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Obstetric Violence from the Perspectives of Midwifery and Nursing Students

Ebelik ve Hemşirelik Öğrencilerinin Gözünden Obstetrik Şiddet

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ABSTRACT

The aim of this study is to determine the views and experiences of midwifery and nursing students about obstetric violence during the birth process.

This cross-sectional and descriptive study was conducted with 201 midwifery and nursing students studying at a university and taking part in labor between January and May 2023. "Personal Information Form", "Obstetric Violence Diagnosis Form" and "Witnessing Obstetric Violence Form" developed by the researchers were used to collect data.

The mean age of the participants was 22.14±2.28, and 40.3% were studying in nursing and 59.7% in midwifery. 59.2% of the students took an active role in the birth process. Midwifery students defined the types of violence more than nursing students: "routine enema, perineal shaving and amniotomy", "restriction of the movements/gait of the pregnant", "application of fundal pressure", "prohibition of eating and drinking during the birth process" and "giving baby food without permission". It was determined that midwives mostly witnessed "prohibition of eating and drinking during labor (85%)" and "blaming the pregnant woman in case of insufficient pushing (83.3%)", while the nurses witnessed "frequent vaginal examinations performed by different people (67.9%)" and "prohibition of accompanying persons (66.7%)".

In this study, it was seen that midwifery and nursing students did not have enough awareness of obstetric violence. In midwifery and nursing education, it is thought that giving education to provide respectful care to the mother during the birth process will contribute to the prevention of obstetric violence and the positive birth experience of mothers.

Keywords: Delivery Obstetric, Exposure to Violence, Midwifery, Nursing, Students

ÖZ

Bu çalışmanın amacı ebelik ve hemşirelik öğrencilerinin doğum sürecinde obstetrik şiddete ilişkin görüş ve deneyimlerini belirlemektir.

Kesitsel ve tanımlayıcı tipte tasarlanan bu çalışma, Ocak-Mayıs 2023 tarihleri arasında bir üniversitede öğrenim gören ve doğum eyleminde rol alan 201 ebelik ve hemşirelik öğrencisiyle yürütüldü. Verilerin toplanmasında araştırmacılar tarafından geliştirilen "Kişisel Bilgi Formu", "Obstetrik Şiddeti Tanılama Formu" ve "Obstetrik Şiddete Tanık olma Formu" kullanıldı.

Katılımcıların yaş ortalaması 22.14±2.28 olup %40,3'ü hemşirelik, %59,7'si ebelik bölümünde okumaktaydı. Doğum sürecinde öğrencilerin %59,2'si aktif rol almıştı. Ebelik öğrencileri hemşirelik öğrencilerine göre "rutin lavman, perine tıraşı ve amniyotomi uygulanması", "gebenin hareketlerinin/yürüyüşünün kısıtlanması", "fundal basınç uygulanması", "doğum sürecinde yeme içmenin yasaklanması" ile "izinsiz bebeğe mama verilmesi" şiddet türlerini daha fazla tanımlamaktaydı. Ebelerin en çok "doğum sürecinde yeme içmenin yasaklanmasına (%85)", "ıkınmanın yetersiz olduğu durumda gebenin suçlanmasına (%83,3)", hemşirelerin ise "vajinal muayenenin sık sık ve farklı kişiler tarafından yapılmasına (%67,9)", "doğumda eşlik edecek kişilerin yasaklanmasına (%66,7)" tanık oldukları saptandı.

Bu çalışmada ebelik ve hemşirelik öğrencilerinin obstetrik şiddete yönelik yeterli bilgi ve farkındalığa sahip olmadığı görülmüştür. Ebelik ve hemşirelik eğitiminde, doğum sürecinde anneye saygılı bakım sunmaya yönelik eğitim verilmesinin obstetrik şiddetin önlenmesine ve annelerin olumlu doğum deneyimi yaşamalarına katkı sağlayacağı düşünülmektedir.

Anahtar Kelimeler: Doğum Obstetrik, Şiddete Maruz Kalma, Ebelik, Hemşirelik, Öğrenciler

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INTRODUCTION

Respectful and honorable healthcare to the individual is a fundamental right for every pregnant woman and contributes to a positive birth experience.[1] Abuse and ill-treatment in the birth process is an important health problem that is associated with women's right to receive quality health care and not be subjected to violence, and that jeopardizes the bodily integrity of women.[2] "Obstetric violence (OV)" is a specific form of violence against women that violates human rights. This infringement is a relatively new concept in global health science, which has adopted different terminologies such as disrespect, maltreatment, or obstetric violence. All terms highlight the harmful impact of violence, the over-medicalization of childbirth, violations of women's human rights and its sexist nature.[3, 4]

Obstetric violence, more specifically, consists of any detrimental action, physical and/or psychological harm due to neglect and disrespectful treatment or neglect that causes unnecessary suffering or harm to the woman, without her consent or with disrespect for her autonomy, during pregnancy, childbirth and postpartum period in healthcare.[5-7] Obstetric violence includes many types of violence such as verbal abuse, applications without permission or information, not giving analgesia, preventing the presence of a birth attendant, not protecting privacy, psychological violence (aggressive, discriminatory, authoritarian or rude treatment), unauthorized cesarean or episiotomy practices, using oxytocin without medical indication to accelerate labor, application of the Kristeller's maneuver, forcing women to stay in bed, prohibiting access to food and liquids, and restricting freedom of movement.[1, 7] The World Health Organization, in its 2014 Declaration on the Prevention and Elimination of Disrespect and Abuse During Birth Care in Health Centers, warns that there are large numbers of women who are subjected to disrespectful and aggressive treatment during childbirth care.[8]

Obstetric violence may adversely affect maternal, fetal and perinatal outcomes, deterring women from seeking care in their future pregnancies.[9] In addition to not using the recommended procedures, unnecessary applications that may do harm, the use of not recommended and/or old applications cause consequences such as dystocia, hemorrhage and neonatal hypoxia at birth, as well as preventable health consequences such as maternal dissatisfaction and postpartum depression.[10] In a study conducted with 17.541 women, it was determined that 38.3% of pregnant women were exposed to obstetric violence.[11] In a study conducted with 899 mothers who gave birth in the last 12 months, 67.4% of mothers reported obstetric violence (25.1% verbal, 54.5% physical and 36.7% psychological).[8] In a study conducted in our country, obstetric violence was reported by 76.4% of women.[12] Many obstetric interventions related to OV are not considered disrespectful and abusive practices by health professionals, so they may not even be aware that they are involved in violent practices.[13] Although obstetric violence is common, studies examining the knowledge, attitude and awareness of health professionals on the subject are limited. In a study conducted with midwives, it was determined that midwives do not see obstetric violence as abuse, but as a birth strategy that facilitates successful birth and is beneficial to women.[2] Similarly, in another study, it was reported that midwives and nurses noticed obstetric violence but described some practices as violence.[14]

The knowledge and awareness of health professionals is very important in providing women-centered obstetric care services well and avoiding obstetric violence practices. Lack of sufficient knowledge and awareness may cause obstetric violence to continue.[15] The first step is to start gaining knowledge and awareness about obstetric violence during undergraduate education. Therefore, education of health professionals, standardization of care through the implementation of clinical practice guidelines, and health initiatives that promote humanization of birth will be key to eradicating obstetric violence. In our country,

studies examining the opinions of nursing and midwifery students regarding obstetric violence are limited. For these reasons, the aim of this study is to determine the views and experiences of midwifery and nursing students regarding obstetric violence.

MATERIALS AND METHODS

Study Design

This study was conducted as a cross-sectional descriptive study to determine the views and experiences of midwifery and nursing students regarding obstetric violence. The study meets the three main characteristics of a cross-sectional study: it was conducted within a specific time frame (January to May 2023), targeted a specific population (midwifery department students and 3rd-4th year nursing department students at a university), and aimed to describe the current views and experiences of these students.

Population and Sample of the Research

The population of the research consisted of midwifery department students and 3rd and 4th year nursing department students at a university in the spring semester of 2022-2023 academic year. Since nursing students complete the theory and clinical practice components of the "Women's Health and Diseases Nursing" course during the fall semester of their 3rd year, they possess the requisite knowledge to share informed opinions and experiences regarding obstetric violence. Consequently, only 3rd and 4th year nursing students were included in the study.

Participants are required to have clinical experience in the field of obstetrics in order to share their opinions and experiences about obstetric violence. For this reason, students who observed at least one normal birth were included in the study and purposeful sampling method was used. The research was conducted face to face between January and May 2023 with 201 students.

Collection of Data

In the study, there was the Personal Information Form, the "Obstetric Violence Diagnosis and Witnessing Form", which was created by the researchers in line with the literature. The questions in the questionnaire were sent to two experts in the field of health sciences to evaluate their suitability and clarity for the purpose of the study. After the expert evaluation, the sentences with spelling and expression errors in the questions were revised and applied by giving their final form.

After briefing students about the research, data was collected face-to-face by obtaining voluntary consent from the participants.

Inclusion and Exclusion Criteria

Inclusion criteria were fluency in reading and speaking Turkish; enrollment as a student at the midwifery or nursing department of Kent University; having observed normal birth.

Exclusion criteria included undergoing current psychiatric treatment involving pharmacotherapy or psychotherapy.

Measurement and Instruments

Personal Information Form

This form developed by the researchers consisted of a total of 12 questions evaluating the age of the students, their class, the department they studied, their role in the birth process, and the care provided by health professionals to pregnant women.

"Diagnosing Obstetric Violence" and "Witnessing Obstetric Violence" Form

Developed by researchers according to the literature, this form consisted of 68 questions in total, including questions to determine the level of knowledge of students about obstetric violence and the obstetric violence they witnessed.[16-18]

Statistical Analysis

Data were analyzed using the Statistical Program for Social Science 20.0 (SPSS) package program, using descriptive and parametric statistical analysis methods. First,

descriptive analyzes were made for the descriptive characteristics of the students. These analyses were determined as frequency, percentage, mean. Pearson chi-square test was used to compare categorical variables. Statistical significance value was evaluated as $p<0.05$.

Variables of the Research

Dependent Variables: "Diagnosing Obstetric Violence Form" and "Witnessing Obstetric Violence Form"

Independent Variables: Sociodemographic characteristics (age, gender, economic status, department and class etc.) of students

Ethical Considerations

For the study, ethics committee approval from Kent University Health Sciences Scientific Research and Publication Ethics Committee (dated 04.01.2023 and numbered 2023-01) and Kent University Faculty of Health Sciences Dean's Office (dated 03.01.2023 and E-21837828-044) Institutional permission (numbered-18978) was obtained. Verbal consent/approval was obtained from the students who would participate in the research after the purpose of the research was explained and attention was paid to the voluntary basis.

Limitations of the Research

The limitation of this study is that it was conducted with midwife and nurse students at a single university.

FINDINGS AND DISCUSSION

The mean age of the participants in the study was 22.14±2.28. 40.3% of the students were studying nursing and 59.7% were studying midwifery. 60.2% of the students were studying in the 3rd grade. More than half of the students (62.7%) expressed their economic status as "income equal to expenditure". While 40.8% of the students took part as observers during the birth process, 59.2% of them took an active role. The most active part in the birth process was the second stage of birth. The rate of students who did not think that pregnant women received adequate care by health professionals during delivery was 42.8%. The most common reasons why pregnant women could not receive adequate care during delivery were "Health professional maltreatment", "The birth environment does not have suitable conditions" and "High workload of healthcare professionals" (Table 1).

Table 1. Introductory Characteristics of Midwifery and Nursing Students Participating in the Study (N=201)

Variables	Mean (SD)
Age, mean (SD), y	22,14±2,28
	n (%)
Department of study	
Midwifery	120 (59.7)
Nursing	81 (40.3)
Grade	
3rd Grade	121 (60.2)
4th Grade	80 (39.8)
Economic condition	
Income less than expenses	53 (26.4)
Income equal to expense	126 (62.7)
Income more than expenses	22 (10.9)
Took an active role in the birth process	
Yes	82 (40.8)
No	119 (59.2)
The stage in which an active role was taken in the birth process[a] (n=82)	
1. Stage (Dilation and effacement)	27 (32.9)
2. Stage (Expulsion)	40 (48.7)
3. Stage (Removing the placenta)	28 (34.1)
4. Stage (Bleeding control)	25 (30.4)

Table 1. (Continues)

Do you think that pregnant women receive adequate care by health professionals during the birth process?	
Yes	48 (23.4)
Not sure	68 (33.8)
No	86 (42.8)

If your answer is No, can you explain why she did not receive adequate care?* (n=86)	
Health professional maltreatment	36 (41.8)
The birth environment does not have suitable conditions	20 (23.2)
High workload of healthcare professionals	19 (22.09)
Insufficient knowledge and skills of the health professional	11 (12.7)
Lack of equipment	10 (11.6)
Midwives not taking an active role	5 (5.81)

*SD: Standard Deviation, %: Percentage, * Multiple options*

The types of obstetric violence that midwifery students had the most knowledge of were "Physical interventions such as hitting, pushing, pinching the legs of the woman during the birth process (90.8%)", "Blaming the pregnant woman when pushing is insufficient (90%)" and "Not paying attention to the privacy of the pregnant woman in the delivery room (89.2%)", which included physical and psychological violence and care without privacy. The types of obstetric violence they had the least knowledge of were the routine practices seen in the clinic such as, "Not recommending epidural anesthesia (12.5%)", "Routine perineal shaving (31.7%)" and "Convincing the pregnant woman to have a cesarean section during the prolonged delivery period (36.7%)".

The types of obstetric violence that nursing students have the most knowledge of are "Not paying attention to the privacy of the pregnant woman in the delivery room (95.1%)", "Physical interventions such as hitting, pushing, pinching the legs of the woman during the birth process (91.4%)" and "Disregard for women's decisions (90.1%)", which included care without privacy, physical violence and dishonorable care. The types of obstetric violence they had the least knowledge of were “Not recommending epidural anesthesia (12.3%)”, “Routine enema application (23.5%)” and “Routine perineal shaving (23.5%)” and these were similar routine practices seen in the clinic.

Midwifery students were significantly better able to define the following items in obstetric violence compared to nursing students; “Routine enema application (42.5% vs. 23.5%)”, “Routine perineal shaving (31.7% vs. 23.5%)”, “Routine amniotomy (47.5% vs. 27.2%)”, “Restriction of the pregnant's movements/walk (72.5% vs. 54.3%)”, “Application of fundal pressure (45% vs. 25.9%)”, “Prohibition of eating and drinking during birth (42.5% vs. 28.4%)” and “Feeding formula to baby without permission from the mother (80% vs. 60.5%)” (Table 2).

Table 2. Opinions of Midwifery and Nursing Students on the Diagnosis of Obstetric Violence (N=201)

Statements	Midwife (n=120)			Nurse (n=81)			χ2*	
	Yes	Not sure	No	Yes	Not sure	No		
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	Test	*P*
1. Sharing the delivery room with more than one pregnant woman	76 (63.3)	20 (16.7)	24 (20)	51 (63)	16 (19.8)	14 (17.3)	0.447	.80
2. Not leaving the choice of birth decision to the pregnant	80 (66.7)	14 (11.7)	26 (21.7)	46 (56.8)	17 (21)	18 (22.2)	3.843	.17
3. Routine enema administration	51 (42.5)	34 (28.3)	35 (29.2)	19 (23.5)	35 (43.2)	27 (33.3)	8.425	.01
4. Routine perineal shaving	38 (31.7)	36 (30)	46 (38.3)	19 (23.5)	17 (21)	45 (55.6)	5.807	.04
5. Forcing the pregnant woman into the lithotomy position	68 (56.7)	31 (25.8)	21 (17.5)	53 (65.4)	19 (23.5)	9 (11.1)	2.049	.35
6. Immediate cutting of the umbilical cord	45 (37.5)	41 (34.2)	34 (28.3)	23 (28.4)	27 (33.3)	31 (38.3)	2.672	.26

Table 2. (Continues)

7. Routine amniotomy	57 (47.5)	38 (31.7)	25 (20.8)	22 (27.2)	40 (49.4)	19 (23.5)	9.153	.01
8. Restriction of movements/walking of the pregnant woman	87 (72.5)	15 (12.5)	18 (15)	44 (54.3)	19 (23.5)	18 (22.2)	7.292	.02
9. Unauthorized vaginal examination	99 (82.5)	12 (10)	9 (7.5)	71 (87.7)	2 (2.5)	8 (9.9)	4.412	.11
10. Frequent vaginal examination by different people	94 (78.3)	14 (11.7)	12 (10)	63 (77.8)	9 (11.1)	9 (11.1)	0.072	.96
11. Failure to take action to relieve labor pain	83 (69.2)	17 (14.2)	20 (16.7)	55 (67.9)	11 (13.6)	15 (18.5)	0.118	.94
12. Not paying attention to the privacy of the pregnant woman in the delivery room	107 (89.2)	3 (2.5)	10 (8.3)	77 (95.1)	-	4 (4.9)	3.009	.22
13. Not recommending epidural anesthesia	15 (12.5)	57 (47.5)	48 (40)	10 (12.3)	41 (50.6)	30 (37)	0.207	.90
14. Convincing the pregnant woman to have a cesarean section during the prolonged delivery period	44 (36.7)	45 (37.5)	31 (25.8)	31 (38.3)	28 (34.6)	22 (27.2)	0.18	.91
15. Disregard for women's decisions	104 (86.7)	8 (6.7)	8 (6.7)	73 (90.1)	3 (3.7)	5 (6.2)	0.86	.65
16. Not informing the pregnant about the birth process and procedures	99 (82.5)	8 (6.7)	13 (10.8)	65 (80.2)	6 (7.4)	10 (12.3)	0.165	.92
17. Failure to obtain the consent of the pregnant woman about the birth process and procedures	108 (90)	3 (2.5)	9 (7.5)	68 (84)	4 (4.9)	9 (11.1)	1.732	.42
18. Application of fundal pressure	54 (45)	41 (34.2)	25 (20.8)	21 (25.9)	37 (45.7)	23 (28.4)	7.525	.02
19. Taking pictures of themselves or the baby without the consent of the pregnant woman	105 (87.5)	5 (4.2)	10 (8.3)	69 (85.2)	2 (2.5)	10 (12.3)	1.212	.54
20. Performing episiotomy without anesthesia	86 (71.7)	22 (18.3)	12 (10)	57 (70.4)	16 (19.8)	8 (9.9)	0.064	.96
21. Blaming the pregnant woman when pushing is insufficient	108 (90)	5 (4.2)	7 (5.8)	70 (86.4)	3 (3.7)	8 (9.9)	1.155	.56
22. Prohibition of eating and drinking during birth	51 (42.5)	36 (30)	33 (27.5)	23 (28.4)	23 (28.4)	35 (43.2)	6.183	.04
23. Failure to cover the patient during delivery	84 (70)	18 (15)	18 (15)	60 (74.1)	16 (19.8)	5 (6.2)	4.051	.13
24. Opposing the woman's verbal responses to pain	102 (85)	5 (4.2)	13 (10.8)	72 (88.9)	4 (4.9)	5 (6.2)	1.322	.51
25. The woman not being allowed to shout	105 (87.5)	3 (2.5)	12 (10)	66 (81.5)	6 (7.4)	9 (11.1)	2.864	.23
26. Physical interventions such as hitting. pushing. pinching the legs of the woman during the birth process	109 (90.8)	2 (1.7)	9 (7.5)	74 (91.4)	2 (2.5)	5 (6.2)	0.28	.86
27. Abusing. shouting or insulting the mother during the birth process	75 (62.5)	27 (22.5)	18 (15)	39 (48.1)	22 (27.2)	20 (24.7)	4,590	.10

Table 2. (Continues)

28. Unauthorized emergency cesarean delivery	88 (73.3)	21 (17.5)	11 (9.2)	62 (76.5)	12 (14.8)	7 (8.6)	0.294	.86
29. No skin-to-skin contact	92 (76.7)	16 (13.3)	12 (10)	65 (80.2)	8 (9.9)	8 (9.9)	0.564	.75
30. Feeding baby formula without mother's permission	96 (80)	14 (11.7)	10 (8.3)	49 (60.5)	15 (18.5)	17 (21)	9.889	.007
31. Giving priority/concession to some pregnant women in the delivery process	77 (64.2)	30 (25)	13 (10.8)	49 (60.5)	21 (25.9)	11 (13.6)	0.426	.80
32. Prohibition of accompanying persons at birth	79 (65.8)	35 (29.2)	6 (5)	61 (75.3)	13 (16)	7 (8.6)	5.099	.07
33. Failure to do or postpone an application that should be done during the birth process	92 (76.7)	17 (14.2)	11 (9.2)	67 (82.7)	6 (7.4)	8 (9.9)	2,180	.33

**Pearson Chi-Square Test*

The types of obstetric violence witnessed by midwifery students the most were found to be “Prohibition of eating and drinking during the birth process (85%)”, “Accusing the pregnant woman when pushing is insufficient (83.3%)”, “Frequent vaginal examination done by different people (81%,7)” and “Prohibition of accompanying persons at birth (81.7%)”. The types of obstetric violence they witnessed the least were found to be “Routine perineal shaving (15%)”, “Taking pictures of themselves or the baby without the consent of the pregnant woman (18.3%)”, “Abusing, shouting or insulting the mother during the birth process (21.7%)” and “Feeding baby formula without mother's permission (21.7%)”.

The most common types of obstetric violence witnessed by nursing students were found to be “Frequent vaginal examination by different people (67.9%)”, “Prohibition of accompanying persons at birth (66.7%)” and “Not paying attention to the privacy of the pregnant woman in the delivery room (59,3%)”. The types of obstetric violence they witnessed the least were found to be "Taking pictures of themselves or the baby without the consent of the pregnant woman (13.6%)", "Abusing, shouting or insulting the mother during the birth process (14.8%)" and "Feeding baby formula without mother's permission (14.8%)”.

Midwifery students witnessed significantly more of the following items compared to nursing students; “Forcing the pregnant woman into the lithotomy position (65% vs. 46.9%)”, “Immediate cutting of the umbilical cord (76.7% vs. 58%)” and "Restriction of movements/walking of the pregnant (56.7% vs. 37%)”, “Frequent vaginal examination performed by different people (81.7% vs. 67.9%)” and “Accusing the pregnant in case of insufficient pushing (83.3% vs. 48.2%)”, “Prohibition of eating and drinking during childbirth (85% vs. 54.3%)”, “Opposing the pregnant’s verbal responses to pain (75% vs. 51.9%)”, “The pregnant not being allowed to shout (57.5% vs. 30.9%)”, “Physical interventions such as hitting, pushing, pinching the legs of the woman during the birth process (64.2% vs. 34.6%)”, “Unauthorized emergency cesarean delivery (66.7% vs. 43%)” and “Prohibition of accompanying persons at birth (81.7% vs. 66.7%)” (Table 3).

Table 3. Characteristics of Obstetric Violence Witnessed by Midwifery and Nursing Students (N=201)

Statements	Midwife (n=120)		Nurse (n=81)		χ^{2*}	
	Yes	No	Yes	No		
	n (%)	n (%)	n (%)	n (%)	Test	*P*
1. Sharing the delivery room with more than one pregnant woman	66 (55)	54 (45)	39 (48.1)	42 (51.9)	0.91	.34

Table 3. (Continues)

2. Not leaving the choice of birth decision to the pregnant	68 (56.7)	52 (43.3)	39 (48.1)	42 (51.9)	1.410	.23
3. Routine enema administration	47 (39.2)	73 (60.8)	30 (37)	51 (63)	0.093	.76
4. Routine perineal shaving	18 (15)	102 (85)	20 (24.7)	61 (75.3)	2.963	.08
5. Forcing the pregnant woman into the lithotomy position	78 (65)	42 (35)	38 (46.9)	43 (53.1)	6.482	.01
6. Immediate cutting of the umbilical cord	92 (76.7)	28 (23.3)	47 (58)	34 (42)	7.878	.005
7. Routine amniotomy	43 (35.8)	77 (64.2)	25 (30.9)	56 (69.1)	0.533	.46
8. Restriction of movements/walking of the pregnant woman	68 (56.7)	52 (43.3)	30 (37)	51 (63)	7.458	.006
9. Unauthorized vaginal examination	73 (60.8)	47 (39.2)	41 (50.6)	40 (49.4)	2.056	.15
10. Frequent vaginal examination by different people	98 (81.7)	22 (18.3)	55 (67.9)	26 (32.1)	5.041	.02
11. Failure to take action to relieve labor pain	70 (58.3)	50 (41.7)	37 (45.7)	44 (54.3)	3,110	.07
12. Not paying attention to the privacy of the pregnant woman in the delivery room	75 (62.5)	45 (37.5)	48 (59.3)	33 (40.7)	0.214	.64
13. Not recommending epidural anesthesia	31 (25.8)	89 (74.2)	24 (29.6)	57 (70.4)	0.351	.55
14. Convincing the pregnant woman to have a cesarean section during the prolonged delivery period	44 (36.7)	76 (63.3)	22 (27.2)	59 (72.8)	1.982	.15
15. Disregard for women's decisions	72 (60)	48 (40)	42 (51.9)	39 (48.1)	1.308	.25
16. Not informing the pregnant about the birth process and procedures	68 (56.7)	52 (43.3)	35 (43.2)	46 (56,8)	3.505	.06
17. Failure to obtain the consent of the pregnant woman about the birth process and procedures	44 (36.7)	76 (63.3)	25 (30.9)	56 (69.1)	0.722	.39
18. Application of fundal pressure	94 (78.3)	26 (21.7)	41 (50.6)	40 (49.4)	16.844	<.001
19. Taking pictures of themselves or the baby without the consent of the pregnant woman	22 (18.3)	98 (81.7)	11 (13.6)	70 (86.4)	0.796	.37
20. Performing episiotomy without anesthesia	47 (39.2)	73 (60.8)	22 (27.2)	59 (72.8)	3.092	.07
21. Blaming the pregnant woman when pushing is insufficient	100 (83.3)	20 (16.7)	39 (48.1)	42 (51.9)	28.066	<.001
22. Prohibition of eating and drinking during birth	102 (85)	18 (15)	44 (54.3)	37 (45.7)	22,900	<.001
23. Failure to cover the patient during delivery	68 (56.7)	52 (43.3)	38 (46.9)	43 (53.1)	1.846	.17
24. Opposing the woman's verbal responses to pain	90 (75)	30 (25)	42 (51.9)	39 (48.1)	11.494	.001
25. The woman not being allowed to shout	69 (57.5)	51 (42.5)	25 (30.9)	56 (69.1)	13.781	<.001
26. Physical interventions such as hitting. pushing. pinching the legs of the woman during the birth process	77 (64.2)	43 (35.8)	28 (34.6)	53 (65.4)	16.98	<.001
27. Using bad language. shouting or insulting the mother during the birth process	26 (21.7)	94 (78.3)	12 (14.8)	69 (85.2)	1.481	.22
28. Unauthorized emergency cesarean delivery	80 (66.7)	40 (33.3)	35 (43.2)	46 (56.8)	10.869	.001

Table 3. (Continues)

29. No skin-to-skin contact	46 (38.3)	74 (61.7)	24 (29.6)	57 (70.4)	1.614	.20
30. Feeding baby formula without mother's permission	26 (21.7)	94 (78.3)	12 (14.8)	69 (85.2)	1.481	.22
31. Giving priority/concession to some pregnant women in the delivery process	30 (25)	90 (75)	22 (27.2)	59 (72.8)	0.118	.73
32. Prohibition of accompanying persons at birth	98 (81.7)	22 (18.3)	54 (66.7)	27 (33.3)	5.902	.01
33. Failure to do or postpone an application that should be done during the birth process	45 (37.5)	75 (62.5)	29 (35.8)	52 (64.2)	0.06	.80

**Pearson Chi-Square Test*

Obstetric violence starts from the pregnancy period and continues until the postpartum period. In this study, which was conducted to determine the views and experiences of midwifery and nursing students regarding obstetric violence during the birth process, it was determined that the students took part in the second stage of labor most actively in the birth process and 42.8% thought that the pregnant women could not receive adequate care by health professionals during the birth process. The most common reason why pregnant women could not receive adequate care during delivery was "maltreatment of health professionals". In a study conducted with women in the third month after giving birth, women stated that they did not receive adequate care during childbirth and were exposed to verbal abuse, unwanted procedures, and physical abuse.[19] In a study conducted in the USA, it was determined that one out of six women was exposed to more than one maltreatment during childbirth, and they experienced problems such as scolding, shouting, threatening or not responding to requests for help.[20] The results of these studies, similar to our study, reveal the maltreatment applied by health professionals during the birth process. Inadequate care and mistreatment by health professionals can negatively affect women's physical and psychological health during the birth process. This situation poses a serious problem for patient safety and quality management in healthcare systems. To prevent obstetric violence, it is crucial to implement changes in health policies and practices and to develop standard protocols and guidelines that enhance the quality of care. Furthermore, legal regulations and practices to protect patient rights need to be strengthened.

The most frequently reported cases of obstetric violence were the rejection of accompanying persons, the lack of information about different procedures performed during care, unnecessary cesarean application, deprivation of the right to feed and walking, unjustified routine and repetitive vaginal examinations, frequent use of oxytocin to accelerate labor, episiotomy without the consent of women, and the Kristeller maneuver implementation. In a study conducted in Mexico, women stated that vaginal examinations during childbirth are a painful practice and that their privacy is not taken care of because these examinations are carried out by different people.[21] In the study conducted with 24,126 women in Mexico, it was observed that 33.3% were exposed to obstetric violence, 23.6% were exposed to abuse and violence, and 17.1% were exposed to care without consent.[22] In another study conducted with 1854 mothers, it was found that two out of three women (65.3%) experienced obstetric violence and were most frequently exposed to care without privacy, abandoned care, dishonorable care and physical abuse.[4] In the present study, the most common types of obstetric violence witnessed by students were prohibiting eating and drinking during childbirth, blaming the pregnant woman when pushing is insufficient, frequent vaginal examinations performed by different people, and prohibition of accompanying persons. The high number of patients per midwife/nurse throughout our country and the insufficient number of

personnel increase the workload of healthcare professionals. This situation causes the health professionals working in delivery rooms to show a tendency to accelerate the birth processes and therefore not to provide adequate care to women during the birth process. In addition, the fact that most of the students were put into practice in education and research hospitals and the frequent vaginal examinations in these institutions may have affected their witnessing status.

All experienced obstetric violence can eventually lead to permanent physical, mental and emotional damage.[23] In a study conducted in India, it was found that women who were exposed to obstetric violence experienced higher rates of complications during delivery and postpartum period.[24] In a qualitative study with women exposed to obstetric violence, it has been determined that they experience emotions such as anxiety, stress, anger, helplessness, fear and sadness due to the obstetric violence they are exposed to.[25] In a study conducted in Spain, it was found that women who were exposed to verbal or psycho-emotional obstetric violence were at higher risk of postpartum depression.[26] Considering the negative effects of obstetric violence in the short and long term, necessary steps should be taken to prevent it.

The culture of acceptability of obstetric violence is an important driver contributing to its normalization. Unfortunately, it is stated that many midwives see obstetric violence not as abuse, but as a birth strategy that facilitates successful birth and is beneficial to women.[2] As a result of a qualitative study conducted with midwives in Ghana, it was revealed that violence in the delivery room normalized and the intensity of violence increased in the second stage of birth. Midwives reported that they used or witnessed physical violence against women during the birth process, women were left alone, women with HIV were stigmatized, and verbal abuse such as shouting occurred.[2] In a study conducted to measure the perception of obstetric violence among health science students, it was found that 52.7% of the students thought that immigrant women were treated worse during childbirth.[18] In a cross-sectional study conducted on midwives in Spain in 2021, it was determined that almost all of the midwives (92.6%) knew the term obstetric violence, but 74.8% did not believe that obstetric violence had the same meaning as malpractice. In addition, 56.9% of the midwives stated that they observed obstetric violence rarely and 26.5% regularly.[17] While most midwives consider physical assault as obstetric violence, they did not accept some behaviors included in the international definitions of obstetric violence, such as not introducing themselves to the women they care for or not giving enough information about the procedures performed, as obstetric violence. In addition, 97.5% of midwives believe that raising awareness about the issue is one of the main points to reduce this problem.[17] In the present study, it was found that midwifery and nursing students had more information about physical, psychological and obstetric violence types where privacy was not observed, but they did not see routine practices as obstetric violence. This indicates that students have a low level of awareness that some routine practices actually involve violence or may potentially lead to negative consequences. This finding shows that obstetric violence should be defined in education programs and practical experiences, awareness should be increased and appropriate practices should be encouraged. Students studying midwifery and nursing should be aware that there are different types and dimensions of obstetric violence. In addition, having knowledge about evidence-based practices at birth will be an important step in increasing awareness of obstetric violence and preventing it. In addition, it was found in the study that midwifery students had more knowledge in describing the types of obstetric violence and witnessed more obstetric violence than nursing students. It is expected from this result of the study that midwifery education focuses more on issues related to obstetrics and women's health, midwifery students have more clinical experience with birth processes, have more active participation in the birth process, and have more opportunities to recognize and

witness obstetric violence. Therefore, in case of having sufficient information about obstetric violence, the result is that awareness will be high when obstetric violence is witnessed.

Education is an important tool in the prevention of obstetric violence. In Qatar, a video consisting of a dramatized obstetric violence scenario was shown to a team of healthcare professionals consisting of obstetricians, obstetrical nurses and midwives, and their knowledge and attitudes towards obstetric violence were examined. As a result of the study, it was determined that 52% of the participants had heard the term obstetric violence before, 48% could define this term correctly, and 63% had witnessed obstetric violence in their working life.[27] In a study conducted in our country, it was determined that midwives and nurses improved their care behaviors and communication skills after the training program aimed at preventing obstetric violence. In addition, it was found that the care perceptions and satisfaction score averages of women who received care from these midwives and nurses increased after the training.[28] In another study, it was stated that obstetric violence education given to health science students increased students' knowledge and awareness about obstetric violence.[29] In a study conducted in Brazil, the importance of nurses' education in the face of obstetric violence was emphasized and it was recommended to have courses on obstetric violence in gynecology nursing graduate programs.[30] After the 8-hour seminar on obstetric violence given to nursing and medical students, it was determined that the students became conscious about obstetric violence. It has been stated that the trainings to be given on obstetric violence will raise awareness among students and enable them to recognize and define obstetric violence.[29] It is thought that including "respectful maternity care" in undergraduate education, defining obstetric violence, and conveying interventions to prevent obstetric violence are important for preventing obstetric violence.

CONCLUSIONS AND RECOMMENDATIONS

Quality and humanized principles should guide the care of pregnant women and care processes during labor and delivery. It is the duty of health services and health professionals to provide health care to the pregnant, mother and newborn with dignity and respect for the rights of the individual. In this study, it was seen that midwifery and nursing students did not have enough awareness of obstetric violence. Obstetric violence should be prevented in order to respect human rights, prevent physical and psychological harm to women, and increase the quality of health care services. In this regard, it will be an important step to raise awareness, to organize training programs for health professionals and women about the birth process, women's rights and obstetric violence. To prevent obstetric violence, it is necessary to make appropriate legal regulations or update existing laws. It is necessary to establish and implement policies and protocols for the prevention of obstetric violence in healthcare institutions. It is important to strengthen support mechanisms for victims of obstetric violence and to establish appropriate mechanisms for receiving complaints. In midwifery and nursing education, it is thought that giving education to provide respectful care to the mother during the birth process will contribute to the prevention of obstetric violence and the positive birth experience of mothers.

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