

Original Article

Routine Interventions During Normal Birth: Women's Birth Experiences and Expectations

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Abstract

Background: Routine medical interventions in the birth process cause in a disruption of the natural process of birth and the mother to experience negative and unhappy birth.

Objective: To evaluate labor interventions performed during normal birth and women's birth experiences and expectations.

Methodology: This descriptive, cross-sectional study was conducted from January to June 2017 with 331 women. A questionnaire was used for data collection, and a chi-square test was used for analysis.

Results: The most commonly practiced intervention was restricted eating and drinking (100%), followed by induction/provocation (85.8%), enema (75.8%), amniotomy (45.9%), continuous electronic fetal monitoring (43.5%), fundal pressure (52.9%), and episiotomy (88.8%). Most women (83%) had to remain immobile during labor, and all gave birth in the supine position. Additionally, 63.4% received partially supportive care from health personnel, half were given no information on the process being performed, and approximately three-quarters (73.4%) were not included in the decision-making process during labor. Half of the women stated that health personnel did not respect them or their privacy and that their attitudes and behavior were bad, and 89.7% gave birth in a single-person labor room.

Conclusions: These results indicate that the normal birthing process is being medicalized. More than half of the women were not satisfied with the attitudes and behaviors of the health care providers from whom they received care and reported negative birth experiences.

Keywords: Birth, Expectation, Experience, Intervention, Intrapartum care, Labor

Introduction

Currently, given technological developments, births are performed in hospitals and under the control of doctors, and the normal birthing process has become increasingly medicalized

(Hodnett et al. 2013; Vural & Senturk Erenel 2017). Birth is an instinctive process that occurs by itself without intervention through the action of hormones (Sercekus & Isbir 2012). Although obstetric interventions such as induction,

episiotomy, enema, and cesarean section (C/S), which are defined as medicalization of birth, are extremely important for the mother's and baby's health, these applications should not become routine and should not be used unless obligatory (Vural & Senturk Erenel 2017; Calik, Karabulutlu & Yavuz 2018; WHO 2018).

Evidence-based studies noted that routine medical interventions in the birthing process have disrupted the natural birth process, risk the health of the baby and mother, and result in longer hospitalizations and higher birth costs (Vural & Senturk Erenel 2017; Calik, Karabulutlu & Yavuz 2018; WHO 2018). These interventions result in a negative and unhappy birth experience for the mother, who may search for alternative methods for subsequent births (Calik, Karabulutlu & Yavuz 2018).

The World Health Organization (WHO) projects a world with quality health care for all mothers and babies during birth and the postnatal period (Gungor & Beji 2012; WHO 2018). Thus, obstetric care has become more important, and evidence-based research has been performed in this area. Stopping routine interventions in normal births will increase maternal satisfaction and reduce the cost of care (Calik, Karabulutlu & Yavuz 2018).

A key reason for unnecessary interventions in the birthing process is the inadequacy of prenatal care and counseling. Adequate prenatal care and counseling by health professionals with evidence-based guidelines will protect the health of the mother and the fetus and prevent unnecessary interventions (Basgol & Beji 2015).

This study evaluated the routine interventions performed during a normal birth and women's birth experiences and expectations.

Methodology

Study Design and Participants: This descriptive, cross-sectional study was conducted between January and June 2017 on women who had a normal birth at the maternity clinic of an Education and Research Hospital of the Ministry of Health in Izmir, Turkey. Most women giving birth in this hospital had moved from different regions and had a low socioeconomic status.

In Turkey, the C/S rate (53.1%) (OECD 2017) was subtracted from the annual number of births at the hospital (4,200) to determine the number of normal births (2,310). According to the

sample whose population was known, 331 samples were required with an error of $\alpha = 0.05$ (Yazicioglu & Erdogan 2004).

Inclusion criteria: The criteria for inclusion were a normal birth at term (between 37 and 42 weeks), being able to communicate, and agreeing to participate in the study.

Measures: A questionnaire prepared by the researchers in line with the literature was used to collect the data (Hodnett et al. 2013; Basgol & Beji 2015; Chalmers & Dzakpasu 2015; WHO 2015). The questionnaire consisted of three parts. The first part assessed individual and obstetric characteristics, the second part assessed routine interventions in labor and delivery (interventions in the first and second phases of labor), and the third part assessed birth experiences and expectations of the included women.

A draft of this questionnaire was reviewed by approximately three stakeholders and subject experts for content validity and flagging of any necessary revisions or additions. A pilot study ($n = 10$) was conducted before the present study to ensure the comprehensibility and conformability of the questionnaire items. After the comments were reviewed, a final version of the questionnaire was created.

The hospital's maternity ward includes two labor rooms, each with six beds, and three delivery rooms with a one-person delivery table. The women enter the labor room in the first stage of birth. They are taken to the individual delivery room during the second stage, and one or two hours after birth, they are taken to the obstetrics ward.

The data collection was performed in two stages. In the first stage, the individual characteristics of the women in the maternity room were recorded, along with the interventions performed during the birth process. The second stage occurred in the obstetrics ward following the birth, when the women were asked about their birth experiences and expectations. Face-to-face interviews were conducted, and the oral statements of the women and health personnel, record files, and researcher observations were used.

Statistical Analyses: The data were analyzed using SPSS Statistics 25.0 Program (IBM Corp; Armonk, NY, USA). Numerical variables were shown as the mean (standard deviation), and categorical variables were given as the number and percentages. Pearson's chi-square test was

used for the categorical variables. A significance level of $p < 0.05$ was accepted for all hypotheses.

Ethical Considerations

Ethical approval for the research was obtained from ethics committee and oral consent was obtained from the women participating in the study.

Results

The average age of the 331 women was 25.95 ± 3.73 years (range, 20–40), and the average gestational age was 38.93 ± 0.808 weeks. The individual and obstetric characteristics of the participants are shown in Table 1. Routine obstetric interventions used in the first and second stages of labor are shown in Table 2.

Table1. Individual characteristics of women

Characteristics (N:331)	Mean/ SD (Min-max)	n	%
Age group (years)			
≤ 24 age	25.95 ± 3.73	131	39.6
≥ 25 age	(20-40)	200	60.4
Education status			
Literate		101	30.5
Primary school (≤ 8 yıl)		184	55.6
High school		46	13.9
Work status			
Yes		48	14.5
No		283	85.5
Economic status			
Low income		161	48.6
Middle income		170	51.4
Ethnic region in Turkey			
Western and Central Anatolia Region		129	38.9
Eastern Anatolia Region		136	41.1
Migrant (Syria)		66	20.0
Parity			
Primiparus	1.87 ± 0.876	134	40.5
Primiparus	(1-4)	197	59.5
Attending prenatal birth preparation training			
Yes		29	8.8
No		302	91.2
Stage of labor			
Latent phase		241	72.8
Active phase		90	27.2
Medical staff in delivery			
Midwife-nurse		32	9.7
Doctor		299	90.3

Table 2. Use of routine interventions in vaginal labor and birth.

Variables	Total		Age group(years)		Test	Parity		Test
	(N: 331)		≤24age	≥25age	χ^2	Primiparus	Primiparus	χ^2
	n	%	n	%*	P	n	%*	p
Interventions in the first phase of labor								
Induction								
Yes	284	85.8	103 (78.6)	181 (90.5)	.003	97 (72.4)	187 (94.9)	< .000
No	47	14.2	28 (21.4)	19 (9.5)		37 (27.6)	10 (5.1)	
Enema								
Yes	251	75.8	101 (77.1)	150 (75.0)	.695	93 (69.4)	158 (80.2)	.024
No	80	24.2	30 (22.9)	50 (25.0)		41 (30.6)	39 (19.8)	
Amniotomy								
Yes	152	45.9	80 (61.1)	72 (36.0)	< .000	71 (53.0)	81 (41.1)	.033
No	179	54.1	51 (38.9)	128 (64.0)		63 (47.0)	116 (58.9)	
Electronic fetal monitoring (EFM)								
Never	64	19.3	23 (17.6)	41 (20.5)	.455	33 (24.6)	31 (15.7)	.036
Intermittent	123	37.2	54 (41.2)	69 (34.5)		53 (39.6)	70 (35.5)	
Continuous	144	43.5	54 (41.2)	90 (45.0)		48 (35.8)	96 (48.7)	
Maternal mobility in action (standing, strolling, squatting)								
Never	275	83.1	115 (87.8)	160 (80.0)	.073	115 (85.8)	160 (81.2)	.299
Partially	56	16.9	16 (12.2)	40 (20.0)		19 (14.2)	37 (18.8)	
Interventions in the second phase of labor								
Fundal pressure								
Yes	175	52.9	97 (74.0)	78 (39.0)	< .000	104 (77.6)	71 (36.0)	< .000
No	156	47.1	34 (26.0)	122 (61.0)		30 (22.4)	126 (64.0)	
Episiotomy								
Yes	294	88.8	127 (96.9)	167 (83.5)	< .000	134 (100)	160 (81.2)	< .000
No	37	11.2	4 (3.1)	33 (16.5)		0 (0.0)	37 (18.8)	
Perineal rupture / laceration								
Yes	130	39.3	64 (48.9)	66 (33.0)	.004	51 (38.1)	79 (40.1)	.709
No	201	60.7	67 (51.1)	134 (67.0)		83 (61.9)	118 (59.9)	

Skin-to-skin contact

Yes	97	29.3	46 (35.1)	51 (25.5)	.065	63 (47.0)	34 (17.3)	<
No	234	70.7	85 (64.9)	149 (74.5)		71 (53.0)	163 (82.7)	.000

Breastfeeding during the first 15 minutes

Yes	31	9.4	28 (21.4)	3 (1.5)		29 (21.6)	2 (1.0)	<
No	300	90.6	103 (78.6)	197 (98.5)	<.000	105 (78.4)	195 (99.0)	.000

X^2 : chi-square test, *Column percentage,

Table 3. Women's birth experiences and expectations.

Variables (N: 331)	n	%
Discomfort from the crowds of the delivery room		
Yes	261	78.9
No	70	21.1
Discomfort from delivery desk or birth position		
Yes	255	77.0
No	76	23.0
Emotional support and care by health personnel		
Never	111	33.5
Partially	210	63.4
Continuous	10	3.0
Giving information about the interventions and making explanations		
Never	164	49.5
Partially	157	47.4
Continuous	10	3.0
Participation in the decision-making process of interventions		
Never	243	73.4
Partially	82	24.8
Continuous	6	1.8
Respectfulness by health personnel		
Yes	177	53.5
No	154	46.5
Respect for privacy by health personnel		
Yes	172	52.0
No	159	48.0
Attitudes and behaviors of health personnel		
Good	21	6.4
Moderate	134	40.5

Bad	176	53.1
Negative approaches of health personnel		
Negative verbal approaches	144	43.6
Positive verbal approaches	5	1.5
Both verbal and physical negative approaches	31	9.3
Expectations of women for the delivery room		
Quiet, single room	297	89.7
A room where we can ask for midwives when we have pain	34	10.3
Ask for husband or family to be in the delivery room		
Yes	221	66.8
No	110	33.2
Meeting the expectations of care and interventions by health personnel		
Yes	88	26.6
No	243	73.4

A partograph was used, and eating and drinking were restricted during the birth process for all the women. The pregnant women reported receiving no relaxation or massage techniques by the health care provider (HCP) to reduce labor pains. Perineal shaving, epidural anesthesia, and the use of forceps or vacuum were not implemented, and all women gave birth in a supine position.

Obstetric interventions applied during labor were compared statistically with parity. In the first stage of birth, induction/provocation ($p < 0.001$), enema ($p < 0.05$), and continuous electronic fetal monitoring (EFM) ($p < 0.05$) were performed more frequently in high multipara women than in primipara women ($p < 0.001$). Amniotomy application ($p < 0.05$), fundal pressure ($p < 0.001$), and episiotomy (100%) ($p < 0.001$) were performed more frequently in primipara women than in multipara women. Following birth, skin-to-skin contact and breastfeeding in the first 15 minutes were reported significantly more frequently by primipara women than multipara women ($p < 0.001$) (Table 2). The birth experiences and expectations of the women are reported in Table 3.

Discussion

Previous studies have found that women who received support from childbirth preparation classes adapted better to the birth process and

had more positive perceptions of birth (Sercekus & Isbir 2012).

Furthermore, pregnancies and births without risks should be perceived as natural processes by midwives and obstetricians. Since the beginning of the 20th century, births have become medicalized, and hospital-based births have become widespread (Basgol & Beji 2015; Vural & Senturk Erenel 2017). An important indicator of this is the continuously increasing C/S rates in our country. Compared with cesarean rates in other OECD countries, Turkey ranks the highest (53.1%) (OECD 2017).

Very few women in this study (8.8%) received childbirth preparation training, and 90.3% of the births occurred under a physician's control. Births should be midwife and mother-centered. In the present day in many countries, births occur in hospitals, and births are viewed as a medical intervention with pregnant women viewed as patients. Consequently, the continuous support that women used to receive intrapartum is gradually being lost (Hodnett et al. 2013).

Routine Interventions in Labor: In Turkey, rates of obstetric intervention may differ according to the hospital's type and size, location (urban or rural area), whether it is a government or private hospital, and according to maternal characteristics and the knowledge and equipment available to those providing care. However,

obstetric interventions are reported to be used frequently (Basgol & Beji 2015; Vural & Senturk Erenel 2017; Calik et al. 2018).

In this study, 72.8% of the pregnant women were admitted to the delivery room in the latent phase. The WHO has recommended based on very strong research waiting until the active phase of the first stage before taking the woman to the delivery room (WHO 2018).

Perineal shaving is not recommended before vaginal birth. Pubic or perineal shaving was not performed on any women in this study. However, most of the women received induction/provocation (85.8%), three-quarters had an enema, and approximately half received an amniotomy. The practices of induction and amniotomy were higher in multipara women. In a study conducted in a public hospital in a province in the east of Turkey, 22.2% of pregnant women received perineal shaving, and two-thirds received an enema, elective induction, and intravenous fluid and nutrient restriction applications (Calik, Karabulutlu & Yavuz 2018). International organizations and evidence-based studies do not recommend restricting water and food or perineal shaving or routine enema in births where there is no risk (Hodnett et al. 2013; Singata, Tranmer & Gyte 2013; WHO 2015, 2018; Calik, Karabulutlu & Yavuz 2018). Early oxytocin and early amniotomy are not recommended for preventing delay in birth (Smyth, Markham & Dowswell 2013; WHO 2018). Induction and early amniotomy without indications increase the frequency of serious complications and the need for additional interventions such as C/S (Hodnett et al. 2013; Singata, Tranmer & Gyte 2013).

In this study, oral liquid and food were restricted for all the women. In low-risk women, oral liquid and food are recommended during the birth process. A systematic evaluation of previous studies concluded that intravenous liquid routinely administered to pregnant women whose oral liquid had been restricted reduced the time for delivery (Creedon et al. 2013).

In this study, EFM was applied to 80.7% of the women during labor, and continuous EFM was administered significantly more frequently in multiparous women. Approximately 91% of the women in a study by Chalmers et al. (2009) reported receiving EFM while giving birth. In two studies, approximately two-thirds of women who had a vaginal delivery used continuous EFM

(Chalmers et al. 2009; Calik, Karabulutlu & Yavuz 2018). In a spontaneous birth with a healthy mother, using continuous EFM to assess the wellbeing of the baby is not recommended. Instead, routine evaluation of the baby's wellbeing with a fetoscope or doppler is recommended. Continuous EFM restricts the choice of actions during the birth process, specifically regarding the birth position and ability to move freely, and can cause stress for the mother. Furthermore, continuous EFM increases the rates of C/S and instrumental vaginal births (Alfrevic, Devane & Gyte 2013; WHO 2018). A partogram was used with all the women. The current findings do not imply that a partogram is necessary for standard labor; however, it is recommended by the WHO (WHO 2018).

Women are recommended to take the position they find most comfortable during labor; they should move freely and be supported and allowed to adopt an upright position (standing, walking, or squatting) (Makuch 2010; Singata, Tranmer & Gyte 2013; WHO 2015, 2018; Kibuka & Thornton 2017).

Restricting mobilization hinders passage of the fetus down the birth canal and increases pain by increasing the pressure of the fetus on the lumbosacral area. This lengthens the birth process by decreasing endorphins and oxytocin. The fetus is negatively affected by this process, and thus the mother-baby interaction and indirectly the family are negatively affected (Kibuka & Thornton 2017). There is clear and significant evidence that gait and upright positions shorten labor and reduce the need for an epidural and C/S risk during the first stage of labor (Lawrence et al. 2013).

The woman should not be forced into any birth position and should be supported in the position where she feels most comfortable (WHO 2018). In the second stage of delivery, lying on your back increases episiotomy and instrumental delivery.

In this study, epidural analgesia and forceps or a vacuum were not used in the second stage of birth. The use of epidural analgesia in the birth process is effective in reducing pain. The WHO recommends epidural analgesia for healthy pregnant women who want to ease pain (WHO 2018). The use of epidural analgesia in birth is progressively increasing in Turkey and has been reported in 35% of births in private hospitals and

11% of births in university hospitals (Ertugrul 2009). In a study conducted in Canada by Chalmers et al. (2009), more than half of the women with a vaginal birth were given an epidural or spinal analgesia (57.3%). In births where epidural analgesia is applied, rates of dysfunctional events, birth by vacuum or forceps, and C/S increase (Hodnett et al. 2013). As an analgesia, women who want to ease pain during the birth process are recommended to try progressive muscle relaxation, breathing, music and awareness, and other relaxation techniques, or manual techniques such as massage or warm compress (Sercekus & Isbir 2012; WHO 2018).

The rate of episiotomy was very high in this study, and one out of three women had undesirable perineal tears/lacerations. The proportion of women given an episiotomy was higher in primipara women than in multipara women. Chalmers et al. (2009) reported that 20.7% of women with a vaginal birth received an episiotomy.

To reduce perineal trauma in the second stage of childbirth and to ease spontaneous birth, perineal massage, warm compresses, and using the hands to protect the perineum are recommended in accordance with the woman's choice and the facilities available (WHO 2018). In a systematic examination on the use of routine episiotomy in vaginal births, perineal trauma occurred 30% less frequently in the group without routine episiotomy. The evidence that perineal trauma was reduced when routine episiotomy was performed was considered inadequate (Jiang et al. 2017). Performing an episiotomy creates fear in the mother and increases pain in the area after birth, and because the mother experiences pain after the birth, it is difficult to breastfeed (Vural & Senturk Erenel 2017).

Fundal pressure was applied to more than half the women (52.9%) in this study and occurred significantly more frequently in primipara women (77.6%). Manual fundal pressure is not recommended in the second stage of birth to ease birth (WHO 2018). Evidence of the benefits and harms of application in studies with fundal pressure is insufficient, and studies involving the effects on the maternal perineum and the safety of the baby are necessary (Carroli & Mignini 2009; Asheim et al. 2011).

This study reported low postnatal skin-to-skin contact (29.3%) and breastfeeding rates in the first 15 minutes (9.4%). These rates were higher

for primipara women than for multipara women. Skin-to-skin contact with the mother is recommended in the first hour following birth for newborn infants without complications to prevent hypothermia, support breastfeeding, and developing a feeling of trust (WHO 2018).

In the study, postnatal skin-to-skin contact (29.3%) and breastfeeding rate of the baby in the first 15 minutes (9.4%) were found to be low. These rates were found to be higher for primipara women than for multipar women. Skin to skin contact with the mother is recommended in the first hour following birth for newborn infants without complications in order to prevent hypothermia and to support breastfeeding (Moore et al. 2012; WHO 2018).

Birth Experiences and Expectations: A positive birth experience includes the constant support of specialist medical staff and the birth of a healthy baby, in which the woman participates in the decision-making process, in a physically and psychologically safe environment (WHO 2018). A woman's experience of giving birth can vary in connection with many factors such as interventions performed during the birth process, the midwife's expectations, education level, support provided during birth, and the physical condition of the maternity room. Support of health personnel is important for a positive birth experience, and HCPs must meet the physical, emotional, and social needs of the pregnant woman throughout the process (Ozcan & Aslan 2015).

Three-quarters of the women in the study reported that the labor room was crowded and the birth table and birth position were uncomfortable. Two-thirds of the women received partial emotional support and physical care from health personnel and were not given information on the interventions performed. Only one in four women were included in the decision-making process. As the women's perception of support from HCPs in the birth process increased, perceived control increased and anxiety and negative mental state decreased (Isbir & Inci 2014). Giving women information or education on fetal condition and changes in procedure during the birth process reduces their anxiety and enables their participation in decisions. The women stated that they expected HCPs to respond to their questions, teach them calming and relaxation techniques, and provide

support (Daglar & Guler 2004; Basgol & Beji 2015).

A study by Chalmers and Dzakpasu (2015) reported that there was more communication between women with no intervention in a vaginal birth and care providers. The WHO recommends care that provides all women with respect and privacy, avoids bad treatment, guarantees their freedom, and provides informed choice and continuous support when giving birth (WHO 2018).

The medicalization of birth removes the women and their families from the decision-making process and thus this process is not based on respect (Vural & Senturk Erenel 2017). Birth should be conducted in a personalized manner, and routine obstetric interventions should not be performed (Aslan & Okumus 2017). A direct correlation exists between interventions performed and women's negative experiences of birth, and communication is better between care providers and women on whom interventions are not performed (Chalmers & Dzakpasu 2015; Aslan & Okumus 2017).

The WHO reported that many women are exposed to disrespect, foul language, and negligence (2015). In this study, half the women (43.6%) reported that HCPs did not respect their personalities and privacy, that their attitudes and behavior were bad, and that they were spoken to negatively by HCPs; three out of four women stated that the care and interventions performed by HCPs in labor did not meet their expectations.

Negligent, uncaring, or disrespectful actions by HCPs must be prevented. In this study, two-thirds of the women stated a need for social support from their husbands or other family members in the maternity room, and most (89.7%) wanted the labor room quiet and private. In a study by Gungor and Beji (2007), the husband's presence had a positive effect on the birth experience. Social and emotional support during childbirth reduces the woman's stress levels, provides encouragement, and gives a feeling of security from the antepartum to the postpartum period and a positive assessment of the process. Receiving continuous support during childbirth reduces the use of analgesia and anesthesia and the rate of interventions in vaginal birth; it also increases satisfaction with the birth process and the time of breastfeeding after the birth (Hodnett, et al. 2013; WHO 2018).

Conversely, negative views of a woman's experience of birth can have negative effects including postpartum depression, negative feelings toward the baby, difficulties with feeding and mother-baby bonding, not fulfilling the role of mother and experiencing problems with breastfeeding, not wanting another pregnancy, experiencing fear of childbirth, preferring a cesarean birth, and inadequacy in sexual relations (Ozcan & Aslan 2015).

Conclusion: This study noted a very high rate of obstetric medical interventions in normal births. Evidence-based and supportive approaches at all stages of childbirth will contribute to reducing misuse, lowering costs, increasing women's positive experiences of birth, and developing health care. Health personnel must provide women with respectful and individual service, and hospitals must implement programs that provide continuous support to pregnant women throughout the childbirth process. HCPs must be educated to provide respectful maternal care and avoid the medicalization of childbirth.

Limitations: This study was conducted in a single public research and training hospital. The results can be generalized to public hospitals. Future studies should be conducted with private universities and public hospitals.

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