**Manager**
Batista *et al.*[9]	2017	Brazil	Comparative quantitative	Yes	No	Yes	No
de Quadros *et al.*[10]	2023	Brazil	Comparative quantitative	Yes	No	No	Yes
Younes *et al.*[11]	2020	Egypt	Comparative quantitative	No	No	Yes	Yes
Zanardo *et al.*[12]	2020	Italy	Comparative quantitative	No	No	Yes	Yes
Alwahaibi *et al.*[13]	2025	Oman	Descriptive quantitative	Yes	No	No	No
Diniz *et al.*[14]	2014	Brazil	Descriptive quantitative	Yes	No	No	Yes
Figueiredo *et al.*[15]	2013	Brazil	Descriptive quantitative	Yes	No	Yes	No
Junges *et al.*[16]	2018	Brazil	Descriptive quantitative	Yes	No	Yes	No
Nieto-Calvache *et al.*[17]	2022	Colombia	Descriptive quantitative	No	Yes	Yes	No
Almeida *et al.*[18]	2018	Brazil	Qualitative	Yes	No	Yes	Yes
Alves *et al.*[19]	2013	Brazil	Qualitative	Yes	Yes	Yes	Yes
Brüggemann *et al.*[20]	2015	Brazil	Qualitative	No	No	Yes	Yes
Johansson M *et al.*[21]	2013	Sweden	Qualitative	Yes	No	Yes	No
Machado *et al.*[22]	2022	Brazil	Qualitative	No	No	Yes	Yes
Maziero *et al.*[23]	2020	Brazil	Qualitative	No	No	No	Yes
Mazzetto *et al.*[24]	2022	Brazil	Qualitative	Yes	No	Yes	No
Muhandule *et al.*[25]	2024	Brazil	Qualitative	Yes	No	Yes	No
Rungreangkulkij *et al.*[26]	2022	Thailand	Qualitative	No	No	Yes	Yes
Summerton *et al.*[27]	2021	South Africa	Qualitative	Yes	Yes	No	Yes
Yaya Bocoum *et al.*[28]	2023	Burkina Faso	Qualitative	No	Yes	No	Yes
Kabakian-Khasholian *et al.*[29]	2018	Egypt, Lebanon, and Syria	Quantitative and qualitative	No	No	No	Yes

The quality assessment of the studies included in the review was conducted using the Mixed Methods Appraisal Tool (MMAT) and showed that, across the four classes of study designs, studies partially met the MMAT criteria. The assessment of confounding, reporting of non-response/refusal rates, issues related to data collection, and justification for the use of mixed-methods approaches were the main gaps identified in the evaluation (Figure 2).

Thematic axes of the review

In line with the questions that guided the review, twelve studies[9,10,13,14,15,16,18,19,21,24,25,27] outlined the profile of individuals who assumed the role of companion to parturients; four studies[17,19,27,28] highlighted recommendations directed to companions; fourteen studies[9,11,12,15,16,17,18,19,20,21,22,24,25,26] addressed recommendations directed to healthcare professionals; and thirteen studies[10,11,12,14,18,19,20,22,23,26,27,28,29] addressed recommendations directed to managers. Only one study[19] encompassed all thematic axes of this review.

a) Description of the companion profile

The twelve studies[9,10,13,14,15,16,18,19,21,24,25,27] that outlined the profile of individuals acting as companions to parturients addressed the topic mainly through the description of sociodemographic characteristics, including sex, educational level, and relationship to the parturient.

Companions chosen by pregnant women were predominantly family members or individuals from their social network[15]. The most prevalent profile of companions during cesarean delivery was that of an adult male, the baby's father, partner, with completed secondary education[9,10,14,16,18,19,24,25]. Some studies reported a higher proportion of female companions compared to male participation[13,27]. Sister, mother, aunt, sister-in-law, godmother, and individuals from the woman's social network were among those who accompanied parturients[10,19,24,25]. In some cases, the father of the parturient and/or her child was identified as the companion[13,16]. Although not related by kinship, the doula was also among those present during childbirth[14].

b) Recommendations directed to companions

Only four studies[17,19,27,28] addressed recommendations directed to individuals acting as companions to parturients. These recommendations contribute to facilitating the progression of the parturition process, as prior preparation increases the companions' satisfaction and sense of security.

Authors recommend that potential companions attend educational sessions in order to acquire knowledge about the parturition process, including the use of non-pharmacological techniques for pain relief. This preparation is expected to enable companions to develop the skills necessary to provide continuous support to the parturient[19,27,28].

Access of companions to maternity sectors requires adjustments to logistical demands. For example, the provision of a safe place to store personal belongings, facilities for changing clothes with privacy, areas for meals, rest, and physiological needs, as well as guidance aimed at facilitating the presence of the companion alongside the parturient with respect and dignity[19].

The first family embrace should be provided by the companion, who should be responsible for bringing the newborn from the care room to the post-anesthesia recovery room, where the companion also awaits the arrival of the puerpera. Support from the companion in the immediate postpartum period should promote or optimize breastfeeding[19].

Given the possibility of adverse conditions arising in the operating room, companions should be informed that their presence may be contingent upon the clinical evolution of the parturient. Complications involving significant blood loss, altered level of consciousness, uncertain fetal prognosis, and other emergency conditions may negatively impact the companion's experience. Recommendations regarding the presence, staying, and removal of companions from the operating room constitute a harmonizing approach to managing such adverse situations[17].

c) Recommendations for healthcare professionals

Fourteen studies[9,11,12,15,16,17,18,19,20,21,22,24,25,26] addressed recommendations directed to healthcare professionals providing care to pregnant women. These recommendations aim to facilitate interaction among the parturient, companion, and multidisciplinary team, as well as to develop a trusting physician–patient relationship and establish a bond among all parties involved, with the goal of achieving favorable outcomes.

There is consensus that childbirth represents one of the most significant moments in women's lives and, consequently, for the entire family. It is advisable that dialogue between healthcare professionals and companions begin early in pregnancy, during prenatal consultations, including information about the characteristics of the childbirth setting, both in logistical and care-related aspects, which may include the provision of written guidance directed to companions[16,18,19,22].

Healthcare professionals should provide balanced information regarding the risks associated with cesarean delivery, adopting a positive and reassuring approach. These perceptions by the companion contribute to reducing stress levels[21].

Improving the childbirth experience for women and companions through the application of family-centered care techniques is important and should be encouraged by healthcare teams, even in higher-risk situations, as it does not compromise interdisciplinary management[17].

The multidisciplinary team should value the presence of the companion, as this ensures emotional support for the woman and strengthens family relationships. The team should treat both the parturient and the companion with respect, considering their preferences, opinions, and needs[15,24].

Healthcare professionals should welcome companions in a positive and respectful manner. It is therefore necessary to enhance strategies for informing pregnant women and their families about women's human rights during childbirth, including the right to have a companion of their choice throughout the parturition process. The dissemination of this information and recognition of these rights by professionals and health institutions are essential to improving quality of care and consolidating the humanization of childbirth in the country[24].

Healthcare professionals must also learn how to interact effectively with individuals supporting pregnant women. This strategy minimizes the risk of interference with professional practices. Professionals who effectively communicate with companions can transform them into collaborators who support both the care team and the parturient. The implementation strategy known as Quality Decision-making by women and providers (QUALI-DEC) supports the presence of a birth companion. Training companions through childbirth edu-

cation during prenatal consultations is important for enabling them to understand how to support the woman and what to expect during labor and birth[26].

Maternal preference for cesarean delivery may generate discomfort not only among healthcare professionals but also for the companion. Such decisions are often influenced by beliefs, including the perception that cesarean delivery is superior to vaginal birth. In this context, healthcare professionals must fulfill their educational role by clearly informing about the risks and benefits of different modes of delivery, thereby assisting the companion in supporting the pregnant woman's decision-making process[25].

Ensuring a positive experience for parturients and their companions is essential in daily professional practice. It is important that companions have a positive experience. To this end, adopting routines to document their experiences and perceptions, as well as implementing feedback mechanisms, can enhance professionals' understanding of the emotional and psychological impact of their actions and behaviors on patients and their families, through assessment of companion satisfaction[20].

Providing satisfaction to the parturient and her companion by acting with respect and full atention to their concerns, offering clear and comprehensible explanations, and demonstrating willingness to meet their needs are professional attitudes that influence companions' satisfaction with the care provided to the woman[9].

Seeking new knowledge, offering training programs to improve knowledge and practices, and establishing continuous evaluation of team performance emerge as strategic tools to increase professionals' awareness regarding support for companions[11,12].

d) Recommendations for managers

Thirteen studies[10,11,12,14,18,19,20,22,23,26,27,28,29] addressed recommendations directed to managers in maternal and child healthcare services. These recommendations are grounded in the legal guarantees of pregnant women's rights and, therefore, in strategies promoting the humanization of childbirth. Through the implementation of work routines, professional encouragement, and awareness, these measures aim to improve care and increase satisfaction among professionals and users of the healthcare system.

Managers are responsible for providing training and professional development regarding relevant legislation. They should incorporate the theme of humanization into institutional training programs and continuing education initiatives, as well as into professional education, thereby fostering differentiated training in healthcare. Managers should also develop informational materials regarding the parturient's right to have a companion and disseminate them in visible locations within healthcare services. In summary, planning and implementing prenatal programs or educational sessions for fathers and potential companions may increase their knowledge about childbirth, reducing fear, anxiety, and nervousness commonly associated with surgical delivery[10,12,20,22,23].

Additionally, managers should intensify actions to mitigate the main barriers hindering companionship during the parturition process. Recommended actions include: (i) promoting discussions on cultural aspects that hinder women's choice of a companion; (ii) adapting physical spaces of delivery and operating rooms to accommodate professionals, parturients, and companions; (iii) training professionals and potential companions regarding their roles during childbirth; (iv) raising awareness among healthcare professionals about the benefits of companion presence for women, newborns, and healthcare teams; (v) increasing awareness of labor regulations to prevent ethical issues arising from interpersonal interactions during childbirth. Finally, managers should consider accountability measures for healthcare services that fail to protect and uphold the rights of parturients[11,14,18,26,28,29].

Regarding the inclusion of companions in obstetric centers for cesarean delivery, managers are advised to consider all existing legal provisions and to establish mechanisms guiding companions from initial care through entry into the surgical sector. Additionally, actions that strengthen family bonding should be implemented, such as providing physical and emotional support to the parturient, respecting early skin-to-skin contact between parents and the newborn, and supporting breastfeeding in the operating room. Furthermore, managers should promote professionals' understanding of the long-term consequences of their attitudes and behaviors during care provided to the parturient and her companion[19,27].

	Non-randomized quantitative[a]					Descriptive quantitative[b]					Qualitative[c]					Mixed[d]				
Author / Criterion	**Representativiness**	**Measurement**	**Outcome**	**Confoundind**	**Exposure**	**Sampling**	**Representativiness**	**Measurement**	**Nonresponse bias**	**Statistics**	**Adequacy**	**Data collection**	**Data analysis**	**Interpretation**	**Coherence**	**Justification**	**Integration**	**Interpretation**	**Divergences**	**Quality by study**
Batista *et al.*[9]	●	●	●	●	●	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
de Quadros *et al.*[10]	●	●	●	●	●	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Younes *et al.*[11]	●	●	●	○	●	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Zanardo *et al.*[12]	○	●	●	○	●	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Alwahaibi *et al.*[13]	x	x	x	x	x	●	●	●	○	●	x	x	x	x	x	x	x	x	x	x
Diniz *et al.*[14]	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x	x	x	x	x	x
Figueiredo *et al.*[15]	x	x	x	x	x	●	●	●	○	●	x	x	x	x	x	x	x	x	x	x
Junges *et al.*[16]	x	x	x	x	x	●	●	●	○	●	x	x	x	x	x	x	x	x	x	x
Nieto-Calvache *et al.*[17]	x	x	x	x	x	●	○	○	●	●	x	x	x	x	x	x	x	x	x	x
Almeida *et al.*[18]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Alves *et al.*[19]	x	x	x	x	x	x	x	x	x	x	●	○	●	●	●	x	x	x	x	x
Brüggemann *et al.*[20]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Johansson *et al.*[21]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Machado *et al.*[22]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Maziero *et al.*[23]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Mazzetto *et al.*[24]	x	x	x	x	x	x	x	x	x	x	●	○	●	●	●	x	x	x	x	x
Muhandule *et al.*[25]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Rungreangkulkij *et al.*[26]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Summerton *et al.*[27]	x	x	x	x	x	x	x	x	x	x	●	○	●	●	●	x	x	x	x	x
Yaya-Bocoum *et al.*[28]	x	x	x	x	x	x	x	x	x	x	●	●	●	●	●	x	x	x	x	x
Kabakian-Khasholian *et al.*[29]	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	○	○	○	●	○

● Fully completed criteria ○ Partially completed criteria X – Not applicable

[a]Quality criteria (Mixed Methods Appraisal Tool) applied to non-randomized quantitative studies: 1. Are participants representative of the target population? 2. Is measurement appropriate with respect to exposure and outcome? 3. Are outcome data complete? 4. Are confounders accounted for in design and analysis? 5. Was the exposure/intervention measured as intended?

[b]Quality criteria (Mixed Methods Appraisal Tool) applied to descriptive quantitative studies: 1. Is the sampling strategy relevant to address the research question? 2. Is the sample representative of the target population? 3. Are measurements appropriate? 4. Is the risk of non-response bias low? 5. Is statistical analysis appropriate to answer the research question?

[c]Quality criteria (Mixed Methods Appraisal Tool) applied to qualitative studies: 1. Is the qualitative approach appropriate to answer the research question? 2. Are qualitative data collection methods adequate? 3. Are findings adequately derived from the data? 4. Is the interpretation sufficiently supported by the data? 5. Is there coherence among data sources, collection, analysis, and interpretation?

[d]Quality criteria (Mixed Methods Appraisal Tool) applied to mixed-methods studies: 1. Is there adequate justification for using mixed methods? 2. Are different components effectively integrated? 3. Are integrated results adequately interpreted? 4. Are divergences between qualitative and quantitative results properly addressed? 5. Do the components meet the quality criteria of each method?

Figure 2 - Quality assessment of the studies included in the review according to the Mixed Methods Appraisal Tool (MMAT).

Mundo Saúde. 2026,50:e18272025
DOI: 10.15343/0104-7809.202650e18272025I

DISCUSSION

This study consisted of a systematic review with a narrative synthesis approach. The review sought publications providing information on the profile of companions and recommendations directed to them, as well as to healthcare personnel, within the context of cesarean delivery. Based on the 21 included studies, it was observed that the child's father is the individual most frequently chosen by women to accompany them during cesarean births, although others — such as the mother, sister, aunt, friend, father, godmother, and sister-in-law — also participate in this moment. There is a wide range of recommendations that should be followed to support the companion.

Socioeconomic conditions may be related to ensuring the presence of a companion alongside the parturient throughout all stages of childbirth. For example, through the Rede Cegonha initiative, the commitment of the healthcare unit where childbirth will occur has been linked during prenatal care, reducing the need for individuals with limited access to quality services to seek care across multiple facilities[16,18,19,22,24].

Measures aimed at increasing the presence of companions alongside parturients must consider the magnitude of such participation. From 2021 to 2023, cesarean deliveries accounted for 4,526,759 procedures in Brazil[30]. This figure highlights the representativeness of this new actor in terms of the need for adaptations, encompassing both functional and structural aspects.

Guidance and recommendations directed to companions assist in the parturition process and optimize interpersonal relationships. An important aspect is the recommendation for participation in educational activities during prenatal care[19,27,28]. This recommendation is timely, given the investment in initiatives promoting participatory fatherhood, with the inclusion of fathers in prenatal care[31,32]. However, the child's father is not the only individual chosen by women to share the childbirth experience[10,13,16,19,24,25,27].

Recommendations directed to healthcare professionals aim to facilitate interaction among the parturient, companion, and multidisciplinary team, through dialogue initiated as early as prenatal consultations[16,18,19,22]. Studies[10,11,12,20,22,23] highlight the need for initiatives related to updating, training, and capacity building, as well as guidance on the importance of compliance with existing legislation[10,11,12,20,22,23].

Recommendations directed to managers are grounded in the legal guarantees of pregnant women's rights, promoting the humanization of childbirth. The adoption of work routines that encourage professional awareness seeks to improve care and enhance satisfaction among professionals and users of the healthcare system[11,14,18,26,28,29].

Several sectors of healthcare services are directly involved with the participation of millions of companions, such as the Nutrition Service, Linen Service, and Hospitality Services, among others. As a consequence, there is a need for structural adaptations to accommodate this new component within and beyond the surgical center, in order to provide dignified conditions for individuals assuming the role of companion to parturients, including the provision of lockers for personal belongings, meal areas, restrooms, among others[19].

The sharing of information regarding the risks associated with cesarean delivery should be conducted by healthcare professionals using a positive and reassuring approach[21]. To support companions in fulfilling their role, the multidisciplinary team should clearly and objectively explain the benefits and risks associated with different modes of delivery[25]. It is also important to inform companions about the anesthetic-surgical procedure in a manner that facilitates understanding of the process and its possible developments, including adverse situations[17].

The companion performs multiple functions within the context of obstetric care, which must be understood by the multidisciplinary team and managers, from the patient's admission to discharge. The presence of a companion increases maternal satisfaction[33,34,35,36,37] and reduces postpartum depression[35,36], in addition to contributing to the strengthening of family bonds[38,39]. The companion provides physical support (assistance with bathing, provision of food and fluids, repositioning, among others), emotional support (encouragement, reassurance, praise), informational support (communicating what is being proposed and performed), and mediation support (acting as a link between the parturient and healthcare professionals)[15,19,28].

Public policy initiatives are of fundamental importance in achieving the goal of humanizing childbirth. Among these is the creation of Rede Alyne in September 2024, a reformulation of Rede Cegonha, which seeks to ensure comprehensive care for pregnant women and newborns by integrating primary and specialized care, and aims to reduce maternal mortality in Brazil by 25% by 2027, with a particular focus on a 50% reduction among Black women[40].

Advantages and limitations

This review study addressed a socially relevant topic: the presence of companions alongside parturients in the operating room. The study extended beyond traditional bibliographic databases to include manual searches on Google, contributing to the inclusion of one-third of the articles in the review. Given that several authors[10,11,12,14,18,19,20,22,23,26,27,28,29] made recommendations directed to management, this thematic axis was incorporated into the review results. Despite its relevance, the study has some limitations. First, few publications addressed the topic clearly and explicitly indicated whether the companion was present in the operating room or delivery room. Second, part of the publications focused on labor and vaginal delivery processes. The decision to limit inclusion based on language may have excluded relevant experiences not reported in Portuguese, English, or Spanish. Finally, considering the period during which the review was conducted (February 2024 to February 2025), the findings should be interpreted with caution.

Failure to comply with the Companion Law was frequently reported, attributed to both lack of information among companions and resistance from healthcare professionals and managers. Although this issue was not within the scope of the present study, it represents a relevant topic for future research, particularly studies exploring tools such as manuals, guidelines, and protocols aimed at optimizing the integration of companions in cesarean operating rooms, grounded in the aforementioned law and scientific evidence.

CONCLUSION

The reviewed literature indicates that the presence of a companion should be encouraged from prenatal care through the moment of birth. Participation during cesarean delivery provides benefits to both the parturient and the newborn, contributing to the humanization of childbirth and improving maternal experience. To achieve this, companions should participate in educational activities during prenatal care. However, adequate guidance must be provided through the implementation of institutional protocols, as well as through training and capacity building of healthcare professionals, in addition to the provision of appropriate services and facilities.

The scenario described in the publications included in this review demonstrates that the legal right of women to have a companion during all stages of childbirth is not yet a reality for all parturients, highlighting the need to correct this social inequity. Evidence underscores the importance of disseminating recommendations that support companions, as well as outlining practices of reception and protection for individuals chosen to share one of the most significant moments in a woman's and family's life. Finally, to contribute to the humanization of childbirth and birth care, it is essential to respect pregnant women's right to have a companion of their choice throughout all stages, from prenatal care to delivery

CRediT author statement

Conceptualization: Camargo JCS; Nascimento MI; Alves VH. Validation: Camargo JCS; Nascimento MI; Alves VH. Investigation: Camargo JCS; Nascimento MI; Alves VH. Resources: Camargo JCS; Nascimento MI; Alves VH. Writing – original draft preparation: Camargo JCS; Nascimento MI; Alves VH. Writing-review and editing: Camargo JCS; Nascimento MI; Alves VH. Visualization: Camargo JCS; Nascimento MI; Alves VH. Supervision: Nascimento MI. Project administration: Nascimento MI.

All authors have read and agreed to the published version of the manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the workreported in this paper.

REFERENCES

1. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da política Nacional de Humanização. Humaniza SUS. Visita aberta e direito ao acompanhante. 2ª Edição. Série B. Textos Básicos de Saúde. Brasília (DF). / Ministério da Saúde, Secretaria de Atenção à Saúde, Núcleo Técnico da Política Nacional de Humanização. Brasília, 2007. [acesso em 15 de março de 2026]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/visita_acompanhante_2ed.pdf
2. Brasil. Presidência da República. Lei No 11.108, de 07 de abril de 2005. Altera a Lei no 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. Diário Oficial da União, de 08 de abril de 2005. Disponível em: https://www.planalto.gov.br/ccivil_03/_ato2004-2006/2005/lei/l11108.htm
3. Burlingame BL. FGI Guidelines Update Series #3 September 15, 2014 Operating Room Requirements for 2014 and Beyond. {acessado em 15 de março de 2026]. Disponível em: https://www.fgiguidelines.org/wp-content/uploads/2015/10/FGI_Update_ORs_140915.pdf
4. Joseph A, Bayramzadeh S, Zamani Z, Rostenberg B. Safety, Performance, and Satisfaction Outcomes in the Operating Room: A Literature Review. HERD. 2018; 11(2):137-150. https://doi.org/10.1177/1937586717705107

5. Popay J et al. Guidance on the conduct of narrative synthesis in systematic reviews. [acessado em 15 de março de 2026]. Disponível em: https://www.semanticscholar.org/paper/Guidance-on-the-Conduct-of-Narrative-Synthesis-in-A-Popay-Roberts/ed8b23836338f6fdea0cc55e161b0fc5805f9e27
6. Liberati A, et al. The PRISMA statement for reporting systematic reviews and meta-analyses of studies that evaluate health care interventions: explanation and elaboration. Ann Intern Med 2009; 151: W65-W94. https://doi.org/10.7326/0003-4819-151-4-200908180-00136
7. Landis JR, Koch GG. The measurement of agreement for categorical data. Biometrics. 1977; 33(1):159–74.
8. Hong QN, et al. Mixed Methods Appraisal Tool (MMAT) [internet] – Version 2018 – User guide. [acessado em 15 de março de 2026] Disponível em: http://mixedmethodsappraisaltoolpublic.pbworks.com/.
9. Batista BD, Bruggemann OM, Junges CF, Velho MB, Costa R. Fatores associados à satisfação do acompanhante com o cuidado prestado à parturiente. Cogitare Enferm. 2017; 22(3). e51355. http://dx.doi.org/10.5380/ce.v22i3.51355
10. Quadros CB, et al. Ausência de acompanhamento familiar e fatores associados nos partos da zona urbana de uma cidade do sul do Brasil: fato ou ficção? Rev Bras Epidemiol [Internet]. 2023; 26: e230053. https://doi.org/10.1590/1980-549720230053.2.
11. Younes RI, Mohamad SE, Salama NS, Heeba MF. Supportive care provided by companion during childbirth and its effect on labor progress and maternal satisfaction. Port Said Sci J Nurs. 2020; 7(3): 218-243. https://doi.org/10.21608/pssjn.2020.48535.1059
12. Zanardo V, Angelini S, Ajao ST, et al. First-time fathers' coping strategies at elective cesarean delivery: A quantitative study. Early Hum Dev. 2020; 143: 104969. https://doi.org/10.1016/j.earlhumdev.2020.104969
13. Alwahaibi N, Alajaimi F, Alhabsi H, Alkalbani A, Aljulandani R. Women's preferences, impacts, and satisfaction with companion support during labour and delivery experiences in Oman. Front Glob Womens Health. 2025; 6: 1524270. https://doi.org/10.3389/fgwh.2025.1524270
14. Diniz CSG, et al. Implementação da presença de acompanhantes durante a internação para o parto: dados da pesquisa nacional Nascer no Brasil. Cad Saúde Pública. 2014; 30: S140-53. https://doi.org/10.1590/0102-311X00127013.
15. Figueiredo MS, Oliveira DKMA, Vieira NRS, Davim RMB, Silva RAR. Possíveis indicadores da assistência obstétrica a parturiente em uma maternidade escola. Cogitare Enferm [Internet]. 2013 Dec 30 [cited 2025 Feb 7];18(4). Disponível em: https://revistas.ufpr.br/cogitare/article/view/34928.
16. Junges CF, Brüggemann OM, Knobel R, Costa R. Support actions undertaken for the woman by companions in public maternity hospitals. Rev Latino-Am Enfermagem [Internet]. 2018;26:e2994. https://doi.org/10.1590/1518-8345.2251.2994.
17. Nieto-Calvache AJ, Hidalgo A, Maya J, Sánchez B, Blanco LF, Sinisterra-Díaz SE, et al. Is there a place for family-centered cesarean delivery during Placenta Accreta Spectrum Treatment?. Rev Bras Ginecol Obstet [Internet]. 2022 Oct;44(10):925-9. https://doi.org/10.1055/s-0042-1751060.
18. Almeida AF, Brüggemann OM, Costa R, Junges CF. Separação da mulher e seu acompanhante no nascimento por cesárea: uma violação de direito. Cogitare Enferm. 2018; 23(2): e53108. https://doi.org/10.5380/ce.v23i1.53108
19. Alves MC, Brüggemann OM, Bampi RR, Godinho VG. The support of the companion choosen by the pregnant mother in a maternity school. Rev Pesq Cuid Fundam Online. 2013;5(3):153. https://doi.org/10.9789/2175-5361.2013v5i3.153-164.
20. Brüggemann OM, Ebele RR, Ebsen ES, Batista BD. No parto vaginal e na cesariana acompanhante não entra: discursos de enfermeiras e diretores técnicos. Rev Gaúcha Enferm [Internet]. 2015;36(spe):152–8. https://doi.org/10.1590/1983-1447.2015.esp.53019.
21. Johansson M, Hildingsson I, Fenwick J. Important factors working to mediate Swedish fathers' experiences of a caesarean section. Midwifery. 2013; 29(9):1041-9. https://doi.org/10.1016/j.midw.2012.09.009
22. Machado VA, Izidoro TA, Elias A. Cesarean deliveries on the scene: humanized nursing care. Rev. Assoc. Méd. Rio Gd. do Sul. 2022; 66(1): 310-314.
23. Maziero CP, Zani AV, Bernardy CCF, Pontes GM, Lago MTG, Pinto KRTF. A não presença do acompanhante no parto: visão dos profissionais da saúde. Rev Pesqui (Univ Fed Estado Rio J, Online) [Internet]. 2021 May 1 [cited 2025 Feb 5];12:531-6. Available from: https://seer.unirio.br/cuidadofundamental/article/view/8627.
24. Mazzetto FMC, Mattos TB, Siqueira FPC, Ferreira MLSM. Presence of a companion from the perspective of the woman during labor, delivery, and postpartum. J Nurs UFPE on line. 2022;16:e252582. doi:10.5205/1981-8963.2022.252582.
25. Muhandule CJLS, Benetti CMS, Fogulin LB, Bento SF, Amaral E. Caesarean delivery on maternal request: the perspective of the postpartum women. BMC Pregnancy Childbirth. 2024; 24(1): 257. https://doi.org/10.1186/s12884-024-06464-5
26. Rungreangkulkij S, et al. Factors influencing the implementation of labour companionship: formative qualitative research in Thailand. BMJ Open. 2022; 12(5): e054946. https://doi.org/10.1136/bmjopen-2021-054946
27. Summerton JV, Mtileni TR, Moshabela ME. Experiences and perceptions of birth companions supporting women in labour at a District Hospital in Limpopo, South Africa. Curationis [Internet]. 2021 [cited 2025 Feb 23]; 44(1): e1-e7. https://doi.org/10.4102/curationis.v44i1.2186
28. Yaya Bocoum F, et al. Women's and health providers' perceptions of companionship during labor and childbirth: a formative study for the implementation of WHO companionship model in Burkina Faso. Reprod Health. 2023; 20(1):46. https://doi.org/10.1186/s12978-023-01597-w
29. Kabakian-Khasholian T, Bashour H, El-Nemer A, Kharouf M, Elsheikh O; Labour Companionship Study Group. Implementation of a labour companionship model in three public hospitals in Arab middle-income countries. Acta Paediatr. 2018; 107 Suppl 471: 35-43. https://doi.org/10.1111/apa.14540
30. Brasil. Ministério da Saúde. Departamento de Informática do Sistema Único de Saúde. DATASUS – Sistema de Informação sobre Nascidos Vivos – SINASC. Acessado em 01/06/2025. Disponível em: https://datasus.saude.gov.br/informacoes-de-saude-tabnet/
31. Ribeiro CR, Gomes R, Moreira MCN. Encontros e desencontros entre a saúde do homem, a promoção da paternidade participativa e a saúde sexual e reprodutiva na atenção básica. Physis [Internet]. 2017; 27(1):41–60. https://doi.org/10.1590/S0103-73312017000100003
32. Lyra J, Medrado B, Campos DS, Fonseca VN, Nascimento M. A implementação da Política de Saúde do Homem no estado do Rio de Janeiro, Brasil: desafios e perspectivas. Interface (Botucatu). 2025; 29 (Supl. 1): e240373. https://doi.org/10.1590/interface.240373
33. Paiz JC, Souto AS, Martins ACM, Ahne SMS, Baréa M, Giugliani C. Violência obstétrica: entre a percepção das mulheres e as práticas de assistência ao parto. Rev Bras Med Fam Comunidade [Internet]. 2024 Nov 28 [citado 2025 Feb 4]; 19(46): 3852. https://doi.org/10.5712/rbmfc19(46)3852
34. Leal MC, et al. Avanços na assistência ao parto no Brasil: resultados preliminares de dois estudos avaliativos. Cad Saúde Pública [Internet]. 2019;35(7): e00223018. https://doi.org/10.1590/0102-311X00223018
35. Weeks F, Pantoja L, Ortiz J, Foster J, Cavada G, Binfa L. Labor and birth care satisfaction associated with medical interventions and accompaniment during labor among Chilean women. J Midwifery Womens Health. 2017; 62(2): 196–203. https://doi.org/10.1111/jmwh.12499
36. Dornelas ACVR, et al. Abuse, disrespect and mistreatment during childbirth care: contribution of the Ribeirão Preto cohorts, Brazil. Ciênc Saúde Coletiva [Internet]. 2022 Feb; 27(2):535–44. https://doi.org/10.1590/1413-81232022272.01672021
37. Gadappa SN, Deshpande SS. A quasi-experimental study to compare the effect of respectful maternity care using intrapartum birth companion of her choice on maternal and newborn outcome in tertiary care centre. J Obstet Gynaecol India. 2021;71(Suppl 2):84–9. https://doi.org/10.1007/s13224-021-01587-7
38. Ayres LFA, Cnossen RE, Passos CM, Lima VD, Prado MRMC, Beirigo BA. Fatores associados ao contato pele a pele imediato em uma maternidade. Esc Anna Nery [Internet]. 2021; 25(2): e20200116. https://doi.org/10.1590/2177-9465-EAN-2020-0116
39. Pedraza DF. Assistência ao pré-natal, parto e pós-parto no município de Campina Grande, Paraíba. Cad Saúde Colet [Internet]. 2016; 24(4): 460–7. https://doi.org/10.1590/1414-462X201600040092
40. Brasil. Portaria GM/MS nº 5.350, de 12 de setembro de 2024. Altera a Portaria de Consolidação GM/MS nº 3, de 28 de setembro de 2017, para dispor sobre a Rede Alyne. Diário Oficial da União: Seção 1; 2024 set 13: p. 90. Ministério da Saúde. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2024/prt5350_13_09_2024.html

How to cite this article: Camargo, J.C.S., Nascimento, M.I., Alves, V.H. (2026). Inclusion of a companion in the operating room for cesarean delivery: a synthesis of evidence. O Mundo Da Saúde, 50. https://doi.org/10.15343/0104-7809.202650e18272025I. Mundo Saúde. 2026,50:e18272025.