Obstetrics; *Maternal Fetal Medicine and Perinatology*

Effect of Mother-Baby Friendly Facility Accreditation on Midwifery Staff's Perceptions of Obstetric Mistreatment

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ABSTRACT

OBJECTIVE: This study evaluated the impact of Mother-Baby Friendly Facility (MBFBF) accreditation on midwifery staff's perceptions of obstetric mistreatment. The hypothesis tested was that MBFBF-associated training and policy changes would improve awareness and decrease tolerance for mistreatment practices during childbirth.

STUDY DESIGN: This single-center observational pre-post study was conducted in the obstetrics and gynecology unit of a tertiary hospital. Data were collected before and after MBFBF accreditation, which was granted in November 2024. The study included 122 midwifery staff members with at least one year of clinical experience before accreditation. Perception of obstetric mistreatment was assessed using the Turkish version of the Perception of Obstetric Violence in Students Questionnaire (PercOV-S Q).

RESULTS: Significant improvements were observed in the perception of mistreatment, with overall PercOV-S Q scores increasing from 95.50 (87.00–107.00) pre-intervention to 110.50 (83.50–129.00) post-intervention (p=0.027). The key areas of improvement included informed consent (Q1: p<0.001), privacy (Q2: p<0.001), and respectful communication (Q3: p=0.017). Subgroup analysis revealed statistically significant differences in five selected questions (p<0.001), whereas other areas exhibited trends toward improvement.

CONCLUSIONS: The MBFBF accreditation process and associated training significantly enhanced midwifery staff's awareness of obstetric mistreatment, aligning their practices with international guidelines. These findings underscore the importance of structured education and institutional reform in fostering respectful, patient-centered care. Expanding MBFBF accreditation programs globally could help reduce obstetric mistreatment and improve maternal health outcomes.

Keywords: Education; MBFBF; Midwifery mistreatment; Perception

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Introduction

Background: Obstetric mistreatment (OM) is a pervasive issue affecting women globally, regardless of the healthcare system's resource level. Mistreatment during childbirth, including physical violence, verbal abuse, neglect, and coerced medical procedures, remains a serious violation of women's rights. Such practices not only compromise women's dignity but also lead to significant physical and psychological harm (1,2). The World Health Organization (WHO) has recognized the need for systemic changes to address obstetric violence and improve the quality of maternal care (3). Despite advancements in healthcare access and technology, obstetric mistreatment continues to undermine the rights of women, emphasizing the need for cultural and institutional reforms within healthcare settings. The introduction of policies and standards, such as the WHO's Mother-Baby Friendly Initiatives, aims to shift the healthcare system toward more respectful, patient-centered care that prioritizes women's dignity and autonomy during childbirth (4-6).

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FIGO's Mother-Baby Friendly Facility (MBFBF) Model: The International Federation of Gynecology and Obstetrics Mother-Baby Friendly Facility (MBFBF) initiative provides a transformative approach to maternal care by embedding human rights and respectful care practices into institutional protocols (5,6). Rather than focusing solely on the behavior of individual healthcare providers, MBFBF addresses the broader institutional culture and the practices that perpetuate mistreatment. The model promotes key principles such as privacy, informed consent, and patient autonomy, which help counteract the normalization of mistreatment during childbirth. In addition, MBFBF emphasizes the importance of continuous education for healthcare providers, ensuring they are not only skilled in clinical care but also equipped to practice ethically and empathetically. Through comprehensive training, the MBFBF model aims to create a supportive and respectful environment in which all women can experience dignified care during childbirth.

The Role of Education in Shaping Healthcare Practices: Achieving progress in obstetric care necessitates a fundamental shift in how healthcare providers perceive and address mistreatment. This transformation hinges on education, both theoretical and practical, that enables clinicians to identify and challenge ingrained behaviors that may contribute to obstetric violence. Educational programs within the MBFBF framework emphasize the importance of respectful communication, shared decision-making, and evidence-based practices that prioritize patient autonomy and well-being (3). These initiatives are designed to raise awareness of the harmful effects of disrespectful care and equip healthcare providers with the necessary skills to foster a supportive and empowering environment for women during childbirth. Research indicates that educational programs play a critical role in reshaping attitudes and improving clinical practices by addressing the root causes of obstetric mistreatment. The Perception of Obstetric Violence in Students Questionnaire (PercOV-S Q), initially designed and validated by Mena-Tudela et al. in English and Spanish, was later validated in Turkish by Yeniocak et al. This validated tool is now used in the MBFBF adaptation process at our institution to assess and enhance healthcare providers' understanding of obstetric mistreatment (4,7).

The findings of this study have the potential to inform future policy and training programs in maternal care. Documenting the impact of MBFBF accreditation on healthcare providers' perceptions of obstetric mistreatment will provide evidence of the effectiveness of this framework in promoting respectful, patient-centered care. The results could also guide the implementation of similar accreditation programs in other healthcare settings and contribute to the global effort to reduce obstetric mistreatment. This research highlights the critical role of continuous education and institutional support in fostering an environment where women's rights and dignity are respected throughout the childbirth process. Ultimately, the study will contribute to the ongoing conversation on how to create a more respectful and supportive environment for women worldwide during childbirth.

Research Gap and Study Objectives: While existing research has established the prevalence of obstetric mistreatment, a significant gap remains in understanding how specific interventions, such as MBFBF accreditation and its associated educational programs, affect healthcare providers regarding mistreatment. The present study seeks to fill this gap by examining changes in the midwifery staff's perceptions of obstetric mistreatment before and after MBFBF accreditation at our institution. We hypothesize that the implementation of MBFBF policies and training will lead to increased awareness and reduced tolerance for practices that contribute to mistreatment. By assessing shifts in healthcare providers' perceptions, this study aims to offer valuable insights into how structured frameworks like MBFBF can influence attitudes and practices in maternal care.

Material and Method

This study employed a single-center observational pre-post design to evaluate the impact of Mother-Baby Friendly Facility (MBFBF) accreditation on midwifery staff's perceptions of obstetric mistreatment. Data collection occurred in two phases: prior to MBFBF accreditation and immediately following its implementation. This design allowed for a direct comparison of perceptions before and after the accreditation process.

Setting / Ethics Approval and Consent to Participate: This study was conducted following approval from the hospital's ethics committee on October 23, 2024 (Ethics number: 2024.196), by the principles of the Declaration of Helsinki. The unit received MBFBF accreditation in November 2024, following the introduction of institutional policies and educational programs aligned with the MBFBF framework. Electronic informed consent was obtained from all participants before they were allowed to complete the survey, which was administered via hospital email.

Participants: The study population consisted of midwifery staff employed in the obstetrics and gynecology unit during the study period. Eligible participants were those actively involved in labor and delivery care, with at least six months of clinical experience before MBFBF accreditation and the associated training programs (pre-intervention) (n=122), as well as after the hospital received MBFBF accreditation, following the implementation of training and policy changes (post-intervention) (n=122). Pre-intervention data collection was conducted one year before the MBFBF accreditation program, while post-intervention data collection occurred one week after the accreditation. Exclusion criteria included individuals who declined to participate or were unavailable during either data collection phase. A detailed time chart for utilization is shown in Figure 1.

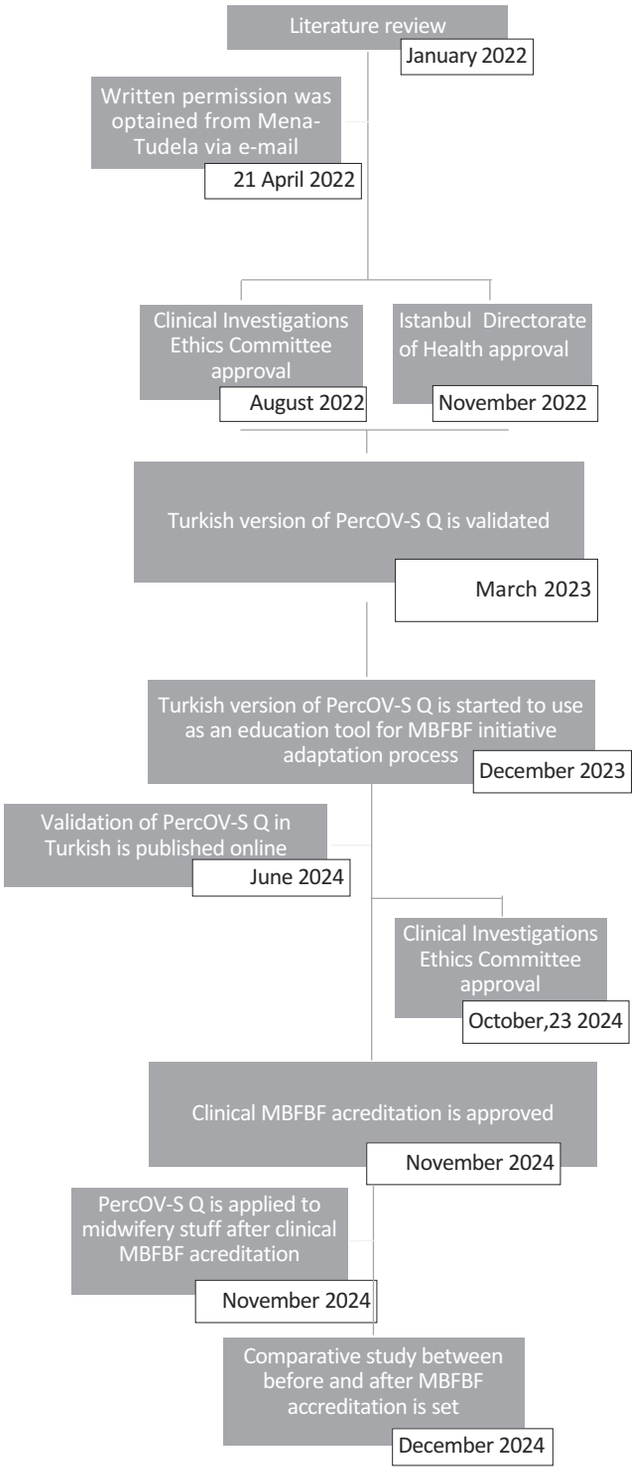

Figure 1: *Time chart for utilization of PercOVS-Q during MBFBF accreditation*

Variables: The primary variable of interest was the perception of obstetric mistreatment, measured using the Turkish version of PercOV-S Q. Secondary variables included demographic characteristics (years of clinical experience, educational background, gravidity, and parity history) and participation in MBFBF training sessions.

Data sources/measurement: The Turkish version of the PercOV-S Q, validated by Yeniocak et al., was utilized to evaluate perceptions of obstetric mistreatment. This questionnaire consists of 33 items rated on a 5-point Likert scale, where higher scores indicate a greater perception of mistreatment. Participants completed the questionnaire at two points: before MBFBF accreditation and the associated training programs (pre-intervention) and after the hospital received MBFBF accreditation, following the implementation of training and policy changes (post-intervention). While the original PercOV-S Q was designed and validated by a diverse group of experts in health and gender, including a medical graduate, a nurse, a lawyer, and a mother with prior experience with obstetric mistreatment, and the study was conducted with nursing, midwifery, and medical students, the Turkish version of the PercOV-S Q was validated with obstetrics and gynecology residents, as coworkers of midwifery staff in the labor ward, who were considered suitable for this purpose, as further pilot testing was not considered necessary.

Bias: Data collection was conducted in a blinded manner regarding participants' identities to minimize social desirability bias. Furthermore, all participants were invited to complete the questionnaire in a private environment to encourage honest responses. The survey was distributed via hospital email accounts and completed electronically by participants in their preferred environment, ensuring privacy. To maintain confidentiality, the survey was completed during participants' time, after work hours, and without any interaction with colleagues and supervisors.

Study size: A sample size calculation was not performed due to the study's observational nature. Instead, all eligible midwifery staff present during the data collection periods were invited to participate.

A post-hoc power analysis was performed based on the total questionnaire score, using a sample size of 122 participants, an effect size of 0.278, and an alpha level of 0.05. The analysis confirmed that the study achieved 84% statistical power, indicating a strong likelihood of detecting a significant effect in the total questionnaire score

Statistical analysis

Descriptive statistics were used to summarize the demographic and clinical characteristics of the participants. Frequencies and percentages were calculated for categorical variables, and cumulative percentages were provided in each category. The distribution of the data was assessed with the Kolmogorov-Smirnov test.

To compare two independent groups, the Mann-Whitney U test was applied for data that did not follow a normal distribution. The Kruskal-Wallis test was used to compare three or more groups with non-normally distributed data. The Wilcoxon signed-rank test was applied to compare two dependent groups with non-normally distributed data. Data were presented as median (25^{th}-75^{th} percentiles) for variables with a

non-normal distribution. All statistical analyses were conducted using the Statistical Package for Social Sciences (SPSS) version 27, with a significance level set at $p<0.05$.

Results

Participant Characteristics: A total of 122 midwifery staff participated in the study. The majority of participants (42.6%) had over five years of clinical experience, followed by 21.3% with four years, and 13.1% with three years. Only 18.9% of participants reported a personal history of pregnancy, and 13.9% had experienced childbirth themselves (Table I).

Changes in Perception of Obstetric Mistreatment: The results of the Turkish-validated PercOV-S questionnaire (Table II) revealed significant differences in several items before and after the MBFBF intervention. Notable improvements were observed in Q1 (1.00 [1.00–1.00] vs. 2.00 [1.00–3.00], $p<0.001$), Q2 (1.00 [1.00–2.00] vs. 2.50 [1.00–4.00], $p<0.001$), Q3 (3.00 [2.00–3.25] vs. 3.00 [2.00–4.00], $p=0.017$), Q4 (2.00 [1.00–3.00] vs. 3.00 [1.00–5.00], $p<0.001$), and Q5 (2.00 [1.00–3.00] vs. 3.00 [1.00–4.00], $p=0.002$). Significant changes were also noted in Q6 ($p=0.004$), Q10 ($p=0.048$), Q14 ($p=0.001$), Q15 ($p<0.001$), Q22 ($p=0.003$), Q23 ($p=0.039$), Q26 ($p=0.001$), Q27 ($p<0.001$), Q28 ($p=0.046$), Q29 ($p=0.007$), and Q31 ($p=0.005$).

The total PercOV-S Q score increased significantly from 95.50 (87.00–107.00) before the intervention to 110.50 (83.50–129.00), $p=0.027$. In contrast, no significant differences were observed in Q7, Q8, Q9, Q12, Q16, Q17, Q18, Q19, Q20, Q24, Q25, Q30, Q32, and Q33 ($p>0.05$).

A subgroup analysis of specific questions (1, 3, 5, 25, 26), showed highly significant improvement ($p<0.001$). In contrast, the other 28 questions showed a trend toward improvement but did not reach statistical significance ($p=0.112$). The overall mean score for the questionnaire increased significantly ($p=0.027$), further emphasizing the effectiveness of MBFBF-associated training and policy implementation (Table III).

The effects of the MBFBF intervention are summarized in Table III. For the selected questions (1, 3, 5, 25, 26), the median score significantly increased from 2.20 (1.80–2.80) to 3.00 (2.20–3.60) ($p<0.001$ for the comparison). For the remaining 28 questions, the median score increased from 3.03 (2.71–3.39) to 3.46 (2.44–3.96), but this change was not statistically significant ($p=0.112$). The total 33 questions mean score, encompassing all questions, showed a statistically significant improvement, increasing from 2.89 (2.63-3.24) to 3.34 (2.53-3.90) ($p=0.027$).

After row-level analysis, column-wise differences were also evaluated.

• Before MBFBF Column

Scores for the selected questions (1, 3, 5, 25, 26) mean scores were significantly different from both the "Other 28 questions mean scores" group and the "Total 33 questions mean scores" group ($p<0.001$). However, there was no significant difference between the "Other 28 ques-tions" and "Total 33 questions mean score" groups ($p=0.528$).

• After MBFBF Column

Scores for the selected questions (1, 3, 5, 25, 26) remained significantly different from the "Other 28 questions" group ($p=0.013$). However, no significant difference was observed be-tween the "Selected questions" and the "Total 33 questions mean scores" group ($p=0.063$). Similarly, there was no significant difference between the "Other 28 questions mean scores" and "Total 33 questions mean scores" groups ($p>0.999$).

Table I: *Summary of midwifery experience, pregnancy history, and birth history of participants*

Category	Response	Frequency	Percent (%)	Cumulative Percent (%)
Years of experience	1	16	13.1	13.1
	2	12	9.8	23.0
	3	16	13.1	36.1
	4	26	21.3	57.4
	≥5	52	42.6	100.0
Pregnancy history	No	99	81.1	81.1
	Yes	23	18.9	100.0
Birth history	No	105	86.1	86.1
	Yes	17	13.9	100.0
Total		122	100.0	100.0

Notes: The percentages for each category are based on the total number of participants (n=122). Cumulative percent represents the cumulative total of the percentage values across the categories within each variable.
n: Number of participants, %: Percentage

Table II: *Turkish Validated PercOV-S Questionnaire Before and After the MBFBF Intervention*

Question	Before MBFBF	After MBFBF	p-value
Q1	1.00 (1.00-1.00)	2.00 (1.00-3.00)	***p<0.001**
Q2	1.00 (1.00-2.00)	2.50 (1.00-4.00)	***p<0.001**
Q3	3.00 (2.00-3.25)	3.00 (2.00-4.00)	***p=0.017**
Q4	2.00 (1.00-3.00)	3.00 (1.00-5.00)	***p<0.001**
Q5	2.00 (1.00-3.00)	3.00 (1.00-4.00)	***p=0.002**
Q6	2.00 (1.00-3.25)	3.00 (1.00-5.00)	***p=0.004**
Q7	4.00 (3.00-5.00)	4.00 (1.00-5.00)	*p=0.570
Q8	3.00 (2.00-5.00)	4.00 (2.00-5.00)	*p=0.440
Q9	1.00 (1.00-3.00)	2.00 (1.00-4.00)	*p=0.072
Q10	2.00 (1.00-3.00)	3.00 (2.00-3.00)	***p=0.048**
Q11	5.00 (3.00-5.00)	5.00 (1.00-5.00)	*p=0.442
Q12	2.00 (2.00-5.00)	4.00 (1.00-5.00)	*p=0.285
Q13	4.00 (3.00-5.00)	5.00 (1.75-5.00)	*p=0.497
Q14	5.00 (4.00-5.00)	5.00 (1.00-5.00)	***p=0.001**
Q15	3.00 (1.00-4.00)	4.00 (2.75-5.00)	***p<0.001**
Q16	2.00 (1.00-3.00)	3.00 (1.00-3.00)	*p=0.125
Q17	3.00 (2.00-4.00)	4.00 (1.00-5.00)	*p=0.401
Q18	3.00 (2.00-4.00)	4.00 (1.00-5.00)	*p=0.212
Q19	3.00 (2.00-4.00)	3.00 (3.00-5.00)	*p=0.086
Q20	5.00 (3.00-5.00)	4.50 (1.00-5.00)	*p=0.100
Q21	4.00 (2.00-5.00)	4.00 (2.00-5.00)	*p=0.598
Q22	4.00 (3.00-5.00)	4.00 (2.00-5.00)	***p=0.003**
Q23	4.00 (3.00-5.00)	5.00 (1.00-5.00)	***p=0.039**
Q24	3.00 (2.00-4.00)	4.00 (2.00-5.00)	*p=0.265
Q25	3.00 (2.00-4.00)	3.00 (2.00-4.00)	*p=0.434
Q26	2.00 (1.00-3.00)	3.00 (1.00-4.00)	***p=0.001**
Q27	1.00 (1.00-2.00)	3.00 (1.00-4.00)	***p<0.001**
Q28	3.00 (1.00-3.25)	3.00 (2.00-4.00)	***p=0.046**
Q29	4.00 (3.00-5.00)	4.00 (1.00-5.00)	***p=0.007**
Q30	4.00 (3.00-5.00)	4.00 (1.00-5.00)	*p=0.150
Q31	1.00 (1.00-3.00)	1.00 (1.00-5.00)	***p=0.005**
Q32	3.00 (1.75-3.00)	3.00 (1.00-3.00)	*p=0.417
Q33	3.00 (2.00-4.00)	3.00 (1.75-5.00)	*p=0.908
Total Score	95.50 (87.00-107.00)	110.50 (83.50-129.00)	***p=0.027**

*Notes: Data with non-normal distribution are presented as median (25th–75th percentiles). Bold text indicates statistically significant results, p<0.05. *Wilcoxon test was used.*
MBFBF: Mother and Baby Friendly Birth Facility, PercOV-S: Perception of Obstetric Violence in Students

Table III: *Mean Questionnaire Scores for Subgroup Analysis (Questions Aligning with ACOG Recommendations: 1, 3, 5, 25, 26), Remaining Questions, and Summarizing Total Survey Mean Scores Before and After MBFBF Intervention*

Question	Before MBFBF	After MBFBF	p-value
Questions 1-3-5-25-26 mean scores	2.20[a] (1.80-2.80)	3.00[a] (2.20-3.60)	[1]**p<0.001**
Other 28 Questions mean scores	3.03[b] (2.71-3.39)	3.46[b] (2.44-3.96)	[1]p=0.112
Total 33 Questions mean scores	2.89[b] (2.63-3.24)	3.34[a,b] (2.53-3.90)	[1]**p=0.027**
p-value	[2]**p<0.001**	[2]**p=0.010**	

Notes: Data with non-normal distribution are presented as median (25th–75th percentiles). Bold text indicates statistically significant results, p<0.05. Each subscript letter denotes a subset of "Question" categories whose column proportions do not differ significantly from each other at the 0,05 level. [1]Wilcoxon test was used. [2]Kruskal-Wallis test was used.
MBFBF: Mother and Baby Friendly Birth Facility

Discussion

Overview of Findings: The study revealed significant improvements in midwifery staff's perceptions of obstetric mistreatment following the implementation of the Mother-Baby Friendly Facility (MBFBF) accreditation and associated training programs. The overall increase in awareness, reflected in higher scores on the PercOV-S Q, underscores the critical role of structured educational and institutional reforms in addressing obstetric violence. This discussion will contextualize the findings within broader guidelines and initiatives, including those of the World Health Organization (WHO) and the American College of Obstetricians and Gynecologists (ACOG) while highlighting the MBFBF's specific contributions (3,8).

Distinction Between Mistreatment and Violence in Obstetric Care: While the term “obstetric violence” has gained traction in legislative and academic discussions, it may inadvertently imply intentional harm by healthcare providers, which could oversimplify the issue (4,9-13). As noted by D'Gregorio et al., “violence” typically refers to deliberate acts of harm, whereas “mistreatment” is a broader term encompassing a range of abusive and harmful behaviors, including non-consensual procedures, verbal abuse, and neglect. In the context of obstetric care, mistreatment often stems from systemic issues, inadequate training, or cultural practices rather than intentional violence (9). For this reason, we proposed using the term “obstetric mistreatment” in our previous study, as it more accurately reflects the spectrum of disrespectful or abusive behaviors that can occur during childbirth (7). This distinction is crucial for guiding interventions aimed at education and systemic reforms, as it shifts the focus from attributing blame to individual providers to addressing the broader structural issues that contribute to suboptimal care. By framing the issue as “mistreatment,” we align with the WHO's emphasis on respectful maternity care while acknowledging the complex factors that contribute to these harmful practices (3).

Obstetric Mistreatment and the Role of Guidelines

WHO Framework for Respectful Maternity Care

The World Health Organization’s framework for respectful maternity care emphasizes the principles of dignity, equity, and human rights. The WHO underscores that mistreatment during childbirth, such as verbal abuse, physical harm, non-consensual care, and neglect, violates these principles and can have long-term psychological and physical consequences for women and families. The WHO has advocated for systemic changes that integrate respectful maternity care into all levels of healthcare delivery, emphasizing the importance of education and accountability mechanisms (3).

In this study, the MBFBF accreditation directly aligned with the WHO's guidelines by embedding human rights-focused principles into practice. Participants' improved scores in questions addressing privacy, informed consent, and patient autonomy reflect an alignment with these international standards, demonstrating the potential of MBFBF programs to operationalize the WHO’s vision.

ACOG’s Recommendations for Reducing Obstetric Mistreatment: The American College of Obstetricians and Gynecologists (ACOG) provides additional guidance, recommending the integration of evidence-based practices with a focus on individualization of clinical implementations, shared decision-making, informed consent, and cultural competence. ACOG identifies clinician education as a cornerstone for reducing obstetric mistreatment and promoting equitable maternal care. Furthermore, ACOG stresses the importance of teamwork and communication in fostering a culture of respect within maternity care settings (14,15).

The MBFBF model incorporates these recommendations by emphasizing continuous staff education, team-based care, and communication skills training. This study’s findings corroborate ACOG’s stance, as the structured training sessions during MBFBF accreditation significantly enhanced midwives' perceptions of respectful care practices (6,8).

A subgroup analysis of specific questions (1, 3, 5, 25, 26), which at first glance align with ACOG's recommendations in the First Stage of Labor Management Guideline, was conducted. These recommendations include: 'ACOG recommends amniotomy for patients undergoing augmentation or induction of labor to reduce the duration of labor (strong recommendation, high-quality evidence),' 'ACOG recommends either low-dose or high-dose oxytocin strategies as reasonable approaches to the active management of labor to reduce operative deliveries (strong recommendation, high-quality evidence),' and 'ACOG recommends that cesarean delivery be performed in patients with active phase arrest of labor (strong recommendation, low-quality evidence)' (14). The analysis included items that, at first glance, may appear to overlap negatively.

The MBFBF Initiative: A Comprehensive Framework: The MBFBF model goes beyond simply modifying individual behaviors; it focuses on transforming institutional culture, policies, and practices. Its key principles include ensuring privacy during childbirth, obtaining informed consent for all procedures, promoting shared decision-making, reducing unnecessary interventions, and fostering a supportive environment for breastfeeding and skin-to-skin contact (8).

In this study, the significant improvement in perceptions regarding informed consent and respectful communication suggests that the MBFBF training successfully translated these principles into practice. Notably, the program’s inclusion of both theoretical education and practical workshops allowed participants to critically examine ingrained behaviors and adopt evidence-based, ethical practices.

The findings also support the effectiveness of MBFBF’s multidisciplinary approach, which fosters collaboration among healthcare providers. This aligns with evidence indicating that institutional reforms and interprofessional teamwork are essential for sustainable changes in healthcare delivery (4).

Implications for Global and Local Healthcare Systems

Bridging Gaps in Education and Practice

The study highlights education as a transformative tool for reshaping attitudes and practices. Despite the universal recognition of obstetric mistreatment as a significant issue, gaps in education and training persist, particularly in resource-limited settings. The PercOV-S Q scores showed the most improvement in areas related to informed consent and privacy, suggesting that these domains may be especially susceptible to enhancement through targeted education.

The findings suggest that the MBFBF framework could be a model for integrating respectful care principles into clinical practice across diverse settings. By leveraging educational tools like the PercOV-S Q, institutions can systematically assess and address gaps in knowledge and attitudes among healthcare providers (4,8).

Aligning with Global Health Goals: The WHO's Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality), emphasize the need for equitable and dignified maternal healthcare. The MBFBF model supports these goals by embedding respectful care practices into institutional policies, thus contributing to improved maternal health outcomes and gender equity. The findings from this study reinforce the importance of integrating frameworks like MBFBF into national healthcare policies to achieve these global objectives (3).

Addressing Cultural and Institutional Barriers: While the improvements observed in this study are promising, some cultural and institutional barriers to respectful maternity care persist. For instance, while significant changes were seen in key questions related to dignity and respect, other areas showed less pronounced improvement. This suggests that additional measures, such as continuous education, policy reinforcement, and community engagement, may be necessary to address deeply ingrained practices and attitudes.

Strengths and Limitations: A key strength of this study is the use of the validated PercOV-S Q questionnaire, which provides a reliable measure of perceptions related to obstetric mistreatment. The pre-post design further enhances the study by enabling a direct evaluation of changes following MBFBF accreditation.

However, the single-center design and relatively small sample size of midwifery healthcare providers limit the generalizability of the findings. To address this, future research should include multicenter studies with larger and more diverse samples of healthcare professionals to validate these results and evaluate the long-term impact of MBFBF initiatives.

This study relied solely on self-reported data to assess perceptions of mistreatment, which may introduce bias. Future research could incorporate additional methods, such as patient feedback, direct observational assessments, and qualitative interviews, to provide a more comprehensive and multidimensional understanding of the issue.

External factors, including changes in hospital policies, workloads, and institutional dynamics, may have influenced the outcomes. Controlling for these variables in future studies will help improve the robustness and validity of the conclusions.

Finally, the findings underscore the importance of implementing structured MBFBF training programs across various healthcare settings. Expanding the use of this validated survey tool to include other healthcare professionals, such as medical students, residents, and midwives, can enhance its applicability and promote a globally supportive and respectful clinical environment.

Conclusion

The implementation of MBFBF accreditation significantly improved midwifery staff's perceptions of obstetric mistreatment, particularly in areas related to informed consent, privacy, and respectful communication. These findings align with WHO and ACOG guidelines, emphasizing the role of structured education and institutional reforms in promoting respectful, patient-centered individualized care. By integrating the MBFBF model into maternity care settings, healthcare institutions can take meaningful steps toward reducing obstetric mistreatment and advancing global health goals.

Sustained efforts to expand MBFBF accreditation, coupled with ongoing education and cultural change initiatives, are essential for fostering environments where every woman receives dignified, respectful care during childbirth.

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Ethics approval and consent to participate: All participants signed informed written consent before being enrolled in the study. The study was reviewed and approved by the ethics committee of Basaksehir Cam and Sakura City Hospital (Ethics approval reference number: 2024/196 date 23.10.2024). All procedures were performed according to the Declaration of Helsinki.
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Availability of Data/Materials: The data supporting this study is available through the corresponding author upon reasonable request.
Authors' contributions: CT and ASY designed the study, analyzed and interpreted the data, and drafted the manuscript. ASY, ED participated in data analysis, interpretation, and draft revision. ASY and EA participated in data collection and result interpretation. ED and EA assisted with data collection and analysis. CT and ASY designed the study and critically revised the manuscript. All authors read and approved the final manuscript.
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References

1. Horesh D, Garthus-Niegel S, Horsch A. Childbirth-related PTSD: is it a unique post-traumatic disorder? J Reprod Infant Psychol. 2021;39(3):221-4. Doi: 10.1080/02646838.2021.1930739. PMID: 34027767.
2. Çetin SA, Ergün G, Işık I. Obstetric violence in southwestern Turkey: Risk factors and its relation-ship to postpartum depression. Health Care Women Int. 2024;45(2):

217-35. Doi: 10.1080/07399332.2023.2172411. PMID: 36 862241.

3. Organization WH. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. World Health Organization, 2014.
4. Mena-Tudela D, Cervera-Gasch A, Alemany-Anchel MJ, Andreu-Pejó L, González-Chordá VM. Design and validation of the PercOV-S questionnaire for measuring perceived obstetric violence in nursing, midwifery and medical students. Int J Environ Res Public Health. 2020;17 (21):8022. Doi: 10.3390/ijerph17218022. PMID:3314 33 68, PMCID: PMC7662790.
5. Miller S, Lalonde A. The global epidemic of abuse and disrespect during childbirth: History, evidence, interventions, and FIGO's mother-baby friendly birthing facilities initiative. Int J Gynaecol Obstet. 2015;131 Suppl 1: S49-52. Doi: 10.1016/j.ijgo.2015.02.005. PMID: 26433506.
6. Miller S, Lalonde A. The global epidemic of abuse and disrespect during childbirth: History, evi-dence, interventions, and FIGO's mother-baby friendly birthing facilities initiative. Int J Gynaecol Obstet. 2015;131 Suppl 1:S49-52. Doi: 10.1016/j.ijgo.2015.02.005. PMID:26433506.
7. Yeniocak AS, Tercan C, Dagdeviren E, Yucel B. Validation of the perception of obstetric violence in students questionnaire into Turkish: Insights from healthcare settings. Actual Gyn. 2024;16:46-52.
8. International Federation of Gynecology and Obstetrics; International Confederation of Midwives; White Ribbon Alliance; International Pediatric Association; World Health Organization; Interna-tional Federation of Gynecology and Obstetrics. Mother-baby friendly birthing facilities. Int J Gynaecol Obstet. 2015;128 (2):95-9. Doi: 10.1016/j.ijgo.2014.10.013. PMID: 25467915.
9. Pérez D'Gregorio R. Obstetric violence: a new legal term introduced in Venezuela. Int J Gynaecol Obstet. 2010;111(3):201-2. Doi: 10.1016/j.ijgo.2010.09.002. PMID:20926074.
10. Dias M, Mori V. Obstetric violence in Brazil: an integrated case study. International Journal of Nursing, Midwife and Health Related Cases. 2018;4(6):20-8.
11. Delay C, Sundstrom B. The legacy of symphysiotomy in Ireland: A reproductive justice approach to obstetric violence. Reproduction, Health, and Medicine: Emerald Publishing Limited; 2019. p. 197-218. Doi: 10.1108/s1057-629020190000020017.
12. Pickles C. Eliminating abusive 'care': A criminal law response to obstetric violence in South Africa. South African Crime Quarterly. 2015;54:5-16. Doi: 10.4314/sacq.v54i1.1.
13. Reuther, M.L. Prevalence of Obstetric Violence in Europe: Exploring associations with trust, and care-seeking intention. Bachelor's Thesis, University of Twente, Enschede, The Netherlands, 2021.
14. First and Second Stage Labor Management: ACOG Clinical Practice Guideline No. 8. Obstet Gynecol. 2024;143(1):144-62. Doi: 10.1097/AOG.000000000000 5447. PMID: 38096556.
15. American College of Obstetricians and Gynecologists. Ethical decision-making in obstetrics and gynecology. ACOG Tech Bull. 1989;136:1-7. PMID: 11659205.