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Women's preferences and experiences of birthing practices in Turkey: A cross-sectional study

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Abstract

In this study, the aim was to evaluate the preferences and experiences interventions among women in Turkey. A total of 347 women who gave birth vaginally participated in this analytical cross-sectional study. Data were collected using the face-to-face interview technique in the clinic rooms within the first 24 hours after delivery, when the women's babies were asleep, allowing the mothers to comfortably answer the questions before discharge. The arithmetic mean, standard deviation and number-percentage distributions of the data were calculated. Of them, 81% had a positive birth experience at birth. The majority of the participating women did not want to undergo non-evidence based interventions with a limited effect during the intrapartum period. While evidence-based intrapartum care is provided, women's preferences should be taken into account, they should be informed about evidence-based interventions and these interventions should be performed during the intrapartum period. *(Afr J Reprod Health 2024; 28 [7]: 71-82).*

Keywords: Evidence based practice; intrapartum care; labor; positive birth experience; women prefences

Résumé

Dans cette étude, l'objectif était d'évaluer les préférences et les expériences d'interventions chez les femmes en Turquie. 347 femmes ayant accouché par voie vaginale ont participé à cette étude analytique transversale. Les données ont été collectées à l'aide de la technique d'entretien en face-à-face dans leurs chambres de la clinique dans les 24 heures suivant l'accouchement, lorsque les bébés des femmes dormaient et que les mères pouvaient facilement répondre aux questions avant leur sortie. La moyenne arithmétique, l'écart type et les distributions en nombre et en pourcentage des données ont été calculées.Parmi eux, 81 % ont vécu une expérience positive à la naissance. La majorité des femmes participantes ne souhaitaient pas subir d'interventions non fondées sur des données probantes et ayant un effet limité pendant la période intrapartum. Bien que des soins intrapartum fondés sur des données probantes soient fournis, les préférences des femmes doivent être prises en compte, elles doivent être informées des interventions fondées sur des données probantes et ces interventions doivent être effectuées pendant la période intrapartum. *(Afr J Reprod Health 2024; 28 [7]: 71-82).*

Mots-clés: Expérience positive de l'accouchement; pratique fondée sur des données probantes soins intrapartum; préférences des femmes; travail

Introduction

Childbirth is an incredible experience with its physiological, psychological and social aspects, and has important meanings for women, families and society[1-4]. The new Global Strategy for Women's, Children's, and Adolescents' Health aims to fulfill Sustainable Development Goal three by setting global agendas to ensure women and their babies achieve full health and well-being[5]. Newborns' healthy development starts in the womb and progresses through birth, which is vital for both the mother and the baby's life potential.

There isn't a universal or standardized concept for 'normality' in labor and delivery. Interventions can be performed during labor to initiate, accelerate, end, regulate or monitor the physiological process of birth[6-8]. Interventions during labor should provide safe, standard, and quality care, favoring evidence-based practices that promote normal labor and improve perinatal outcomes, thus replacing routine interventions[8-11].

Our review of the literature on interventions performed during labor demonstrated that routine vaginal examination, amniotomy, bladder catheterization, labor induction,

episiotomy and enema were performed. Mobilization and oral fluid intake were restricted, continuous/intermittent electronic fetal monitoring (CTG) and intravenous (IV) hydration were implemented, no companion was allowed during delivery, skin-to-skin contact wasn't provided, women were in supine positions during labor, and invasive procedures such as cesarean section were widely performed[12-18]. Some researchers state that some intrapartum interventions aren't helpful or effective. Therefore, they recommend that some of these interventions should be carried out while others shouldn't[8,9,12,19]. Reasons and rates of the implementing these interventions differ from country to country and region to region due to cultural factors and lack of standardization[8,9,12,19,20]. However, "women-centered care" should form the basis of care in labor. Women's wishes and preferences should be taken into account to establish effective communication and encourage active participation in childbirth, which is essential for the individuality of birth[8,19]. In addition, if a psychologically safe environment for childbirth is to be created women should be carefully listened to take lessons from their birth experiences[21,22]. The psychological aspects of labor and delivery have generally drawn little attention in the planning of obstetric care or in clinical practice. Therefore, in institutions where obstetric care is provided, women should approve of interventions they are to undergo, they should allow them to be performed, and their preferences should be determined[12,13,19,23]. In a study conducted in Iran, women's needs and expectations are classified into the following seven main categories: physiological, psychological, informational, social and relational, esteem, safety and medical needs[24]. A woman's active participation in labor will increase her satisfaction with the labor, decrease the number of interventions, shorten the duration of the labor and make her have a positive perception of the birth[7,22,25]. The goal of care during labor is to prevent maternal and newborn morbidity and mortality, enhance mothers' birth satisfaction, and ensure a healthy start for newborns. Health facilities and personnel should avoid unnecessary interventions to maintain satisfaction and reduce costs.

Our main objective in the present study was to evaluate the interventions performed during labor and mothers' demand for these interventions by considering their views in Turkey. Additionally, we expect that the data we obtained from this study will be important providing evidence for interventions performed during labor.

Research Questions

1. What is the frequency of interventions performed during labor?
2. Do mothers demand to undergo interventions performed during labor?
3. Do the parity of the mothers, planned pregnancy status, their receiving training on preparation for childbirth, the stage of labor at the time of arrival at the hospital for labor, and the duration of labor affect interventions in labor?

Methods

Study design and participants

The study is an analytical and cross-sectional study. The study was conducted at a tertiary training and research hospital's obstetrics clinic, targeting women who delivered within a one-year period (N=2648 according to hospital records). Using the Statcalc tool in EpiInfo Version 6, the sample size was calculated to be 347, accounting for a 5% margin of error, a 95% confidence interval, and a 10% reserve sample. Data collection began in July 2019 and proceeded until the necessary sample size was met. The study included volunteer mothers who had uncomplicated vaginal births and no pregnancy or labor complications. Women who were referred from another health institution were excluded in the study.

Data collection

After informing the women participating in the study about its purpose, their verbal and written consent was obtained. Data were collected using the face-to-face interview technique in their rooms in the clinic within the first 24 hours after delivery when the women's babies were asleep and the mothers could comfortably answer the questions before they were discharged. Data on cervical dilatation at the time of arrival at the hospital, delivery time, induction, enema and episiotomy opening status about the mothers were obtained from the clinical files.

Measurements

The study data were collected with the "Questionnaire" prepared in line with the literature[8,9,17]. The questionnaire consists of the following four parts: The first part has nine questions about the mother's socio-demographic characteristics, the second part has 10 questions about the mother's obstetric history, dilatation (in cm.) when she is brought to the hospital and duration of labor, the third part has 19 questions about the interventions determined according to the WHO Intrapartum Care Management Guidelines and performed during labor. The interventions were classified as recommended and non-recommended interventions in labor.

Interventions deemed appropriate in labor

Providing emotional support, providing information about how to cope with labor pain, massaging the back and lowers back of the mother, teaching breathing-relaxation techniques, mobilizing and/or changing position in bed, oral nutrition status, doing perineal massage, respecting the mother's decisions and protecting her privacy. An example of recommended interventions: "*Were you emotionally supported during labor? Yes/No. If the mother's choice is "No", then the following question is asked: "Would you like to receive emotional support? Yes/No.*

Interventions not recommended during labor

"CTG, induction, enema, perineal shaving, fundal pressure and episiotomy.*" An example of non-recommended interventions: "Were you administered an enema during labor? Yes/No.* If the mother's choice is "*No*", then the following question is asked: *"Would you like to be administered enema during labor? Yes/No.* In the fourth part, questions such as *"Who delivered the baby (midwife/ physician)?",* and was included.

Data analysis

The arithmetic mean, standard deviation and number-percentage distributions of the data were calculated. The analysis of the data obtained from the study was performed on the computer using the Statistical Package for Social Science (SPSS) program. Descriptive information on women was given in numbers, percentage distributions and mean values. The Chi-square test was used in the analytical part of the study.

Ethical approval

Before the study was conducted ethical approval was obtained from the Scientific Research and Publication Ethics Board (Decision date: May 25, 2019, Decision Number: 19-5.2T/22), permission was obtained from the Provincial Health Directorate and (Date: July 17, 2019, number: 24404279-702.99), written permission was obtained from the chief physician of the Training and Research Hospital where the study was to be conducted (Date: July 17, 2019, number: 24404279-702.99-306), verbal and written consent of the women included in the study sample was obtained after they were informed about the purpose of the study.

Results

The study results were presented under two main headings. The first part presented the women's socio-demographic and obstetric characteristics, while the second part focused on the interventions performed during labor, the comparison of these interventions with variables thought to affect them, and the women's requests for interventions during labor. The socio-demographic characteristics (age group, education status, and occupation) and obstetric characteristics of the participating women were given in Table 1.

In table 2, the distribution of the health personnel who delivered the baby and health personnel who the mothers wanted to perform delivery was given. There was a statistical difference between the health personnel who performed delivery and the health personnel who the mothers wanted to perform delivery in terms of midwifery ($p<0.05$).

In Table 3, interventions performed during labor in line with the WHO's recommendations, and the comparison of these interventions with the variables thought to affect them were given. Of the variables, parity, whether pregnancy was an intended one, whether the women received training on preparation for childbirth, and the stage of delivery when the women were brought to the hospital for delivery didn't affect interventions performed during labor ($p>0.05$).

Table 1: Participating women's socio-demographic and obstetric characteristics

Socio-Demographic Characteristics	Number	%
Age group (years)		
≤19	23	6.6
20-24	98	28.2
25-29	110	31.8
30-34	67	19.3
≥35	49	13.1
Mean of age was 27.3±5.55 (Min: 17.0-Max: 42.0) **years.**		
Educational status		
Uneducated	18	5.2
Primary school	203	58.5
High school	76	21.9
Higher education	50	14.4
Occupation		
Homemaker	299	86.2
Government official	15	4.3
Worker	33	9.5
Obstetric Characteristics		
Parity		
Primiparous	123	35.4
Multiparous	224	64.6
Average number of births: 2.43±1.35 (Min.:1.0; Max.: 9.0)		
Is the pregnancy an intended one?		
Yes	282	81.3
No	65	18.7
Have you received training on preparation for labor?		
Yes	22	6.3
No	325	93.7
Cervical dilatation at the time of arrival at the hospital		
0-3 cm (Latent phase)	167	48.1
4-6 cm (Active phase)	110	31.7
7-9 cm (transition phase)	70	20.2
Duration of labor		
Immediately after admission to the hospital	31	8.9
1-3 hours	87	25.1
4-6 hours	77	22.2
≥7 hours	152	43.8
Did you have a positive birth experience?		
Yes	281	81.0
No	66	19.0
Total	**347**	**100.0**

Interventions not recommended by the WHO but performed during labor, and the comparison of these interventions with the variables such as parity, whether the pregnancy is an intended one, stage of delivery at the time of arrival at the hospital, duration of labor were given in Table 4. There was a significant relationship between the women's willing to become pregnant and the interventions such as fundal pressure and episiotomy incision, and between the stage of delivery at the time of arrival at the hospital and the interventions such as CTG, induction, enema and episiotomy ($p<0.05$).

In Graph 1, the distribution of the interventions recommended by the WHO which were performed during labor and the percentages of the mothers who didn't undergo the intervention were given. In Graph 2, the distribution of the interventions not recommended by the WHO but performed during labor and the percentages of the mothers who didn't undergo the intervention were given.

Discussion

We conducted the present study to assess labor interventions and whether mothers wished to have them. Most participants were young and had multiparous, which may have made it easier for them to access information and brought experience with labor. However, only a small percentage had labor preparation training, possibly due to a lack of awareness of its importance or health personnel assuming it unnecessary.

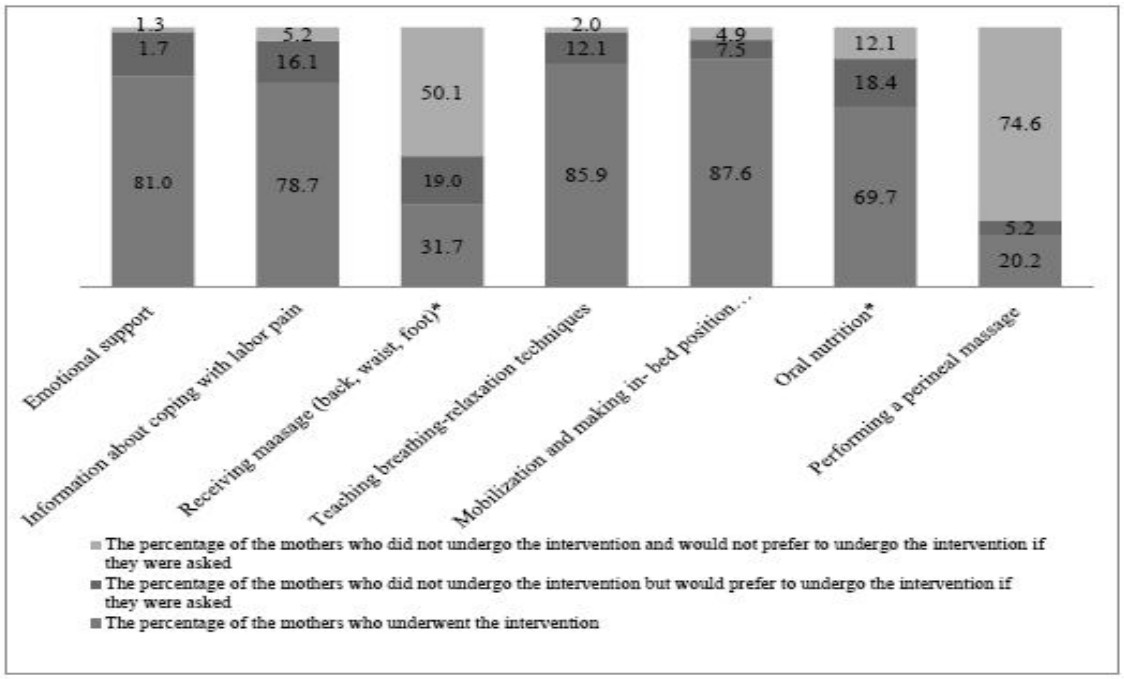
The highest rates of emotional support, information about how to cope with labor pain, teaching breathing-relaxation techniques and mobilizing and/or changing position in bed were provided to the mothers, and the mothers also requested these applications. It was determined that interventions performed during labor in line with the WHO recommendations, were not affected by mothers' parities, planned pregnancy status, receiving training on preparation for labor, or the stage of labor at the time of arrival at the hospital. In addition, the stage of labor and duration of labor at the time of mothers' arrival at the hospital affected the use of induction and enema.

Table 2: Health personnel who delivered the baby and health personnel who the mothers wanted to perform delivery

	Health personnel who the mothers wanted to deliver the baby							
Health personnel who delivered the baby	**Midwife**		**Physician**		**Total**			
	N	**%**	**N**	**%**	**N**	**%**	**χ2**	**p**
Midwife	251	83.4	50	16.6	301	100.0	71.409	.000
Physician	12	26.1	34	73.9	46	100.0		
Total	**263**	**75.8**	**84**	**24.2**	**347**	**100.0**		

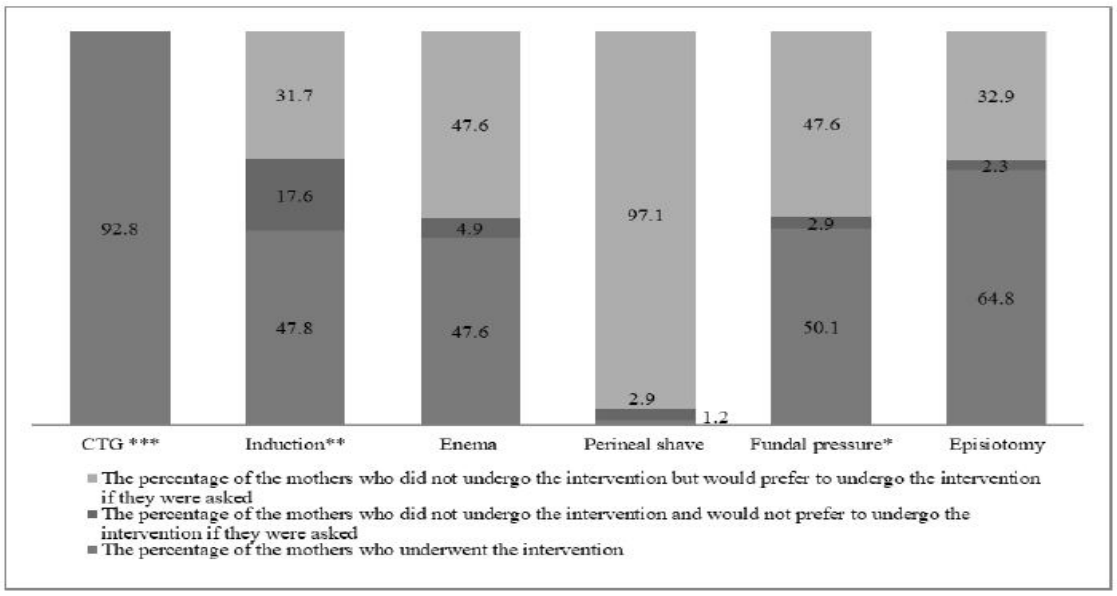
Table 3: Interventions performed during labor in line with the WHO's recommendations, and the comparison of these interventions with the variables thought to affect them

	Providing emotional support		**Providing information about how to cope with labor pain**		**Massaging the back and lower back of the mother**		**Teaching breathing-relaxation techniques**		**Mobilizing and/or changing position in bed**		**Oral nutrition status**		**Doing perineal massage**		
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Total**
Parity	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**
Primiparous	82.1	17.9	80.5	19.5	36.6	63.4	87.0	13.0	88.6	11.4	70.7	29.3	17.9	82.1	100.0
Multiparous	80.4	19.6	77.7	22.3	29.0	71.0	85.3	14.7	87.1	12.9	69.2	30.8	21.4	78.6	100.0
p	.775		.586		.150		.748		.736		.808		.486		
Is the pregnancy an intended one?															
Yes	82.3	17.7	78.7	21.3	30.9	69.1	86.5	13.5	86.5	13.5	70.6	29.4	22.0	78.0	100.0
No	75.4	24.6	78.5	21.5	35.4	64.6	83.1	16.9	92.3	7.7	66.2	33.8	2.3	87.7	100.0
p	.221		1.000		.554		.437		.295		.549		.088		
Receiving training on preparation for labor															
Yes	81.8	18.2	90.9	9.1	50.0	50.0	81.8	18.2	81.8	18.2	68.2	31.8	22.7	77.3	100.0
No	80.9	19.1	77.8	22.2	30.5	69.5	86.2	13.8	88.0	12.0	69.8	30.2	20.0	80.0	100.0
p	1.000		.185		.095		.531		.333		.816		.784		
Cervical dilatation at the time of arrival at the hospital															
Latent phase	79.6	20.4	78.4	21.6	28.7	71.3	86.8	13.2	85.0	15.0	71.3	28.7	21.6	78.4	100.0
Active phase	81.8	18.2	78.2	21.8	35.5	64.5	87.3	12.7	91.8	8.2	68.2	31.8	20.0	80.0	100.0
transition phase	82.9	17.1	80.0	20.0	32.9	67.1	81.4	18.6	87.1	12.9	68.6	31.4	17.1	82.9	100.0
p	.817		.953		.488		.486		.243		.838		.741		
Duration of labor															
Immediately	83.9	16.1	74.2	25.8	32.3	67.7	74.2	25.8	71.0	29.0	64.5	35.5	22.6	77.4	100.0
1-3 hours	82.8	17.2	79.3	20.7	29.9	70.1	86.2	13.8	93.1	6.9	64.4	35.6	16.1	83.9	100.0
4-6 hours	80.5	19.5	72.7	27.3	31.2	68.8	85.7	14.3	88.3	11.7	63.6	36.4	24.7	75.3	100.0
≥7 hours	79.6	20.4	82.2	17.8	32.9	67.1	88.2	11.8	87.5	12.5	77.0	23.0	19.7	80.3	100.0
p	.909		.367		.970		.246		**.016**		.081		.573		
Total	**281**	**66**	**273**	**74**	**110**	**237**	**298**	**49**	**304**	**43**	**242**	**105**	**70**	**277**	**347**
	(81.0)	**(19.0)**	**(78.7)**	**(21.3)**	**(31.7)**	**(68.3)**	**(85.9)**	**(14.1)**	**(87.6)**	**(12.4)**	**(69.7)**	**(30.3)**	**(20.2)**	**(79.8)**	**(100.0)**



*The participants gave multiple responses **Not all the participants responded to this question

Graph 1. **Interventions recommended by the WHO to be performed during labor and the mothers' demands for these interventions (%)**



*The participants gave multiple responses **Not all the participants responded to this question
***The intervention was performed but the mothers were not asked if they would want to undergo the intervention.

Graph 2. **The interventions not recommended by the WHO but performed during labor and the mothers' demands for these interventions (%)**

Table 4: Interventions not recommended by the WHO but performed during labor, and the comparison of these interventions with the variables thought to affect them

	Performing CTG		**Performing induction**		**Performing enema**		**Performing perineal shaving**		**Performing fundal pressure**		**Performing episiotomy**		
	Yes	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	
Parity	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**(%)**	**Total**
Primiparous	96.7	3.3	50.4	49.6	52.8	47.2	0.8	99.2	73.2	26.8	91.1	8.9	100.0
Multiparous	90.6	9.4	46.4	53.6	44.6	55.4	1.3	98.7	37.5	62.5	50.4	49.6	100.0
P	**.049**		.502		.146		1,000		**.000**		**.000**		
Is the pregnancy an intended one?													
Yes	93.3	6.7	46.1	53.9	47.5	52.5	1.1	98.9	52.8	47.2	69.1	30.9	100.0
No	90.8	9.2	55.4	44.6	47.7	52.3	1.5	98.5	38.5	61.5	46.2	53.8	100.0
P	.436		.215		1.000		.566		**.040**		**.001**		
Receiving training on preparation for labor													
Yes	90.9	9.1	59.1	40.9	50.0	50.0	0.0	100.0	59.1	40.9	81.8	18.2	100.0
No	92.9	7.1	47.1	52.9	47.4	52.6	1.2	98.8	49.5	50.5	63.7	36.3	100.0
P	.666		.378		.829		1.000		.510		.107		
Stage of delivery at the time of arrival at the hospital													
Latent phase	98.8	1.2	57.5	42.5	59.3	40.7	1.2	98.8	52.7	47.3	78.4	21.6	100.0
Active phase	98.2	1.8	47.3	52.7	50.9	49.1	0.9	99.1	50.0	50.0	55.5	44.5	100.0
Transition phase	70.0	30.0	47.3	52.7	14.3	85.7	1.4	98.6	44.3	55.7	47.1	52.9	100.0
P	**.000**		**.000**		**.000**		.948		.497		**.000**		
Duration of labor													
Immediately after presenting to the hospital	38.7	61.3	19.4	80.6	6.5	93.5	3.2	96.8	45.2	54.8	45.2	54.8	100.0
1-3 hours	94.3	5.7	28.7	71.3	39.1	60.9	0.0	100.0	39.1	60.9	43.7	56.3	100.0
4-6 hours	98.7	1.3	46.8	53.2	44.2	55.8	1.3	98.7	53.2	46.8	67.5	32.5	100.0
≥7 hours	100.0	0.0	65.1	34.9	62.5	37.5	1.3	98.7	55.9	44.1	79.6	20.4	100.0
P	**.000**		**.000**		**.000**		.525		.075		**.000**		
Total	**322 (92.8)**	**25 (7.2)**	**166 (47.8)**	**181 (52.2)**	**165 (47.6)**	**182 (52.4)**	**4 (1.2)**	**343 (98.8)**	**174 (50.1)**	**173 (49.9)**	**225 (64.8)**	**122 (35.2)**	**347 (100.0)**

Performing episiotomy was affected by the mothers' parities, planned pregnancy status, training on preparation for labor, stage of labor at the time of arrival at the hospital and duration of labor.

The worldwide increase in births given in hospitals offers an opportunity to reduce maternal morbidity and mortality, and health inequalities. In order to use these opportunities most effectively, health professionals should implement evidence-based and universally accessible interventions[7,18,26]. However, there was little improvement in the provision of quality maternal care services in India although the rate of births given in health institutions increased from 39% to 79% 2005-2016[27]. These results indicate that while some women don't receive care and services in line with their needs in some settings, some women undergo unnecessary interventions in some health institutions[8].

The study found that while a high number of women received emotional support during labor, those who did not receive it overwhelmingly expected it. Interestingly, women who arrived at the hospital in the latent phase and experienced prolonged labor reported positive birth experiences, despite lower rates of emotional support. This suggests a gap between the need for support in extended labor and what is provided. The expectation of emotional support from those who did not receive it underscores its importance in contributing to a positive birth experience[22,28]. In the literature, it is stated that the mother should be accompanied by someone she prefers during labor to support her[8,21,22], however, due to hospital conditions, no companions were accepted in the delivery room and therefore the necessary support was given by midwives. As was stated in a systematic review conducted in Africa, in deliveries achieved in public institutions,

emotional support was given at a lower rate[20]. It is stated that the support given in labor increases the rate of spontaneous vaginal delivery and shortens the duration of delivery, that fewer women develop depressive symptoms and that such support is beneficial in terms of having positive birth experience[7,17,21,22,29].

In the provision of labor support, using methods and techniques to help women cope with labor pain is also a factor which enables them to have a positive birth experience[8,22]. The study found that a high percentage of women were informed about pain management techniques during labor. Among those not informed, 16.1% wished they had been. Correspondingly, a high number were taught breathing and relaxation techniques, which WHO suggests as moderately reliable for managing labor pain[8]. In the present study, of the women who weren't taught breathing and relaxation techniques, those who wanted to be taught these techniques comprised 12.1% of all the participants. Informing the participating women about how to cope with labor pain and teaching them breathing-relaxation techniques had no effect on any of the independent variables of the present study. In a study conducted in Turkey, the women were taught breathing and relaxation techniques used during labor and the majority of them wanted to be taught these techniques[7]. Women who use relaxation and control techniques and who are massaged during labor can effectively cope with labor pain, have shorter duration of delivery, and have a positive birth experience[8,17,29,30].

The current study found that while 69.1% of mothers didn't receive massages during labor, only 19.0% had expected to be massaged. This may indicate a lack of awareness about massage's benefits in childbirth or that women don't realize they can request it. Massaging the sacral area, back, and feet can help alleviate pain during labor[17]. Massage involves touching. Therefore, the cultural characteristics of the women may also have affected their desire not to be massaged[31]. In addition, the fact that there wasn't one that the women could ask to massage them during the labor when they had pain may have affected their being massaged or desire to be massaged because in the hospital where the study was conducted, it wasn't possible to allocate a midwife to every pregnant woman to follow up her and to give care to her constantly.

If a woman isn't mobilized during labor, not only does her satisfaction with the birth decrease but also her and the fetus's health is negatively affected[32,33]. In the present study, there was a significant relationship between the time spent in the delivery room, and mobilization or changing the women's position in bed. Mobilization or changing the woman's position in bed was more common in those whose delivery lasted between 1-3 hours. In labor, administrating IV fluid, or performing induction or CTG restricts the woman's movements[8,32]. If the woman's mobilization is restricted, changing the woman's position in bed is recommended. Pregnant women's having freedom of movement during labor had positive effects; however, in meta-analysis. There wasn't difference between the pregnant women[33]. In our study, we compared those who walked with those who remained in bed during the first stage of labor in relation to vaginal or interventional delivery outcomes. Despite only half of the mothers expressing a desire to move or change position, about 90% were actually mobilized. Mobility is crucial for managing labor pain effectively.

Although the fetal monitoring rate was high in the present study, monitoring was applied intermittently and the mothers were encouraged to change their positions during monitoring. Since continuous fetal monitoring isn't an evidence-based practice in terms of restricting maternal mobilization, its reliability level is low[8].

The study highlighted the importance of maternal nutrition and hydration as part of supportive care during labor. Given that mothers arrived in the latent phase and labor lasted 7 hours or more, fulfilling their nutritional and hydration needs was essential. The lack of demand for food could be attributed to past birthing experiences or prevailing beliefs about birth risks, including anesthesia-related emergencies and the potential for aspiration pneumonia due to delayed gastric emptying, as per Mendelson's concerns[34,35]. According to current evidence, oral nutrition in labor strengthens the mother, meets her energy needs, can prevent ketosis, enables her to participate in labor more actively and improves maternal satisfaction[8,34]. A meta-analysis compared women who weren't allowed to consume fluids and food with those allowed to consume but restrictedly and found no difference between the

two approaches in terms of negative outcomes at birth[16].

Founded that providing information, respect, and privacy to birthing women led to high satisfaction levels with their birth experience and perinatal care[30]. Current guidelines suggest that women with low risk of complications should not be restricted from oral intake during labor. The present study showed high rates of oral nutrition provided and requested by women, underscoring that restricting food and fluids doesn't improve clinical outcomes or labor duration, and women's preferences should be honored[9]. Therefore, it is necessary to assess the obstetrical condition of the pregnant woman and to give care to her according to her needs.

According to current evidence, in the second stage of labor, perineal massage is recommended to reduce perineal trauma and tears and to provide spontaneous delivery depending on the woman's preferences and available options[8,32,36,37]. Overall, moderate-quality evidence suggests that warm compresses and massage can reduce third-and fourth-degree tears, but the effect of these techniques on other outcomes is unclear or inconsistent. Poor-quality evidence suggests that hand-off techniques may reduce episiotomy[38]. Perineal massage is regularly performed not only in the antenatal period but also in the second stage of labor. In the current study, of the participating women, 20.2% underwent perineal massage. Of the women who didn't want to have it comprised 74.6% of all the participating women.

At what level and at what stage should women participate indecision-making process during labor? Obtaining the informed consent from women about the interventions should not mean that they participate in decision making. Caregivers should provide information for women at the level that women can understand. Caregivers should also ensure that women participate in the care and treatment process by taking women's demands into account[25]. As labor progresses, patients can make changes in their decisions. If they do, informed consent should be obtained from them at every stage of birth in order to avoid ethical dilemmas[39,40]. The study from Turkey[41] highlighted the main issue in childbirth as the rejection of medical practices by pregnant women (96.6%), and a concerning trend of women demanding discharge under life-threatening conditions. Conversely, the least common problems were the exclusion of women from decision-making and breaches of privacy during delivery. Additionally, the study reported a high incidence of non-WHO-recommended[8] interventions, during labor, reflecting a broader increase noted in the literature[42,43]. While the parity status of women affected such interventions as CTG, fundal pressure and episiotomy, the stage of labor at admission to the hospital and the duration of labor affected the implementation of interventions such as CTG, induction, enema and episiotomy.

Additionally, about half of the participating women underwent enemas and inductions. Investigated the effect of the time of admission to the delivery room on the labor process and reported that enemas were administered to 69.1% of the women[14]. This rate is consistent with those in the literature. Because routine enemas and other interventions lead to discomfort in mothers, they should be avoided. Among the women who didn't have labor induced, only 17.6% of all participants indicated they would have liked induction, likely due to a lack of understanding of the necessary conditions and risks, or a desire for quicker labor progression. Induction rates were higher in those who arrived at the hospital in the latent phase and those with labor durations of 4-6 hours. However, induction should only be done when medically indicated[44,45]. In a systematic review in which women's expectations and satisfaction of induction were investigated, women who underwent induction were not satisfied, they were more stressed, and they didn't have a positive birth experience[42,46].

In our study, it was determined that very few of those who weren't given enema and fundal pressure expected these interventions, and that although very few wanted episiotomy, the majority of them underwent episiotomy. The evidence for all these interventions isn't strong[8]. The rate of performing enema, induction and fundal pressure is also high in other studies[14,47]. The timing of hospital admission and the length of labor influenced the use of enemas during delivery, while factors such as parity and whether the pregnancy was planned impacted the use of fundal pressure. These factors, along with the stage of labor at admission and delivery duration, also affected episiotomy rates. Multiparous women often refused fundal pressure, likely due to past childbirth experiences. An Indian

study reported a 29% rate of fundal pressure application, used when a woman cannot push effectively to expedite delivery[48].

Investigated the effect of fundal pressure and reported that manual fundal pressure had no effect on spontaneous vaginal delivery, invasive delivery, cesarean section, duration of the second stage, and low arterial cord pH in newborns[47]. It was reported that women who underwent manual fundal pressure had cervical tears more than did the women in the control group and that there wasn't neonatal death, serious maternal morbidity or death in the former group. Although the rate of primiparous mothers was low in the present study, episiotomy was performed at a high rate, which suggests that episiotomy is performed routinely. ACOG doesn't recommend routine implementation of episiotomy in vaginal deliveries[49]. In the literature, it is stated that those admitted to the hospital for delivery at an early stage undergo more interventions[14,48,50].

Shaving of the perineum had no effect on any independent variable. According to the systematic compilation, the rate of perineal shaving in the participants ranged between 6% and 14.3%. Perineal shaving is a cultural and individual preference[51]. Perineal shaving is also recommended in skilled childbirth education materials in India. Additionally, perineal shaving is more commonly performed in private hospitals[48]. In woman-centered care, all women have the right to receive adequate care during labor[8]. Although most recommended interventions were frequently performed, the reasons why some women didn't receive them warrant further investigation. The women in the study particularly wanted mobility, pain management education, breathing-relaxation exercises, CTG monitoring, and respect for their decisions during labor. Primiparous women were less likely to undergo WHO-recommended interventions, possibly due to a lack of awareness of labor procedures. Despite the range of interventions, a high percentage reported a positive birth experience.

Conclusion

The findings obtained from this study indicate that interventions whether or not they were recommended by the WHO were performed at a high rate. Of the participants, those who presented to the hospital in the latent phase and those who had prolonged labor underwent these interventions more frequently. Variables such as parity, intended pregnancy and the duration of delivery positively affected the women's birth experiences.

References

1.Bjelica AN, Cetkovic A, Trninic-Pjevic L and Mladenovic-Segedi. The phenomenon of pregnancy-a psychological view. Ginekologia Polska. 2018; 89(2):102-106. DOI: 10.5603/GP.a2018.0017.

2.Diamond RM, Brown KS and Miranda J. Impact of COVID-19 on the perinatal period through a biopsychosocial systemic framework. Contemporary Family Therapy. 2020; 42(3):205–216. https://doi.org/10.1007/s10591-020-09544-8

3. International Confederation of Midwiwes (ICM). Philosophy and Model of Midwifery Care. 2014. https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-philosophy-and-model-of-midwifery-care.pdf, Accessed July 1, 2021.

4. Olza IP, Leahy-Warren Y, Benyamini, Kazmierczak M, Karlsdottir SI, Spyridou A,Esther Crespo-Mirasol E, Lea Takács L, Hall JP, Margaret Murphy M, Jonsdottir SS, Soo Downe S and Nieuwenhuijze MJ. Women's psychological experiences of physiological childbirth: A meta-synthesis. BMJ Open.2018; 8, e020347. doi:10.1136/ bmjopen-2017-020347.

5.UNDP, Sustainable Development Goals. 2021. https://www.tr.undp.org/content/turkey/tr/home/sustainable-development-goals/goal-3-good-health-and-well-being.html (Avaible in: 12.10.2021)

6.Abalos E, Oladapob OT, Chamillard M, Diaz V, Pasquale J, Bonet M, Souza JP and Gulmezoglu MA. Duration of spontaneous labour in 'low-risk' women with 'normal' perinatal outcomes: A systematic review. European Journal of Obstetrics & Gynecology and Reproductive Biology.2018; 223, 123-132.doi: 10.1016/j.ejogrb.2018.02.026

7.Uzel HG and Yanıkkerem E. Evidence-based practice during ıntrapartum period: preferences of women giving birth. Journal of Nursing Effect. 2018; 11(1), 26-34. Retrieved from https://dergipark.org.tr/tr/pub/deuhfed/issue/46786/586673

8.World Health Organization (WHO). WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization. 2018.Licence: CC BY-NC-SA 3.0 IGO. ISBN 978-92-4-155021-5

9.Semrau KEA, Miller KA, Lipsitz S, Bowman FJ, Karlage A, Neville BA, Krasne M, Gass J, Jurczak A, Singh VP, Singh S, Delaney MM, Hirschhorn LR, Kodkany B, Kumar V and Gawande AA.. Does adherence to evidence-based interventions during childbirth prevent perinatal mortality? A post-hoc analysis of 3,274 births in Uttar Pradesh, India. BMJ Global Health.2020; 5:e002268. DOI:10.1136/ bmjgh-2019-002268

10.Başgöl Ş and Kızılkaya Beji N. Common practices and evidence based approach in first stage of labor. Journal of Duzce University Health Sciences Institute. 2015; 5(2), 32-39. Retrieved from https://dergipark.org.tr/tr/pub/duzcesbed/issue/4849/66631.

11.Lehane E, Leahy-Warren P, O'Riordan C, Savage E, Drennan J, O'Tuathaigh C, O'Connor M, Corrigan M, Burke F, Hayes M, Lynch H, Sahm L, Heffernan E, O'Keedde E, Blake C, Horgan F and Hegarty J.. Evidence-based practice education for healthcare professions: an expert view. BMJ Evid Based Med. 2019; 24:103–108. DOI: 10.1136/bmjebm-2018-111019

12.Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK and Cuthber A. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews. 2017; 7. CD003766. DOI: 10.1002/14651858.CD003766.pub6.

13.Masuda C, Ferolin SK, Masuda K, Smith C and Matsui M. Evidence-based intrapartum practice and its associated factors at a tertiary teaching hospital in the Philippines, a descriptive mixed-methods study. BMC Pregnancy and Childbirth. 2020; 20:78, doi: 10.1186/s12884-020-2778-5.

14.Colak MB and Ozturk Can H. Effects of the time of pregnant women's admission to the labor ward on the labor process and interventions, Health Care for Women International.2021; 42:4-6, 563-579, DOI: 10.1080/07399332.2020.1716763

15.Leal MC, Pereira APE, Domingues RMSM, Filha MMT, Dias MAB, Nakamura-Pereira M, Bastos MH and Da Gama SGN. Obstetric interventions during labor and childbirth in Brazilian low risk women. Cad Saúde Pública.2014; 30 Sup:S17-S47. doi: 10.1590/0102-311X00151513.

16.Singata M, Tranmer J and Gyte GML. Restricting oral fluid and food intake during labour. Cochrane Database of Systematic Reviews. 2013; 8. Art. No.: CD003930. DOI: 10.1002/14651858.CD003930.pub3.

17.Smith CA, Levett KM, Collins CT, Dahlen HG, Ee CC and Suganuma M. Massage, reflexology and other manual methods for pain management in labour. Cochrane Database of Systematic Reviews. 2018; 3. Art. No: CD009290. DOI: 10.1002/14651858.CD009290.pub3.

18.Şahin M and Erbil N. Birth and medicalization. Ordu University Journal of Nursing Studies. 2019; 2(2),120-130. Retrieved from https://dergipark.org.tr/tr/pub/ouhcd/issue/49155/572283

19.Sethi R, Tholandi M, Amelia D, Pedrana A and Ahmed S. Assessment of knowledge of evidence-based maternal and newborn care interventions among midwives and nurses in six provinces in Indonesia. Int J Gynecol Obstet. 2019; 144 (1-Suppl):51–58.https://doi.org/10.1002/ijgo.12735

20.Gwacham-Anisiobi U and Banke-Thomas A. Experiences of health facility childbirth in Sub-Saharan Africa: A Systematic Review of Qualitative Evidence. Matern Child Health J. 2022;26, 481–492. https://doi.org/10.1007/s10995-022-03383-9;

21.Downe S, Finlayson K, Oladapo OT, Bonet M and Gulmezoglu AM. What matters to women during childbirth: A systematic qualitative review. PLoS ONE. 2018; 13(4):e0194906. https://doi.org/10.1371/ journal.pone.0194906.

22.Leinweber J, Fontein-Kuipers Y, Karlsdottir SI, Ekström-Bergström A, Nilsson C, Stramrood C and Thomson G. Developing a woman-centered, inclusive definition of positive childbirth experiences: A discussion paper. Birth.2023; 50(2), 362-383. DOI: 10.1111/birt.12666

23.Moridi M, Pazandeh F, Hajian S and Potrata B. Midwives' perspectives of respectful maternity care during childbirth: A qualitative study. PLoS ONE. 2020; 15(3): e0229941. https://doi.org/ 10.1371/journal.pone.0229941.

24.Iravani M, Zarean E, Janghorbani M and Bahrami M. Women's needs and expectations during normal labor and delivery. J Educ Health Promot. 2015; 4: 6. https://doi.org/10.4103/2277-9531.151885 PMID: 25767817

25.Villarmea S and Kelly B. Barriers to establishing shared decision-making in childbirth: Unveiling epistemic stereotypes about women in labour. J Eval Clin Pract. 2020; 26:515–519. https://doi.org/10.1111/jep.13375.

26.Miller S, Abalos E, Chamillard M, Ciapponi A, Colaci D, Comande D, Diaz V, Geller S, Hanson C, Langer A and Manuelli V. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. The Lancet.2016; 388(10056), 2176-2192. https://doi.org/ 10.1016/S0140-6736(16)31472-6.

27.Radhakrishnan T,Vasanthakumari KP and Babu PK. Increasing trend of caesarean rates in India: evidence from NFHS-4, J. Med. Sci. Clin. Res.2017; 5(8), doi:http://dx.doi.org/10.18535/jmscr/v5i8.3.

28.Wang M, Song Q, Xu J, Gong Y, Lee AC and Chen Q. Continuous support during labour in childbirth: a Cross-Sectional study in a university teaching hospital in Shanghai, China, BMC Pregnancy and Childbirth.2018; 18:480https://doi.org/10.1186/s12884-018-2119-0

29.Rabello DR, Umarani J and Agarwal A. Effectiveness of labor supportive measures on selected maternal physiological parameters, labour pain and maternal satisfaction a review. Journal of Population Therapeutics and Clinical Pharmacology. 2023; 30 (15), 259-270.https://doi.org/10.47750/jptcp.2023.30.15.028.

30. Baranowska B, Kajdy A, Pawlicka P, Pokropek E, Rabijewski M, Sys D and Pokropek A.. What are the critical elements of satisfaction and experience in labor and childbirth-a cross-sectional study. Int J Environ Res Public Health. 2020; 17(24):9295. DOI: 10.3390/ijerph17249295.

31.Köksal Ö and Duran ET. Investigation of the effect of culture on the perception and reflection of labor pain. Gümüşhane University Journal of Health Sciences. 2023; 12(1),155-166. DOI: 10.37989/gumussagbil.908657.

32.Akın B, Soğukpınar N and Akman L. Evaluation the effects of maternal mobilization on mode of birth and

newborn health status ın the fırst phase of birth. Gümüshane University Journal of Health Sciences. 2017; 6(2),33-41. Retrieved from https://dergipark.org.tr/tr/pub/gumussagbil/issue/32272/359550.

33.Lawrence A, Lewis L, Hofmeyr GJ and Styles C. Maternal positions and mobility during first stage labour. Cochrane Database Syst Rev. 2013; 9;(10):CD003934.doi: 10.1002/14651858.CD003934.pub4.

34.Koç E, and Şahin N. Oral Nutrition during birth. Zeynep Kamil Tıp Bülteni. 2016; 47:4; 124-127.https://jag.journalagent.com/zkmj/pdfs/ZKMJ-03274-REVIEW_ARTICLE-KOC.pdf

35.Mendelson CL. The aspiration of stomach contents into the lungs during obstetric anesthesia. Am J Obstet Gynecol.1946; 52:191-205.

36.Marcos-Rodríguez A, Leirós-Rodríguez R and Hernández-Lucas P. Efficacy of perineal massage during the second stage of labor for the prevention of perineal injury: A systematic review and meta-analysis. Int J Gynecol Obstet. 2023; 00: 1- 9. doi:10.1002/ijgo.14723.

37.Akın B, Colak MB, Oztürk Can H and Küni F. Interventions of midwives working in delivery rooms for protection of perineum during intrapartum period and their feedback on these applications. The Journal of Maternal-Fetal & Neonatal Medicine. 2022; 35(1),24-29. DOI: 10.1080/14767058.2020.1812573

38.Aasheim V, Nilsen ABV, Lukasse M and Reinar LM. Perineal techniques during the second stage of labour for reducing perineal trauma. Cochrane Database of Systematic Reviews. 2017; 6. Art. No.: CD006672. DOI: 10.1002/14651858.CD006672.pub3.

39.Akın Ö, Şahbaz G and Yücesoy H. Ethical problems and responsibilities of health professionals in birth management. YOBU Faculty of Health Sciences Journal. 2021; 2(1), 38-48. Retrieved from https://dergipark.org.tr/tr/pub/yobusbf/issue/68639/1077948.

40.Flanigan J. Obstetric autonomy and informed consent. Ethic Theory Moral Practice. 2016;19: 225–244. DOI 10.1007/s10677-015-9610-8.

41. Ozturk M, Alan S and Kadıoğlu S. Ethical issues in the delivery room: a field study Cukurova Medical Journal. 2019; 44(1): 183-194. https://dergipark.org.tr/tr/pub/cumj/issue/42403/440675.

42.Coates D, Goodfellow A and Sinclair L. Induction of labour: experiences of care and decision-making of women and clinicians. Women and Birth. 2020; 33(1),e1-e14.DOI: 10.1016/j.wombi.2019.06.002.

43. Kulakaç Ö. Medicalization of childbirth from a feminist perspective. Kulakaç Ö, Editor. Medicalization of Women's Health; Life Periods of Women, İnterventions and Precautions. 1st Edition. Ankara: Turkey Clinics. 2021; 22- 35.

44. National Institute for Health and Clinical Excellence (NICE). Induction of labour: NICE clinical guideline 70. 2008. Manchester.

45.World Health Organization (WHO). WHO recommendations on outpatient settings for induction of labour. 2022. Available in https://www.who.int/publications/i/item/9789240055810

46.Ezeanochie MC, Olaqbuji B and Ande A. Women's concerns and satisfaction with induced labour at term in a Nigerian population. The Nigerian Postgraduate Medical Journal. 2013; 20(1), 1-4.https://journals.lww.com/npmj/Abstract/2013/20010/Women_s_concerns_and_satisfaction_with_induced.1.aspx

47.Hofmeyr GJ, Vogel JP, Cuthbert A and Singata M. Fundal pressure during the second stage of labour. Cochrane Database of Systematic Reviews. 2017; 3. Art. No.: CD006067. DOI: 10.1002/14651858.CD006067.pub3.

48.Sharma G, Penn-Kekana L, Halder K and filippi V. An investigation into mistreatment of women during labour and childbirth in maternity care facilities in Uttar Pradesh, India: A mixed methods study. Reprod Health. 2019; 16,7. https://doi.org/10.1186/s12978-019-0668-y.

49.American College of Obstetricians and Gynecologists. ACOG's Committee on Practice Bulletins—Obstetrics. Practice Bulletin No. 165: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. Obstet Gynecol.2016; 128(1):e1-e15. doi: 10.1097/AOG.0000000000001523. PMID: 27333357.

50.Chuma C, Kihunrwa A, Matovelo D and Mahendeka M. Labour management and Obstetric outcomes among pregnant women admitted in latent phase compared to active phase of labour at Bugando Medical Centre in Tanzania. BMC pregnancy and childbirth. 2014; 14(1),68. https://doi.org/10.1186/1471- 2393-14-68.

51.Basevi V and Lavender T. Routine perineal shaving on admission in labor (Review). Cochrane Database of Systematic Reviews. 2014; 11,CD001236.doi:10.1002/ 14651858.CD001236.pub2.