

The Effect of Some Components of the Safe and Respectful Mother Baby-Family Maternity Care Initiative on Mothers' Perception of Supportive Care: A Cross-Sectional Study

Güvenli ve Saygılı Anne Bebek-Aile Doğum Bakımı Girişiminin Bazı Bileşenlerinin Annelerin Destekleyici Bakım Algısına Etkisi: Kesitsel Çalışma

^{1b} Hanife Nurseven ŞİMŞEK^a, ^{1b} Hülya DEMİRCİ^a, ^{1b} Alev YALNIZ^b

^aManisa Celal Bayar University Faculty of Health Sciences, Department of Midwifery, Manisa, Türkiye

^bManisa Merkezefendi State Hospital, Midwife Polyclinic, Manisa, Türkiye

This study was presented as an oral presentation at 1st International 3rd National Birth Preparation Education and Training Congress October 18-21, 2018, İzmir, Türkiye.

ABSTRACT Objective: The current research was conducted to examine the effects of some components of the safe and respectful mother baby-family maternity care initiative on mothers' perception of supportive care. **Material and Methods:** The research was carried out cross-sectionally with 325 women at a state hospital, which adopted the safe and respectful mother baby-family maternity care initiative. The research data were collected using the "Descriptive Information Form" and the "Scale of Women's Perception for Supportive Care Given During Labor". The data were evaluated using number, percentage, mean, and the Mann-Whitney U test. **Results:** The total mean score of the Scale of Women's Perception for Supportive Care Given During Labor was 122.53±13.46 (minimum: 33, maximum: 132), and it was found that women's perception of supportive care was good. It was determined that women who could reach the midwife providing care whenever they wanted during labor, whose privacy was taken care of, and whose oral nutrition and fluid intake were not restricted had a better perception of supportive care, and a statistically significant difference was found between them ($p<0.05$). **Conclusion:** Some components of the safe and respectful mother baby-family maternity care initiative were found to increase mothers' perception of supportive care. This initiative can allow midwives to allocate more time to their supportive roles by reducing the use of unnecessary interventions. Additionally, more women can be provided with safe and respectful mother baby-family maternity care by increasing the number of hospitals adopting this initiative.

ÖZET Amaç: Bu araştırma, güvenli ve saygılı anne bebek-aile doğum bakımı girişiminin bazı bileşenlerinin annelerin destekleyici bakım algısına etkisini incelemek amacıyla yapılmıştır. **Gereç ve Yöntemler:** Araştırma kesitsel olarak, güvenli ve saygılı anne bebek-aile doğum bakımı girişimini benimseyen bir devlet hastanesinde 325 kadınla yürütülmüştür. Araştırmanın verileri "Tanıtıcı Bilgi Formu" ve "Doğumda Verilen Destekleyici Bakıma İlişkin Kadının Algısı Ölçeği" kullanılarak toplanmıştır. Veriler sayı, yüzde, ortalama ve Mann-Whitney U testi kullanılarak değerlendirilmiştir. **Bulgular:** Doğumda Verilen Destekleyici Bakıma İlişkin Kadının Algısı Ölçeği toplam puan ortalaması 122,53±13,46 (minimum: 33, maksimum: 132) ve kadınların destekleyici bakım algısının iyi olduğu saptanmıştır. Doğum eyleminde her istediğinde bakım veren ebeye ulaşabilen, mahremiyetine özen gösterilen, oral beslenmesi ve sıvı alımı kısıtlanmayan kadınların destekleyici bakım algısının daha iyi olduğu ve aralarında istatistiksel olarak anlamlı bir farklılık saptanmıştır ($p<0,05$). **Sonuç:** Güvenli ve saygılı anne bebek-aile doğum bakımı girişiminin bazı bileşenlerinin annelerin destekleyici bakım algısını artırdığı saptanmıştır. Bu girişim, gereksiz müdahalelerin kullanımını azaltarak ebelerin destekleyici rollerine daha fazla zaman ayırmalarını sağlayabilir. Ayrıca bu girişimi benimseyen hastanelerin sayısı artırılarak daha fazla kadına güvenli ve saygılı anne bebek-aile doğum bakımı sunulabilir.

Keywords: Supportive care initiative; childbirth; midwifery; mother; baby

Anahtar Kelimeler: Destekleyici bakım girişimi; doğum; ebelik; anne; bebek

TO CITE THIS ARTICLE:

Şimşek HN, Demirci H, Yalınız A. The effect of some components of the safe and respectful mother baby-family maternity care initiative on mothers' perception of supportive care: A cross-sectional study. Türkiye Klinikleri J Health Sci. 2025;10(1):36-43.

Correspondence: Hanife Nurseven ŞİMŞEK

Manisa Celal Bayar University Faculty of Health Sciences, Department of Midwifery, Manisa, Türkiye

E-mail: hanife.ege.2006@hotmail.com



Peer review under responsibility of Türkiye Klinikleri Journal of Health Sciences.

Received: 31 Jul 2024

Received in revised form: 23 Oct 2024

Accepted: 10 Nov 2024

Available online: 03 Feb 2025

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Increased cesarean section rates worldwide, the increasing overuse of obstetric technologies, and not applying scientific evidence in favor of normal, physiological childbirth have created a need for clear guidelines to provide optimal maternal care. The International MotherBaby Childbirth Initiative (IMBCI): Mother-Friendly Childbirth Initiative's (MFCI) 10 steps were implemented to promote a healthy maternal care model by the Coalition for Improving Maternity Services (CIMS) established in the United States of America in 1996. The purpose of the IMBCI 10 Steps is to improve care throughout the reproductive years in order to save lives, prevent diseases and harm from the overuse of obstetric technologies, and enhance maternal and infant health. In 2005, the CIMS was transformed into the International MotherBaby Childbirth Organization (IMBCO) and established the International Committee.^{1,2} The IMBCO and the International Federation of Gynecology and Obstetrics (FIGO) developed a single global initiative to provide guidance and support for safe and respectful maternal care, the International Childbirth Initiative (ICI):³ 12 Steps to Safe and Respectful MotherBaby-Family Maternity Care, which was put into action at the FIGO World Congress in 2018. The ICI provides clear steps for implementing evidence-based maternity care worldwide by recognizing the interaction between the mother-baby dyad and the family environment and their interactions with healthcare professionals and systems.^{2,3}

Step 4 of the ICI states that the mother's right to continuous support during labor and birth should be acknowledged, she should be informed of the benefits of this support, and she can receive this support from people of her choice. These people may include the father, partner, family member, professional support (midwife, doula), or others.^{1,3,4} The amount of support from caregivers, the quality of relationships with caregivers, personal expectations, and involvement in the decision-making process affect women's satisfaction with childbirth experience.⁵ Continuous support during labor has been associated with a more positive birth experience for women and newborns, increased rates of spontaneous vaginal birth, a shorter duration of labor, decreased number of cesarean sections and interventional vaginal births, lower anal-

gesic requirement, and fewer babies with a low 5-minutes appearance, pulse, grimace, activity and respiration score.^{3,4,6,7} The midwife-led continuous care model has been found to be effective in experiencing less regional analgesia, fewer interventional vaginal births, fewer preterm births before the 37th week, fewer fetal losses and fetal deaths before and after the 24th week, and more spontaneous vaginal births.⁸ It has been stated that more than 50 short-term, medium-term, and long-term outcomes can be improved with midwifery care, including decreased maternal and neonatal mortality and morbidity, a decrease in stillbirths and preterm births, decreased number of unnecessary interventions, and improvements in psychosocial and public health outcomes.⁹

The foundations of the MFCI in Türkiye were laid in 2010. A State Hospital, Akhisar Mustafa Kirazoğlu State Hospital, and Turgutlu State Hospital were awarded the title of "mother-friendly hospital" for the first time in Türkiye in 2015. According to the latest data from the Ministry of Health, there are currently 131 mother-friendly hospitals.¹⁰⁻¹² In Türkiye, obstetricians manage childbirths at an increasing rate (83%), and the rate of childbirths managed by midwives is decreasing. In 2018, only 16% of childbirths were managed by a midwife or nurse.¹³ According to the Health Statistics Yearbook 2022 data, the current cesarean section rate is 60.1%, whereas the primary cesarean section rate is 31.1%.¹⁴ Non-evidence-based obstetric practices such as routine enema application, restricting mobility and nutrition, routine procedures to induce and accelerate labor, birth in the lithotomy position, and routine episiotomy are common in Türkiye. Women are not allowed to have a companion with them during labor.^{11,15} Very few studies have been conducted on safe and respectful mother baby-family maternity care in Türkiye.^{16,17} Despite having adopted the ICI, non-evidence-based interventions for women in labor are still widely implemented in hospitals. It is thought that safe and respectful mother baby-family maternity care will positively affect women's perception of supportive care, but no research on this issue has been found. In this regard, the purpose of the present study is to examine the effects of some components of safe and respectful mother baby-family maternity care on mothers' perception of supportive care.

MATERIAL AND METHODS

TYPE OF RESEARCH

This research was conducted descriptive and cross-sectionally.

PLACE AND TIME OF THE STUDY

The research was carried out between January 5 and April 27, 2018, at a state hospital, which adopted safe and respectful mother baby-family maternity care.

SAMPLE OF THE STUDY

When calculating the sample size in the study, the number of women who gave normal birth (n=1,910) at a state hospital gynecology and obstetrics service between January 1 and December 31, 2016, was taken as a basis, and at least 320 women constituted the sample size with a 50% unknown prevalence, 95% confidence interval, and a 0.05 margin of error in the program Epi Info 7. The study sample comprised 325 postpartum women who presented to the hospital on the specified dates and met the inclusion criteria. The study included women who agreed to participate in the research, gave vaginal birth, did not experience any postpartum complications, and did not have communication difficulties or mental disabilities.

DATA COLLECTION TOOLS

The research data were collected using the “Descriptive Information Form” and the “Scale of Women’s Perception for Supportive Care Given During Labor”. Data were collected by face-to-face interview technique.

Descriptive Information Form: This form consists of three sections, including sociodemographic, obstetric characteristics, and safe and respectful mother baby-family maternity care initiatives, and 21 questions. The researchers developed the questions by reviewing the literature.^{1,18,19}

Scale of Women’s Perception for Supportive Care Given During Labor: It was developed by Uludağ and Mete in 2013 to determine the supportive care received during labor by postpartum women who gave normal birth. The scale, which is applied in

the first 24 hours postpartum, has 33 items. The scale’s subscales are comforting behaviors, education, and disturbing behaviors, and it is a 4-point Likert-type scale. A minimum of 33 and a maximum of 132 points are obtained from the scale. A higher score on the scale indicates better women’s perception of supportive care.¹⁸ Cronbach’s Alpha coefficient of the original scale was 0.94, and it was found to be 0.94 in this study.

ANALYSIS

The data obtained within the scope of the study were evaluated using the package SPSS 22.0 (IBM, Armonk, NY, USA). Number, percentage, mean and standard deviation were used in descriptive data. Since the data did not comply with normal distribution, the Mann-Whitney U test was conducted. Values at a p<0.05 level were considered statistically significant.

ETHICAL CONSIDERATIONS OF THE STUDY

The necessary ethics committee approval for the study was received from Manisa Celal Bayar University, Faculty of Medicine Health Sciences Ethics Committee (date: January 4, 2018 no: 20478486). To collect research data, necessary permissions were obtained from the Health Directorate of the province where the study was conducted and the chief physician of the hospital. Women who agreed to take part in the research were informed about the study, and their verbal and written consent was obtained. The research followed the principles of the Declaration of Helsinki.

RESULTS

The descriptive characteristics of women are shown in [Table 1](#).

During labor, 61.8% of the women underwent induction, 74.8% underwent continuous electronic fetal monitoring, 81.8% were restricted in their movement, and 92.3% underwent frequent and repetitive vaginal examination ([Table 2](#)).

The mean scores of the women on the Scale of Women’s Perception for Supportive Care Given During Labor (SWPSCGDL) and the mean total scores of the sub-dimensions are given in [Table 3](#).

TABLE 1: Distribution of women's descriptive characteristics.

Characteristics	n	%
Age±SD [Minimum-Maximum]	28.63±6.26	[18-46]
Education		
Did not receive formal education	39	12.0
Primary school	101	31.1
Secondary school	99	30.5
High school	70	21.5
University	16	4.9
Employment Status		
Employed	66	20.3
Unemployed	259	79.7
Parity		
1	94	28.9
2	129	39.7
3 and more	102	31.4
A person providing support during labor		
There is	116	35.7
None	209	64.3
The person a woman wants to support her during labor		
Husband	85	26.2
Mother	122	37.5
Other	67	21.6
The ability to reach the midwife whenever desired		
Yes	313	96.3
No	12	3.7

SD: Standard deviation.

TABLE 2: Distribution of interventions applied during labor.

Characteristics	n	%
Induction		
Yes	201	61.8
No	124	38.2
Restriction of oral feeding		
Yes	28	8.6
No	297	91.4
Restriction of fluid intake		
Yes	23	7.1
No	302	92.9
Continuous fetal monitoring		
Yes	243	74.8
No	82	25.2
Freedom of movement		
Yes	59	18.2
No	266	81.8
Frequent vaginal touching		
Yes	300	92.3
No	25	7.7
Epidural analgesia		
Yes	19	5.8
No	306	94.2
Total	325	100.0

TABLE 3: Distribution of women's Scale of Women's Perception for Supportive Care Given During Labor and subscale mean scores.

SWPSCGDL	Minimum	Maximum	\bar{X} ±SD
Comforting behaviors subscale	15.00	60.00	54.27±7.85
Education subscale	8.00	32.00	29.81±3.87
Disturbing behaviors subscale	10.00	40.00	38.44±3.66
Total Score	33.00	132.00	122.53±13.46

SWPSCGDL: Scale of Women's Perception for Supportive Care Given During Labor; SD: Standard deviation.

Upon examining the comparison of some components of safe and respectful mother baby-family maternity care and the SWPSCGDL and subscale mean scores, it was found that the SWPSCGDL mean scores were higher and all subscales were statistically significant in women who could reach the midwife providing care whenever they wanted, whose oral fluid intake and nutrition were not restricted, and whose privacy was taken care of ($p<0.05$), (Table 4).

DISCUSSION

The study aimed to examine the relationship between some components of safe and respectful mother baby-family maternity care and mothers' perception of supportive care. This study found that women's perception of supportive care was good and women who could reach the midwife providing care whenever they wanted had a higher perception of supportive care. Studies have indicated that women's perceptions of supportive care given during labor are high.²⁰⁻²² A meta-analysis showed that women appreciated continuous support during labor.⁷ This study determined that women who did not have support during labor had a higher perception of supportive care and found a significant difference in the disturbing behaviors subscale. The reason for this is that, although one-quarter of women wanted their husbands to support them, having to manage the birth process with a supporter they did not prefer may have disturbed them. Although women's preferences for supporters during labor vary depending on interpersonal relationships, culture, values, or birth environment, women prefer people with positive attitudes to achieve positive outcomes.⁷ The WHO recommends that women receive support from a person of their

TABLE 4: Comparison of some components of safe and respectful mother baby-family maternity care and the Scale of Women's Perception for Supportive Care Given During Labor and subscale mean scores.

Some characteristics of supportive care	Comforting behaviors subscale	Education subscale	Disturbing behaviors subscale	Total Score
	$\bar{X}\pm SD$	$\bar{X}\pm SD$	$\bar{X}\pm SD$	$\bar{X}\pm SD$
A person providing support during labor				
There is (n=116)	53.06±9.15	29.39±4.29	37.75±4.53	120.21±16.16
None (n=209)	54.94±6.95	30.04±3.60	38.83±3.01	123.82±11.55
	Z=-1.795*	Z=-1.401*	Z=-2.615*	Z=-2.148*
	p=0.073	p=0.161	p=0.009	p=0.032
The ability to reach the midwife providing care whenever desired				
Yes (n=313)	54.89±6.92	30.09±3.42	38.61±3.47	123.60±12.00
No (n=12)	38.08±12.64	22.50±6.98	34.08±5.59	94.67±19.41
	Z=-4.555*	Z=-4.196*	Z=-5.269*	Z=-4.906*
	p=0.000	p=0.000	p=0.000	p=0.000
Restriction of oral feeding				
Yes (n=28)	51.46±7.57	26.79±6.29	37.50±3.43	115.75±14.08
No (n=297)	54.54±7.84	30.10±3.44	38.54±3.68	123.18±13.25
	Z=-2.785*	Z=-3.061*	Z=-2.862*	Z=-3.534*
	p=0.005	p=0.002	p=0.004	p=0.000
Restriction of fluid intake				
Yes (n=23)	51.70±7.40	27.61±6.13	37.35±3.64	116.52±13.87
No (n=302)	54.47±7.86	29.98±3.61	38.53±3.66	122.98±13.35
	Z=-2.276*	Z=-2.222*	Z=-2.150*	Z=-2.758*
	p=0.023	p=0.026	p=0.032	p=0.006
Frequent and repetitive vaginal examination				
Yes (n=300)	54.44±7.96	29.92±3.86	38.57±3.51	122.93±13.58
No (n=25)	52.28±6.19	28.56±3.88	36.96±4.97	117.80±11.20
	Z=-2.406*	Z=-2.411*	Z=-1.824*	Z=-2.949*
	p=0.016	p=0.016	p=0.068	p=0.003
Taking care of privacy				
Yes (n=313)	54.66±7.45	29.94±3.73	38.57±3.55	123.19±12.79
No (n=12)	43.91±10.78	26.41±5.83	35.08±4.90	105.42±19.28
	Z=-3.879*	Z=-2.408*	Z=-3.495*	Z=-3.897*
	p=0.000	p=0.016	p=0.000	p=0.000
Epidural analgesia				
Yes (n=19)	52.42±8.55	28.00±5.52	36.16±4.96	116.58±15.10
No (n=306)	54.37±7.81	29.93±3.73	38.59±3.53	122.90±13.30
	Z=-0.967*	Z=-1.698*	Z=-2.908*	Z=-1.806*
	p=0.333	p=0.090	p=0.004	p=0.071
Induction				
Yes (n=201)	53.95±7.80	29.88±4.29	38.64±3.11	122.47±12.77
No (n=124)	54.80±7.93	29.71±4.01	38.13±4.40	122.64±14.57
	Z=-1.660*	Z=-0.258*	Z=-0.167*	Z=-1.086*
	p=0.097	p=0.796	p=0.867	p=0.278
Continuous electronic fetal monitoring				
Yes (n=243)	54.67±7.53	30.07±3.65	38.75±3.50	123.49±12.89
No (n=82)	53.09±8.68	29.05±4.41	37.55±3.99	119.68±14.76
	Z=-1.383*	Z=-1.865*	Z=-3.067*	Z=-2.352*
	p=0.167	p=0.062	p=0.002	p=0.019
Freedom of movement				
Yes (n=59)	54.36±6.55	30.05±2.58	37.34±4.13	121.75±10.42
No (n=266)	54.25±8.12	29.76±4.11	38.69±3.51	122.71±14.06
	Z=-0.889*	Z=-0.667*	Z=-3.723*	Z=-2.261*
	p=0.374	p=0.505	p=0.000	p=0.025

*Mann-Whitney U test; SWPSCGDL: Scale of Women's Perception for Supportive Care Given During Labor; SD: Standard deviation.

choice during labor and childbirth to improve obstetric outcomes and increase satisfaction with the services women receive.^{4,6} Step four of the ICI states that women can receive continuous support from people of their choice during labor and childbirth.³ Due to the positive effects of supportive care on obstetric and neonatal outcomes, it should be taken into account and respected that women manage the process with a supporter of their choice.

The study found that women whose fluid intake and oral nutrition were not restricted had higher perceptions of supportive care. Studies conducted in hospitals that adopted the safe and respectful mother baby-family maternity care initiative reported that oral fluid and food intake was restricted in 59.1% and 70.8% of women, respectively.^{16,17} In a study, knowledge and values gained from professional and personal childbirth experiences, practice contexts, work environments, clinical guidelines, policies, obstetric control, and women's preferences and comfort affected midwifery practices for oral food intake in low-risk women during labor.²³ The evidence suggests that there is no justification for restricting oral fluid intake and eating in women at low risk of complications during labor, and the WHO recommends oral fluid intake and eating during labor for all low-risk women.^{4,24} The 6th step of the ICI recommends and encourages evidence-based practices such as oral fluid intake and nutrition.³ Midwives are usually primarily responsible for healthy women with low-risk pregnancies. In this respect, midwives can support fluid intake and oral nutrition because they have autonomous decision-making authority.

This study revealed that while women undergoing electronic fetal monitoring (EFM) had a higher perception of supportive care, they were uncomfortable with this practice. In a study conducted in a hospital which adopted the safe and respectful mother baby-family maternity care initiative, while 99% of women underwent continuous EFM throughout labor, 22.4% stated that fetal heartbeats were listened to intermittently with a Doppler.¹⁶ Although continuous EFM provides a written record, women cannot move freely during labor, cannot change positions easily, and cannot use a birthing pool to ensure comfort during labor.²⁵ Continuous EFM has been asso-

ciated with an increasing number of cesarean sections and interventional births that pose risks to mothers without reducing neonatal and maternal mortality.^{4,25,26} The presence of technology in the field of childbirth affects the way midwives work and their women-centered approaches.²⁷ In healthcare institutions, healthcare professionals neglect the emotional and social aspects of labor by focusing on the technological dimensions of labor in their relationships with women.²⁸ The WHO does not recommend continuous cardiotocography to evaluate fetal health in healthy pregnant women in spontaneous labor but recommends using a Doppler ultrasound device or Pinard fetal stethoscope to listen to fetal heartbeats.⁴ The 7th step of the ICI states that harmful practices, such as continuous electronic fetal monitoring, should be avoided.³ In this regard, intermittent listening to fetal heartbeats in low-risk women in labor may enable midwives to allocate more time to their supportive roles by reducing unnecessary interventions.

Whereas women who underwent frequent and repeated vaginal examination had a higher perception of supportive care, this practice was found to comfort and inform women. Furthermore, women whose privacy was taken care of had a higher perception of supportive care. A study found that women's experiences were more positive if women were informed before the vaginal examination, their privacy was ensured, and the same midwife/doctor performed the vaginal examination.²⁹ Other studies have reported that women tolerate the examination because they regard it as necessary and inevitable.^{30,31} The environment, privacy, and especially the midwife-led continuous care model have been shown to have a significant positive effect on women's examination experience.³¹ Other methods employed to evaluate the progress of labor include intrapartum ultrasound and monitoring external physical and behavioral cues. Vaginal examinations can be distressing for women, and the overdiagnosis of dystocia can lead to iatrogenic morbidity due to unnecessary intervention.³² Digital vaginal examinations at 4 hour intervals are recommended for routine evaluation during the active first stage of labor in low-risk women.⁴ However, it has been stated that there is no sufficient

evidence to support the routine use of vaginal examination or its alternatives.³² The seventh step of the ICI states that harmful practices, such as frequent and repetitive vaginal examinations, should be avoided.³ Adopting a physiological birth approach, supporting women's preferences, and integrating midwife-led continuous care models into the healthcare system will ensure a more positive birth experience by preventing unnecessary vaginal examinations.

It was found that women in whom walking, movement, and positioning were provided to reduce pain during labor had a higher perception of supportive care, while women whose movement was restricted had a lower perception of supportive care and they were disturbed by this situation. A study reported that women who gave birth while standing up had a higher support perception.³³ A study conducted in a hospital which adopted the safe and respectful mother baby-family maternity care initiative stated that 94.5% of women were not provided with freedom of movement throughout labor.¹⁶ There is evidence that walking and upright positions at the first stage of labor reduce the duration of labor, the risk of cesarean section, the need for epidural analgesia, and the likelihood of episiotomy and are not associated with adverse effects on maternal and infant health.^{34,35} The WHO recommends freedom of movement throughout labor and encouraging vertical positions in low-risk women.⁴ The 6th step of the ICI recommends and encourages evidence-based practices such as freedom of movement.³ Individualized supportive care provided with the approach that every woman and every birth is different and the body and the baby work in harmony can make labor more effective.

Since adopting and implementing the ICI in the institution which received the title of the first "mother-friendly hospital" would take time, this might have affected the results. Although the ICI has started to be adopted at an increasing rate, the results

cannot be generalized to the entire population. All these constitute the study's limitations.

CONCLUSION

This study determined that some components of the safe and respectful mother baby-family maternity care initiative increased mothers' perception of supportive care. With an evidence-based and humanistic approach, this initiative can allow midwives to allocate more time to their supportive roles by reducing the use of unnecessary interventions. It is possible to contribute to improving obstetric and neonatal outcomes by integrating midwife-led continuous care models into the healthcare system. Additionally, more women can be provided with safe and respectful mother baby-family maternity care by increasing the number of hospitals adopting this initiative. Safe and respectful mother baby-family maternity care should be supported, and multi-center studies with larger sample sizes should be conducted on this subject.

Source of Finance

During this study, no financial or spiritual support was received neither from any pharmaceutical company that has a direct connection with the research subject, nor from a company that provides or produces medical instruments and materials which may negatively affect the evaluation process of this study.

Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: Hanife Nurseven Şimşek; **Design:** Hülya Demirci; **Control/Supervision:** Hülya Demirci; **Data Collection and/or Processing:** Alev Yalnız; **Analysis and/or Interpretation:** Hülya Demirci, Hanife Nurseven Şimşek; **Literature Review:** Hanife Nurseven Şimşek, Alev Yalnız; **Writing the Article:** Hanife Nurseven Şimşek; **Critical Review:** Hülya Demirci.

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