

**Araştırma Makalesi/Research Article**

**The Feeling of Discomfort and Self- Esteem Experienced by Women in the  
Vaginal Examination during the Birth Process**

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*Kadınların Doğum Sürecinde Yapılan Vajinal Muayenede Yaşadıkları Rahatsızlık Hissi ve Benlik Saygısı*

**ABSTRACT**

**Aim:** The research was conducted to evaluate the discomfort and self-esteem experienced by women during vaginal examination during birth.

**Method:** The study was conducted with 253 women in the maternity unit. Research data were collected using Personal and Obstetric Characteristics Form, Questionnaire for Vaginal Examination during Birth, Questionnaire for Feeling of Discomfort during Vaginal Examination at Birth, and Two-Dimensional Self-Esteem: Adaptation of the Self-Liking/SelfCompetence Scale.

**Findings:** It was observed that there was a statistically significant difference between women's privacy practices during vaginal examination, their pain/discomfort, the health professional who performed the practice, the number and location of vaginal examinations, the gender of the person performing the examination and the status of showing the necessary sensitivity and the mean scores of feeling discomfort. In addition, it was observed that there was a statistically significant difference between the mean scores of self-love and self-efficacy according to the income status of women, the status of thinking that sufficient information was given before vaginal examination, and the place of examination.

**Conclusion:** In the study, it was observed that the feeling of discomfort was affected by factors such as privacy, pain, the number and location of vaginal examination, the gender of the person performing the examination and the sensitivity shown, while self-esteem was affected by income status, the status of thinking that sufficient information was given before vaginal examination and the location of the examination. Midwives are recommended to care for women with a holistic approach during vaginal examination during the birth process.

**Keywords:** Childbirth, discomfort, self-esteem, vaginal examination

**ÖZ**

**Amaç:** Araştırma, kadınların doğum sürecinde yapılan vajinal muayenede yaşadıkları rahatsızlık hissi ve benlik saygısının değerlendirilmek amacıyla yapılmıştır.

**Yöntem:** Araştırma doğumhane biriminde 253 kadın ile gerçekleştirilmiştir. Araştırma verileri Kişisel ve Obstetrik Özellikler Formu, Doğum Sürecinde Yapılan Vajinal Muayenelere Yönelik Soru Formu, Doğumda Vajinal Muayene Sırasında Yaşanılan Rahatsızlık Hissi Sorulama Formu ve İki Boyutlu Benlik Saygısı Ölçeği: Kendini Sevme/Özyeterlik Ölçeği kullanılarak toplanmıştır.

**Bulgular:** Kadınların vajinal muayene sırasında yapılan mahremiyeti sağlama uygulamaları, ağrı/rahatsızlık yaşama durumları, uygulamayı yapan sağlık profesyoneli, vajinal muayene sayısı ve yeri, muayeneyi yapan kişinin cinsiyeti ve gerekli hassasiyeti gösterme durumu ile rahatsızlık hissi puan ortalamaları arasında istatistiksel açıdan anlamlı bir farklılık olduğu görülmüştür. Ayrıca araştırmada kadınların gelir durumu, vajinal muayene öncesi yeterli bilgi verildiğini düşünme durumu, muayene yapılma yeri ile kendini sevme ve öz-yeterlilik puan ortalamaları arasında istatistiksel olarak anlamlı bir farklılığın olduğu görülmüştür.

**Sonuç:** Araştırmada rahatsızlık hissini mahremiyet, ağrı, vajinal muayene sayısı ve yeri, muayeneyi yapan kişinin cinsiyeti ve gösterilen hassasiyet gibi faktörlerin etkilediği benlik sayısını ise gelir durumu, vajinal muayene öncesi yeterli bilgi verildiğini düşünme durumu ve muayene yapılma yerinin etkilediği görülmüştür. Ebelerin doğum sürecinde yapılan vajinal muayenede kadınlara bütüncül yaklaşımla bakım vermeleri önerilir.

**Anahtar kelimeler:** Benlik saygısı, doğum, rahatsızlık hissi, vajinal muayene

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## GENİŞLETİLMİŞ ÖZET

Vajinal doğum, uterus büyümesinin son aşamasına ulaştığında ve bebek dış ortamda yaşamını sürdürbilecek duruma geldiğinde gerçekleşir. Miadında, baş ve pelvis uyumsuzluğu olmayan, vertex pozisyonunda, sağlıklı bir anne ve fetüs ile tek ve canlı bir fetüs ile vajinal doğumun kendiliğinden başlaması beklenir. Doğum eylemi sırasında vajinal muayene, sağlık profesyonelleri tarafından doğum eyleminin seyrini belirlemek için sıkılıkla tercih edilen bir uygulamadır. Doğum eylemi sırasında vajinal muayene, rahim ağzının dilatasyonu ve efasmanı, amniyon sıvısının rengi ve kokusu, pelvik yapının doğuma uygunluğu, fetüsün prezantasyonu ve pozisyonu gibi parametreleri değerlendirmenin yanı sıra doğum eylemindeki anormal yüksek riskli durumları erken dönemde tespit etmek amacıyla yapılır. Vajinal muayene, doğum sürecindeki ebelik uygulamaları açısından önemli bir uygulamadır. Dünya Sağlık Örgütü, yüksek risk grubundaki gebeler dışında, doğumun ilk evresinde ve membranların rüptüründen sonra en az 4 saatte bir aynı ebe tarafından vajinal muayene yapılmasını önermektedir. Ayrıca İngiltere Ulusal Sağlık ve Klinik Mükemmeliyet Bakım Enstitüsü de vajinal muayenenin doğum eylemi sırasında 2 ila 4 saatte bir yapılabileceğini belirtmektedir. Ancak uluslararası kuruluşların önerilerine rağmen ebelerin doğum sürecinde sıkılıkla kayıt dışı vajinal muayene yaptıkları bildirilmektedir. Oysa vajinal muayeneler önceden belirlenmiş protokoller takip etmek yerine, serviks ve fetüs hakkında bilgiye ihtiyaç duyulduğunda kadının onayı alındıktan sonra yapılmalıdır. Bu durumda en uygun yaklaşım, sağlık çalışanlarının klinik değerlendirmelere ek olarak kadına duygusal destek ve doğru bilgilendirme sağlamasıdır. Bu nedenle bu çalışma, kadınların doğum sürecinde vajinal muayene sırasında yaşadıkları rahatsızlıklar ve benlik saygılarını incelemek amacıyla yapılmıştır. Çalışma, Mayıs 2021 ve Aralık 2022 tarihleri arasında Türkiye'nin batısındaki bir devlet hastanesinin doğum ünitesinde 253 kadın ile analitik kesitsel olarak yürütülmüştür. Çalışmaya 37 hafta ve üzeri gebeliği olan, düşük riskli, 18-37 yaş aralığında, tek fetüsü olan, hastanede aktif doğum eylemi gerçekleştiren ve çalışmaya katılmayı gönüllü olarak kabul eden kadınlar dahil edilirken, yüksek riskli, prezantasyon-pozisyon anomalisi olan ve sezaryen ile doğum yapan kadınlar çalışma dışı bırakılmıştır. Araştırma verileri Kişisel ve Obstetrik Özellikler Formu, Doğum Sürecinde Yapılan Vajinal Muayenelere Yönelik Soru Formu, Doğumda Vajinal Muayene Sırasında Yaşanılan Rahatsızlık Hissi Sorgulama Formu ve İki Boyutlu Benlik Saygısı Ölçeği: Kendini Sevme/Özyeterlik Ölçeği kullanılarak toplanmıştır. Araştırma verilerinin değerlendirilmesinde sayı, yüzde, ortalama, standart sapma değerleri kullanılmış,

ayrıca t testi ve ANOVA analizlerinden yararlanılmıştır. Vajinal muayene sırasında mahremiyet uygulamaları, ağrı/rahatsızlık, uygulamayı yapan sağlık çalışanı sayısı, yapılan vajinal muayene sayısı, muayeneyi yapan sağlık çalışanının cinsiyeti, muayene yeri tercihi ve muayeneyi yapan sağlık çalışanının gerekli hassasiyeti gösterdiğini düşünme durumunun kadınların rahatsızlık hissini etkilediği görülmüştür. Ayrıca çalışmada kadınların gelir durumunun, vajinal muayene öncesinde yeterli bilgi verildiğini düşünme durumunun ve muayene yerinin kendini sevme ve öz yeterlilik düzeylerini etkilediği sonucuna ulaşılmıştır.

## INTRODUCTION

Vaginal delivery occurs when the uterus has reached its final stage of growth and the baby is able to survive in the external environment. Vaginal birth is expected to start spontaneously with a single and live foetus at term, without head and pelvis incompatibility, in the vertex position and with a healthy mother and foetus (Taşkın, 2012). Vaginal examination during labour is a frequently preferred practice by health professionals to determine the course of labour (Dixon & Foureur, 2010). Vaginal examination during labour is performed to evaluate parameters such as dilatation and effacement of the cervix, colour and odour of the amniotic fluid, suitability of the pelvic structure for delivery, presentation and position of the fetus, and it is also performed to detect abnormal high-risk conditions in the early stages of labour (Esencan and Daştan, 2023; Maternity, 2012; Stewart, 2008). Vaginal examination is an important practice in terms of midwifery practices during the birth process (Özkan et al., 2016). The World Health Organisation (WHO) recommends that vaginal examination should be performed by the same midwife at least every 4 hours in the first stage of labour and after the rupture of the membranes, except for pregnant women in the high-risk group (WHO, 2003). In addition, the UK National Institute for Health and Clinical Excellence Care states that vaginal examination can be performed every 2 to 4 hours during labour (NICE, 2007). However, despite the recommendations of international organisations, it is reported that midwives often perform unrecorded vaginal examinations during labour (Downe et al., 2013; Stewart, 2008). However, vaginal examinations should be performed after obtaining the woman's consent when information about the cervix and foetus is needed, rather than using predetermined protocols (Mete et al., 2016). In this case, the most appropriate approach is to provide emotional support and accurate information to the woman, as well as clinical evaluations by health professionals providing care. Therefore, this study was conducted to examine the discomfort and self-esteem of women during vaginal examination during the birth process.

## MATERIALS AND METHODS

The analytical cross-sectional study was conducted between May 2021 and December 2022 in the maternity unit of a state hospital in western Turkey. The sample calculation of the study was made using the sampling method with known population (n: 575), 95% confidence interval ( $\alpha=0.05$ ),  $P=0.5$  and found to be 230 pregnant women. Considering possible losses, this number was determined as 253 and the study was completed with this sample number. Women with a pregnancy of 37 weeks or more, low risk, between the ages of 18-37, with a single foetus, who had active labour in the hospital and who voluntarily accepted to participate in the study were included in the study, while women with high risk, presentation-position anomalies and women who had a caesarean section were excluded from the study.

The research data were collected within the first 24 hours after delivery with the following forms.

Personal and Obstetric Characteristics Form; it is a form prepared by the researchers questioning the personal and obstetric characteristics of women (Lai & Levy, 2002; Swahnberg et al. 2011; Muliira et al. 2013).

Questionnaire for Vaginal Examinations During labour is a form prepared by researchers who questioned women's experiences and thoughts about the vaginal examinations (VE) performed during labour (Borders et al. 2012; Hassan et al. 2012'a, Hassan et al. 2012'b).

Discomfort Experienced During Vaginal Examination in Childbirth Questionnaire Form is a form prepared by the researchers, in which the discomfort experienced by women during VE in childbirth is visually marked on the scale by scoring between 0 (no discomfort at all) and 10 (very uncomfortable) (Güneş & Karaçam, 2017).

Two Dimensional Self-Esteem Scale: Self-Love / Self-Efficacy Scale; The scale developed by Tafarodi and Swann (2001) to measure self-esteem consists of self-efficacy and self-love dimensions. These two sub-dimensions can have separate scores or a general self-esteem score can be found by adding the scores (Tafarodi & Swann, 2001). The adaptation studies of the scale in our country were conducted by Doğan (2011).

Number, percentage, mean, standard deviation values were used in the evaluation of the research data, and t test and ANOVA analyses were also used.

Written permission was obtained from the Aydin Adnan Menderes University Faculty of Health Sciences Non-Interventional Clinical Research Ethics

Committee (Date: 25.01.2023, Protocol no: 2021/027) and Izmir Provincial Health Directorate. The study was conducted in accordance with the ethical standards set out in the Declaration of Helsinki. In addition, the study was conducted on a voluntary basis and consent was obtained from the women to participate in the study.

## FINDINGS

In the study, no statistically significant difference was found between women's age, education, employment and income status, place of residence, family type and social security status, number of pregnancies, children, abortions and curettage, gestational week, pregnancy planning status, regular prenatal check-ups and participation in prenatal preparation class and the mean score of discomfort ( $p>0.05$ ).

**Table 1.** Comparison of mean scores of discomfort according to vaginal examination characteristics of women (n=253)

Characteristics	Number (%)	Mean±SD	F/t	p
<b>Assistance during the preparation phase before VE</b>				
Yes	155 (61.3)	5.58±2,37	0.104	0.901
No	31 (12.2)	5.45±2,36		
Partially	67 (26.5)	5.45±1,82		
<b>Practices to ensure privacy in VE</b>				
Curtain / screen closed	81 (32.0)	5.55±2.50	0.652	<b>0.039*</b>
Door closed	157 (62.1)	5.99±2.01		
Covered	15 (5.9)	4.21±2.86		
<b>Pain/discomfort during VE</b>				
Yes	59 (23.3)	6.99±2.78	1.505	<b>0.024*</b>
No	76 (30.1)	5.22±2.41		
Partly	118 (46.6)	5.56±2.46		
<b>Number of health professionals applying VE</b>				
By the same person	78 (30.8)	4.99±2.78	0.741	<b>0.036*</b>
By two different people	19 (7.5)	5.74±2.41		
By three different people	115 (46.5)	6.55±2.34		
By four or more different people	41 (16.2)	7.01±2.67		
<b>Number of VE</b>				
1-3	40 (15.8)	4.45±1.34	1.652	<b>0.032*</b>
4-6	132 (52.2)	5.01±2.78		
7-9	60 (23.7)	6.15±2.69		
10 and above	21 (8.3)	7.22±1.63		
<b>Gender of the health professional administering VE</b>				
Female	115 (45.4)	4.85±1.16	1.365	<b>0.045*</b>
Male	3 (2.2)	7.89±2.51		
Both of them	135 (53.4)	6.91±2.74		
<b>Availability of the option not to accept VE</b>				
Yes	34 (13.4)	5.36±2.15	0.365	0.378
No	219 (86.6)	5.15±1.74		

In the study, no statistically significant difference was found between the mean score of discomfort and the status of women being assisted in the preparation phase before VE and being offered the option of not accepting VE ( $p>0.05$ ). On the other hand, it was observed that there was a statistically significant difference between the practices to ensure privacy during VE, the status of experiencing pain/discomfort, the number of health professionals performing VE, the number of VEs, the gender of the health professional performing VE and the mean score of discomfort ( $p<0.05$ ) (Table 1).

**Table 2.** Comparison of the mean scores of discomfort according to women's thoughts about vaginal examination (n=253)

Characteristics	Number (%)	Mean±SD	F/t	p
<b>Thinking that sufficient information was given before VE</b>				
Yes	192 (75.9)	6.21±2.16		
No	23 (9.1)	6.25±2.16	0.423	0.089
Partially	38 (15.0)	5.99±1.46		
<b>Information on examination results after VEs given status</b>				
Yes	171 (67.6)	5.63±1.62		
No	16 (6.3)	5.57±1.22	0.852	0.532
Partially	66 (26.1)	5.81±2.56		
<b>VE application location preference</b>				
Own bed	138 (54.5)	4.89±1.56		
Examination table	114 (45.1)	7.01±2.78	0.145	<b>0.001*</b>
<b>The health professional who is asked to perform the VE application</b>				
Doctor	98 (38.7)	5.23±1.88		
Midwife	155 (61.3)	5.41±2.34	0.452	0.685
<b>Reason for asking the doctor to administer the VE**</b>				
Because he is more knowledgeable and experienced.	171 (67.6)	5.23±1.88		
Because it is suitable for your education	158 (62.5)	5.41±2.34	1.752	0.856
<b>Reason for wanting the midwife to administer the VE**</b>				
Because she has experience.	138 (54.5)	5.25±1.15		
Since she's been following the birth from the beginning.	118 (46.6)	5.11±2.36		
Because she's a woman.	219 (86.6)	5.65±1.74	0.452	0.632
Because it is suitable for your education	155 (61.3)	5.47±1.98		
<b>Health professional who is not asked to apply VE</b>				
Doctor	3 (0.8)	5.78±2.74		
Nurse	16 (6.3)	5.64±2.44		
Student	235 (92.9)	5.36±1.72	0.467	0.745
<b>Health professional who is not asked to apply VE</b>				
Feeling uncomfortable	165 (65.2)	5.36±2.14		
Being male	208 (82.2)	5.17±2.61	0.751	0.741
<b>Reason for not wanting the nurse to administer the VE**</b>				
Thinking that their education is not appropriate	115 (45.5)	5.89±1.86		
Don't think that your job is not to give birth	219 (86.6)	6.45±2.15	0.632	0.506
<b>Reason for not wanting the student to implement the VE**</b>				
Lack of experience	245 (96.8)	5.78±2.15		
Thinking that you can make mistakes	180 (71.1)	5.41±2.36	0.954	0.554
Thinking that their knowledge is insufficient	138 (54.5)	5.63±2.45		
<b>The health professional administering VE is required the state of thinking that you show sensitivity</b>				
Yes	218 (86.2)	4.81±2.35		
No	5 (2.0)	6.74±2.13	<b>0.682</b>	<b>0.032*</b>
Partially	30 (11.8)	5.12±2.41		

In the study, the mean discomfort score ( $4.89\pm1.56$ ) of the women who chose their own bed as the VE application site preference was found to be statistically significantly lower than the women who preferred the examination table ( $7.01\pm2.78$ ) ( $p<0.05$ ). In addition, it was observed that there was a statistically significant difference between the state of thinking that the health professional applying VEs showed the necessary sensitivity and the mean score of discomfort ( $p<0.05$ ) (Table 2).



In the study, it was observed that there was no statistically significant difference between the mean scores of self-love and self-efficacy with women's age, education, employment status and family types ( $p>0.05$ ); however, there was a statistical difference with their income status ( $p<0.05$ ) (Table 3).

**Table 3.** Comparison of mean scores of self-love and self-efficacy scale according to socio-demographic characteristics of women (n=253)

Characteristics	Self-Love	Self-Efficacy
	Mean $\pm$ SD	Mean $\pm$ SD
<b>Old</b>		
$\leq 25$	35.16 $\pm$ 2.17	25.32 $\pm$ 1.23
26-30	35.22 $\pm$ 2.32	25.41 $\pm$ 2.42
$\geq 31$	35.36 $\pm$ 2.78	25.63 $\pm$ 1.55
<b>F</b>	1.564	1.856
<b>p</b>	0.452	0.536
<b>Education</b>		
Primary school	35.25 $\pm$ 1.13	25.23 $\pm$ 3.45
Middle school	35.63 $\pm$ 2.25	25.36 $\pm$ 1.36
High school	35.45 $\pm$ 2.47	25.41 $\pm$ 2.14
University and above	35.41 $\pm$ 1.85	25.96 $\pm$ 1.28
<b>F</b>	1.639	1.745
<b>p</b>	0.216	0.452
<b>Work</b>		
Yes	35.36 $\pm$ 2.78	25.22 $\pm$ 1.74
No	35.47 $\pm$ 3.32	25.63 $\pm$ 1.16
<b>t</b>	1.756	1.852
<b>p</b>	0.457	0.365
<b>Income</b>		
Income less than expenditure	35.36 $\pm$ 3.52	25.01 $\pm$ 1.15
Income equals expenditure	35.65 $\pm$ 1.25	25.63 $\pm$ 2.36
Income more than expenditure	39.93 $\pm$ 2.36	28.63 $\pm$ 2.52
<b>F</b>	1.639	1.756
<b>p</b>	<b>0.036*</b>	<b>0.055*</b>
<b>Place to live</b>		
Village	35.96 $\pm$ 1.14	25.25 $\pm$ 4.15
Urban	35.25 $\pm$ 2.85	25.25 $\pm$ 2.85
<b>t</b>	1.369	1.753
<b>p</b>	0.452	0.523
<b>Family type</b>		
Nuklear	35.45 $\pm$ 1.42	25.99 $\pm$ 1.58
Extended	35.78 $\pm$ 3.12	25.65 $\pm$ 2.89
<b>t</b>	0.951	0.752
<b>p</b>	0.358	0.389
<b>social security</b>		
Yes	35.78 $\pm$ 2.89	25.69 $\pm$ 3.25
None	35.35 $\pm$ 3.25	25.47 $\pm$ 1.99
<b>t</b>	0.258	0.456
<b>p</b>	0.523	0.489

In the study, no statistically significant difference was found between the mean scores of women's pregnancy, number of living children, number of miscarriages and abortions, gestational week, planned pregnancy, regular prenatal check-ups, attending prenatal preparation class and self-love and self-efficacy ( $p>0.05$ ) (Table 4).

**Table 4.** Comparison of mean self-love and self-efficacy scores of women according to obstetric characteristics (n=253)

Characteristics	Self-Love	Self-Efficacy
	Mean $\pm$ SD	Mean $\pm$ SD
<b>Total number of pregnancies</b>		
1	35.23 $\pm$ 2.20	5.69 $\pm$ 2.04
2	35.32 $\pm$ 2.66	5.35 $\pm$ 3.36
3	35.41 $\pm$ 2.10	5.68 $\pm$ 2.45
4 and above	35.36 $\pm$ 2.63	5.96 $\pm$ 2.68
<b>F</b>	1.785	1.856
<b>p</b>	0.563	0.632
<b>Number of living children</b>		
None	35.52 $\pm$ 1.02	25.36 $\pm$ 2.96
1	35.62 $\pm$ 0.41	25.24 $\pm$ 1.14
2	35.41 $\pm$ 2.62	25.74 $\pm$ 3.44
3 and above	35.96 $\pm$ 1.41	25.15 $\pm$ 2.68
<b>F</b>	1.754	1.954
<b>p</b>	0.432	0.369
<b>Number of miscarriages</b>		
None	35.22 $\pm$ 1.96	25.15 $\pm$ 1.25
1	35.69 $\pm$ 2.52	25.68 $\pm$ 2.15
2 and above	35.44 $\pm$ 3.58	25.14 $\pm$ 2.35
<b>F</b>	2.452	1.963
<b>p</b>	0.365	0.452
<b>Number of abortions</b>		
None	35.36 $\pm$ 1.74	25.82 $\pm$ 2.14
1	35.48 $\pm$ 1.12	25.12 $\pm$ 2.35
<b>t</b>	1.853	1.746
<b>p</b>	0.496	0.356
<b>Pregnancy week</b>		
37-39	35.96 $\pm$ 1.25	25.85 $\pm$ 2.24
40-42	35.41 $\pm$ 3.03	25.63 $\pm$ 2.98
<b>t</b>	2.896	1.967
<b>p</b>	0.428	0.369
<b>Planned pregnancy</b>		
Yes	35.44 $\pm$ 1.14	25.85 $\pm$ 4.20
No	35.14 $\pm$ 2.36	25.35 $\pm$ 2.66
<b>t</b>	1.856	1.256
<b>p</b>	0.452	0.354
<b>Regular antenatal check-ups</b>		
Yes	35.36 $\pm$ 1.15	25.13 $\pm$ 2.27
No	35.99 $\pm$ 1.86	25.54 $\pm$ 2.85
<b>t</b>	2.856	2.785
<b>p</b>	0.285	0.321
<b>Attending a prenatal preparation class</b>		
Yes	35.31 $\pm$ 1.24	25.17 $\pm$ 2.11
No	35.14 $\pm$ 1.95	25.82 $\pm$ 2.74
<b>t</b>	1.758	1.954
<b>p</b>	0.423	0.452

In the study, there was no statistically significant difference ( $p>0.05$ ) between the mean scores of self-love and self-efficacy according to the women's being helped in the preparation phase before VE, ensuring privacy, feeling pain/discomfort, the number and gender of health professionals performing VE, the number of VEs, and being offered the option of not accepting VEs (Table 5).

**Table 5.** Comparison of mean scores of self-love and self-efficacy scale according to VE characteristics of women (n=253)

Characteristics	Self-Love	Self-Efficacy
	Mean ±SD	Mean ±SD
<b>Assistance during the preparation phase before VE</b>		
Yes	35.56±1.25	25.36±1.34
No	35.63±2.89	25.74±2.78
Partially	35.78±2.26	25.96±1.85
<b>F</b>	1.458	1.536
<b>p</b>	0.213	0.452
<b>Practices to ensure privacy in VE</b>		
Curtain / screen closed	35.38±1.96	25.47±2.89
Door closed	35.25±2.53	25.63±2.37
Covered	35.63±2.35	25.41±1.75
<b>F</b>	1.289	1.364
<b>p</b>	0.345	0.369
<b>Pain/discomfort during VE</b>		
Yes	35.95±1.75	25.85±2.45
No	35.56±1.85	25.34±2.34
Partially	35.35±2.36	25.71±1.78
<b>F</b>	1.478	1.368
<b>p</b>	0.452	0.359
<b>Number of health professionals applying VE</b>		
By the same person	35.36±1.86	25.83±2.68
By two different people	35.74±2.75	25.76±2.89
By three different people	35.96±2.32	25.38±1.87
By four or more different people	37.56±3.21	25.35±2.77
<b>F</b>	1.742	1.368
<b>p</b>	0.319	0.299
<b>Number of VE</b>		
1-3	35.22±2.52	25.28±1.77
4-6	35.36±2.94	25.58±2.57
7-9	35.74±3.35	25.73±2.95
10 and above	35.96±1.41	25.36±1.89
<b>F</b>	1.654	1.357
<b>p</b>	0.281	0.287
<b>Gender of the health professional administering VE</b>		
Female	35.75±1.15	25.38±2.37
Male	35.65±2.36	25.01±2.74
Both of them	35.35±2.14	25.51±1.36
<b>F</b>	1.956	1.754
<b>p</b>	0.212	0.245
<b>Availability of the option not to accept VE</b>		
Yes	35.74±2.22	25.21±1.23
No	35.36±1.77	25.37±2.27
<b>t</b>	1.236	1.245
<b>p</b>	0.236	0.269

**Table 6.** Comparison of the mean scores of the Self-Love and Self-Efficacy Scale according to women's thoughts about vaginal examination (VE) (n=253)

Characteristics	Self-Love	Self-Efficacy
	Mean ±SD	Mean ±SD
<b>Thinking that sufficient information was given before VE</b>		
Yes	38.39±1.74	28.21±2.11
No	35.13±2.36	25.32±1.14
Partially	35.21±1.25	25.54±2.35
<b>F</b>	2.147	1.999
<b>p</b>	<b>0.014*</b>	<b>0.021*</b>
<b>Information on examination results after VEs given status</b>		
Yes	35.36±1.64	25.45±1.13
No	35.41±1.25	25.67±1.17
Partially	35.57±2.62	25.21±2.81
<b>F</b>	1.587	1.698
<b>p</b>	0.113	0.214
<b>VE application location preference</b>		
Own bed	36.98±1.43	26.69±2.23
Examination table	35.06±2.12	25.17±1.12
<b>t</b>	1.854	1.964
<b>p</b>	<b>0.032*</b>	<b>0.021*</b>
<b>The health professional who is asked to perform the VE application</b>		
Doctor	35.37±1.95	25.14±1.35
Midwife	35.44±2.12	25.75±2.95
<b>t</b>	2.135	2.856
<b>p</b>	0.365	0.254
<b>Reason for asking the doctor to administer the VE**</b>		
Because he is more knowledgeable and experienced.	35.84±1.25	25.36±1.74
Because it is suitable for your education	35.25±2.11	25.14±2.38
<b>t</b>	1.785	1.367
<b>p</b>	0.412	0.325
<b>Reason for wanting the midwife to administer the VE**</b>		
<b>Because she has experience.</b>	35.36±1.36	25.36±2.34
Since she's been following the birth from the beginning.	35.75±1.86	25.24±2.12
Because she's a woman.	35.25±1.71	25.75±1.07
Because it is suitable for your education	35.15±1.36	25.14±2.81
<b>F</b>	2.745	2.364
<b>p</b>	0.585	0.458
<b>Health professional who is not asked to apply VE</b>		
Doctor	35.06±1.25	25.47±1.87
Nurse	35.12±2.17	25.23±1.14
Student	35.09±1.89	25.07±2.07
<b>F</b>	2.698	2.745
<b>p</b>	0.452	0.321

In the study, it was found that there was a statistically significant difference between the mean scores of women's self-love and self-efficacy and the place of VE application ( $p<0.05$ ). In addition, in the study, it was observed that there was no statistically significant difference between the mean scores of self-love and self-efficacy with the status of women being informed about the examination results after

VEs, the preference of the health professional they wanted to perform VE, the reasons for wanting the doctor and midwife to perform VE, the preference of the health professional they did not want to perform VE ( $p>0.05$ ) (Table 6).

## DISCUSSION

In our study, it was determined that more than half of the women expressed the option of closing the door among the practices to ensure privacy during VE, and it was observed that practices to ensure privacy during VE affected women's feeling of discomfort. In a study, women stated that privacy should be given importance in order to feel comfortable during vaginal examination (Güneş & Karaçam, 2017). In addition, another study showed that women's vaginal examination experiences varied depending on the privacy factor (Tandoğan et al., 2024). These results are important in showing that practices to ensure privacy during VE are important.

In our study, it was determined that approximately half of the women experienced partial pain/discomfort during VE, and it was observed that the feeling of pain/discomfort during VE affected the feeling of discomfort. In the study of Güneş and Karaçam (2017), it was reported that the majority of women (26.3%) felt discomfort during vaginal examination. (2011), it was reported that the majority of women (83.0%) felt discomfort during vaginal examination and some (18.0%) felt extreme discomfort. In their study, Erkek and Özer (2020) reported that 88.4% of women experienced discomfort during vaginal examination and the reason for women's discomfort was that vaginal examination was a 'stressful' practice (40.5%). In addition, in a study conducted by Hassan et al. (2012), it was reported that 81.0% of women felt pain, 68.0% felt discomfort, 5.0% felt embarrassment and 5.0% felt like they were going to die during vaginal examination. Similarly, Erbil et al. (2008) reported that women experienced moderate anxiety, 62.5% embarrassment, 38.8% distress, 37.9% fear and 21.7% pain before gynaecological examination. According to these findings, it can be said that vaginal examination is a stressful event and women feel discomfort during vaginal examination.

Approximately half of the women who participated in our study stated that their VE was performed by three different people. It was determined that there was a statistically significant difference between the number of health professionals performing VE and the mean score of discomfort. In a study, almost all of the women who gave birth stated that they wanted to be alone, in a single room, in a single room, that the person performing VE was a woman and that they wanted to be VE by a doctor (Erkek and Özer 2020).

These results can be said that VE is an intimate practice and women feel uncomfortable because different people are performing this examination.

It was found that half of the women participating in our study were performed 4-6 times, and it was observed that the number of VEs affected the feeling of discomfort. In a study, it was stated that vaginal examination is a necessary practice to monitor women's health, to detect risky situations early and to treat diseases (Güneş and Karaçam 2017), on the other hand, in another study, it was stated that continuous vaginal examination and lack of care during the examination caused women to experience pain and discomfort, anxiety, negative emotions such as fear, shame, guilt, powerlessness, and decreased satisfaction with childbirth (Downe et al. 2013). In addition, in the study of Erkek and Özer (2020), women stated that vaginal examination was important (61.2%), it was performed to evaluate cervical patency (46.9%) and it should be performed when necessary (75.2%). These results are important in terms of emphasising that VE in labour should be performed when necessary and unnecessary applications should be avoided.

In our study, it was observed that more than half of the women were examined by both male and female health professionals. However, in our study, it was observed that the gender of the health professional performing vaginal examination affected the feeling of discomfort. Namely; in our study, it was found that the mean discomfort score of women who answered male to the gender of the health professional performing vaginal examination was the highest. In previous studies, it has been found that the health professionals performing the examination are mostly women and women prefer both sexes to be examined (Hilden et al. 2003, Swahnberg et al. 2011, Erkek and Özer 2020). In another study, women stated that they would be more uncomfortable if the gender of the health personnel performing the vaginal examination was male (78.3%) (Tan et al., 2022). This can be explained by the fact that women feel more comfortable during vaginal examination, do not feel embarrassed, and that having the same physical characteristics as women creates a relaxing effect on women.

According to our study, it is seen that women who are examined in their own bed feel less discomfort. In the study of Güneş and Karaçam (2017), it was observed that women did not want to be examined on the gynaecology table. Therefore, the woman's own bed may be a good option for VE.

In our study, it is seen that the state of thinking that the health professional applying VEs shows the necessary sensitivity affects the feeling of discomfort. Studies

have shown that women often have a positive communication with healthcare professionals performing gynaecological examination (Güneş and Karaçam 2017, Swahnberg et al. 2011). In the study of Erkek and Özer (2020), women stated that the health personnel performing VE should be more gentle, be slower, explain more and provide psychological support. In the study of Demir and Yeşiltepe Oksay (2014), it is seen that women have similar expectations from health professionals. As it is understood from the previous studies and the results of the current study, the expectations towards healthcare professionals are mostly in the direction of positive communication and body language of the employees.

In our study, it was observed that self-esteem increased as the income status of women increased. This may be explained by the fact that one of the many factors affecting the development of self-esteem is the socioeconomic status of the person (Sayan et al., 2001).

In our study, it was found that providing sufficient information before VE positively affected self-esteem. Similarly, in the study of Güneş and Karaçam (2017), it was reported that women have expectations that health professionals who perform the examination should provide information about the examination in order to reduce their negative feelings during vaginal examination.

In our study, it is seen that performing the VE in their own bed positively affects women's self-esteem. In the study of Güneş and Karaçam (2017), it was reported that women did not want the examination to be performed on the gynaecology table in order to feel more comfortable during VE. These results are important in terms of showing that the woman's own bed is a suitable place for VE.

## CONCLUSION AND RECOMMENDATIONS

It was observed that the privacy practices performed during vaginal examination, the status of experiencing pain/discomfort, the number of health professionals performing the practice, the number of vaginal examinations performed, the gender of the health professional performing the examination, the preference of the place of examination, and the status of thinking that the health professional performing the examination showed the necessary sensitivity affected women's feeling of discomfort. It was concluded that the income status of women, the status of thinking that sufficient information was given before vaginal examination, and the place of examination affected the levels of self-love and self-efficacy. Based on the

results of the research, midwives provide care to women with a holistic approach in vaginal examination during the birth process can be recommended. In addition the cause and effect relationship could not be fully established in the study and it is recommended that longitudinal or experimental designs be conducted in the future. At the same time, it is thought and suggested that conducting studies on vaginal examination during the birth process with larger samples, in groups with different cultural and demographic characteristics or in different types of hospitals, and examining women's in-depth experiences through qualitative interviews or mixed-method studies in addition to quantitative studies will make additional contributions to the literature.

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### Ethics Committee Approval:

Written permission was obtained from the Aydin Adnan Menderes University Faculty of Health Sciences Non-Interventional Clinical Research Ethics Committee (Date: 25.01.2023, Protocol no: 2021/027) and Izmir Provincial Health Directorate.

**Hakem/Peer-review:** External referee evaluation.

### Author Contributions:

Idea/Concept: SY, KA; Design: SY, KA; Supervision/Consulting: KA; Data Collection and/or Processing: SY; Analysis and/or Interpretation: SY, KA; Literature Review: SY, KA; Writing: SY, KA; Critical Review: SY, KA; Funding acquisition: SY, KA

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