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Components of obstetric violence: A descriptive study on physical abuse, non-consented care and non-confidential care

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Abstract

Objective: This study aimed at assessing the components of obstetric violence of women in receiving care during labor and postnatal period.

Material and methods: This research was designed as a web-based descriptive study. The study was conducted with 556 women who had a vaginal delivery were within the first 6 weeks after delivery. The data of the research were collected between November-December 2021.

Results: The mean age of women was 27.33±5.75, and the mean gestational week was 38.96±1.42. It was determined that while 95% of the women who underwent the intervention had a vaginal examination for less than 4 hours, 86.9% of them had no freedom of positioning at birth, and information was not provided to 41.2% of them before shaving, 22.2% of them before the amniotomy, 6.3% of them before oxytocin administration, 7.8% of them before episiotomy administration, 23.6% of them before fundal pressure, and 88.9% of them before vacuum support. It was found that 69.8% of the women did not have a companion during the delivery process, 67.1% of them were not involved in the decisions during the delivery process, and 93.9% of them asked for getting permission and providing information in the interventions during the delivery process. Additionally, the difference between the distributions of exposure to obstetric violence according to some sociodemographic and obstetric characteristics of the women was not statistically significant ($p<0.05$).

Conclusion: According to the result of the study, it was determined that women were subjected to some types of obstetric violence during labor and the delivery process.

Key words: obstetric violence, physical abuse, non-consented care, non-confidential care, midwifery

Introduction

Obstetric violence (OV), is a specific type of violation of women's rights in medical practice during health care related to the child birth processes [1]. Women who give birth may be subjected to different forms of OV in the delivery room during labor and in the early postnatal period [2]. Exposure to such maltreatment and abuse creates a psychological distance between expectant mothers and caregivers, and consequently, women who are afraid of being exposed to abuse and violence avoid applying to health systems [3, 4]. Avoidance of going to the hospital and thus getting away from the health system becomes a more significant barrier than geographical or financial barriers among the barriers encountered in providing maternal health care [3, 5].

For expectant mothers who receive obstetric care, respectful care at birth is defined as "a universal human right that includes respect for women's feelings, dignity, choices and preferences and also pays regard to ethical principles" [6, 7]. It is indicated that women are exposed to many disrespectful and abusive treatments by health care workers while receiving care during the

birth process and in the early postnatal period. These treatments include physical abuse (beating, slapping and pinching), failure to provide sufficient information and to obtain consent in the interventions or care to be provided (e.g., for cesarean section or tubal ligation), disregard for privacy in care (e.g., lack of physical privacy or sharing confidential information), insulting while providing care (e.g., shouting, scolding and insulting comments), leaving alone (e.g., leaving alone during delivery), discrimination based on ethnic origin, age or wealth, or detention in institutions for non-payment of care fees [8-11].

In 2015, the world's leading authorities (The World Health Organization-WHO, The International Confederation of Midwives-ICM, The International Federation of Gynecology and Obstetrics-FIGO, The White Ribbon Alliance-WRA and The International Pediatric Association-IPA) reached a consensus on the Mother and Baby Friendly Birth Facility (MBFBF) program and determined seven basic categories of disrespect and abuse in this intervention: 1) Physical abuse: hitting, roughly forcing legs apart, fundal pressure for normal delivery; 2) Non-consented care: no informed consent for procedures, such as when provider elects to perform unnecessary episiotomy; 3) Non-confidential care: no privacy (spatial, visual, or auditory); 4) Non-dignified care: humiliation by shouting, blaming, or degrading; 5) Discrimination based on specific patient attributes: HIV status, ethnicity, age, marital status, language, economic status, educational level, etc.; 6) Abandonment of care: facility closed despite being 24/7, or if open, no staff can or do attend delivery; 7) Detention in facilities: Not releasing mother until bill is paid [12]. By declaring a consensus, these authorities propose a number of criteria and indicators to facilitate classification of health institutions in accordance with maternal and newborn care. Some of these criteria are as follows: "Every woman has the right to a positive birth experience and dignified and caring care during childbirth, even in case of complications. Every woman and every newborn baby should be protected from unnecessary intervention, practices and procedures that are not based on evidence, practices that do not respect their culture, physical integrity and dignity" [13].

The United Nation General Assembly published a report identifying violence against women in reproductive health services, especially the situation of women subjected to obstetric violence during delivery (July-2019) and called for countries to mobilize against such abusive practices [14]. It recommends adopting a human rights-based approach to the various forms of maltreatment to which women are subjected in the obstetric context by insisting that it not only violates women's right to a life free from violence, but also endangers their right to life, health, physical autonomy and autonomy [15].

While some countries in the world legally define obstetric violence and consider the practices as a crime, Turkey has not yet made a legal definition of obstetric violence. Naturally, limited evidence on OV was found in the literature review. Therefore; this study aimed at assessing the components of obstetric violence of women in receiving care during labor and postnatal period, in Turkey 2021.

Materials and methods

Study design and participants

This web-based descriptive study was planned to determine the components of obstetric violence. The survey questions in the study were created by reviewing the national and international literature. As a result of the literature review, there were 15 questions to determine the components of obstetric violence, apart from the personal information form. Computer-assisted, self-interviewing (CASI) was used as it would allow for more efficient collecting of research data. However, the evaluation of the components of obstetric violence form could not be validated due to the technical unavailability of proper focus group related to the web character of the study.

The sample size was calculated by performing power analysis in OpenEpi, version 3, publicly available statistical software (http://www.openepi.com). In this study, assuming 50% of the components of obstetric violence, the sample size was calculated as at least 383 women, with an error level of 5%, a two-sided significance level with a confidence interval of 95% and a power of 80%. 590 women initially participated in the study; however, 556 valid questionnaires were evaluated since the questionnaires of the women who did not meet the inclusion criteria (n=15) and filled out the questions incompletely (n=19) were not taken into consideration.

The inclusion criteria for the study were determined as: women who had a vaginal delivery, who were within the first 6 weeks after delivery (postpartum period), who had no risk in pregnancy, who had a healthy baby, and who were aged 18 and older.

The exclusion criteria of the study were determined as: women who were diagnosed with psychological illness, who had mental disability, who were hospitalized in the intensive care unit after delivery, and whose babies stayed in the intensive care unit.

Measures

The results of the study were collected through questionnaire forms developed by using the Google forms application (https://docs.google.com/forms) between November-December 2021. The prepared questionnaire form was shared on accessible social media platforms (facebook, instagram, twitter, etc.) where women in the postpartum period shared about themselves and their babies. In the first stage of the questionnaire, the criteria for inclusion in the study were included. In order to ensure the participation of those who were in the puerperal period, women who did not meet the inclusion criteria and stated this were not included in the study.

Accordingly, information about the subject and aim of the study was shared on the first page of the questionnaire form, and a consent text, in which it was determined that the information and answers of the participants would be kept confidential, was added. Voluntary postpartum women who approved the consent text were directed to the online survey platform prepared via an electronic link.

Personal information form

The personal information form was developed by the researchers and was structured in three parts. The first part included questions determining some descriptive characteristics of women (age, educational level, employment status, income status, etc.), the second part included questions determining their obstetric characteristics (gestational week, number of pregnancies, number of abortions, number of curettages, etc.), and the third part included questions about preparation for labor, and delivery (participation in prenatal education classes, mode of delivery, etc.) (13-15).

The form prepared to evaluate the components of obstetric violence

This form was prepared with reference to the disrespect and abuse categories in the *Mother and Baby Friendly Birth Facility (MBFBF) jointly published by the world's leading authorities (The World Health Organization-WHO, The International*

Confederation of Midwives-ICM, The International Federation of Gynecology and Obstetrics-FIGO, The White Ribbon Alliance-WRA and The International Pediatric Association-IPA) in 2015 (12). Among these published categories, there are questions aimed at determining the categories of "Physical abuse", "Non-consented care" and "Non-confidential care".

Abuse categories

Physical abuse assessment questions: Questions prepared to determine the situations of continuous application of Non-Stress Test (NST), oral restriction during delivery, frequent vaginal examinations (at intervals of less than 4 hours), and inability to take the desired position during labor and delivery. (The questions were determined as follows: NST Implementation Status, Fluids and oral intake, Vaginal examination status, Did you have freedom of position until birth?, Did you have position freedom at the time of birth?)

Non-consented care assessment questions: Questions prepared to determine the situations of shaving, application of enema, performing amniotomy, Bladder catheter application, oxytocin application, performing episiotomy, fundal application, Vacuum-assisted delivery without obtaining consent. (The questions were determined as follows: Shaving, Enema, Amniotomy, Bladder catheter application status, Induction of labor with oxytocin, Episiotomy, Fundal pressure, Vacum assisted delivery)

Non-confidential care assessment questions: Questions prepared to determine the situations of ensuring privacy, and restrictions on birth partners. (The questions were determined as follows: Was your privacy considered important during the birth process?, Was your privacy considered important at the time of birth?, Were you free to have any companion you want with you during the birth process?)

Data analysis

The data obtained within the scope of the study were first organized in Microsoft Excel and then transferred to the SPSS 25.0 for Windows (SPSS, Chicago, Il, USA) package program and evaluated. The data and descriptive statistics are presented as numbers and percentages. Statistical significance was determined as $p<0.05$.

Ethical considerations

Ethical approval was obtained from XXX University Non-Invasive Clinical Research and Publication Ethics Committee to conduct this study (Decision No: 2021/2329). This study was conducted in accordance with the Principles of the Declaration of Helsinki. On the first page of the questionnaire, informed consent indicating that they accepted the study was obtained from the women.

Results

A total of 556 women who had a vaginal delivery were evaluated in the study. While the mean age of women was 27.33±5.75 (range 18-46), it was determined that 78.8% of them had high school or below education, 79.9% of them had health insurance, 85.3% of them were unemployed, 81.1% of them had middle income, and 86.5% of them had a nuclear family structure. The mean gestational week of the women was 38.96±1.42 (range 30-42) and it was determined that 64.2% of them were multigravida, 85.6% of them had never had a miscarriage, 96.8% of them had no curettage, and 39.4% of them had at least one living child. It was determined that 98.7% of the women did not attend the prenatal education class and that 72.8% of them did not read books and magazines about delivery.

The distribution of women according to their exposure to physical abuse during the birth process is presented in Table 1. It was determined that while 86.7% of women had intermittent NST, 54.1% of them did not have oral restriction, 95% of them had vaginal examination at intervals of less than 4 hours, 91.5% of them had freedom of position until delivery, and 86.9% of them did not have freedom of position during delivery (Table 1).

Table 1 The Distribution of Women According to Their Exposure to Physical Abuse During the Birth Process

Variables	**Interventions**	
	n (556)	**%**
NST Implementation Status		
Continuous NST performed	74	13.3
Intermittent NST performed	482	86.7
Fluids and oral intake		
Yes	255	45.9
No	301	54.1
Vaginal examination status		
At intervals of less than 4 hours	528	95.0
At least 4 hours apart	28	5.0
Did you have freedom of position until birth?		
Yes	509	91.5
No	47	8.5
Did you have position freedom at the time of birth?		
Yes	73	13.1
No	483	86.9

Table 2 The Distribution of Women According to Their Exposure to Non-Consented Care During the Birth Process

Variables	Interventions		Information	
	n	%	n	%
Shaving				
Yes	17	3.1	10	58.8
No	539	96.9	7	41.2
Enema				
Yes	22	4.0	15	68.2
No	534	96.0	7	31.8
Amniotomy				
Yes	180	32.4	140	77.8
No	376	67.6	40	22.2
Bladder catheter application status				
Yes	124	22.3	112	90.3
No	432	77.7	12	9.7
Induction of labor with oxytocin				
Yes	431	77.5	404	93.7
No	125	22.5	27	6.3
Episiotomy				
Yes	358	64.4	330	92.2
No	198	35.6	28	7.8
Fundal pressure				
Yes	258	46.4	197	76.4
No	298	53.6	61	23.6
Vacum assisted delivery				
Yes	9	1.6	1	11.1
No	547	98.4	8	88.9

The distribution of women according to their exposure to non-consented care during the birth process is presented in Table 2. In the care provided to women, it was determined that while 3.1% of them were shaved and 41.2% of them were not informed before the procedure, enema was applied to 4.0% of them and 31.8% of them were not informed before the procedure, 32.4% of them underwent amniotomy and 22.2% of them were not informed before the procedure, bladder catheter was applied to 22.3% of them and 9.3% of them were not informed before the procedure, oxytocin was applied to 77.5% of them and 6.3% of them were not informed before the procedure, 64.4% of them had an episiotomy and 7.8% of them were not informed before the procedure, fundal pressure was applied to 46.4% of them and 23.6% of them were not informed before the procedure, and 1.6% of them were provided with vacuum-assisted delivery and 88.9% of them were not informed before the procedure (Table 2).

The distribution of women according to their exposure to non-confidential care during the labor process and during delivery is presented in Table 3. Accordingly, it was determined that the privacy of 95% of the women during the birth process and 95.9% of the women during delivery was protected. It was determined that 69.8% of the women did not have a companion during delivery (Table 3).

Table 3 The Distribution of Women According to Their Exposure to Non-Confidential Care During the Labor Process and During Delivery

Variables	n	%
Was your privacy considered important during the birth process?		
Yes	528	95.0
No	28	5.0
Was your privacy considered important at the time of birth?		
Yes	533	95.9
No	23	4.1
Were you free to have any companion you want with you during the birth process?		
Yes	168	30.2
No	388	69.8

The distribution of women according to their participation in decisions and their expectations during the delivery process is presented in Table 4. It was determined that 67.1% of the women were not included in the decisions during the delivery process, and that 93.9% of them asked for permission from them before the procedure to be applied during the delivery process and to be informed about the procedure (Table 4).

Table 4 The Distribution of Women According to Their Participation in Decisions and Their Expectations During the Delivery Process

Variables	n (556)	%
Participation in decisions during the birth process		
Yes I'm involved	27	4.9
I'm partially involved	156	28.0
No I'm not included	373	67.1
Obtaining permission and providing information on interventions during the birth process		
No I do not want to	11	2.0
I would partially	23	4.1
Yes I would	522	93.9

The distribution of women according to their exposure to physical abuse, non-consented care and non-confidential care during the labor process and during delivery is presented in Table 5. When the women's exposure to obstetric violence was questioned, it was determined that 37.7% of women who were exposed to physical violence had vaginal examinations less than 4 hours apart, and this rate was 95.1% for those included in the study. It was determined that oxytocin was administered in 30.8% of women exposed to Non-Consented Care, and this rate was 79.7% in those included in the study. It was determined that 13.7% of the women whose non-confidential care status were evaluated had a companion during the birth, and this rate was 31.1% in those included in the study (Table 5).

Table 5 The Distribution of Women According to Their Exposure to Physical abuse, Non-consented care and Non-confidential care

		Responses n (%)	Percent of Cases* (%)
		Yes	
Physical Abuse *(During the birth process)*	NST Implementation Status	34 (2.4)	6.1
	Fluids and oral intake	255 (18.2)	45.9
	Vaginal examination status	528 (37.7)	95.1
	Freedom of position until birth	509 (36.4)	91.7
	Freedom at the time of birth	73 (5.2)	13.2
	Total	1399 (100)	252.1
Non-Consented Care *(During the birth process)*	Shaving	17 (1.2)	3.1
	Enema	22 (1.6)	4.1
	Amniotomy	180 (12.9)	33.3
	Bladder catheter application status	124 (8.9)	22.9
	Induction of labor with oxytocin	431 (30.8)	79.7
	Episiotomy	358 (25.6)	66.2
	Fundal pressure	258 (18.4)	47.7
	Vacum assisted delivery	9 (0.6)	1.7
	Total	1399 (100)	258.6
Non-Confidential Care *(During the labor process and during delivery)*	Privacy during the birth process	528 (43)	97.4
	Privacy at the time of birth	533 (43.4)	98.3
	Freely having any companion during the birth process	168 (13.7)	31.1
	Total	1229 (100)	226.8

** MR: Multiple Response*

The distribution of women according to their exposure to physical abuse, non-consented care and non-confidential care according to some sociodemographic and obstetric characteristics is presented in Table 6. Accordingly, it was determined that the difference between the distributions of exposure to physical abuse, non-consented care and non-confidential care according to the age, education status, pregnancy week, parity, miscarriage, curettage and number of living children status of the women was not statistically significant ($p<0.05$; Table 6).

Table 6 The distribution of women according to their exposure to physical abuse, non-consented care and non-confidential care according to some sociodemographic and obstetric characteristics

	Physical Abuse (n, %)		Test[a], p value	**Non-Consented Care** (n, %)		Test[a], p value	**Non-Confidential Care** (n, %)		Test[a], p value
Age	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**	
≤ 25 years	24, 2.7	208, 38.4	p=0.563	5, 0.9	216, 38.8	p=0.457	280, 37.4	13, 2.3	p>0.999
≥ 26 years	30, 3.9	294, 55.0		12, 2.2	323, 58.1		320, 57.6	15, 2.7	
Education status									
≤High school	26, 5.0	383, 74.2	p=0.664	15, 2.7	423, 76.1	p=0.546	418, 75.2	20, 3.6	p=0.344
≥University	8, 1.6	99, 19.2		2, 0.4	116, 20.9		110, 19.8	8, 1.4	
Pregnancy week									
≤ 36 w	4, 0.8	49, 9.5	p=0.769	3, 0.5	56, 10.1	p=0.410	58, 10.4	1, 0.2	p=0.344
≥ 37 w	30, 5.8	433, 83.9		14, 2.5	483, 86.9		470, 84.5	27, 4.9	
Parity									
Primigravid	20, 1.8	195, 35.6	p=0.362	9, 1.6	190, 34.2	p=0.197	186, 33.5	13, 2.3	p=0.232
Multigravid	34, 4.7	307, 57.9		8, 1.4	349, 62.8		342, 61.5	15, 2.7	
Miscarriage									
Yes	13, 0.6	80, 13.6	p=0.453	1, 0.2	79, 14.2	p=0.489	77, 13.8	3, 0.5	p=0.784
No	41, 6.0	422, 79.8		16, 2.9	460, 82.7		451, 81.2	25, 4.5	
Curettage									
Yes	12, 0.4	19, 1.7	p=0.160	1, 0.2	17, 3.1	p=0.433	18, 3.2	0, 0.0	p> 0.999
No	42, 6.2	483, 91.7		16, 2.8	522, 93.9		510, 91.7	28, 5.1	
Number of living children									
1- 2 children	31, 4.1	342, 64.3	p=0.445	11, 2.0	369, 66.4	p=0.793	358, 64.4	22, 4.0	p=0.299
≥ 3 children	23, 2.5	160, 29.1		6, 1.1	170, 30.5		170, 30.5	6, 1.1	

[a] *Fisher's Exact Test*

Discussion

The WHO's first recommendation for a positive birth experience is respectful maternal care. Respectful maternal care refers to the care provided in a way that protects the dignity, privacy and confidentiality of all women with a human rights-based approach [16]. In this study conducted to determine the components of obstetric violence, it was found that while more than one-tenth of the women underwent continuous NST, approximately half of them were restricted for oral fluid and food intake, and almost all of them underwent vaginal examination at intervals of less than four hours (Table 1, Table 5). Practices such as increased unnecessary birth interventions and the routine use of ineffective and potentially harmful practices pave the way for obstetric violence by causing disrespectful maternal care [16]. Furthermore, the implementation of unnecessary interventions causes physical abuse, which is one of the categories of disrespect and abuse in maternal care. However, contrary to the results in the study, in the World Health Organization's positive birth guide, continuous cardiotocography/NST is not recommended for the evaluation of fetal health in healthy pregnant women with spontaneous delivery, oral fluid and food intake during labor is recommended in low-risk pregnant women, and vaginal examination at least every four hours is recommended in the routine evaluation of the first stage of labor in low-risk women [16]. Furthermore, according to the Mother-Friendly Hospital Program of the Ministry of Health of the Republic of Turkey, non-evidence-based interventions should not be routinely applied. Accordingly, pregnant women should not be starved, fluid intake should not be interrupted, and touch should not be applied frequently [17]. In parallel with the result of the study, in the study conducted on women in Turkey in order to determine the pregnancy and birth experiences of puerperant women with a vaginal delivery and their views on the mode of delivery, it was determined that 12% of women underwent continuous NST and 75.07% of them were restricted for oral intake. Furthermore, while there was no difference between the experiences of pregnant women who underwent continuous NST or intermittent NST at the time of delivery, it was determined that the experiences of pregnant women with oral restriction at the time of delivery were significantly negative compared to those without oral restriction [18]. In a study conducted by Uzel and Yanıkekrem to determine the preferences of women regarding evidence-based practices in the intrapartum period, it was determined that only 0.6% of women were allowed for oral intake during delivery [19]. Despite the recommendations of international organizations, it is reported that midwives frequently perform unregistered vaginal examinations [20]. In the study conducted by Stepherd and Cheyne to determine the causes and frequency of vaginal examination during delivery, it was determined that almost 70% of the healthcare team performed vaginal examinations at intervals of more than four hours [21]. In another study conducted on Turkish women to determine their experiences of vaginal examination during the normal delivery process and the factors affecting it, it was found that women were exposed to unnecessary and frequent vaginal examination [22]. These results show that unnecessary birth interventions were highly performed for the pregnant women included in the study and that the pregnant women were not pleased with these practices.

According to the result of our study, it was determined that although the vast majority of women took the position they wanted in the first stage of labor, contrary to the

recommendations of national and international organizations, this rate changed sharply in the second stage of labor and the majority of women could not take the position they wanted (Table 1). In the positive birth guide of the World Health Organization, supporting movement in the first stage of labor, encouragement of pregnant women, and upright position are recommended in low-risk pregnant women, and in the second stage, it is also recommended to encourage the woman to adopt a birth position that she prefers, including the upright position [23]. Furthermore, nowadays, mothers being in the position where they feel most comfortable during delivery, and the mother's ability to walk in the room as they wish are among the Mother-Friendly Hospital Implementation Criteria of the Ministry of Health [17]. Except for certain circumstances, it is not beneficial for the pregnant woman to lie down during delivery, and it may even cause fetal and maternal harm in low-risk pregnancies [24-26]. As a result of the qualitative study conducted with 7 women to investigate the perceptions and experiences of mothers and midwives regarding the use of the supine position during labor and delivery, it was reported that mothers who gave birth took the position preferred by the midwife participating in delivery and that only one mother was given the opportunity to choose a position during delivery. Furthermore, the study revealed that midwives primarily performed deliveries only in the supine position [27]. In a study, it was determined that approximately half of the women were restricted in movement during delivery, and that positive perception levels of these women about delivery were lower compared to those without movement restriction [18]. In another study conducted to evaluate women's birth experience and postpartum satisfaction, it was determined that approximately half of the women gave a negative answer to the question “The staff encouraged me about the delivery method I wanted” [28].

According to another result obtained in our study, approximately half of women with perineal shaving during delivery, one-third of women who had an enema, approximately one fourth of women who had amniotomy and fundal pressure, and almost all of the women who underwent vacuum application indicated that they were not informed before the procedure (Table 2). Similar to the result of the study, in the study conducted by Meijer et al., it was determined that information was not provided to more than half of women before perineal shaving and enema application, approximately half of women who had fundal pressure, and two-thirds of women before the forceps application, which is used when intervention is required such as vacuum [29]. In the study conducted by Özmen to determine the services received by women and their expectations for nursing approaches during gynecological examination, approximately half of the women stated that the nurse did not inform them about the pre-examination procedure [30]. In the study conducted to determine the frequency of induction use in labor and its relationship with postpartum depression score, it was determined that women experienced fear of induction due to their lack of knowledge about the procedure [31]. Medical interventions that can be performed without informing the woman about the health status of herself or her unborn baby lead to cases of maltreatment and thus obstetric violence [32]. However, in practice, women cannot always get the information they need to make conscious decisions [29]. In accordance with the 2018 intrapartum care recommendations of the World Health Organization, it is recommended to establish effective communication between health care professionals and women giving birth by using simple and culturally acceptable methods for a positive birth experience [23]. In this context, it is indicated that healthcare professionals should present the information needed by women and their families in a clear, concise and understandable way, should avoid medical language and use pictorial and graphic materials when necessary, should explain the procedures to women and their families, and should ensure that verbal or, where appropriate, written informed consent is obtained for pelvic exams and other procedures [16].

According to another result of our study, almost all of the women indicated that their privacy was protected both during and at the time of delivery (Table 3, Table 5). In parallel with the result of the study, in the study conducted on Turkish women to determine the effect of birth expectations on primiparous women's perceptions of birth experience, it was determined that almost all of the women's privacy perceptions about delivery were at the expected level and above [33]. Respecting privacy is one of the patients' rights to protection [34]. In the World Health Organization's positive birth guide, it is stated that it is important to respect the wishes of all women and that cultural sensitivities should be regarded. If there are no separate rooms in the institution providing care services, in other words, if there is a ward system with more than one bed, it is emphasized that attention should be paid to ensure the privacy and confidentiality of all women with dividers such as curtains and screens [23].

In the study, it was determined that two-thirds of the women were not allowed to have any companion they wanted during the delivery process (Table 3, Table 5). Similar to the result of the study, in the study conducted by Meijer et al., it was found that approximately half of the women with a vaginal delivery were not allowed to have any companion they wanted with them during the delivery process [29]. For a positive birth experience, it is recommended that all women should be allowed to have a companion (spouse, friend, relative, healthcare worker, daula, etc.) during labor and delivery [23]. Furthermore, according to the Mother-Friendly Hospital Program of the Ministry of Health of the Republic of Turkey, pregnant women should be able to feel comfortable and at home with a suitable companion and freedom of movement should be provided [17]. The practices apart from these practices are within the scope of non-confidential care and lead to obstetric violence.

In the study, two-thirds of the women considered that they were not included in the decisions taken during labor and delivery, and almost all of them wanted to be informed about the decisions taken in their next birth (Table 4). In parallel with the result of our study, in a study on women who gave birth in Turkey, it was determined that the majority of women gave a negative answer to the question "I was involved in making decisions about my treatment and care during the delivery process" [35]. In another study on Turkish women, it was found that participants expected healthcare professionals to be friendly and informative [22].

According to the last result obtained in our study, it was determined that the difference between the distribution of exposure to Physical abuse, Non-consented care and Non-confidential care according to the age, education status, pregnancy week, parity, miscarriage, curettage and number of living children status of the women was not statistically significant (Table 6). In this case, it was determined that exposure to obstetric violence does not differ according to sociodemographic and obstetric characteristics. As a matter of fact, in a study conducted to support our study finding, discrimination and obstetric violence in maternity wards were evaluated and it was determined that there was no difference between the distribution of exposure to obstetric violence according to the sociodemographic and obstetric characteristics of women [36].

Limitations of the study

This study has some important limitations. First, the data were collected only from women who had a vaginal delivery. Therefore, the obtained results cannot be generalized to all women in the postpartum period. Although a retrospective approach is appropriate for this study, a longitudinal format may be adopted for future studies. Nevertheless, this study provides solid evidence for the determinants of physical abuse, non-consented care and non-confidential care, which are the components of obstetric violence in Turkey.

Conclusion and recommendations

According to the result of the study obtained, it was determined that women were subjected to obstetric violence due to continuous NST application, oral intake restriction, frequent vaginal examination, not being given freedom to take the desired position during delivery, not being informed about the interventions performed, and not being allowed to have a companion during delivery. Moreover, the women in the study indicated that their privacy was regarded.

These results show that some practices should be changed in order to prevent obstetric violence and provide improvements in this field. Accordingly, it is recommended that expectant mothers should be fully and accurately informed about the interventions in delivery before the procedure, should be allowed to have a companion with them and should be allowed to take the position they want, and that in-service trainings on not performing interventions unless necessary should planned and the necessary policies should be established. Furthermore, midwives are recommended to adopt the principles of respectful maternal care during delivery.

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References

1. Williams CR, Jerez C, Klein K, Correa M, Belizán JM, Cormick G. Obstetric violence: a Latin American legal response to mistreatment during childbirth. *BJOG*. 2018;125(10):1208-1211. https://doi.org/10.1111/1471-0528.15270
2. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy Plan*. 2018;33(1):e26-e33. https://doi.org/10.1093/heapol/czu079
3. World Health Organization (WHO) (2015). Health in 2015 from MDGs to SMDGs. Geneva. Retrieved from https://www.who.int/data/gho/publications/mdgs-sdgs Accessed date: November 2021
4. U.S. Agency for International Development (USAID) 2014–2020 Maternal Health Vision (2014). Retrieved from https://www.usaid.gov/sites/default/files/documents/1864/MCHVision.pdf Accessed date: November 2021
5. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: a systematic review. *PloS one.* 2017;12(3). https://doi.org/10.1371/journal.pone.0174084
6. Windau-Melmer T. A guide for advocating for respectful maternity care. Washington, DC: Futures Group. *Health Policy Project.* 2013;(1):1-8. https://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=189
7. Reis V, Deller B, Carr C, Smith J. Respectful Maternity Care: Country Experiences: Survey Report. Washington DC: United States Agency for International Development. 2012.
8. d'Oliveira AFPL, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. *The Lancet.* 2002;359(9318):1681-1685. https://doi.org/10.1016/S0140-6736(02)08592-6
9. Miller S et al. Quality of care in institutionalized deliveries: the paradox of the Dominican Republic. *Int J Gynaecol Obstet*. 2003;82(1):89-103. https://doi.org/10.1016/S0020-7292(03)00148-6
10. d'Ambruoso L, Abbey M, Hussein J. Please understand when I cry out in pain: women's accounts of maternity services during labour and delivery in Ghana. BMC Public Health. 2005;5(1):1-11. https://doi.org/10.1186/1471-2458-5-140
11. Browser D, Hill K. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis - USAID. (2015). Accessed date: December 2021. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf
12. The Mother and Baby Friendly Birth Facility (MBFBF) Accessed date: December 2021 https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/MBFBF-guidelines.pdf
13. Miller S, Lalonde A. The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother− baby friendly birthing facilities initiative-International *Int J Gynaecol Obstet.* 2015;131(1):49-52. https://doi.org/10.1016/j.ijgo.2015.02.005
14. The United Nation General (July-2019). Accessed date: December 2021 https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx
15. Šimonović D. (2019). Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. New York: United Nations General Assembly. [New York] : UN, 11 July 2019, Accessed date: December 2021 https://digitallibrary.un.org/record/3823698
16. Yıldız H. Pozitif doğum deneyimi için intrapartum bakım modeli: Dünya Sağlık Örgütü önerileri. (Intrapartum care model for a posıtıve chıldbırth experıence: World Health Organızatıon' recommendatıons). *Kocaeli Üniversitesi Sağlık Bilimleri Dergisi*. 2019;5(2):98-105. https://doi.org/10.30934/kusbed.546900
17. The Ministry of Health of the Republic of Turkey (MHRT) (2017). Mother-Friendly Hospital Program, Retrieved from https://hsgm.saglik.gov.tr/tr/kadin-ve-ureme-sagligi-programlari/anne-dostu-hastane-program%C4%B1.html Accessed date: November 2021
18. Erciyes Ü. (2016). The pregnancy, birth experience and the opinions reparding delivery type of the puerperants, after vaginal birth. (Unpublished master dissertation). İstanbul Medipol University.
19. Uzel Gökdemir, H, Yanıkkerem E. Evidence-based practice during ıntrapartum period: preferences of women giving birth. DEUHFED. 2018;11(1):26-34. https://doi.org/10.33808/clinexphealthsci.765157

20. Moncrieff G, Gyte GML, Dahlen HG, Thomson G, Singata-Madliki M, Clegg A, Downe S. Routine vaginal examinations compared to other methods for assessing progress of labour to improve outcomes for women and babies at term. *Cochrane Database of Systematic Reviews.* 2022; (3),Art. No.: CD010088. https://doi.org/10.1002/14651858.CD010088.pub3
21. Shepherd A, Cheyne H. The frequency and reasons for vaginal examinations in labour. *Women and Birth*. 2013;26(1):49-54. https://doi.org/10.1016/j.wombi.2012.02.001
22. Yıldırım G, Bilgin NÇ. Women's experıences of vagınal examınatıon durıng normal chıldbırth and affectıng factors: A qualıtatıve study. *Anadolu Hemşirelik ve Sağlık Bilimleri Dergisi.* 2021; 24(2):220-230. https://doi.org/10.17049/ataunihem.856233
23. WHO recommendations Intrapartum care for a positive childbirth experience. Accessed date: December 2021 https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf
24. ACOG, The American College of Obstetricians and Gynecologists. (2017). *Approaches To Limit Intervention Du¬ring Labor And Birth Committee Opinion.* https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2019/02/approaches-to-limit-intervention-during-labor-and-birth
25. Yılmaz K, Polat O, Kocamaz B. Defansif tıp uygu¬lamalarının hukuksal açıdan incelenmesi. (The legal analysis of defensive medicine acts). Türkiye Adalet Akademisi Dergisi. 2014;16:19-51.
26. Gottvall K, Allebeck P, Ekeus C. Risk factors for anal sphincter tears: the importance of maternal position at birth. BJOG: *Int. J. Obstet. Gynaecol.* 2007; 114(10):1266-1272. https://doi.org/10.1111/j.1471-0528.2007.01482.x
27. Mselle LT, Eustace L. Why do women assume a supine position when giving birth? The perceptions and experiences of postnatal mothers and nurse-midwives in Tanzania. *BMC Pregnancy Childbirth.* 2020;20(1):1-10. https://doi.org/10.1186/s12884-020-2726-4
28. Uysal B. (2017). *Assessment of women's birth experience and postpartum Satisfaction (Unpublished master dissertation)*. Eskişehir Osmangazi University
29. Meijer M, Brandão T, Cañadas S, Falcon K. Components of obstetric violence in health facilities in Quito, Ecuador: A descriptive study on information, accompaniment, and position during childbirth. *Int J Gynaecol Obstet.* 2020;148(3):355-360. https://doi.org/10.1002/ijgo.13075
30. Özmen N. (2012). *The Nursing Services Concerning Nursing Approaches And Expectations Of Women During Gynecological Examination* (Unpublished master dissertation). University of Hacettepe
31. Erdem E, Ege E. (2019). Frequency of induction use in labor and its relationship with postpartum depression score (Unpublished master dissertation). Necmettin Erbakan University.
32. Pryrodni Prava Ukraina. Mistreatment and violence against women during reproductive health care with a focus on childbirth: the case of Ukraine. United Nations Special Rapporteur on violence against women by the civil society organization. 2017; https://www.ohchr.org/Documents/Issues/Women/SR/ReproductiveHealthCare/Pryrodni%20Prava%20Ukraina.pdf
33. Aslan Ş, Okumuş F. The ınfluence of childbirth expectation on primiparous women's perceptions of their birth experience. *Arc Health Sci Res.* 2017;4(1):32-40. https://doi.org/10.17681/hsp.287497
34. Fırat A. Türkiye sağlık işletmelerinde hasta hakları ve sorumlulukları. (Patient Rights and Responsibilities in Health Care Establishments in Turkey). *İstanbul Gelişim Üniversitesi Sağlık Bilimleri Dergisi.* 2017; 2:157-173. https://dergipark.org.tr/tr/pub/igusabder/issue/30932/332354
35. Muslu A, Yanıkkerem E. Doğum Beklentileri ve Deneyimleri Ölçeği'nin Türkçe formunun geçerlilik güvenirlik çalışması. (Turkish Form Validity and Reliability of the Childbirth Expectations and Experiences Scale). *Dokuz Eylül Üniversitesi Hemşirelik Fakültesi Elektronik Dergisi*. 2020;13(4):231-244. https://doi.org/10.46483/deuhfed.577938
36. Santiago RV, Monreal LA, Rojas Carmona A, Domínguez MS. "If we're here, it's only because we have no money…" discrimination and violence in Mexican maternity wards. *BMC Pregnancy Childbirth.* 2018;18(1):244. https://doi.org/10.1186/s12884-018-1897-8