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RETURN TO NATURAL CHILDBIRTH: ARE OUR MIDWIVES READY FOR THIS? A CROSS-SECTIONAL STUDY FROM WESTERN TÜRKİYE**

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ABSTRACT

This study aimed to report current knowledge and opinions of midwives regarding natural birth. Cross-sectional data were collected from 213 midwives. Data were analyzed using descriptive statistics and Chi-square test. Midwives' mean age and work experience were 37.85±5.81 and 18.36±6.49 years, respectively. Midwives assisted in normal births (65.3%), C-sections (33.3%) and natural births (1.6%), and indicated that the C-section is the riskiest birth (72.3%). Only 35% of midwives had received childbirth *preparation classes* training. Many midwives did not know about natural birth at all (21.2%) or about preparations for natural birth (41.7%). The midwives supported normal and natural births and believed such births to be healthy, but were not knowledgeable regarding natural birth and preparations for natural birth, and continued conventional birth practices.

Keywords: Midwives, Natural Childbirth, Knowledge, Opinion.

DOĞAL DOĞUMA DÖNÜŞ: EBELER BUNA HAZIR MI? TÜRKİYE'NİN BATISINDAN KESİTSEL BİR ÇALIŞMA

ÖZ

Bu çalışmanın amacı ebelerin doğal doğuma ilişkin bilgi ve düşüncelerini belirlemektir. Kesitsel özellikteki çalışma 213 ebeden toplanmıştır. Veriler, tanımlayıcı istatistikler ve Ki-Kare analizi ile değerlendirilmiştir. Ebeler ortalama 37.85±5.81 yaşındadır ve 18.36±6.49 yıldır çalışmaktadır. Ebelerin %65,3'ü normal, %33,3'ü sezaryen, %1,6'sı doğal doğum yapmıştır. Ebelere göre en riskli doğum şekli sezaryendir (%72,3). Ebelerin %35'i doğuma hazırlık eğitimi almıştır. Ebelerin %21,2'si doğal doğumu ve %41,7'si doğal doğum için yapılacak hazırlıkları bilmemektedir. Ebeler normal ve doğal doğumu sağlıklı bulmakta ve desteklemekte, ancak doğal doğumu ve hazırlığını yeterince bilmemekte ve geleneksel doğum yaklaşımlarını devam ettirmektedirler.

Anahtar Kelimeler: Ebe, Doğal Doğum, Bilgi, Düşünce.

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1. INTRODUCTION

Birth is a natural physiological process and external interventions affect the normal course of labor. In the natural process, the human body is programmed for normal spontaneous vaginal delivery (Fabbri et al., 2016). Since normal delivery is a term that ignores maternal outcomes (Ely et al., 2020) and atraumatic normal delivery occurs in only 33-40% of women who intend to have a vaginal delivery (Caudwell-Hall et al., 2018), this concept can be misleading. The concept of "normality" in birth is not universal or standardized. Although normal birth and natural birth are used interchangeably, natural birth often refers to the birth without medical intervention in which the mother is actively involved in the birth according to her own instincts (Queensland Clinical Guidelines, 2017). Many births can proceed without unnecessary medical interventions (WHO, 2018). Today, many interventions that are routinely applied by the healthcare team without evidence interfere with the natural progression of childbirth (Barol Kurtoğlu & Kaya, 2019). So, in many parts of the world women cannot receive quality intrapartum care by being exposed to unnecessary medical interventions such as labor induction, oxytocin supplementation, cesarean delivery, operative vaginal delivery, episiotomy enema, perineal shaving, IV fluids and amniotomy. These intrusive approaches and practices are not sensitive to women's preferences, values and needs, and they also limit women's capacity to give birth, resulting in negative birth experiences (WHO, 2018).

While birth is a universal experience, the perceived severity of pain varies with women and can be associated with women’s opinions regarding childbirth. Additionally, negative birth experiences, rumors about childbirth experiences and scenes of painful births in the media create a negative image of childbirth, which leads women to prefer caesarean section (C-section) (Suwanrath et al., 2021). World Health Organization (WHO) recommends that the C-section rates should be 10%-15% (WHO, 2018). The American College of Obstetricians and Gynecologists (ACOG) emphasizes that a caesarean is a surgical intervention, likely to create many risks, and should not be performed upon request before 39 weeks of gestation (ACOG, 2019b). International Federation of Gynecologists and Obstetricians (FIGO) supports also baby- and mother-friendly birth care (Lalonde et al., 2019, 2021). However, C-section rates are much higher in low-, middle- and upper-income countries ranging from 1.4%-56.4%. Its rate is 40.5% in Latin America and the Caribbean, 32.3% in North America, 31.1% in Oceania, 25% in Europe, 19.2% in Asia and 7.3% in Africa (WHO, 2018). Despite attempts to increase normal births in Türkiye

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(Erbaydar, 2021; T.C. Sağlık Bakanlığı, 2017, 2022), C-section rates increased from 36.7% in 2008 to 54.4% in 2021 (Akadlı Ergöçmen et al., 2009; T.C. Sağlık Bakanlığı, 2022). Türkiye ranks second after Mexico in cesarean deliveries in OECD countries (OECD, 2019; T.C. Sağlık Bakanlığı, 2022). The increase of C-sections is generally attributed to social pressure and fear of malpractice suits among physicians, the inability to perform painless birth at all centers, performing C-sections upon request, the extension of caesarean indications and deficiencies in monitoring and conducting birth by midwives, birth anxiety and fear, social factors such as under health insurance coverage, first time mothers, childbirth in the private health institutions, those staying in the Western region and urban areas, and having the highest level of wealth (Antoniou et al., 2022; Erbaydar, 2021; T.C. Sağlık Bakanlığı, 2022). Various interventions, including induction, amniotomy, episiotomy, enema and vaginal examination, are also performed more frequently than necessary in normal vaginal births. In addition, fluid intake, nutrition and mobility are restricted, and birth frequently occurs in the lithotomy position. These interventions carried out at high rates had a negative impact on women's childbirth experience (Dasikan et al., 2020; Erbaydar, 2021; WHO 2018). Today's conscious women want to manage and be at the center of the birth, use non-medical methods for birth pain, have a pleasant birth experience and share the experience with their spouses (Karlström et al., 2015; WHO, 2018). Therefore, health professionals should observe, provide guidance and avoid all unnecessary interventions during a birth process.

The WHO and Lamaze International published a guide to six evidence-based practices for health professionals to increase natural births (NBs). The guide states that birth can occur with minimum intervention. Moreover, women should start labor spontaneously, move freely, receive emotional and physical support, move in positions other than the supine and keep their babies with them after birth (Lamaze International, 2007; WHO, 2018). The Coalition for Improving Maternity Services (CIMS) also published a ten-step mother-friendly care guide (CIMS, 2015). Similarly, Internatıonal Childbirth Initiative (ICI) published a*12 steps* to *safe* and *respectful* mother-baby–family *maternity care,* and draw attention to NBs (Davis-Floyd 2022; Lalonde et al., 2019, 2021).

In Türkiye, The Ministry of Health initiated the mother-friendly hospital program in 2010. National mother-friendly hospital standards, guidelines and evaluation tools were developed. Implementation began in 2015. 455 health care workers were trained in January 2020 and 73 hospitals have been certified as mother-friendly hospitals (Erbaydar, 2021). The Ministry of Health recently indicated also

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that health centers should make appropriate arrangements for women to have normal and natural births without interventions, offer appropriate education to health staff and increase birth preparation courses (T.C. Sağlık Bakanlığı, 2022). The most important aspects of this issue are providing prenatal education programs regarding NB, childbirth preparation courses and encouraging women. Prenatal education offers information regarding birth and the postpartum period to women and their spouses and thus helps couples make effective decisions, develop coping strategies and have positive birth experiences (Erbaydar, 2021; Lamaze International, 2007). Childbirth preparation classes and continuous support during childbirth decrease the need for analgesia and interventions; increase natural, spontaneous births; reduce pain, fear and anxiety; and contribute to adaptation to childbirth and positive birth experiences, perceptions and satisfaction (ACOG, 2019a; Sak et al., 2022).

It is important for health professionals, particularly for midwives, to provide guidance for NB to increase knowledge regarding the issue. The International Confederation of Midwives (ICM) emphasizes that midwives should enhance women's self-confidence and prevent complications to improve NBs (ICM, 2014b, 2014c, 2017). It is crucial for midwives to adopt an individualized approach, be sensitive, involve women in decisions and encourage mothers to cooperate. NB depends on midwives' knowledge, therapeutic communication skills, autonomy, philosophy, clinical experience and midwifery care models (Bagheri et al., 2021; ICM, 2017, 2019, 2021; Onchonga et al., 2020).

In this context determining the current status of midwives' knowledge, opinions, attitudes, skills, etc., regarding NB is an inevitable first step in changing their role by recognizing their educational needs, revising educational programs and developing midwifery care models for NB (Hildingsson et al., 2021; Liu et al., 2021; Nilsson et al., 2019; Onchonga et al., 2020). This study seeks to determine midwives' levels of knowledge and opinions regarding NB.

2. METHOD

There were 384 midwives in the primary, secondary and tertiary health care centers in Aydın in southwestern Türkiye: 100 midwives at Family Health Care Centers I to IX and Mother and Child Health and Family Planning Center, 275 midwives at Aydın Maternity Hospital and nine midwives in the Maternity and Obstetrics Clinic of Adnan Menderes University Research and Practice Hospital. The samples represented 55.5% of the study population and included 213 midwives who agreed to

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participate and were available at the time of the study. These midwives were actively working at primary (n=84), secondary (n=120) and tertiary (n=9) health care centers.

Data were collected *via* a self-rated questionnaire based on the literature. The questionnaire was piloted by 15 midwives at the Aydın Government Hospital and revised as necessary. The questionnaire included 10 questions regarding midwives' socio-demographics and nine questions regarding their knowledge of NB, five of which were open-ended and four closed-ended. Responses to questions about NB were considered to be either correct or incorrect based on the literature. The questionnaire also included two open-ended and two closed-ended questions and 27 statements (three of which were negative statements) regarding midwives' opinions of NB. The midwives marked their responses to the statements on a five-point scale (completely agree, agree, cannot decide, disagree and completely disagree).

In the study, the principles of the Declaration of Helsinki and the rules of research and publication ethics were followed and necessary permissions were obtained. Questionnaires were completed by midwives under the supervision of a researcher within 10-15 minutes. Data were analyzed with descriptive statistics and Chi-square test; P<0:05 was considered as significant.

3. RESULTS

3.1. Descriptive Features of Midwives

The mean age of the midwives was 37.85±5.81 years (range: 23-52), 64.3% had an income equal to their expenses, and 88.7% were married and had children (1.90±0.55). Participants were two-year (70.0%) and four-year (16.0%) university or nursing high-school graduates (14%). The mean work experience was 18.36±6.49 years. The midwives were working in primary (39.4%), secondary (56.3%) or tertiary (4.2%) health care centers.

The midwives themselves had experienced normal births (65.3%), C-sections (33.3%) or NBs (1.6%). The time from the last birth was 1-5 years in 25.5% and 6-10 years in 36.7% of midwives. Midwives experiencing normal birth considered the birth healthy and without risk (75%), and midwives experiencing C-sections preferred the caesarean to avoid birth-related complications (57.1%).

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Only 5% of midwives had childbirth preparation classes training. Of those who had training, 33.3% received the training at the school and 26.2% through prenatal courses.

3.2. Knowledge of Midwives Regarding NB

Most midwives had heard the term NB (75.5%). The midwives hearing about NB were aged 22-34 years (X^2=6.152, P= 0.046) and had received childbirth preparation classes training (P=0.001). Other variables had no effect on this issue (P>0.05).

Participants defined NB as giving birth without any intervention (57.9%), giving birth without receiving any help (11.8%) and labor beginning spontaneously and occurring without induction (11.2%). NB was defined accurately by 34.8% of nursing high school graduates, 58.1% of two-year university graduates and 76.9% of four-year university graduates (X^2=8.903, P= 0.012). NB was also defined correctly by 67.5% and 34.7% of midwives wanting or not wanting to receive NB education, respectively (P=0.000). No other variables affected the knowledge of NB (P>0.05).

Most participants (67.9%) believed NB to be beneficial; however, 21.2% of the midwives were not familiar with its benefits (Table 1). Of the former group, 33.3% noted that NB is the healthiest with the fewest complications. A significantly high rate of midwives receiving prenatal education (80%) believed NB to be beneficial compared with those not receiving education (61.1%) (X^2= 10.554, P=0.005). In addition, compared with the midwives experiencing their last birth ≥11 years ago (54%), a significantly high rate of those midwives giving birth 1-10 years ago (72.6%) believed NB to be useful (X^2=6.113, P= 0.047). Other variables were not significant (P>0.05).

The midwives believed that health professionals and women (pregnant or non-pregnant) require education in NB (21.7%). The attendants themselves (70%) also wanted to receive NB education (Table 1). Of the midwives desiring education, 84.6% were four-year university graduates although education did not make a significant difference (P>0.05). However, age and work experience were important. A significantly high percentage of midwives aged 23-34 years (84.8%) and those aged 35-44 years (66.1%) desired NB education compared with midwives aged 45-52 years (59.1%) (X2=6.857, P= 0.032). Of midwives with 1-10 years' work experience, 95.7% wanted to receive education, as did 65.2% of those

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midwives with 11-20 years' work experience and 67.7% of midwives with ≥21 years' work experience (X^2=8.374, P= 0.015). All other variables were not significant (P>0.05).

Some midwives mentioned requiring educational and emotional support (57.7%), prenatal care (38.9%) and childbirth preparation classes training in addition to therapy (30.1%) to assist at NBs; however, 41.7% did not know what to do, and 78.2% emphasized the need for additional education to increase NBs (Table 1).

Table 1. Knowledge of Midwives Regarding Natural Birth (n=213)

Knowledge Regarding Natural Birth	n	%
Does natural birth have benefits? (n=184)		
Yes	125	67.9
No	20	10.9
Don't know	39	21.2
What preparations are necessary to give birth naturally? (n=136)		
Exercise and going for a walk	9	6.6
Childbirth preparation classes courses training and therapy	41	30.1
Emotional preparation	10	8.4
No preparations are needed.	2	1.5
I don't know.	15	41.7
Prenatal and postnatal monitoring and care	14	38.9
Going for a walk, nutrition, everything	3	2.2
Good mood and going for walks	6	16.7
Education and exercise	29	21.3
What should be done to increase the number of natural births? (n=133)		
Education should be offered.	104	78.2
Public awareness regarding the benefits of natural birth should be raised by educational programs and mass media.	8	6.0
Physicians, midwives and nurses should be educated.	6	4.6
Pregnant women and health professionals should be educated, and hospital policies should be developed (Family-friendly hospitals).	4	3.0
Education programs and systems should be adjusted for natural birth.	4	3.0
Conscious attempts should be made.	2	1.5
C-section rates should be reduced.	1	0.7
Natural birth centers should be established.	1	0.7
I don't know.	3	2.3

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3.3.Opinions of Midwives Regarding NB

The midwives were in favor of normal (70.7%) or natural birth (18%); 38.6% of the former believed a normal birth to be healthy and less risky. Of the midwives who favored natural birth, 61.3% believed natural birth to be the best choice without interventions. Childbirth preparation classes training had no effect on midwives' views regarding types of birth ($p>0.05$).

The C-section was identified as the riskiest birth for complications (83.8%) because a caesarean is a surgical intervention (24.5%) and is associated with postpartum complications (21.8%); surgery, anesthesia and labor-related complications (19.1%); and bleeding and anesthesia complications (19.1%). Only 4.3% of participants believed NB to be risky because NB is not assisted by health professionals (4 midwives), its complications are not well known and intervening in NB is difficult (2 midwives).

The midwives considered birth to be a natural, healthy function of the body (99.5%) and a process with two dimensions, psychosocial and life (90.9%). Additionally, NB was considered spontaneous (89.5%), births with the fewest possible interventions were considered healthier (85.6%), and postpartum mother-baby bonding was considered important (98.1%) (Table 2). For 98.5% of midwives, prenatal information and support influenced preference of birth-type, 74% believed that NB could occur in a hospital, 68.4% stated women not at risk could stay at home during the painful portion of labor, and 88.9% recommended hospitalization when the water breaks.

According to participants, women should not maintain a constant position during NB (75.9%), and women should move freely during labor (65.3%) (Table 2). Midwives who were familiar with NB and midwives who were not agreed with these ideas (59.7% and 75.8%, respectively [X^2=5.749, P=0.056]). The midwives believed that standing up, walking, sitting upright, squatting, kneeling, crawling and lying on the lateral side facilitate the downward movement of the baby and the birth (65.9%) (Table 2). These positions were agreed upon by 54.8% and 76% of midwives familiar or not familiar with NB, respectively (X^2=6.610, P=0.014). Of midwives, 35.8% thought that women could spontaneously give birth either standing or in any position whereas 42.6% disagreed. These positions were also supported by 66.7% of the midwives with 1-10 years' work experience, 30.9% of midwives with 11-20 years' work experience and 31.3% with ≥21-years' work experience (X^2=13.202, P=0.010). Moreover, 65.2% of single midwives and 32.2% of married midwives agreed with this view (X^2=10.275, P=0.006).

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Most midwives (96.5%) reported that emotional support could decrease stress and facilitate the birth (Table 2). Midwives believe that breathing exercises and relaxation techniques facilitate the birth (97.1%); music, bathing and massage render the birth easier (91.5%); enemas, rupturing the amniotic sac, administering analgesics and applying pressure to the abdomen should be avoided (67.2%); women should make their own decisions and choices regarding NB (56.8%); and women may eat and drink in the absence of risk (49.2%). Additionally, some midwives thought birthing in the supine position increases the risk of tears and episiotomy (38.9%) and renders women passive (43.9%).

Although only 17.1% of midwives believed that an episiotomy should be performed in all births; 83.4% believed an episiotomy could enlarge the canal and prevent severe tears. The use of episiotomy was supported by 75.4% and 87.7% of midwives who had received or not received childbirth preparation classes training, respectively (X^2=6.705, P=0.035). Additionally, 73% of midwives believed the umbilical cord should be dissected soon after birth.

Table 2. Opinions of the Midwives Regarding Natural Birth

Opinions Regarding Natural Birth	Agree		Cannot decide		Disagree	
	n	%	n	%	n	%
Mothers and their babies should be together after birth. (n=207)	203	98.1	1	0.5	3	1.4
Emotional support during birth decreases stress and facilitates the birth. (n=201)	194	96.5	2	1.0	5	2.5
Spontaneously beginning labor is natural childbirth. (n=200)	179	89.5	14	7.0	7	3.5
Women should move freely during childbirth. (n=196)	128	65.3	29	14.8	39	19.9
Positions such as standing, walking, sitting upright, squatting, kneeling and lying on one side facilitate the downward movement of the baby and the birth. (n=205)	135	65.9	28	13.7	42	20.5
Births with the fewest possible interventions are healthier. (n=202)	173	85.6	14	6.9	15	7.4

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4. DISCUSSION

The present study is the first study identifying possible problems (information needs and opinions) of the midwives, who are responsible for normal and NBs, regarding to NB. However, the study was conducted in Aydın and does not reflect the entire population, which is an important limitation. Additionally, collection of data utilizing a self-rated questionnaire did not allow an in-depth analysis of midwives' opinions.

Because pregnancy and birth are natural and healthy functions of the body, women can and should give birth naturally and spontaneously without unnecessary interventions. Health professionals should only observe and intervene when necessary. In Türkiye, normal and at-risk births are generally attended by midwives under the supervision of gynecologists in secondary health care centers and by gynecologists in tertiary health care centers. Mother-friendly hospitals, recently becoming popular and piloted by the Ministry of Health in some cities, have drawn attention to NB (Erbaydar, 2021). Midwives, having the most important responsibility in managing the preparation stage, should have appropriate knowledge and background and adopt the philosophy of NB (Bagheri et al., 2021; Edmonds et al., 2020; ICM, 2014a,b,c, 2021; WHO, 2018). Midwives believe birth is normal and natural, in general (ICM, 2014b, 2014c, 2017). However, there is very limited information about their knowledge, skills and practices regarding natural birth. A preliminary study indicated that 38.5% of midwifery students had heard of NB, 34.9% defined NB correctly and 96.4% of these students wanted to receive education in NB (Amanak & Akdolun Balkaya, 2013). Subsequent studies show a significant increase in NB awareness. It was found that 68% of nurses and midwives working in obstetrics clinics had heard of the concept of natural birth before, 61.3% had insufficient knowledge on natural birth, and 70.8% wanted to receive training on this subject (Güleç Şatır et al., 2018). In the study of Olgaç and Karaçam (2017), in which the views of nurses, midwives and obstetricians were examined, the majority (75.2%) correctly defined the concept of natural birth. This studies indicates that midwives have heard about NB but do not know much about NB. In addition, midwives frequently confused NB with normal birth. Compared with midwifery students examined by Amanak and Akdolun Balkaya (2013), a higher proportion of midwives had heard about NB (approximately 2/3) and knew about NB (57.9%) in this study. Also, young midwives had a higher rate of hearing NB because they had received birth preparation courses. Those midwives who had heard about NB defined this type of birth as spontaneous and without interventions. The fact that young midwives

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and those who graduated from four-year university programs know more about NB can be attributed to the recent inclusion of NB in midwifery curricula. However, midwives' paradoxical approach to NB and wanting to receive more education regarding NB highlights that this topic has not taught effectively. There is no evidence that all current childbirth preparation classes trainings also do include NB, because there is no clear connection between receiving childbirth preparation classes training and correctly defining NB.

NB occurs with as little interventions as possible (Darra, 2009; Lothian, 2014). Women should be involved in decisions regarding the birth of their children and arrange the environment for their comfort. Expectant mothers should get ready for childbirth by childbirth preparation courses. These courses should offer adequate information regarding NB and coping strategies and help mothers develop self-confidence, which engender positive birth experiences (Camlibel & Mete, 2020; Lothian, 2014). Many studies have shown that women receiving high-quality prenatal education and attending birth preparation courses prefer more frequently a normal birth (Masoumi et al., 2016; Mousavi et al., 2022; Pinar et al., 2018). Births performed in natural environments and managed by midwives are reported to obviate interventions, allow women to make personal arrangements and provide positive outcomes for women and babies (ICM, 2017, 2021; Stark et al., 2016). However, only 57.7% of midwives were of the opinion that woman need education and support to experience a normal birth in this study. Although NB is common in some countries such as Norway and Netherland (Logsdon et al., 2017; Preis et al., 2018), it is a new concept in Türkiye (T.C. Sağlık Bakanlığı, 2022), and women give birth in Türkiye on conventional obstetric chairs. One study revealed that 47.3% of midwifery students were unfamiliar with preparations for NB (Amanak & Akdolun Balkaya 2013). Similarly, this study showed that 41.7% of midwives were unfamiliar with preparations for NB. Therefore, both pregnant women and midwives should be offered education for NB.

Amanak and Akdolun Balkaya observed that midwifery students were familiar with not only the benefits (67.3%) but also the harm (59.6%) caused by NB (Amanak & Akdolun Balkaya 2013). Similarly, a high percentage of midwives in this study knew the benefits of NB (67.9%). However, only 33.3% of all midwives could explain NB's benefits, and there was no significant correlation between education and knowledge of the benefits of NB. The reasons may be that NB has only recently been incorporated into the midwifery curricula in certain schools; midwives have different levels of education, and because of

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the use of conventional obstetric chairs. The higher percentage (80%) among midwives receiving childbirth preparation classes training also emphasizes the importance of education. Most midwives who gave birth in the last 10 years believed NB beneficial (72.6%), possibly because of recent attempts by the Ministry of Health to reduce C-section rates (T.C. Sağlık Bakanlığı, 2022).

Regardless of their educational background, 70% of the sample and younger midwives with 1-10 years of experience wanted more education regarding NB, and more than 2/3 of the midwives emphasized the need for this education in this study. The duration of prenatal birth education and the time from the last birth were not correlated with the desire to receive education in NB. These findings suggest that contents of available prenatal education were not satisfactory. Midwives appeared to be sensitive to NB; however, it is clear that appropriate standardized education programs should be initiated immediately (T.C. Sağlık Bakanlığı, 2022).

Although fear of birth pain, the possibility of harm to babies, increased educational levels and various socio-cultural factors cause the selection of C-section (ACOG, 2019b; Antoniou et al., 2022; Fabbri et al., 2016; Suwanrath et al., 2021; WHO, 2018), there are increasing attempts to decrease C-section rates. The WHO, Lamaze International, CIMS, ICM and the Turkish Ministry of Health support mother-friendly practices (CIMS, 2015; ICM, 2017, 2021; Lamaze International 2007; T.C. Sağlık Bakanlığı, 2022; WHO, 2018;). Significantly, supportive attitudes and health professionals functioning as knowledge providers encourage normal and natural births (ACOG, 2019a; Bagheri et al., 2021; ICM, 2021; Lothian, 2014). The questions are whether midwives are adequately prepared for this role and whether midwives understand their responsibilities in these areas. Only one-third of midwifery students in Aydın (Amanak & Akdolun Balkaya 2013) and approximately 75% of midwives in this study had heard of NB although there were many contradictions. Midwifery students considered the C-section the riskiest type of birth (90.5%), and high rates of these students would prefer normal births for women (87%-76.3%); however, the rate of those in favor of NB was quite low (8.9%). In this study most midwives also believed the C-section to be the riskiest type of birth, and 70.7% and 18% of the midwives stated that women should prefer normal and natural births, respectively. Notably, 90%-99.5% of midwives defined pregnancy and birth as physiological and multidimensional processes and mentioned the effects of prenatal information and support on selection of types of birth. Parallel to the popularity of mother-friendly practices and consistent with the results of the study by Amanak and Akdolun Balkaya (2013), most

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midwives in this study also agreed on mother-baby bonding after birth (98.1%), the stress-relieving and facilitator role of perinatal emotional support (96.5%), the spontaneous nature of NB (89.5%), and the avoidance of interventions to achieve healthier births (85.6%). These findings are important in terms of spreading NB. However, the results of Nilsson et al. indicate that health professionals do not inform and support pregnant women (Nilsson et al., 2010). A study revealed that 63.4% of women 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. Besides, the 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 (Daşıkan et al., 2020).

In Türkiye, women give birth on conventional obstetric chairs and cannot move freely although practices may vary with health centers. Compatible with the literature (Amanak & Akdolun Balkaya 2013), more than half of the participants (65.3%) and a high percentage of those defining NB correctly (75.8%) support freedom of movement during birth. Moreover, more than half of the midwives (65.9%) and a high percentage of those defining NB correctly (76%) agreed on the facilitating effects of standing up, walking, being upright, squatting, kneeling, crawling or lying on one side. These findings indicate that detailed explanations of NB in in-service trainings for midwives can contribute to increasing the rate of NBs.

Although a high percentage of the midwives agreed that women should not be confined to a constant position (75.9%), some of the midwives were in favor of giving birth standing or at in another position (35.8%) and were aware of the risk of tears and episiotomy in the supine position (38.9%) and the pacifying effects of the supine and semi-fowler positions (43.9%). These findings suggest a lack of knowledge regarding appropriate birth positions. A higher percentage of single midwives (65.2%) and midwives with 1-10 years of work experience (66.7%) were in favor of giving birth in any position. Perhaps the reason was that NB has become more popular recently or these midwives may have been exposed to this subject.

Generally, cervical dilatation should be at least 3-4 cm, and there should be regular uterine contractions upon admission. Fulfillment of these criteria shortens the time spent in the delivery room before birth, reduces the amount of oxytocin and analgesics and enhances women's autonomy regarding the birth

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(Lauzon et al., 2001). Although midwives agreed that NB can be performed in hospitals (74%) and women can remain at home during labor (68.4%), the majority of the midwives noted that pregnant women should go to the hospital when their water breaks (88.9%) and that the umbilical cord should be dissected soon after birth (73%). These findings indicate that although midwives were in favor of NB, they nevertheless adhered to traditional practices, requiring support and training in this area.

Midwifery-led care is a high-certainty, evidence-based strategy to improve maternity care (Edmonds et al., 2020). In midwife-directed NB, women can use relaxation techniques such as moving freely, listening to music, having a bath or massage; obtain the necessary knowledge and support; avoid interventions except when medically indicated; keep the babies with their mothers after birth; and initiate breastfeeding sooner (ACOG, 2019a; Bagheri et al., 2021; Guzewicz & Sierakowska, 2022; Hua et al., 2018; Jiang et al., 2018). Consistent with the literature, the midwives in this study also believed that listening to music, having a massage (91.5%), deep breathing exercises and other relaxation methods (97.1%) facilitate the birth and that babies should be given to their mothers (98.1%) and breastfed soon after birth (96.1%). However, only half of the midwives believed that women should make their own decisions during NB (56.8%), possibly because of the beliefs that mothers do not have the right to express their opinions and that decisions regarding birth can only be made by physicians and/or midwives.

Although there is insufficient evidence that food and drink should be restricted during childbirth (Fiszer & Weiniger, 2023, WHO 2018), women are not given food or drink; these needs are met intravenously (Daşıkan et al., 2020; WHO 2018). Rates of induction and episiotomy should be ≤10% or ≤20% (Goer et al., 2007; WHO, 2018), and frequently used interventions such as enema, induction, amniotomy, fundal pressure, prolonged straining by the Valsalva maneuver and episiotomy are disadvantageous (Akyıldız et al., 2021; Berghella et al., 2008; CIMS, 2015; Daşıkan et al., 2020; Goer et al., 2007; WHO 2018). In the present study, as opposed to traditional practices, the midwives mentioned that women could eat and drink water in the absence of risk (49.2%) and that unnecessary interventions such as enema, rupturing the amniotic sac, induction, analgesia and fundal pressure should be avoided. Clearly, midwives were open to change; however, they require more information and support to institute these changes.

Episiotomy should not be used routinely, because episiotomy causes serious perineal lacerations, perineal infections, postpartum pain, discomfort and dyspareunia and prevents women from performing

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their own care (WHO, 2018). Amanak and Akdolun Balkaya (2013) reported that although midwifery students do not support episiotomy, these students do believe that episiotomies prevent tears. In addition, most midwives (82.9%) in this study were against routine episiotomy although the midwives believed that an episiotomy would enlarge the birth canal and prevent serious tears (83.4%). Only 13% of those respondents who received childbirth preparation classes training believed that an episiotomy prevents tears. These findings suggest that the midwives had conflicting ideas regarding episiotomies and that content and/or education methods of prenatal classes' courses should be thoroughly re-evaluated.

5. CONCLUSION

Despite mother-friendly practices and attempts to decrease C-section rates and support for normal and natural births by the Turkish Ministry of Health, NB has nevertheless not garnered the necessary interest from health staff, which has also occurred in many other countries. Studies regarding the reasons for this have been unsuccessful; however, the dependency of midwives on obstetricians and giving birth on conventional obstetric chairs appear to be strong barriers. Certainly, another reason is the universal resistance to change of the midwives, nurses, physicians and the women themselves. According to the findings of this study, the primary reason for this resistance appears to be lack of knowledge and perhaps the lack of necessary skills of midwives. An analysis of the midwives' answers to various questions indicates clear paradoxes in their approach to the issue and information, if given to them, has not been assimilated. More research to understand the factors affecting the practice of midwifery, organizational arrangement and adoption of new regulations appears to be inevitable and will increase NBs and possibly normal, healthy births as well.

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